REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

CONSECO SENIOR HEALTH INSURANCE COMPANY

AS OF March 31, 2008

Conducted from March 23, 2009

through

March 4, 2010

By

Market Conduct Section

Life and Health Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 23-0704970
NAIC: 76325

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I, Jacqueline K. Cunningham, Commissioner of Insurance of the Commonwealth of Virginia, do hereby certify that the annexed copy of the Market Conduct Examination of Conseco Senior Health Insurance Company, conducted at the State Corporation Commissions Bureau of Insurance in Richmond, VA, as of March 31, 2008, is a true copy of the original Report on file with this Bureau, and also includes a true copy of the Company's response to the findings set forth therein, the Bureau's review letter, the Company's offer of settlement, and the State Corporation Commission's Settlement Order in Case No. INS-2010-00203.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this Bureau at the City of Richmond, Virginia this 7th day of November, 2011.

Jacqueline K. Cunningham
Commissioner of Insurance

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of Conseco Senior Health Insurance Company (hereinafter referred to as "CSHIC") was conducted under the authority of various sections of the Code of Virginia and regulations found in the Virginia Administrative Code, including but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317 and 38.2-1809 of the Code of Virginia, (hereinafter referred to as "the Code"), as well as 14 VAC 5-120-10 et seq and 14 VAC 5-170-10 et seq.

A previous claims investigation covering the period January 1, 2003, through March 1, 2005, was conducted by the Consumer Services section of the Life and Health Market Regulation Division of the Bureau of Insurance. The investigation was concluded on June 30, 2005. As a result of that investigation, CSHIC made a settlement offer that was accepted by the State Corporation Commission on August 3, 2005, in case No. INS-2005-00144.

A previous Target Market Conduct Examination covering the period of July 1, 2005, through December 31, 2005, was concluded on August 23, 2006. As a result of that examination, CSHIC made a settlement offer that was accepted by the State Corporation Commission on February 27, 2007, in Case No. INS-2007-00061.

In addition to the areas examined during the current examination, CSHIC's practices were reviewed for compliance with the recommendations made to CSHIC as a result of the examiners' findings during the previous examination and the requirements of the Orders issued by the Commission.

The current examination revealed violations that were also noted in the previous examination. Various sections of this Report will refer to recommendations in the prior examination for which CSHIC had agreed to change its practices in these instances to comply with the Code and regulations; however, CSHIC has not done so. Therefore, in the examiners' opinion, CSHIC has knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

The scope of the current examination was confined to a review of CSHIC's individual specified disease (cancer) business. However, upon discovery of instances of non-compliance that would potentially affect other lines of business, a small sample of individual specified disease (heart/stroke), individual life, and Medicare supplement claims was reviewed. The period of time covered for the current examination, generally, was January 1, 2008, through March 31, 2008. The examination was initiated on March 23, 2009, at the office of the State Corporation Commission's Bureau of Insurance. An on-site examination was conducted from July 20, 2009, through July 23, 2009, and completed at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia, on March 4, 2010. The violations cited and the comments included in this Report are the opinions of the examiners.

The purpose of the examination was to determine whether CSHIC was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code. Compliance with the following regulations was considered in this examination process:

14 VAC 5-120-10 et seq.	Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies;
14 VAC 5-170-10 et seq.	Rules Governing Minimum Standards for Medicare Supplement Policies; and
14 VAC 5-400-10 et seq.	Rules Governing Unfair Claim Settlement Practices.

The examination included the following areas:

- Policy and Other Forms
- Complaints
- Claim Practices

Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to CSHIC during the course of the examination.

II. COMPANY HISTORY

Conseco Senior Health Insurance Company (CSHIC), a stock life and health insurance company domesticated in the Commonwealth of Pennsylvania, was issued a license on December 4, 1987, to transact the business of insurance in the Commonwealth of Virginia.

The Company was originally formed in Pennsylvania, on July 5, 1887, as a society for beneficial purposes as the Home Beneficial Society. Through Articles of Agreement filed with the Secretary of the Commonwealth of Pennsylvania on December 1, 1964, the Company was reincorporated as a stock limited life insurance company and the name was changed to Signal Life Insurance Company.

The name was changed in 1968 to Penn Treaty Life Insurance Company (PTLIC). PTLIC was suspended in January of 1970 and all its business was reinsured by Pilgrim Life Insurance Company. The Company was subsequently sold and the suspension lifted. In January 1977, Great Valley Investors, Inc. purchased all of the issued and outstanding shares of common stock of the Company. In November 1985, Great Valley Investors, Inc. changed its name to American Travellers Corporation (ATC). On June 10, 1996, the Company's name was changed to American Travellers Life Insurance Company (ATLIC).

On December 17, 1996, Conseco, Inc. (Conseco) acquired ATLIC when it purchased ATC. At that time, ATLIC became a wholly-owned subsidiary of CIHC, Inc. (CIHC), a wholly-owned subsidiary of Conseco. Centralization of the common service functions moved to Carmel, Indiana, in September of 1997, with claims processing

being performed in Chicago, Illinois, until 2004, at which time these operations moved to Carmel, Indiana.

In 1997, Conseco reorganized its holding company structure, with ATLIC becoming a wholly-owned subsidiary of CIHC. In addition, ATLIC acquired wholly-owned subsidiaries Jefferson National Life Insurance Company of Texas and Continental Life Insurance Company. On May 30, 1997, ATLIC was the surviving entity in a merger with an affiliated company, Transport Life Insurance Company (TLIC), a life insurer domiciled in the State of Texas. On November 2, 1998, the name of the Company was changed from American Travellers Life Insurance Company to Conseco Senior Health Insurance Company.

CSHIC operates in 46 states, the District of Columbia, and the U.S. and British Virgin Islands. CSHIC has not actively marketed its policies in Virginia since the spring of 2003. It predominately has long-term care, specified disease (cancer), and specified disease (heart/stroke) business in force.

As of December 31, 2007, total net admitted assets were $3,401,109,603 and accident and health direct premiums earned in Virginia during 2007 totaled $5,660,375.

III. POLICY AND OTHER FORMS

The scope of the examination did not include a review of policy forms issued during the examination time frame. However, a review of policy forms in connection with the 39 cancer, 5 heart/stroke, and 11 Medicare supplement claims revealed the following violations.

HEART/STROKE POLICY

Section 38.2-318 A of the Code states that any insurance policy or form containing any condition or provision that is not in compliance with this title shall be valid, but shall be construed and applied in accordance with the conditions and provisions required by this title. Section 38.2-3519 A of the Code states, in part, that the Commission may issue rules and regulations establishing minimum standards for benefits under specified disease coverage in individual policies of accident and sickness insurance. Section 38.2-3519 C of the Code states that no policy shall be delivered or issued for delivery in this Commonwealth that does not meet the prescribed minimum standards for the categories of coverage listed in subsection A. 14 VAC 5-120-50 9 states that specified disease policies shall not deny benefits to any covered person for the specified disease(s) nor for any other condition(s) or disease(s) directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

As discussed in Review Sheet PF08, the review revealed that the heart/stroke policy, 10895-VA et al., contains the following exclusion that does not support compliance with the minimum standards set forth in 14 VAC 5-120-50 9:

> This Policy provides benefits for Heart Disease, Heart Attack or Stroke as defined herein. This Policy does not cover any other disease or sickness or incapacity other than Heart Disease, Heart Attack or Stroke even though such disease, sickness or incapacity may be caused, complicated or otherwise affected by Heart Disease, Heart Attack or Stroke.

CSHIC agreed with the examiners observations. However, CSHIC stated that "…the Company only began issuing the policy after the Virginia Department of Insurance approved the policy on June 14, 1989." Although the form was approved for use, any policy or form containing any condition or provision that is in non-compliance shall be construed and applied in accordance with Title 38.2, as required by § 38.2-318 A of the Code. The minimum standards set forth in 14 VAC 5-120-10 et seq. were issued under the authority established by § 38.2-3519 of the Code. Therefore, CSHIC was in violation of 14 VAC 5-120-50 9 in each and every instance the form was issued.

MEDICARE SUPPLEMENT POLICIES

Sections 38.2-316 A and 38.2-316 C 1 of the Code and 14 VAC 5-170-130 A require that any policy, contract or plan, or any certificate or evidence of coverage issued in Virginia shall not be delivered unless a copy of the form has been filed with and approved by the Commission.

As documented in Review Sheet PF07, the review revealed 1 violation of each of these sections where policy form 10679 et al. was issued prior to approval. Although CSHIC was able to document that 10679-VA et al. was filed with and approved by the Commission, the generic version rather than the Virginia specific version was issued. In response to the use of generic forms, CSHIC indicated that they

were issued in error prior to Conseco's acquisition of this block of business from Transport Life Insurance Company.

APPLICATIONS/RIDERS/ENDORSEMENTS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application, rider and endorsement forms prior to use. 14 VAC 5-100-50 1 requires that the form number must appear on each form submitted in the lower left-hand corner of the first page.

The review revealed that the following application and endorsement forms were issued prior to approval.

Form	Number Issued	Review Sheet	Line of Business
LRC-END-7	43	PF06	Cancer
CSHIC-1002 (CFO)	1	PF07	Medicare Supplement

In the aggregate, there was a total of 44 violations of §§ 38.2-316 B and 38.2-316 C 1 of the Code. As discussed in Review Sheet PF07, a generic application was used rather than the Virginia specific version. CSHIC indicated that generic forms were issued in error prior to Conseco's acquisition of this block of business from Transport Life Insurance Company. As discussed in Review Sheet PF06, CSHIC agreed that endorsement form LRC-END-7 had not been filed with and approved by the Commission. CSHIC indicated that this endorsement was used a total of 43 times in connection with a policy issued or issued for delivery in Virginia. As required by 14 VAC 5-120-80 B, CSHIC was able to provide documentation that a signed acceptance or a written request was received from the policyholder endorsing the

reduction to the Unlimited Radiation Therapy and Chemotherapy Benefit Rider that was originally selected by the policyholder at the time of application.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer issuing an accident and sickness policy shall file its explanation of benefits forms for approval. These explanation of benefit forms shall be subject to the requirements of § 38.2-316 or § 38.2-4306 as applicable. Section 38.2-3407.4 D of the Code defines "explanation of benefits" as any form provided by an insurer which explains the amounts covered under a policy or plan or shows the amounts payable by a covered person to a health care provider. 14 VAC 5-100-40 2 states that forms which are submitted as replacements, revisions or modifications of previously approved forms, must be clearly indicated in the letter of transmittal and shall set forth the exact changes that are intended. 14 VAC 5-100-50 1 states that the form number must appear in the lower left-hand corner of the first page. 14 VAC 5-100-50 3 states that a form must be submitted in the final form in which it is to be marketed or issued, sufficiently completed in “John Doe” fashion to indicate how it is intended to be used.

In connection with the findings of the last Report, CSHIC filed and received approval on November 8, 2006, for an EOB that, by bracketing certain data, was to be used for its Medicare supplement, Health Indemnity, Disability, Cancer and Long Term Care business. As discussed in Review Sheet PF01, during the review of the cancer claims, it was revealed that the cancer EOB had been altered from the filed and approved form, in violation of § 38.2-3407.4 A of the Code each and every time CSHIC’s EOB form was used during the examination time frame. The review also

revealed that the cancer EOBs failed to contain a form number in the lower left-hand corner, as required by 14 VAC 5-100-50 1.

In addition, as discussed in Review Sheet PF02, CSHIC sends a separate form letter for any claim or portion of a claim that is denied. CSHIC disagreed that these forms are required to be filed for approval stating that:

> Section 38.2-3407.4 D., essentially says that "explanation of benefits" shall include any form provided by an insurer which explains the amounts covered under a policy. The form paragraphs/letters in question do not explain benefits under an insured's policy. The language in those paragraphs /letters is actually denying claims/benefits. As a result, we don't believe the paragraphs/letters need to be filed with the Department.

The examiners do not concur. The form letters explain the amounts not covered and payable by a covered person to a provider and, therefore, are EOB forms as defined by § 38.2-3407.4 D of the Code.

Due to the fact that violations of § 38.2-3407.4 A were discussed in the prior Report, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

IV. COMPLAINTS

CSHIC's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

The total population of 1 written complaint received during the examination time frame was reviewed. The review revealed that CSHIC was in substantial compliance with this section.

V. CLAIM PRACTICES

The examination included a review of CSHIC's claim practices for compliance with §§ 38.2-510 and 38.2-3407.1 of the Code and 14 VAC 5-120-10 et seq., Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of closed cancer, heart/stroke, Medicare supplement, and individual life claims. All claims were processed at CSHIC's home office in Carmel, Indiana. The examiners were provided a copy of CSHIC's claim manual.

With respect to cancer claims, CSHIC did not maintain records of how the original benefit was calculated or how any applicable adjustments made to the benefit amount paid were calculated. Each time there was a question regarding the file, the calculation had to be re-worked from the beginning. This resulted in substantial variances among each calculation attempt made during the course of the examination. In many instances, CSHIC was unable to determine or document how a previous benefit determination was calculated by its own claims staff.

PAID CLAIM REVIEW

A sample of 20 from a total population of 70 paid individual cancer claims; the total population of 1 paid individual heart/stroke claim; and a sample of 8 from a total population of 78 paid Medicare supplement claims were reviewed. CSHIC counts each

pro-rata share of death proceeds paid to 2 or more listed beneficiaries under a single policy as a separate claim. However, for purposes of the review, the examiners considered all proceeds due and payable at the death of the insured and paid under 1 policy to multiple beneficiaries as 1 claim. Of the 3 individual life claims provided by CSHIC, there was 1 unique claim reviewed.

Section 38.2-514 B of the Code states that no person shall provide to a claimant an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed that, in 19 instances, the EOB failed to disclose the method of benefit calculation. An example is discussed in Review Sheet CL01. CSHIC agreed with the examiners' observations.

As discussed below, the review revealed that CSHIC failed to timely acknowledge and pay claims, failed to offer fair and reasonable amounts, unreasonably denied portions of the claim, and failed to pay interest.

Interest

Section 38.2-3407.1 B of the Code states that interest upon claim proceeds shall be computed daily at the legal rate of interest from the date of 15 working days from the insurer's receipt of proof of loss to the date of claim payment. In response to memo CLMEM01, CSHIC indicated that "the turn around time from claim payment to the check being mailed is the next business day." For purposes of calculating interest, the examiners consider the date the check is placed in the mail to be the date of claim payment.

Of the 29 paid accident and sickness claims reviewed by the examiners, CSHIC failed to pay interest in each of the 11 instances where interest was required to have been paid, in violation of § 38.2-3407.1 B of the Code. An example is discussed in Review Sheet CL04, where CSHIC agreed with the examiners' observations.

Due to the fact that violations of § 38.2-3407.1 B were discussed in the prior Report and Orders issued, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

TIME PAYMENT STUDY

The time payment study was computed by measuring the time it took CSHIC, after receiving the properly executed proof of loss, to issue a check for payment. The term "working days" does not include Saturdays, Sundays, or holidays. The study was conducted on the total sample of 30 paid claims.

PAID CLAIMS

Claim Type	Working Days To Settle	Number of Claims	Percentage
Individual Cancer	0 – 15	11	55%
	16 – 20	2	10%
	Over 20	7	35%
Individual Heart/Stroke	0 – 15	1	100%
	16 – 20	0	0%
	Over 20	0	0%
Medicare Supplement	0 – 15	0	0%
	16 – 20	0	0%
	Over 20	8	100%
Individual Life	0 – 15	1	100%
	16 – 20	0	0%
	Over 20	0	0%

Of the 30 claims reviewed for the time study, 57% of the claims were not settled within 15 working days. CSHIC's procedures require it to make payment on a Virginia claim within 15 working days of receipt of complete proof of loss. The examiners would recommend that CSHIC follow its established procedures to reduce the percentage of claims paid after 15 working days.

DENIED CLAIM REVIEW

The total population of 19 denied individual cancer claims; a sample of 4 from a total population of 15 denied individual heart/stroke claims; and a sample of 3 from a total population of 30 denied Medicare supplement claims were reviewed.

As discussed below, the review revealed that CSHIC failed to timely acknowledge and deny claims, denied benefits covered under the policy, and failed to provide insureds with a reasonable explanation of the basis for claim denials.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

The total sample of 56 paid and denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices. The review revealed that the instances of non-compliance were limited to the Medicare supplement, cancer, and heart/stroke claims.

14 VAC 5-400-40 A states that no insurer shall knowingly obscure or conceal from a claimant policy provisions that are pertinent to a claim.

14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time.

14 VAC 5-400-50 D requires every insurer, upon receiving notification of a claim, to promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements.

14 VAC 5-400-60 A requires that within 15 working days after receipt of properly executed proofs of loss, the insurer shall advise the claimant of acceptance or denial of the claim by the insurer.

14 VAC 5-400-60 B requires that if the investigation of a claim has not been completed, every insurer shall, within 45 days from the date of the notification of the claim and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

14 VAC 5-400-70 A states that any denial of a claim must be given to a claimant in writing and the claim file of the insurer shall contain a copy of the denial.

14 VAC 5-400-70 B requires an insurer to include a reasonable explanation of the basis for the denial of a claim in the written denial.

14 VAC 5-400-70 D requires an insurer to offer to a first party claimant an amount which is fair and reasonable as shown by the investigation of a claim, provided the amount offered is within policy limits and in accordance with policy provisions.

The review was conducted using the date the check was mailed as the settlement date. The areas of non-compliance are discussed in the following paragraphs.

14 VAC 5-400-40 A – In 21 instances, a policy provision was knowingly obscured or concealed from a claimant, when such provision was pertinent to a claim. An

example is discussed in Review Sheet CL03, where CSHIC failed to pay the anesthesia benefit and the correct amount for the surgical biopsies as outlined in the policy schedule. CSHIC agreed with the examiners' observations and adjusted the claim to pay the benefits due along with interest.

14 VAC 5-400-50 A – In 9 instances, a claim was not acknowledged within 10 working days after receipt of notification. An example is discussed in Review Sheet CL31. CSHIC agreed with the examiners' observations.

14 VAC 5-400-50 D – In 1 instance, upon receiving notification of a claim, the necessary claim forms, instructions, and reasonable assistance was not promptly provided so that the claimant could comply with the policy conditions and the insurer's reasonable requirements. An example is discussed in Review Sheet CL22, where CSHIC received documentation representing the facility fees; however, a request for the surgeon's bill needed to make a benefit determination was not sent to the insured until 141 days later. CSHIC agreed with the examiners' observation and stated that "this issue is being reviewed by management to determine how claim guidelines should be revised to eliminate a recurrence of this oversight."

14 VAC 5-400-60 A – In 22 instances, a claimant was not advised of acceptance or denial of a claim within 15 working days after proof of loss was received. An example is discussed in Review Sheet CL29, where CSHIC took 60 working days to advise the claimant of denial of the claim. CSHIC agreed with the examiners' observations.

14 VAC 5-400-60 B – In 7 instances, within 45 days from the date of notification of a claim and every 45 days thereafter, CSHIC failed to send the claimant a letter

setting forth the reasons additional time was needed for investigation of the claims. An example is discussed in Review Sheet CL13. CSHIC agreed with the examiners' observations.

14 VAC 5-400-70 A – In 2 instances, the claimant was not provided a written denial. An example is discussed in Review Sheet CL06. CSHIC agreed with the examiners' observations.

14 VAC 5-400-70 B – In 19 instances, claims were denied without a reasonable explanation of the basis for the denial. An example is discussed in Review Sheet CL04, where CSHIC denied services as "other services related to radiation therapy" when radiation treatment planning was billed. According to the Schedule, $150 should have been paid under the Radiation Therapy Consultation Benefit. CSHIC agreed with the examiners' observations.

14 VAC 5-400-70 D – In 21 instances, a fair and reasonable amount was not offered to a first party claimant. An example is discussed in Review Sheet CL20, where CSHIC failed to pay for side effects as a result of cancer or the treatment of cancer. The review revealed that, when the claims administration was transferred from Chicago, Illinois to Carmel, Indiana in 2004, CSHIC ceased to pay for cancer side effects. 14 VAC 5-120-50 9 prohibits denying benefits to any covered person for other conditions or diseases directly caused or aggravated by the cancer or the treatment of the cancer. In response to Review Sheet CL15 on September 9, 2009, CSHIC indicated that "…as of 9/8/09 the claims department is servicing cancer claims in compliance with subsection 9 of 14 VAC 4-120-50, and side effect drugs will be covered as was done prior to 2004."

CSHIC voluntarily re-serviced and provided documentation for the majority of the claims reviewed in the sample where benefits were underpaid. For the sampled cancer claims, an additional $37,311.39 in underpaid benefits and $4,067.89 in interest has been paid, totaling $41,379.28. For the sampled heart/stroke claim, an additional $375 in underpaid benefits and $40.38 in interest has been paid, totaling $415.38.

CSHIC's failure to comply with the above regulations occurred with such frequency as to indicate a general business practice, placing CSHIC in violation of §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 3, 38.2-510 A 5, 38.2-510 6 and 38.2-510 A 14 of the Code. Violations of 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, and §§ 38.2-510 A 2 and 38.2-510 A 5 were also cited in the

previous Report and are; therefore, knowing violations. Section 38.2-218 of the Code sets forth penalties that may be imposed for knowing violations.

THREATENED LITIGATION

There were no claims that involved threatened litigation during the examination time frame.

VI. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, CSHIC shall:

1. As recommended in the prior Report, establish and maintain procedures to ensure that all explanation of benefit forms (EOBs) are filed with and approved by the Commission prior to use, as required by § 38.2-3407.4 A of the Code;
2. Establish and maintain procedures to ensure that the EOBs provided to an insured or claimant clearly and accurately disclose the method of benefit calculation, as required by § 38.2-514 B of the Code;
3. Establish and maintain procedures to ensure that any policy, contract or plan has been filed with and approved by the Commission prior to being issued or issued for delivery in Virginia, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code;
4. Establish and maintain procedures to ensure that all applications, riders, or endorsements are filed with and approved by the Commission prior to use, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code;
5. Review and reopen all cancer claims processed during the years 2006, 2007, 2008, 2009 and the current year and ensure that claims were paid in accordance with the Virginia policy provisions, as opposed to the generic policy that was issued;

   For all active cancer policies that were issued or issued for delivery in Virginia, ensure that the insured individuals have a policy that has been filed with and approved by the Commission. Prior to taking action for those that

were issued without approval, submit a remediation plan to the Forms and Rates section of the Life and Health Market Regulation division;

6. Review and reopen all cancer and heart/stroke claims processed during the years 2004, 2005, 2006, 2007, 2008, 2009 and the current year and make adjustments in accordance with the minimum standards set forth in 14 VAC 5-120-10 et seq., to include 14 VAC 5-120-50 9. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid.";

7. For the in force cancer and heart/stroke policies, file an amendment/endorsement with the Forms and Rates section of the Life and Health Market Regulation division to clarify what is done for procedures not set forth in the policy schedule or the 1964 California Relative Value Schedule;

8. As recommended in the prior Report, establish and maintain procedures for the payment of interest due on claim proceeds, as required by § 38.2-3407.1 B of the Code;

9. Beginning in 2008, the year subsequent to when remediation efforts ceased as a result of the prior Report, review and reopen all cancer claims through the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insureds for the required interest along with letters of explanation stating that "As a result of a

Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was not previously paid.";

10. Review and reopen all Medicare supplement claims processed during the years 2005, 2006, 2007, 2008, 2009, and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insureds for the required interest along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was not previously paid.";
11. As recommended in the prior Report, review and strengthen its established procedures to ensure that claims are paid within 15 working days;
12. As recommended in the prior Report, establish and maintain procedures to ensure that it does not knowingly obscure or conceal from a claimant policy provisions pertinent to a claim, as required by 14 VAC 5-400-40 A and § 38.2-510 A 1 of the Code;
13. As recommended in the prior Report, establish and maintain procedures to ensure that it acknowledges the receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A and § 38.2-510 A 2 of the Code;
14. Review its established procedures to ensure that, upon receiving notification of a claim, it promptly provides necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy

conditions and the insurer's reasonable requirements, as required by 14 VAC 5-400-50 D;

15. As recommended in the prior Report, establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code;

16. As recommended in the prior Report, establish and maintain procedures to ensure that notification of a pending claim under investigation is sent 45 days from the date of notification and every 45 days thereafter, as required by 14 VAC 5-400-60 B and § 38.2-510 A 3 of the Code;

17. Review its established procedures to ensure that any denial of a claim is given to a claimant in writing and the claim file contains a copy of the denial, as required by 14 VAC 5-400-70 A;

18. As recommended in the prior Report, establish and maintain procedures to ensure that the claimant is provided with a reasonable explanation of the basis for the denial of the claim in the written denial, as required by 14 VAC 5-400-70 B and § 38.2-510 A 14 of the Code;

19. Establish and maintain procedures to ensure that a first party claimant is offered an amount which is fair and reasonable as shown by the investigation of a claim, as required by 14 VAC 5-400-70 D and § 38.2-510 A 6 of the Code;

20. Review the specified disease policy forms issued in Virginia by each affiliate company and ensure that the insured individuals have a policy that has been

filed with and approved by the Commission, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code. Prior to taking action for those that were issued without approval, submit a remediation plan to the Forms and Rates section of the Life and Health Market Regulation division;

21. Review and reopen the specified disease claims (cancer and heart/stroke) for each affiliate company processed during the years 2005, 2006, 2007, 2008, 2009, and the current year and (1) ensure that claims were paid in accordance with the filed and approved Virginia policy provisions; (2) make adjustments in accordance with the minimum standards set forth in 14 VAC 5-120-10 et seq., to include 14 VAC 5-120-50 9; (3) for the in force cancer and heart/stroke policies, file an amendment/endorsement with the Forms and Rates section of the Life and Health Market Regulation division to clarify what is done for procedures not set forth in the policy schedule or the 1964 California Relative Value Schedule; and (4) make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that [this claim was underpaid and/or this interest was not previously paid];" and

22. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

VII. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by CSHIC's officers and employees during the course of this examination is gratefully acknowledged.

Carly Daniel, AIE, AIRC, and R. Weldon Hazlewood, ACS, FLMI, CIE, AIRC, FLHC, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Market Conduct Section 1
Life and Health Market Regulation Division
Bureau of Insurance

VIII. REVIEW SHEET SUMMARY BY AREA

POLICY FORMS
§§ 38.2-316 A and 38.2-316 C 1, 1 violation, PF07
§§ 38.2-316 B and 38.2-316 C 1, 44 violations, PF06 (43), PF07 (1)
§ 38.2-3407.4 A, in violation each and every time a non-approved EOB was used during the examination time frame, PF01, PF02
14 VAC 5-120-50 9, in violation each and every time a heart/stroke policy was issued, PF08
14 VAC 5-170-130 A, 1 violation, PF07
CLAIM PRACTICES
§ 38.2-3407.1 B, 11 violations, CL04, CL09, CL13, CL31 (8)
§ 38.2-514 B, 19 violations, CL01, CL03, CL04, CL06, CL07, CL08, CL09, CL10, CL11, CL13, CL14, CL15, CL16, CL17, CL18, CL19, CL20, CL21, CL30
14 VAC 5-400-40 A & 38.2-510 A 1, 21 violations, CL01, CL03, CL04, CL06, CL07, CL08, CL09, CL10, CL11, CL13, CL14, CL16, CL17, CL18, CL19, CL20, CL21, CL22, CL26, CL28, CL30
14 VAC 5-400-50 A & § 38.2-510 A 2, 9 violations, CL31 (9)
14 VAC 5-400-50 D, 1 violation, CL22
14 VAC 5-400-60 A & § 38.2-510 A 5, 21 violations, CL02, CL04, CL09, CL13, CL15, CL17, CL20, CL22, CL24, CL25, CL29, CL31 (11)
14 VAC 5-400-60 B & § 38.2-510 A 3, 6 violations, CL04, CL13, CL20, CL22, CL24, CL25, CL29
14 VAC 5-400-70 A, 2 violations, CL06, CL09
14 VAC 5-400-70 B & § 38.2-510 A 14, 19 violations, CL03, CL04, CL06, CL07, CL08, CL09, CL10, CL11, CL12, CL13, CL16, CL17, CL18, CL19, CL20, CL21, CL22, CL23, CL28
14 VAC 5-400-70 D & § 38.2-510 A 6, 21 violations, CL01, CL03, CL04, CL06, CL07, CL08, CL09, CL10, CL11, CL13, CL14, CL16, CL17, CL18, CL19, CL20, CL21, CL22, CL26, CL28, CL30

ALFRED W. GROSS
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

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April 20, 2010

CERTIFIED MAIL 7008 0150 0002 8881 6220
RETURN RECEIPT REQUESTED

Renee Wake, Supervisor
Legal Compliance
Conseco Senior Health Insurance Company
11825 N. Pennsylvania Street
Carmel, IN 46032

RE: Target Market Conduct Examination Report
Exposure Draft

Dear Ms. Wake:

Recently, the Bureau of Insurance conducted a Target Market Conduct Examination of Conseco Senior Health Insurance Company (CSHIC) for the period of January 1, 2008, through March 31, 2008. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of CSHIC, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. CSHIC's response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Market Conduct Section 1
Life and Health Market Regulation Division
Bureau of Insurance
Telephone No. (804) 371-9492

Enclosure
cc: Jacqueline Cunningham

CONSECO®

June 25, 2010

Carly B. Daniel, AIE, AIRC
Principle Insurance Market Conduct Examiner
Market Conduct Section 1
Life and Health Market Regulation Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Re: Target Market Conduct Examination Report of Conseco Senior Health Insurance Company

Dear Ms. Daniel:

I respectfully submit to you the formal response of Conseco Senior Health Insurance Company ("the Company") to the draft of the Target Market Conduct Examination Report "(Report"). The Company appreciates the additional extensions of time the Department has allowed for its response. The Company would like to express its gratitude for the professional and courteous approach of the Department's examiners.

The Company requests the following modifications to the Report. The Sections given in this response refer directly to those sections in the Report, and they are found in the same order as found in the Report.

II. Company History

Company History

The fourth paragraph on page 4 and first and second paragraphs on page 5 of this section read as follows:

"On December 17, 1996, Conseco, Inc. (Conseco) acquired ATLIC when it purchased ATC. At that time ATLIC became a wholly-owned subsidiary of CHIC, Inc. (CHIC), a wholly owned subsidiary of Conseco. Centralization of the common service functions moved to Carmel, Indiana in September of 1997, with claims processing being performed in Chicago, Illinois, until 2004, at which time these operations moved to Carmel, Indiana."

"In 1997, Conseco reorganized its holding company structure, with ATLIC becoming a wholly-owned subsidiary of CHIC. In addition, ATLIC acquired a wholly-owned subsidiary of Jefferson National Life Insurance Company of Texas, which is a wholly-owned subsidiary of CHIC. In addition, ATLIC acquired a wholly owned subsidiary, Continental Life Insurance Company. On May 30, 1997, ATLIC was the surviving entity in a merger with the affiliated company, Transport Life Insurance Company (TLIC), a life insurer domiciled in the state of Texas. On November 2, 1998, the name of the Company changed from American Travellers Life Insurance Company to Conseco Senior Health Insurance Company."

"CSHIC operates in 46 states, the District of Columbia, and the U.S. and British Virgin Islands. CSHIC informed the examiners that it has not actively marketed its policies in Virginia since the spring of 2003. It predominately has long term-care, specified disease (cancer), and specified disease (heart/stroke) business in force."

COMPANY RESPONSE:
The Company respectfully requests that the following paragraphs be revised as follows (as shown in italics):

> "On December 17, 1996, Conseco, Inc. (Conseco) acquired ATLIC when it purchased ATC. At that time ATLIC became *a wholly-owned subsidiary of CIHC, Inc. (CIHC),* a wholly owned subsidiary of Conseco. Centralization of the common service functions moved to Carmel, Indiana in September of 1997, with claims processing being performed in Chicago, Illinois, until 2004, at which time these operations moved to Carmel, Indiana."
>
> "In 1997, Conseco reorganized its holding company structure, *with ATLIC becoming a wholly-owned subsidiary of CIHC.* In addition, ATLIC acquired a wholly-owned subsidiary of Jefferson National Life Insurance Company of Texas*, which is a wholly-owned subsidiary of CIHC.* In addition, ATLIC acquired a wholly owned subsidiary, Continental Life Insurance Company. On May 30, 1997, ATLIC was the surviving entity in a merger with the affiliated company, Transport Life Insurance Company (TLIC), a life insurer domiciled in the state of Texas. On November 2, 1998, the name of the Company changed from American Travellers Life Insurance Company to Conseco Senior Health Insurance Company."
>
> "CSHIC operates in 46 states, the District of Columbia, and the U.S. and British Virgin Islands. CSHIC informed the examiners that *it has not actively marketed Long Term Care policies in Virginia since the spring of 2003.* It predominately has long term-care, specified disease (cancer), and specified disease (heart/stroke) business in force."

III. Policy and Other Forms
Applications/Riders/Endorsements
The second paragraph on page 8 and the first paragraph on page 9 of this section read as follows:

"The review revealed that the following application, rider and endorsement forms were issued prior to approval."

Form	Number Issued	Review Sheet	Line of Business
10892-ICU	1	PF04	Cancer
10633-DDR	3	PF05	Cancer
10632-ICU	1	PF05	Cancer
11050	1	PF05	Cancer
11091	1	PF05	Cancer
IOB rider series 10655 (no form # in lower left-hand corner of page)	1	PF05	Cancer
LRC-END-7	43	PF06	Cancer
CSHIC-102 (CFO)	1	PF07	Medicare Supplement

"In the aggregate, there was a total of 52 violations of 38.2-316- B and 38.2-316 C 1 of the Code. As discussed in Review Sheet PF06, CSHIC agreed that the endorsement form LRC-END-7 had not been filed with and approved by the Commission. CSHIC indicated that this endorsement was used a total of 43 times in connection with a policy issued for delivery in Virginia. As required by 14 VAC 5-120-80 B, CSHIC was able to provide documentation that a signed acceptance or written request was received from the policyholder endorsing the reduction to the Unlimited Radiation Therapy and Chemotherapy Benefit Rider that was originally selected by the policyholder at the time of application."

COMPANY RESPONSE:
The Company respectfully requests that the first paragraph on page 9 be revised as shown:

> "In the aggregate, there was a total of 52 violations of 38.2-316- B and 38.2-316 C 1 of the Code. The generic version of form numbers 10632-ICU, 11050, and 11091 rather than the approved Virginia specific version of the policy forms were issued in error prior to Conseco's acquisition of this block of business from Transport Life Insurance Company. As discussed in Review Sheet PF06, CSHIC agreed that the endorsement form LRC-END-7 had not been filed with and approved by the Commission. CSHIC indicated that this endorsement was used a total of 43 times in connection with a policy issued for delivery in Virginia. As required by 14 VAC 5-120-80 B, CSHIC was able to provide documentation that a signed acceptance or written request was received from the policyholder endorsing the reduction to the Unlimited Radiation Therapy and Chemotherapy Benefit Rider that was originally selected by the policyholder at the time of application."

III. Policy and Other Forms
Explanation of Benefits (EOB)
The second and third paragraphs on page 10 of this section read as follows:

"In addition, as discussed in Review Sheet PF02, CSHIC sends a separate form letter for any claim or portion of a claim that is denied. CSHIC disagreed that these forms are required to be filed for approval stating that:

Section 38.2-3407 D., essentially says that "explanation of benefits" shall include any form provided by an insurer which explains the amounts covered under the policy. The form paragraphs/letters in question do not explain benefits under an insured's policy. The language in those paragraphs/letters is actually denying claims/benefits. As a result, we don't believe the paragraphs need to be filed with the department."

The examiners do not concur. The form letters explain the amounts covered and payable by a covered person to a provider and, therefore, are EOB forms as defined by § 38.2-3407.4 D of the Code.

COMPANY RESPONSE:
The Company respectfully disagrees. Virginia Insurance Code 38.2-3407.4 states:

> **Explanation of benefits forms**
>
> A. Each insurer issuing an accident and sickness insurance policy, a corporation issuing subscription contracts, and each health maintenance organization shall file for approval explanation of benefits forms. These explanation of benefit forms shall be subject to the requirements of § 38.2-316 or § 38.2-4306 as applicable.
>
> B. The explanation of benefits shall accurately and clearly set forth the benefits payable under the contract.
>
> C. The Commission may issue regulations to establish standards for the accuracy and clarity of the information presented in an explanation of benefits.
>
> D. The term "explanation of benefits " as used in this section shall include any form provided by an insurer, health services plan or health maintenance organization which explains the amounts covered under a policy or plan or shows the amounts payable by a covered person to a health care provider.

The Company has not filed its denial paragraphs based on the Company's interpretation of B. above that refers to benefits payable be set forth in an "explanation of benefits" and our interpretation of D. above that refers to amounts covered or amounts payable. There are no amounts covered or amounts payable in claim denials.

The Company is in compliance with Virginia Insurance Regulation 14 VAC 5-400-70 that states in part:

Standards for prompt, fair and equitable settlement of claims applicable to all insurers
Former Citations Regulation 12 s 8

A. Any denial of a claim must be given to a claimant in writing and the claim file of the insurer shall contain a copy of the denial.

B. No insurer shall deny a claim unless a reasonable explanation of the basis for such denial is included in the written denial. Specific reference to a policy provision, condition or exclusion shall be made when a denial is based on such provision, condition or exclusion.

The form paragraphs/letters in question do not explain benefits under an insured's policy. The language in these paragraphs/letters is actually denying claims/benefits.

V. Claim Practices
Unfair Claim Settlement Practices Review
The eighth paragraph on page 16 of this section reads as follows:

"14 VAC 5-400-40 A – in 21 instances, a policy provision was knowingly obscured or concealed from a claimant, when such provision was pertinent to a claim. An example was discussed in Review Sheet CL03, where CSHIC failed to pay the correct amount for surgery and anesthesia as outlined in the policy schedule. CSHIC indicated that the surgery was paid based on the 1964 California Relative Value Schedule (1964 CRVS) point value, which is maintained in its database. CSHIC provided screen prints of the point values and its methodology for calculating values for procedures not listed based on the 1964 and 1969 CRVS."

"The schedule states, in part that:

> If an operation other that those listed is performed for the treatment of a Specified Disease, we will pay the actual fee, not to exceed an amount equal to: the unit value for the operation (as set forth in the 1964 California Relative Value Schedule) multiplied by a factor of $[ ]."

"The review revealed that CSHIC unofficially updates the 1964 CRVS on its own accord in order to expand the table. However, the table is developed the California Medical Association (4th Edition) and was not an evolving table, as it was followed by updated editions released by the Association. Therefore, rather than calculating a point value for the missing procedure, CSHIC should have, in accordance with the policy schedule, paid the actual fee as there was no unit value that would be exceeded."

COMPANY RESPONSE:
The Company respectfully disagrees; the language from the following excerpt of a policy (see attached) for the Surgical Benefit states:

> E. Surgical Benefit. When a surgical operation (other than a biopsy) is performed, we will pay the fee for such operation, including postoperative attendance, in an amount not to exceed that shown in the Surgical Schedule. If an operation other than those listed is performed for the treatment of a Specified Disease, we will pay the actual fee, not to exceed an amount equal to: the unit value for the operation (as set forth in the 1964 California Relative Value Schedule) multiplied by a factor of $34.00. Two or more surgical procedures performed

through the same incision will be considered as one operation. The amount payable for one operation shall not exceed $7,500.

The policy was issued and rates were determined based on this approved contract language. It was never the intent of the policy to pay actual fees when an operation is not listed on the surgical schedule. An amount for a procedure of comparative gravity and severity was considered not to exceed $7,500 for any one operation.

Unfair Claim Settlement Practices Review
Paragraphs one and two on Page 19 of this section reads as follows:

14 VAC 5-40-70 D - In 21 instances, a fair and reasonable amount was not offered to a first party claimant. An example is disclosed in Review Sheet CL20, where CSHIC failed to pay for side effects as a result of cancer or the treatment of cancer. CSHIC disagreed with the examiners' observation stating, in part that:

> The Company respectfully disagrees that the old procedures, prior to 2004, were correct in payment for drugs for the treatment of side effects under the Chemotherapy Benefit. The Chemotherapy Benefit is specific, "We will pay for the actual charges for chemical substances, including chemicals used in the immunotherapy and hormonal therapy and their administration for the purpose of modification or destruction of abnormal tissue."

COMPANY RESPONSE:
The Company previously disagreed because we were citing the language in the generic form, 10632 et al, which was inadvertently issued in error rather than the Virginia version of the policy which should have been issued. The Company acknowledged that it was non-compliant with 14 VAC 5-120-50 (9) and advised that as of September 8, 2009 the Claims Department is servicing cancer claims in compliance with 14 VAC 5-120-50 (9). The Company voluntarily re-serviced and provided documentation for an additional $37,311.39 in underpaid benefits and $4,067.89 in interest has been paid for cancer claims, totaling $41,379.28. And an additional $375.00 in benefits was paid along with $40.38 in interest for a total of $415.38 for heart/stroke claims. These were for claims which were written up by the examiner.

VI. Corrective Action Plan:
Based on the findings stated in this Report, CSHIC shall:

1. As recommended in the prior Report, establish and maintain procedures to ensure that all explanation of benefit forms (EOBs) are filed with and approved by the Commission prior to use, as required by § 38.2-3407.4 A of the Code;

COMPANY RESPONSE:
Procedures have been put in place to file the explanation of benefit forms. The forms will be identified and filed utilizing SERFF.

2. Establish and maintain procedures to ensure that the EOB's provided to an insured or claimant clearly and accurately disclose the method of benefit calculation, as required by § 38.2-541 B of the Code;

COMPANY RESPONSE:
The Company will establish and maintain procedures to ensure that all EOB's provided to an insured or claimant clearly and accurately disclose the method of benefit calculation, as required by § 38.2-541 B of the Code.

3. Establish and maintain procedures to ensure that any policy, contract or plan has been filed with and approved by the Commission prior to being issued or issued for delivery in Virginia, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code;

COMPANY RESPONSE:
The procedures of the company are to file all of the forms that are required to be filed by the statutes/regulations.

4. Establish and maintain procedures to ensure that all applications, riders, or endorsements are filed with an approved by the Commission prior to use, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code;

COMPANY RESPONSE:
The procedures of the company are to file all of the forms that are required to be filed by the statutes/regulations.

5. Review and reopen all cancer claims processed during the years 2006, 2007, 2008, 2009 and the current year and ensure that claims were paid in accordance with the Virginia policy provisions, as opposed to the generic policy that was issued;

COMPANY RESPONSE:
The process for the Company to reopen and review all cancer claims processed in 2006 through current year 2010 is a manual process and will take approximately 24 weeks to complete.

6. For all active cancer policies that were issued or issued for delivery in Virginia, ensure that the insured individuals have a policy that has been filed with and approved by the Commission. Prior to taking action for those that were issued without approval, submit a remediation plan to the Forms and Rates section of the Life and Health Market Regulation division;

COMPANY RESPONSE:
The Company has identified the Cancer policies which were part of a field issue process in place by Transport Life Insurance Company prior to acquisition by CSHIC. It is possible that some of these customers may have received a generic (standard version) policy instead of the approved Virginia version through their field issue process. For our remediation plan, we propose the following: (1) We will compare the generic version of the policy to the approved Virginia version. (2) Amendment riders will be developed which will amend any generic version of a particular policy so it is identical to the Virginia approved version. (3) The amendment riders will be filed with the Department via SERFF. (4) Once approved, each rider will be mailed to inforce insureds with that particular product with an explanation and they will be told to attach the rider to their policy. For those insureds who receive their rider and have an approved VA policy version in their possession, the rider will not change their existing benefits in any way. For insureds who have a generic product, the rider will amend their policy to be identical to the VA approved policy they should have been issued.

7. Review and reopen all cancer and heart/stroke claims processed during he years 2004, 2005, 2006, 2007, 2008, 2009 and the current year and make adjustments in accordance with the minimum standards set forth in 14 VAC 5-120-10 et seq., to include 14 VAC 5-120-50 9. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid.";

COMPANY RESPONSE:
The process for the Company to reopen and review all cancer and heart/stroke claims processed from 2004 through current year 2010 is a manual process and will take approximately 28 weeks to complete.

8. Review and reopen all cancer and heart/stroke surgery claims processed during the years 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009 and the current year and make adjustments in accordance with the original 1964 California Relative Value Schedule (1964 CRVS) point value, as required by the policy provisions. For any values not listed in such schedule, CSHIC shall adjust the claim to pay the actual fee, as set forth in the policy. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid.";

COMPANY RESPONSE:
The Company respectfully disagrees with the Departments interpretation regarding paying the actual fee for surgery. As stated in our response to item V. Claims Practices on page 4, the Company's position is that based on policy language "If an operation other than those listed is performed for the treatment of a Specified Disease, we will pay the actual fee, not to exceed an amount equal to the unit value for the operation (as set forth in the 1964 California Relative Value Schedule)."

It was never the intent of the policy to pay actual fees when an operation is not listed on the surgical schedule. An amount for a procedure of comparative gravity and severity was considered not to exceed $7,500 for any one operation.

9. As recommended in the prior Report, establish and maintain procedures for the payment of interest due on claim proceeds, as required by § 38.2-3407.1 B of the Code;

COMPANY RESPONSE:
We understand the importance of paying interest on all claims that are processed beyond the Prompt Payment regulations set by the State of Virginia. On September 17, 2009 the Company enhanced its claim system to provide the adjuster with an edit (Interest May Be Due) whenever the claim payment was processed beyond the Virginia Prompt Pay guidelines. Additional adaptations to our claim system are underway to automate the interest calculation for the adjuster. This automation is targeted for a 4Q10 production date.

10. Beginning in 2008, the year subsequent to when remediation efforts ceased as a result of the prior Report, review and reopen all cancer claims through the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insureds for the required interest along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was not previously paid.";

COMPANY RESPONSE:
This review will be part of the review for item 7 above which will include the payment of any additional benefits plus interest that is due.

11. Review and reopen all Medicare supplement claims processed during the years 2005, 2006, 2007, 2008, 2009, and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insured for the required interest along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was not previously paid.";

COMPANY RESPONSE:
The process for the Company to reopen and review all Medicare Supplement claims processed from 2005 through current year 2010 is a manual process and will take approximately 12 weeks to complete.

12. As recommended in the prior Report, review and strengthen its established procedures to ensure that claims are paid within 15 working days;

COMPANY RESPONSE:
The Company will review and strengthen its established procedures to ensure that claims are paid within 15 working days.

13. As recommended in the prior Report, establish and maintain procedures to ensure that it does not knowingly obscure or conceal from a claimant policy provisions pertinent to a claim, as required by 14 VAC 5-400-40 A and § 38.2-510 A 1 of the Code;

COMPANY RESPONSE:
The Company respectfully disagrees that it knowingly obscured or concealed from a claimant policy provisions pertinent to a claim, as required by 14 VAC 5-400-40 A and § 38.2-510 A 1 of the Code. We do not agree with the Departments interpretation with regards to the 1964 California Relative Value Schedule. Please refer to items V. Claims Practices and Corrective Action Item # 8 on pages 4 and 7.

14. As recommended in the prior Report, establish and maintain procedures to ensure that it acknowledges the receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A and § 38.2-510 A 2 of the Code;

COMPANY RESPONSE:
The Company will establish and maintain procedures to ensure that it acknowledges the receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A and § 38.2-510 A 2 of the Code.

15. Review its established procedures to ensure that, upon receiving notification of a claim, it promptly provides necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements, as required by 14 VAC 5-400-50 D;

COMPANY RESPONSE:
The Company will review its established procedures to ensure that, upon receiving notification of a claim, it promptly provides necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements, as required by 14 VAC 5-400-50 D.

16. As recommended in the prior Report, establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code;

COMPANY RESPONSE:
The Company will establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code.

17. As recommended in the prior Report, establish and maintain procedures to ensure that notification of a pending claim under investigation is sent 45 days from the date of notification and every 45 days thereafter, as required by 14 VAC 5-400-60 B and § 38.2-510 A 3 of the Code;

COMPANY RESPONSE:
The Company will establish and maintain procedures to ensure that notification of a pending claim under investigation is sent 45 days from the date of notification and every 45 days thereafter, as required by 14 VAC 5-400-60 B and § 38.2-510 A 3 of the Code.

18. Review its established procedures to ensure that any denial of a claim is given to a claimant in writing and the claim file contains a copy of the denial, as required by 14 VAC 5-400-70 A;

COMPANY RESPONSE:
The Company will review its established procedures to ensure that any denial of a claim is given to a claimant in writing and the claim file contains a copy of the denial, as required by 14 VAC 5-400-70 A.

19. As recommended in the prior Report, establish and maintain procedures to ensure that the claimant is provided with a reasonable explanation of the basis for the denial of the claim in the written denial, as required by 14 VAC 5-400-70 B and § 38.2-510 A 14 of the Code;

COMPANY RESPONSE:
The Company will establish and maintain procedures to ensure that the claimant is provided with a reasonable explanation of the basis for the denial of the claim in the written denial, as required by 14 VAC 5-400-70 B and § 38.2-510 A 14 of the Code.

20. Establish and maintain procedures to ensure that a first party claimant is offered an amount which is fair and reasonable as shown by the investigation of a claim, as required by 14 VAC 5-400-70 D and § 38.2-510 A 6 of the Code;

COMPANY RESPONSE:
In those instances were an incorrect policy was issued, as required by 14 VAC 5-400-70 D and § 38.2-510 A 6 of the Code the Company will establish and maintain procedures to ensure that a first party claimant is offered an amount which is fair and reasonable as shown by the investigation of a claim.

21. Review the specified disease policy forms issued in Virginia by each affiliate company and ensure that the insured individuals have a policy that has been filed with and approved by the Commission, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code. Prior to taking action for those that were issued without approval, submit a remediation plan to the Forms and Rates section of the Life and Health Market Regulation division;

COMPANY RESPONSE:
The Company reviewed specified disease policy forms issued by each applicable affiliated company. These companies issued policy forms from a home office issue just as we continue to do today. Through our home office testing and verification processes each state and each product is tested in a model office to ensure the correct approved policy is issued when in production. Therefore, no modifications need to be made to inforce insured's policies with our applicable affiliated companies since they have the correct products.

22. Review and reopen the specified disease claims (cancer and heart/stroke) for each affiliate company processed during the years 2005, 2006, 2007, 2008, 2009, and the current year and (1) ensure that claims were paid in accordance with the filed and approved Virginia policy provisions; (2) make adjustments in accordance with the minimum standards set forth in 14 VAC 5-120-10 et seq., to include 14 VAC 5-120-50 9; (3) where applicable policy provisions apply, make adjustments in accordance with the original 1964 California Relative Value Schedule (1964 CRVS) and, for any values not listed, adjust the claim to pay the actual fee; and (4) make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that [this claim was underpaid and/or this interest was not previously paid];" and

COMPANY RESPONSE:
The issues identified by the examiners are not issues affecting our affiliate companies.

23. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

COMPANY RESPONSE:
The Company's corrective action plans for items 1, 2, 9, 12, 14, 15, 16, 17, 18, 19 and 20 will be provided within 120 days of this Report being finalized. The company will review and document the actions for items 5, 7, 10 and 11; these claims surveys will be performed in conjunction with each other and are voluminous. We respectfully request 200 days, if not before, after this report is finalized to furnish documentation. At this point in time, we would like to keep items 6 and 21 of the corrective action plan open ended until the Department reviews and approves our remediation plans as outlined above. The Company does not believe that a corrective action plan is required for items 3 and 4 as the company procedures are to file all of the forms that are required to be filed by the statutes/regulations. The Company disagrees with the corrective action plans outline in items 8, 13 and 22 relative to the 1964 California Relative Value Schedule.

I look forward to answering any questions you may have regarding this response. The Company wishes to reserve all of its rights with respect to a hearing on the merits of this examination until any disputed issues are resolved.

Thank you for your consideration of the Company's request.

Sincerely,

Renee Wake

Renee Wake, AIRC, ACS
Manager, Government Relations
Market Conduct
CNO Financial Group
11825 N. Pennsylvania Street
Carmel, IN 46302
(317) 817-2070
renee.wake@cnoinc.com

enclosure

COMMONWEALTH OF VIRGINIA

ALFRED W. GROSS
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
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September 23, 2010

CERTIFIED MAIL 7005 1820 0007 5460 5190
RETURN RECEIPT REQUESTED

Renee Wake, Manager
Government Relations, Market Conduct
Conseco Senior Health Insurance Company
11825 N. Pennsylvania Street
Carmel, IN 46302

Re: Target Market Conduct Examination Report
Exposure Draft

Dear Ms. Wake:

The Bureau of Insurance (the Bureau) has completed its review of your June 25, 2010 response to the Target Market Conduct Examination Report of Conseco Senior Health Insurance Company (CSHIC) sent with my letter of April 20, 2010.

Your response addresses corrective actions CSHIC will take or has taken as part of the Corrective Action Plan made in the Report, as well as modifications CSHIC would like made to the Report. This letter addresses these concerns in the same order as presented in your June 25th response. However, since CSHIC's response will also be attached to the final Report, this response does not address all of those issues where CSHIC indicated agreement and/or action taken as a result of the Report.

II. Company History

The Report has been changed to correct any reference to CIHC, Inc. Given that CSHIC ceased writing any new business in April 2003, the Report will not limit the statement regarding CSHIC's marketing activity to long-term care. The revised pages are enclosed for your review.

III. Policy and Other Forms

Applications/Riders/Endorsements

As noted in the Cancer and Medicare Supplement Policies section, the Applications/Riders/Endorsements section now reflects that generic forms were issued

prior to Conseco's acquisition of this block of business from Transport Life Insurance Company. The revised pages are enclosed for your review.

Explanation of Benefits (EOB)
The separate form letters sent to insureds were used to show the amounts not covered and payable by a covered person to a health care provider. The definition of EOB in § 38.2-3407.4 D of the Code incorporates both forms that explain the amounts covered and forms that show the amounts payable by a covered person. Therefore, the fact that CSHIC used one form to show the paid portion(s) of a claim and a separate form to show the denied portion(s) of a claim does not relieve CSHIC from the filing requirements of § 38.2-3407.4 A of the Code.

It is requested that for any form filings submitted, whether new forms or replacements, revisions or modifications of previously approved forms, you clearly indicate in the letter(s) of transmittal that the submission is the result of CSHIC's efforts to comply with this Target Market Conduct Examination's Corrective Action Plan. This includes any potential accommodations made to the form to include the method of benefit calculation, as required by § 38.2-514 B of the Code.

V. Claim Practices

Unfair Claim Settlement Practices Review
14 VAC 5-400-40 A
Although it may not have been CSHIC's intent to pay the actual fees, the policy provision clearly indicates that the actual fee for a surgical operation will be paid if the operation is not listed in the Surgical Schedule and as long as the fee does not exceed a multiplied factor of the unit value set forth in the 1964 California Relative Value Schedule (CRVS). For each of the sample claims reviewed that involved a surgical operation that was not listed in the Surgical Schedule, the amount payable did not exceed the $7,500 limitation outlined in the policy and the procedure did not have a unit value within the 1964 CRVS that would be exceeded. Therefore, according to the policy, the actual fee for such surgical operations should have been paid.

14 VAC 5-400-70 D
The report has been revised to remove CSHIC's initial disagreement regarding compliance with 14 VAC 5-120-50 9. In addition, it has been further clarified that the additional dollar amounts paid by CSHIC were for the claims sampled and reviewed by the examiners. The revised pages are enclosed for your review.

VI. Corrective Action Plan

Corrective Action 5. Review and reopen all cancer claims processed during the years 2006, 2007, 2008, 2009 and the current year and ensure that claims were

paid in accordance with the Virginia policy provisions, as opposed to the generic policy that was issued.

If the review takes longer than 120 days after the Report has been finalized, CSHIC can provide an update on the incomplete items and the examiners will reconsider a request for an extension at that time. Please be aware that for any incomplete remediation action, the examiners may request documentation of any portions that have been completed.

Corrective Action 6. For all active cancer policies that were issued or issued for delivery in Virginia, ensure that the insured individuals have a policy that has been filed with and approved by the Commission. Prior to taking action for those that were issued without approval, submit a remediation plan to the Forms and Rates section of the Life and Health Market Regulation division.

Upon review of the proposal submitted, CSHIC would not be able to receive approval of an amendment to a policy form that has not been filed with and approved by the Commission. Please provide documentation to demonstrate to the examiners satisfaction that CSHIC is working with the Forms and Rates section to submit alternative options for consideration. It is requested that you clearly indicate in the letter(s) of transmittal that the submission is the result of CSHIC's efforts to comply with this Target Market Conduct Examination's Corrective Action Plan.

Corrective Action 7. Review and reopen all cancer and heart/stroke claims processed during the years 2004, 2005, 2006, 2007, 2008, 2009 and the current year and make adjustments in accordance with the minimum standards set forth in 14 VAC 5-120-10 et seq., to include 14 VAC 5-120-50 9. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid."

If the review takes longer than 120 days after the Report has been finalized, CSHIC can provide an update on the incomplete items and the examiners will reconsider a request for an extension at that time. Please be aware that for any incomplete remediation action, the examiners may request documentation of any portions that have been completed.

Corrective Action 8. Review and reopen all cancer and heart/stroke surgery claims processed during the years 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009 and the current year and make adjustments in accordance with the original 1964 California Relative Value Schedule (1964 CRVS) point value, as required by the policy provisions. For any values not listed in such schedule, CSHIC shall adjust the claim to pay the actual fee, as set forth in the policy. Send checks to

the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid."

As discussed above, the policy indicates that the actual fee for a surgical operation will be paid if the operation is not listed in the Surgical Schedule and as long as the fee does not exceed a multiplied factor of the unit value set forth in the 1964 California Relative Value Schedule (CRVS). Since the surgery procedures reviewed within the sample claim files did not fall within the set parameters for payment of a lesser amount, the actual fee should have been paid.

In addition, although the surgery CPT codes reviewed within the sample claim files were not listed on the oldest 1964 CRVS provided to the examiners (revised as of 1990), a comparison of other codes found on this schedule to those codes listed on a schedule that was revised as of 2009 revealed that a lesser amount would have been allowed in 2009 than in 1990 as a result of the unofficial updates made by CSHIC. Therefore, as required by the corrective action plan and in accordance with the policy, CSHIC shall make adjustments using the proper 1964 CRVS point value for those values listed and pay the actual fee for those not listed.

Corrective Action 11. Review and reopen all Medicare supplement claims processed during the years 2005, 2006, 2007, 2008, 2009, and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insureds for the required interest along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was not previously paid."

If the review takes longer than 120 days after the Report has been finalized, CSHIC can provide an update on the incomplete items and the examiners will reconsider a request for an extension at that time. Please be aware that for any incomplete remediation action, the examiners may request documentation of any portions that have been completed.

Corrective Action 13. As recommended in the prior Report, establish and maintain procedures to ensure that it does not knowingly obscure or conceal from a claimant policy provisions pertinent to a claim, as required by 14 VAC 5-400-40 A and § 38.2-510 A 1 of the Code.

The supplemental procedures provided to the examiners on April 1, 2009, in response to CLMEM01 were effective December 19, 2007, and state, in regards to Transport surgeries, the following:

> **Transport Surgeries –** If the policy contains a surgical schedule, calculate the benefit payments for the payable surgeries based on the schedule. If the policy mentions the 64 Relative Value Schedule (RVS), use that to calculate the values for any surgeries that are not listed in the surgical schedule.
>
> If the point value is not listed, email [company representative] (temporary eff. 7/31/08) and copy [company representative] with the policy number and CPT code. New surgeries and values will be added to the RVS page on the Knowledge Center. Make sure to key the code and point value into the Remarks line of the claim when this happens.
>
> If the policy has "actual charge" language, pay the billed amount for the surgeries, up to the limit stated on the schedule.

CSHIC misrepresented pertinent policy provisions by calculating a point value for any procedure not listed in the surgical schedule and continuously revising the point values within the CRVS to allow a lesser amount. The policy states that the CRVS, specifically the edition published in 1964, would be used and, although permitted under the above company procedures, made no reference to such values being variable. The examiners note that the policies contained "actual fee" language and the above procedures indicate that CSHIC should have paid the billed amount based on this fact.

Corrective Action 20. Establish and maintain procedures to ensure that a first party claimant is offered an amount which is fair and reasonable as shown by the investigation of a claim, as required by 14 VAC 5-400-70 D and § 38.2-510 A 6 of the Code.

The examiners acknowledge CSHIC's goal to implement procedures to ensure compliance in those instances where an incorrect policy was issued. However, violations of these sections were not limited or solely the result of the issuance of the generic policy; therefore, CSHIC shall establish and maintain procedures regardless of the policy the claim was considered under.

Corrective Action 21. Review the specified disease policy forms issued in Virginia by each affiliate company and ensure that the insured individuals have a policy that has been filed with and approved by the Commission, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code. Prior to taking action for those that were issued without approval, submit a remediation plan to the Forms and Rates section of the Life and Health Market Regulation division.

CSHIC indicated that it reviewed the specified disease policy forms issued by each applicable affiliated company. Please provide the examiners with a list of each form reviewed, to include a notation as to the applicable affiliated company. Please also

include, for each policy listed, a copy of the form stamped "approved" by the Commission as a result of it being filed for approval.

Corrective Action 22. Review and reopen the specified disease claims (cancer and heart/stroke) for each affiliate company processed during the years 2005, 2006, 2007, 2008, 2009, and the current year and (1) ensure that claims were paid in accordance with the filed and approved Virginia policy provisions; (2) make adjustments in accordance with the minimum standards set forth in 14 VAC 5-120-10 et seq., to include 14 VAC 5-120-50 9; (3) where applicable policy provisions apply, make adjustments in accordance with the original 1964 California Relative Value Schedule (1964 CRVS) and, for any values not listed, adjust the claim to pay the actual fee; and (4) make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that [this claim was underpaid and/or this interest was not previously paid]."

CSHIC simply indicated that the issues revealed during the course of the exam do not extend to its affiliates. However, it was discovered during a consumer complaint that a non-approved form was issued or issued for delivery in Virginia by an affiliate company that contained a limitations and exclusions section that conflicted with 14 VAC 5-120-50 9. The issuance of a form not approved by the Commission was brought to the company's attention. However, no penalty or disciplinary action was taken as a result of acknowledgement by senior officials at the commencement of the target Market Conduct examination that it would extend any corrective action to its affiliate companies for any situation similar in nature that was found to be a violation during the exam review. Given that the current exam revealed relative policy form and claim violations, CSHIC shall review and reopen each affiliate company's specified disease claims as required by this Corrective Action.

Corrective Action 23. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

If any review takes longer than 120 days after the Report has been finalized, CSHIC can provide an update on the incomplete items and the examiners will reconsider a request for an extension at that time. Please be aware that for any incomplete remediation action, the examiners may request documentation of any portions that have been completed.

In regards to Corrective Action items 6 and 21, which require a remediation plan be submitted to the Forms and Rates section of the Life and Health Market Regulation division prior to taking action, the examiners will reconsider the date documentation of

compliance is due if an agreed upon plan is not established prior to this Report being finalized.

Copies of the revised pages (4, 5, 9, and 20) to the Report are attached reflecting the revisions made to the Report in response to CSHIC's comments to the Exposure Draft and are the only substantive changes we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that CSHIC has violated the Unfair Trade Practices Act, specifically §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 3, 38.2-510 A 5, 38.2-510 6, 38.2-510 A 14 and 38.2-514 B of the Code.

In addition, there were violations of §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-3407.1 B, and 38.2-3407.4 A of the Code as well as 14 VAC 5-120-50 9, Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies, 14 VAC 5-170-130 A, Rules Governing Minimum Standards for Medicare Supplement Policies, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-50 D, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 A, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D, Rules Governing Unfair Claim Settlement Practices.

Violations of the above sections of the Code of Virginia can subject CSHIC to monetary penalties of up to $5,000 for each violation and suspension or revocation of its license to transact business in Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter. The Report will not become a public document until the settlement process has been completed.

Very truly yours,

Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Market Conduct Section 1
Life and Health Market Regulation Division
Bureau of Insurance

CBD:mhh
Enclosures
cc: Jackie Cunningham

CNO FINANCIAL GROUP

December 8, 2010

Jacqueline Cunningham, Deputy Commissioner
Carly Daniel, Principal Insurance Market Examiner
State Corporation Commission Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

RE: Conseco Senior Health Insurance Company et al. ("CSHIC" or the "Company") Response to October 6, 2010 Settlement Offer. Case No. INS-2010-00203
Confidentiality Requested

Dear Ms. Cunningham and Ms. Daniel:

Please accept this correspondence as our formal response to your Settlement Offer of October 6, 2010 (hereinafter referred to as the "Settlement Offer"). Thank you for granting us the 6 week extension to provide this response to you. In addition to this letter, we would like to formally request a meeting at your office to discuss the contents herein. Before addressing the specific Corrective Action items, it is important for us to provide CSHIC's position with respect to some issues raised in the Settlement Offer and preceding correspondence.

Explanation of Benefits (EOB).

In the Examination Report, Exposure Draft ("Draft Report"), the Department sets forth a new legal interpretation of section 38.2-3407.4 D of the Virginia Code. Specifically, the Department concludes that section 38.2-3407.4 D requires that CSHIC file all forms that explain the amounts covered under the policy *as well as* the amounts denied under the policy. Section 38.2-3407.4 D, however, provides as follows:

> The term "explanation of benefits" as used in this section shall include any form provided by an insurer . . . which explains the *amounts covered* under a policy or plan or shows the *amounts payable* by a covered person to a health care provider.

Va. Code § 38.2-3407.4D (Emphasis Added). CSHIC interprets this section as not requiring it to file forms which list the amounts denied by the policy, but respects the Department's position. CSHIC will, therefore, on a going forward basis, state the amounts covered as well as amounts denied by CSHIC in its' EOB forms. This will be accomplished as set forth in its response to Corrective Action item 1 below.

1964 California Relative Value Schedule (1964 CRVS).

The Company believes it has handled claims in accordance with its Surgical Benefit policy language. Ms. Daniel's September 23, 2010, letter to Ms. Wake stated in part:

> Although it may not have been CSHIC's intent to pay the actual fees, the policy provision clearly indicates that the actual fee for a surgical operation will be paid if the operation is not listed in the Surgical Schedule and as long as the fee does not exceed a multiplied factor of the unit value set forth in the 1964 California Relative Value Schedule (CRVS). For each of the sample claims reviewed that involved a surgical operation that was not listed in the Surgical Schedule, the amount payable did not exceed the $7,500.00 limitation outlined in the policy and the procedure did not have a unit value within the 1964 CRVS that would be exceeded.

See Ms. Daniel's September 23, 2010, Letter to Ms. Wake, p. 2. CSHIC, however, continues to believe that CSHIC did exactly what its policy requires, to pay any surgical operation not listed in the Surgical Schedule in accordance with the 1964 CRVS.

CSHIC would like to note that it has several Specified Disease policy forms that have a surgical benefit provision. While each has language that is similar in process, they all vary by way of the maximum amount payable for any one operation. Attached for your review is a table which includes all applicable Virginia policy forms with the applicable surgical benefit language. (Exhibit A)

According to the policy language, CSHIC is only limited to paying an amount determined by the unit value found in the 1964 CRVS. If a procedure is not listed in the 1964 CRVS, then the procedure is covered pursuant to the guidance in the 1964 CRVS which instructs to find a similar value for a procedure which is not specifically listed. Therefore, any procedure not found in CSHIC's Surgical Benefit should be paid in accordance with the 1964 CRVS. Attached for your review is an excerpt from the 1964 CRVS with this instruction. (Exhibit B).

The Company would like to request a face-to-face meeting with the Department to continue discussion of CSHIC's policy language and the claim handling process.

Corrective Action Items.

1. ***As recommended in the prior Report, establish and maintain procedures to ensure that all explanation of benefit forms (EOBs) are filed with and approved by the Commission prior to use, as required by § 38.2-3407.4 A of the Code.***

COMPANY 6/25/2010 RESPONSE:
Procedures have been put in place to file the explanation of benefit forms. The forms will be identified and filed utilizing SERFF.

2. ***Establish and maintain procedures to ensure that the EOB's provided to an insured or claimant clearly and accurately disclose the method of benefit calculation, as required by § 38.2-541 B of the Code.***

COMPANY 6/25/2010 RESPONSE:
The Company will establish and maintain procedures to ensure that all EOB's provided to an insured or claimant clearly and accurately disclose the method of benefit calculation, as required by § 38.2-541 B of the Code.

3. ***Establish and maintain procedures to ensure that any policy, contract or plan has been filed with and approved by the Commission prior to being issued or issued for delivery in Virginia, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code.***

COMPANY 6/25/2010 RESPONSE:
The procedures of the company are to file all of the forms that are required to be filed by the statutes/regulations.

4. ***Establish and maintain procedures to ensure that all applications, riders, or endorsements are filed with an approved by the Commission prior to use, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code.***

COMPANY 6/25/2010 RESPONSE:
The procedures of the company are to file all of the forms that are required to be filed by the statutes/regulations.

5. ***Review and reopen all cancer claims processed during the years 2006, 2007, 2008, 2009 and the current year and ensure that claims were paid in accordance with the Virginia policy provisions, as opposed to the generic policy that was issued.***

COMPANY 6/25/2010 RESPONSE:
The process for the Company to reopen and review all cancer claims processed in 2006 through current year 2010 is a manual process and will take approximately 24 weeks to complete.

DEPARTMENT 9/23/2010 RESPONSE:
If the review takes longer than 120 days after the Report has been finalized, CSHIC can provide an update on the incomplete items and the examiners will reconsider a request for an extension at that time. Please be aware that for any incomplete remediation action, the examiners may request documentation from any portions that have been completed.

COMPANY 12/8/2010 RESPONSE:
The Company has begun this process. CSHIC will continue to reopen and review all cancer claims processed in 2006 through current year 2010. It will provide the Department and the examiners with a status report of the progress within 120 days of approval of this response. This status report will set forth the additional time required to complete the review. CSHIC will provide the examiners with any documentation, which is not privileged, within a reasonable time after the examiners request the documentation in writing.

6. ***For all active cancer policies that were issued or issued for delivery in Virginia, ensure that the insured individuals have a policy that has been filed with and approved by the Commission. Prior to taking action for those that were issued without approval, submit a remediation plan to the Forms and Rates section of the Life and Health Market Regulation division.***

COMPANY 6/25/2010RESPONSE:
The Company has identified the Cancer policies which were part of a field issue process in place by Transport Life Insurance Company prior to acquisition by CSHIC. It is possible that some of these customers may have received a generic (standard version) policy instead of the approved Virginia version through their field issue process. For our remediation plan, we propose the following: (1) We will compare the generic version of the policy to the approved Virginia version. (2) Amendment riders will be developed which will amend any generic version of a particular policy so it is identical to the Virginia approved version. (3) The amendment riders will be filed with the Department via SERFF. (4) Once approved, each rider will be mailed to inforce insureds with that particular product with an explanation and they will be told to attach the rider to their policy. For those insureds who receive their rider and have an approved VA policy version in their possession, the rider will not change their existing benefits in any way. For insureds who have a generic product, the rider will amend their policy to be identical to the VA approved policy they should have been issued.

DEPARTMENT 9/23/2010 RESPONSE:
Upon review of the proposal submitted, CSHIC would not be able to receive approval of an amendment to a policy form that has not been filed with and approved by the Commission. Please provide documentation to demonstrate to the examiners (sic) satisfaction that CSHIC is working with the Forms and Rates section to submit alternative options for consideration. It is requested that you clearly indicate in the letter(s) of transmittal that the submission is the result of CSHIC's efforts to comply with this Target Market Conduct Examination's Corrective Action Plan.

COMPANY 12/8/2010 RESPONSE:
The Company will issue the correct policy which should have been issued to each policyholder who received the incorrect policy. This will be accomplished by mailing the correct policy to each policyholder with a letter that states that the policy was issued in error and that a new policy is being issued.

Exhibit A lists all applicable Virginia policy forms. The Company reviewed all policyholders in its various administrative systems that were issued a Virginia policy. This review indicated that only 13 policyholders were issued a policy which may not have been approved by Virginia. Moreover, the Company was unable to locate an approved policy for only 2 policy forms. This information is included in Exhibit A.

7. ***Review and reopen all cancer and heart/stroke claims processed during the years 2004, 2005, 2006, 2007, 2008, 2009 and the current year and make adjustments in accordance with the minimum standards set forth in 14 VAC 5-120-10 et seq., to include 14 VAC 5-***

120-50 9. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid."

COMPANY 6/25/2010 RESPONSE:
The process for the Company to reopen and review all cancer and heart/stroke claims processed from 2004 through current year 2010 is a manual process and will take approximately 28 weeks to complete.

DEPARTMENT 9/23/2010 RESPONSE:
If the review takes longer than 120 days after the Report has been finalized, CSHIC can provide an update on the incomplete items and the examiners will reconsider a request for an extension at that time. Please be aware that for any incomplete remediation action, the examiners may request documentation of any portions that have been completed.

COMPANY 12/8/2010 RESPONSE:
The Company has begun this process. CSHIC will continue to review and reopen all cancer and heart/stroke claims processed during the years 2004 through the current year 2010. It will provide the Department and the examiners with a status report of the progress within 120 days of approval of this response. This status report will set forth the additional time required to complete the review. CSHIC will provide the examiners with any documentation, which is not privileged, within a reasonable time after the examiners request the documentation in writing.

8. ***Review and reopen all cancer and heart/stroke surgery claims processed during the years 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009 and the current year and make adjustments in accordance with the original 1964 California Relative Value Schedule (1964 CRVS) point value, as required by the policy provisions. For any values not listed in such schedule, CSHIC shall adjust the claim to pay the actual fee, as set forth in the policy. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid."***

COMPANY 6/25/2010 RESPONSE:
The Company respectfully disagrees with the Departments interpretation regarding paying the actual fee for surgery. As stated in our response to item V. Claims Practices on page 4, the Company's position is that based on policy language "If an operation other than those listed is performed for the treatment of a Specified Disease, we will pay the actual fee, not to exceed an amount equal to the unit value for the operation (as set forth in the 1964 California Relative Value Schedule)."

It was never the intent of the policy to pay actual fees when an operation is not listed on the surgical schedule. An amount for a procedure of comparative gravity and severity was considered not to exceed $7,500 for any one operation.

DEPARTMENT 9/23/2010 RESPONSE:
As discussed above, the policy indicates that the actual fee for a surgical operation will be paid if the operation is not listed in the Surgical Schedule and as long as the fee does not exceed a multiplied factor of the unit value set forth in the 1964 California Relative Value Schedule (CRVS). Since the surgery procedures reviewed within the sample claim files did not fall within the set parameters for payment of a lesser amount, the actual fee should have been paid.

In addition, although the surgery CPT codes reviewed within the sample claim files were not listed on the oldest 1964 CRVS provided to the examiners (revised as of 1990), a comparison of the other codes found on this schedule to those codes listed on a schedule that was revised as of 2009 revealed that a lesser amount would have been allowed in 2009 than in 1990 as a result of the unofficial updates made by CSHIC. Therefore, as required by the corrective action plan and in accordance with the policy, CSHIC shall make adjustments using the proper 1964 CRVS point value for those values listed and pay the actual fee for those not listed.

COMPANY 12/8/2010 RESPONSE:
As stated above, the Company believes it paid claims in accordance with the policy language. The 1964 CRVS instructs to find similar values for procedures not listed in the 1964 CRVS. This is exactly what CSHIC did. CSHIC would like to request that this topic be discussed further at a face-to-face meeting with the Department.

9. ***As recommended in the prior Report, establish and maintain procedures for the payment of interest due on claim proceeds, as required by § 38.2-3407.1 B of the Code.***

COMPANY 6/25/2010 RESPONSE:
We understand the importance of paying interest on all claims that are processed beyond the Prompt Payment regulations set by the State of Virginia. On September 17, 2009 the Company enhanced its claim system to provide the adjuster with an edit (Interest May Be Due) whenever the claim payment was processed beyond the Virginia Prompt Pay guidelines. Additional adaptations to our claim system are underway to automate the interest calculation for the adjuster. This automation is targeted for a 4Q10 production date.

10. ***Beginning in 2008, the year subsequent to when remediation efforts ceased as a result of the prior Report, review and reopen all cancer claims through the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insureds for the required interest along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was not previously paid."***

COMPANY 6/25/2010 RESPONSE:
This review will be part of the review for item 7 above which will include the payment of any additional benefits plus interest that is due.

COMPANY 12/8/2010 RESPONSE:

The Company began this remediation effort as a result of the previous exam. It did not cease these efforts in 2008; rather it continued to pay interest payments in accordance with the prior exam. CSHIC did not impose a threshold requirement on these claims; rather it paid and continues to pay all interest amounts due regardless of amount. CSHIC can provide the Department and examiners with a spreadsheet of each claim that was remediated including the amount and date paid.

11. Review and reopen all Medicare supplement claims processed during the years 2005, 2006, 2007, 2008, 2009, and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insured for the required interest along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was not previously paid."

COMPANY 6/25/2010 RESPONSE:
The process for the Company to reopen and review all Medicare Supplement claims processed from 2005 through current year 2010 is a manual process and will take approximately 12 weeks to complete.

DEPARTMENT 9/23/2010 RESPONSE:
If the review takes longer than 120 days after the Report has been finalized, CSHIC can provide an update on the incomplete items and the examiners will reconsider a request for an extension at that time. Please be aware that for any incomplete remediation action, the examiners may request documentation of any portions that have been completed.

COMPANY 12/8/2010 RESPONSE:
The Company has nearly completed this remediation effort. This process should not take longer than 120 days, but if it does, CSHIC will provide an update on the incomplete items. Upon request, CSHIC will provide the Department and examiners with a list of each claim that was remediated including the amount and date paid.

12. As recommended in the prior Report, review and strengthen its established procedures to ensure that claims are paid within 15 working days.

COMPANY 6/25/2010 RESPONSE:
The Company will review and strengthen its established procedures to ensure that claims are paid within 15 working days.

COMPANY 12/8/2010 RESPONSE:
The Company has strengthened its established procedures. The current processing time for paying claims is within the statutory requirements.

13. As recommended in the prior Report, establish and maintain procedures to ensure that it does not knowingly obscure or conceal from a claimant policy provisions pertinent to a claim, as required by 14 VAC 5-400-40 A and § 38.2-510 A 1 of the Code.

COMPANY 6/25/2010 RESPONSE:
The Company respectfully disagrees that it knowingly obscured or concealed from a claimant policy provisions pertinent to a claim, as required by 14 VAC 5-400-40 A and § 38.2-510 A 1 of the Code. We do not agree with the Departments interpretation with regards to the 1964 California Relative Value Schedule. Please refer to items V. Claims Practices and Corrective Action Item # 8 on pages 4 and 7.

DEPARTMENT 9/23/2010 RESPONSE:
The supplemental procedures provided to the examiners on April 1, 2009, in response to CLMEM01 were effective December 19, 2007, and state, in regards to Transport surgeries, the following:

> Transport Surgeries – If the policy contains a surgical schedule, calculate the benefit payments for the payable surgeries based on the schedule. If the policy mentions the 64 Relative Value Schedule (RVS), use that to calculate the values for any surgeries that are not listed in the surgical schedule.
>
> If the point value is not listed, email [company representative] (temporary eff. 7/31/08) and copy [company representative] with the policy number and CPT code. New surgeries and values will be added to the RVS page on the Knowledge Center. Make sure to key the code and point value into the Remarks line of the claim when this happens.
>
> If the policy has "actual charge" language, pay the billed amount for the surgeries, up to the limit stated on the schedule.

CSHIC misrepresented pertinent policy provision by calculating a point value for any procedure not listed in the surgical schedule and continuously revising the point values within the CRVS to allow a lesser amount. The policy states that the CRVS, specifically the edition published in 1964, would be used, and although permitted under the above company procedures, made no reference to such values being variable. The examiners note that the policies contained "actual fee" language and the above procedures indicate that CSHIC should have paid the billed amount based on this fact.

COMPANY 12/8/2010 RESPONSE:
The Company believes it has not misrepresented policy provisions. CSHIC paid and continues to pay all claims in accordance with the schedule of benefits provisions. If a procedure is not listed in the Surgical Benefit as set forth in the policy, CSHIC, as required, uses the 1964 CRVS to determine the appropriate value.

The Company, however, would like to clarify its claims handling process to the Department in a face-to-face meeting because of the unique evolution of the 1964 CRVS. Specifically, in or around 1990, the Federal Government became involved with the pricing of medical procedures. In an attempt to standardize medical payments and to prevent price fixing, the Federal Government required that the 1964 CRVS be abandoned as the standard medical payment schedule. As a result, a new table, the Relative Value for Physician's Table ("RVU") became

the standard table for medical values. The 1964 CRVS ceases to exist but was merged into the RVU, therefore making CSHIC's manner of paying claims more complex.

CSHIC handled and continues to handle claims by considering values in the RVU and converting them to the relative value as found in the 1964 CRVS. CSHIC would like to explain this process in detail at a face-to-face meeting. CSHIC would invite the Department's actuaries to this meeting. If this process is unacceptable to the Department, CSHIC would like to further discuss amicable solutions to address the Department's concerns.

14. As recommended in the prior Report, establish and maintain procedures to ensure that it acknowledges the receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A and § 38.2-510 A 2 of the Code.

COMPANY 6/25/2010 RESPONSE:
The Company will establish and maintain procedures to ensure that it acknowledges the receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A and § 38.2-510 A 2 of the Code.

15. Review its established procedures to ensure that, upon receiving notification of a claim, it promptly provides necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements, as required by 14 VAC 5-400-50 D.

COMPANY 6/25/2010 RESPONSE:
The Company will review its established procedures to ensure that, upon receiving notification of a claim, it promptly provides necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements, as required by 14 VAC 5-400-50 D.

16. As recommended in the prior Report, establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code.

COMPANY 6/25/2010 RESPONSE:
The Company will establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code.

17. As recommended in the prior Report, establish and maintain procedures to ensure that notification of a pending claim under investigation is sent 45 days from the date of notification and every 45 days thereafter, as required by 14 VAC 5-400-60 B and § 38.2-510 A 3 of the Code.

COMPANY 6/25/2010 RESPONSE:

The Company will establish and maintain procedures to ensure that notification of a pending claim under investigation is sent 45 days from the date of notification and every 45 days thereafter, as required by 14 VAC 5-400-60 B and § 38.2-510 A 3 of the Code.

18. ***Review its established procedures to ensure that any denial of a claim is given to a claimant in writing and the claim file contains a copy of the denial, as required by 14 VAC 5-400-70 A.***

COMPANY 6/25/2010 RESPONSE:
The Company will review its established procedures to ensure that any denial of a claim is given to a claimant in writing and the claim file contains a copy of the denial, as required by 14 VAC 5-400-70 A.

19. ***As recommended in the prior Report, establish and maintain procedures to ensure that the claimant is provided with a reasonable explanation of the basis for the denial of the claim in the written denial, as required by 14 VAC 5-400-70 B and § 38.2-510 A 14 of the Code.***

COMPANY 6/25/2010 RESPONSE:
The Company will establish and maintain procedures to ensure that the claimant is provided with a reasonable explanation of the basis for the denial of the claim in the written denial, as required by 14 VAC 5-400-70 B and § 38.2-510 A 14 of the Code.

20. ***Establish and maintain procedures to ensure that a first party claimant is offered an amount which is fair and reasonable as shown by the investigation of a claim, as required by 14 VAC 5-400-70 D and § 38.2-510 A 6 of the Code.***

COMPANY 6/25/2010 RESPONSE:
In those instances where an incorrect policy was issued, as required by 14 VAC 5-400-70 D and § 38.2-510 A 6 of the Code the Company will establish and maintain procedures to ensure that a first party claimant is offered an amount which is fair and reasonable as shown by the investigation of a claim.

DEPARTMENT 9/23/2010 RESPONSE:
The examiners acknowledge CSHIC's goal to implement procedures to ensure compliance in those instances were an incorrect policy was issued. However, violations of these section were not limited or solely the result of issuance of the generic policy; therefore CSHIC shall establish and maintain procedures regardless of the policy the claim was considered under.

COMPANY 12/8/2010 RESPONSE:
The Company's policy is always aimed at ensuring first party claimants are offered an amount which is fair and reasonable as shown by the investigation of a claim. Nevertheless, CSHIC will establish and maintain procedures to comply with 14 VAC 5-400-70 D and § 38.2-510 A 6 of the Virginia Code.

21. Review the specified disease policy forms issued in Virginia by each affiliate company and ensure that the insured individuals have a policy that has been filed with and approved by the Commission, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code. Prior to taking action for those that were issued without approval, submit a remediation plan to the Forms and Rates section of the Life and Health Market Regulation division.

COMPANY 6/25/2010 RESPONSE:
The Company reviewed specified disease policy forms issued by each applicable affiliated company. These companies issued policy forms through a home office issue system just as we continue to do today. Through our home office testing and verification processes each state and each product is tested in a model office to ensure the correct approved policy is issued when in production. Therefore, no modifications need to be made to in force insured's policies with our applicable affiliated companies since they have the correct products.

DEPARTMENT 9/23/2010 RESPONSE:
CSHIC indicated that it reviewed the specified disease policy forms issued by each applicable affiliated company. Please provide the examiners with a list of each form reviewed, to include a notation as to the applicable affiliated company. Please also include, for each policy listed, a copy of the form stamped "approved" by the Commission as a result of it being filed for approval.

COMPANY 12/8/2010 RESPONSE:
The Company has completed review of all its affiliated Companies and located only 2 policy forms which may have not been approved in Virginia. Exhibit A lists those policy forms. CSHIC will issue the correct policy which should have been issued to each policyholder who received the incorrect policy. This will be accomplished by mailing the correct policy to each policyholder with a letter that states that the policy was issued in error and that a new policy is being issued.

22. Review and reopen the specified disease claims (cancer and heart/stroke) for each affiliate company processed during the years 2005, 2006, 2007, 2008, 2009, and the current year and (1) ensure that claims were paid in accordance with the filed and approved Virginia policy provisions; (2) make adjustments in accordance with the minimum standards set forth in 14 VAC 5-120-10 et seq., to include 14 VAC 5-120-50 9; (3) where applicable policy provisions apply, make adjustments in accordance with the original 1964 California Relative Value Schedule (1964 CRVS) and, for any values not listed, adjust the claim to pay the actual fee; and (4) make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that [this claim was underpaid and/or this interest was not previously paid]."

COMPANY 6/25/2010 RESPONSE:
The issues identified by the examiners are not issues affected by our affiliate companies.

DEPARTMENT 9/23/2010 RESPONSE:
CSHIC simply indicated that the issues revealed during the course of the exam do not extend to its affiliates. However, it was discovered during a consumer complaint that a non-approved form was issued or issued for delivery in Virginia by an affiliate company that contained a limitations and exclusions section that conflicted with 14 VAC 5/120-50-9. The issuance of a form not approved by the Commission was brought to the company's attention. However, no penalty or disciplinary action was taken as a result of acknowledgement by senior officials at the commencement of the target Market Conduct examination that it would extend any corrective action to its affiliate companies for any situation similar in nature that was found to be a violation during the exam review. Given that the current exam revealed relative policy form and claim violations, CSHIC shall review and reopen each affiliate company's specified disease claims as required by this Corrective action.

COMPANY 12/8/2010 RESPONSE:
The Company agrees to correct the issue found in the single consumer complaint by re-issuing the appropriate form. CSHIC located 11 policyholders who were issued a policy which may have not been approved by Virginia. CSHIC agrees to review all claims for these policyholders.

23. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

COMPANY 6/25/2010 RESPONSE:
The Company's corrective action plans for items 1, 2, 9, 12, 14, 15, 16, 17, 18, 19 and 20 will be provided within 120 days of this Report being finalized. The company will review and document the actions for items 5, 7, 10 and 11; these claims surveys will be performed in conjunction with each other and are voluminous. We respectfully request 200 days, if not before, after this report is finalized to furnish documentation. At this point in time, we would like to keep items 6 and 21 of the corrective action plan open ended until the Department reviews and approves our remediation plans as outlined above. The Company does not believe that a corrective action plan is required for items 3 and 4 as the company procedures are to file all of the forms that are required to be filed by the statutes/regulations. The Company disagrees with the corrective action plans outline in items 8, 13 and 22 relative to the 1964 California Relative Value Schedule.

DEPARTMENT 9/23/2010 RESPONSE:
If any review takes longer than 120 days after the Reports has been finalized, CSHIC can provide an update on the incomplete items and the examiners will reconsider a request for an extension at that time. Please be aware that for any incomplete remediation action, the examiners may request documentation of any portions that have been completed.

COMPANY 12/8/2010 RESPONSE:
Please refer to the responses above.

Conclusion

The Company believes it can amicably resolve most, if not all, the issues posed in the Draft Report and subsequent correspondence including the Settlement Offer. It is not the intent of the Company to be uncooperative. Unless otherwise stated, the Company denies any allegations of wrongdoing, and clarifies that any wrongdoing that is found to have existed was unintentional and will be corrected.

At this time we would like to renew our request to meet with the Department in a face-to-face meeting to discuss the contents of this correspondence. In addition, we would request a phone conference between the Company and the Department to discuss the contents of this letter. Please let us know what timeframe works best for you.

Please contact me if you have any questions or concerns regarding this correspondence at 317-817-5638.

Best regards,

Lisa Harpenau JT

Lisa Harpenau
Counsel, Market Conduct and Regulatory Affairs
lisa.harpenau@cnoinc.com

SURGERY
General Information and Instructions

1. Values for office, home and hospital visits, consultations and other medical services, x-ray and laboratory procedures are listed in the sections entitled "Medicine," "Anesthesia," "Radiology," and "Laboratory."

2. Listed values for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column headed "Follow-up Days." Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis. Where the follow-up period is listed as zero (0) and the item is preceded by an asterisk (*), see (3) below.

3. ASTERISK (*): Where an asterisk (*) precedes a procedure number and its value, the following rules apply:
   (a) The listed value is for the SURGICAL PROCEDURE ONLY.
   (b) ALL POST-OPERATIVE CARE is to be ADDED on a fee-for-service basis.
   (c) When such a procedure requires hospital admission, an additional two (2) units are to be added to the listed value to cover the additional services required. (Items 9020, 9021, or 9022 are not to be used in addition.)
   (d) When such a procedure is carried out at the time of the initial visit, an additional one (1) unit is to be added to the listed value in lieu of item 9001, etc.

4. "SV." ITEMS: "Sv." in the value column indicates that the value is to be calculated as the sum of the various services rendered (e.g., hospital visit, application of cast or splint, detention with patient, office visit, etc.) according to the ground rules covering those services.

5. "BY REPORT": When the value of a procedure is to be determined "by report," the following information may be required:
   (a) Diagnosis (post-operative).
   (b) Size, location and number of lesion(s) or procedure(s) where appropriate.
   (c) Major surgical procedure and supplementary procedure(s).
   (d) Whenever possible, list the nearest similar procedure by number according to these studies.
   (e) Estimated follow-up period.
   (f) Operative time.

6. COMPLICATIONS or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional charges on a fee-for-service basis.

7. When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

8. INDEPENDENT PROCEDURE: Certain of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate charge. When such a procedure is carried out as a *separate entity,* not immediately related to other services, the indicated value for "Independent Procedure" is applicable.

9. MULTIPLE SURGICAL PROCEDURES:
   (a) When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified in this Study.
   (b) When an incidental procedure, (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the value will be that of the major procedure only.

10. PROCEDURES NOT SPECIFICALLY LISTED will be given values comparable to those of the listed procedures of closest similarity.

11. When warranted by the necessity of SUPPLEMENTAL SKILLS, values for services rendered by two or more physicians will be allowed.

12. When the SKILLS OF TWO SURGEONS are required in the management of a specific surgical procedure, by prior agreement, the total value may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. The value may be increased by 25 per cent under these circumstances.

13. INJECTION PROCEDURES in conjunction with radiological service(s) include necessary local anesthesia, placement of needle or catheter and injection of contrast media. (See also Rule 7, page 53.)

14. Necessary drugs, materials and supplies *provided by the physician* may be charged for separately.

SURGICAL ASSISTANTS

		Value
6993	Assist at surgery, 20% of listed unit value(s) of surgical procedure(s)—	
6994	minimum allowance	7.0

INTEGUMENTARY SYSTEM
Skin, Mucous Membrane, Subcutaneous and Areolar Tissues

	Incision	Value	Follow-up Days†	Anes.§
*0101	Incision and drainage of infected or non-infected sebaceous cyst (2nd lesion 50%; each additional lesion 25%)	*2.0	0	3.0+T
*0102	Incision and drainage of furuncle	*2.0	0	3.0+T
*0103	Acne surgery; marsupialization, opening, or removal of multiple milia, comedones, cysts, pustules, etc.	*1.5	0	3.0+T
*0108	Incision and drainage of carbuncle, suppurative hidradenitis and other cutaneous or subcutaneous abscesses, simple	*2.0	0	3.0+T
0109	extensive ..... by report			3.0+T
*0115	Drainage of pilonidal cyst	*2.0	0	3.0+T
*0125	Drainage of onychia or paronychia	*2.0	0	3.0+T
0126	multiple or complicated .. by report			3.0+T
*0130	Incision and removal of foreign body, subcutaneous tissues, simple	*2.0	0	3.0+T
0131	complicated ..... by report			3.0+T
*0140	Drainage of hematoma, simple.	*2.0	0	
0141	complicated ..... by report			3.0+T
*0145	Puncture aspiration of abscess or hematoma	*1.0	0	3.0+T
	Excision			
	Debridement (for abrasions and burns, see 0164, 0330-0334, 0351-0356.)			
*0160	Debridement of extensively eczematized or infected skin up to 10% of the body surface	*2.0	0	3.0+T
*0161	for each additional 10% of body surface, add	*1.0	0	3.0+T
*0162	Debridement of nails, any method, five or less	*2.0	0	3.0+T

*See page 19, Rules 3a, 3b, 3c and 3d before using.
†See page 19, Rules 2, 6 and 7 for meaning.
§See page 15, for calculation of total Anesthesia value.
¶See page 19, Rule 4, to calculate value of this service.

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

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August 30, 2011

CERTIFIED MAIL 7005 1820 0007 5460 5817
RETURN RECEIPT REQUESTED

Lisa Harpenau, Counsel
Market Conduct & Regulatory Affairs
CNO Services LLC
11825 N. Pennsylvania Street
Carmel, IN 46302

Re: Conseco Senior Health Insurance Company

Dear Ms. Harpenau:

The Bureau of Insurance (the Bureau) has completed its review of your December 8, 2010 and January 19, 2011 supplemental responses to the Target Market Conduct Examination Report of Conseco Senior Health Insurance Company (CSHIC), as well as the additional documentation provided on July 12, 2011 and discussed via conference call on August 15, 2011. Your response addresses corrective actions CSHIC will take or has taken as part of the Corrective Action Plan made in the Report, as well as modifications CSHIC would like made to the Report. This letter addresses these concerns in the same order as presented in your December 8th response.

Explanation of Benefits (EOB)

Although, CSHIC emphasized "amounts payable" within the definition of *explanation of benefits*, it further reads "amounts payable *by a covered person"* and is not limited to what is covered and paid for by CSHIC. The examiners note that CSHIC has re-filed its EOBs and is currently working with our Forms and Rates section.

1964 California Relative Value Schedule (1964 CRVS)

In response to CLMEM02 during the examination review, CSHIC indicated, in part, that:

> We are unable to locate a copy of the original CRVS listing prior to any revisions, updates or amendments. Attached is the oldest version on file of the CRVS listings. The CRVS64 and CRVS69 tables are maintained on our BICPS claim system. However, many procedures that are done today are not in these tables. Procedures that are not in the RVS tables must be

calculated. We do a pro-rata comparison then calculate what it should be for 64 or 69.

On January 19, 2011, CSHIC provided a copy of the original 1964 CRVS, which included general information, instructions, and an appendix with the history and mechanics of the study. CSHIC pointed out that, under General Information and Instructions, it states "10. PROCEDURES NOT SPECIFICALLY LISTED will be given values comparable to those of the listed procedures of closest similarity."

Although the appendix further indicates that the Committee on Fees would be the logical study group to make necessary changes or to revise relative values, such values for new procedures have not been available with any systematic study since 1974. For any unlisted procedure, CSHIC indicated that it utilizes the Relative Value for Physician's (RVP) Table to convert Relative Value Units (RVU) for 1964 on a pro rata basis. It is noted that the RVP and CRVS use different methodologies as the relative values in the RVP are based on the time and skill necessary to perform a procedure and do not reflect physician fees like what is presented in the CRVS. Given that CSHIC's approach allows for a greater value than what is simply provided in the RVP and the CRVS instructions allows for similar values to be used for procedures not listed, the examiners accept CSHIC's general business practice. However, the Corrective Action Plan will be revised as described below in this letter.

CSHIC further noted that if a value is not in the surgical schedule or the CRVS, it looks for any values uploaded in its system or found in its Knowledge Center prior to calculating a new value.

Corrective Action Items

6. For all active cancer policies that were issued or issued for delivery in Virginia, ensure that the insured individuals have a policy that has been filed with and approved by the Commission. Prior to taking action for those that were issued without approval, submit a remediation plan to the Forms and Rates section of the Life and Health Market Regulation division.

This corrective action has been addressed in the Company's January 28, 2011, supplemental response and the Bureau's February 28, 2011 response.

8. Review and reopen all cancer and heart/stroke surgery claims processed during the years 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009 and the current year and make adjustments in accordance with the original 1964 California Relative Value Schedule (1964 CRVS) point value, as required by the policy provisions. For any values not listed in such schedule, CSHIC shall adjust the claim to pay the actual fee, as set forth in the policy. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid."

The examiners acknowledge CSHIC's continued disagreement and have provided the above comments in response to the use of the 1964 CRVS for payment of surgical

benefits. Being that the Company indicated many procedures are not in either table and it must do a pro-rata calculation to find comparable values, this Corrective Action will be deleted and replaced with the following:

> *8. For the in force cancer and heart/stroke policies, file an amendment/endorsement with the Forms and Rates section of the Life and Health Market Regulation division to clarify what is done for procedures not set forth in the policy schedule or the 1964 California Relative Value Schedule.*

10. Beginning in 2008, the year subsequent to when remediation efforts ceased as a result of the prior Report, review and reopen all cancer claims through the current year and make interest payments where necessary, as required by § 38.2 3407.1 B of the Code. Send checks to the insureds for the required interest along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was not previously paid."

During the exam review, CSHIC failed to pay interest for each of the cancer claims where interest was due. On June 21, 2011, CSHIC documented its completed remediation efforts.

11. Review and reopen all Medicare supplement claims processed during the years 2005, 2006, 2007, 2008, 2009, and the current year and make interest payments where necessary, as required by § 38.2 3407.1 B of the Code. Send checks to the insureds for the required interest along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was not previously paid."

During the exam review, CSHIC failed to pay interest for each of the Medicare supplement claims where interest was due. On June 21, 2011, CSHIC documented its completed remediation efforts.

13. As recommended in the prior Report, establish and maintain procedures to ensure that it does not knowingly obscure or conceal from a claimant policy provisions pertinent to a claim, as required by 14 VAC 5-400-40 A and § 38.2-510 A 1 of the Code.

CSHIC indicated that the Federal Government required the 1964 CRVS to be abandoned and, since it ceased to exist, the Company merged it into the Relative Value for Physician's Table (RVP). Although the Federal Trade Commission ruled that the CRVS should not be used by physicians, it does not appear that the ruling prevented the use of the CRVS by payers. Please see the examiners comments above regarding the use of the 1964 CRVS.

21. Review the specified disease policy forms issued in Virginia by each affiliate company and ensure that the insured individuals have a policy that has been filed with and approved by the Commission, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code. Prior to taking action for those that were issued without approval, submit a

remediation plan to the Forms and Rates section of the Life and Health Market Regulation division.

This corrective action has been addressed in the Company's January 28, 2011, supplemental response and the Bureau's February 28, 2011 response.

22. Review and reopen the specified disease claims (cancer and heart/stroke) for each affiliate company processed during the years 2005, 2006, 2007, 2008, 2009, and the current year and (1) ensure that claims were paid in accordance with the filed and approved Virginia policy provisions; (2) make adjustments in accordance with the minimum standards set forth in 14 VAC 5-120-10 et seq., to include 14 VAC 5-120-50 9; (3) where applicable policy provisions apply, make adjustments in accordance with the original 1964 California Relative Value Schedule (1964 CRVS) and, for any values not listed, adjust the claim to pay the actual fee; and (4) make interest payments where necessary, as required by § 38.2 3407.1 B of the Code. Send checks to the insureds for the additional amounts along with letters of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that [this claim was underpaid and/or this interest was not previously paid]."

In CSHIC's January 28, 2011 and April 1, 2011, responses, the Company was able to document that a Virginia specific form rather than the generic form provided during the exam review was in fact issues for the majority of the policy forms. The examiners acknowledge that CSHIC will re-issue the appropriate form in connection with the consumer complaint and will review the claims to ensure that they were paid in accordance with the approved Virginia policy provisions. Within 120 days of the Report being finalized, CSHIC shall furnish the examiners with its documentation that this corrective action item has been completed. In addition to the revisions made by the examiners on April 28, 2011, please be advised that the Report's example for Review Sheet CL20 will delete the reference to a generic form. The revised page is enclosed for your review.

For item 2 of this corrective action, the examiners would note that the Company had establish procedures as to how specified disease claims would be processes despite whether or not the policy contained provisions addressing treatment of side effects. Therefore, the Company shall review and reopen all specified disease claims in accordance with the corrective action plan and not just for those 11 policyholders.

For item 3, the previous requirement has been replaced with the following:

> *(3) for the in force cancer and heart/stroke policies, file an amendment/endorsement with the Forms and Rates section of the Life and Health Market Regulation division to clarify what is done for procedures not set forth in the policy schedule or the 1964 California Relative Value Schedule;*

Confidentiality
The Company has requested confidentiality of any written response subsequent to its initial response dated June 25, 2010. The Company's January 19, 2011, January 28, 2011, and April 1, 2011, correspondence addressing its remediation efforts and legal opinion will not be included in the final Report since CSHIC requested confidentiality and the Report does not require documentation of the Company's compliance with the Corrective Action Plan until 120 days after the Report has been finalized. However, CSHIC's December 8, 2010 response addresses the Company's continued disagreement with certain Report findings and, therefore, will be included along with this letter and the examiner's letter of September 23, 2010 to support each position with respect to findings of noncompliance.

Copies of the revised pages to the draft Report are attached. Please let the examiners know within 10 working days of receipt of this letter whether CSHIC would like to settle this matter in accordance with the Deputy Commissioner's letter of October 6, 2010. A revised settlement form has been included given the change in Deputy Commissioner. Please feel free to contact me at 804-371-9492 or carly.daniel@scc.virginia.gov should you have any questions.

Very truly yours,

Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Market Conduct Section 1
Life and Health Market Regulation Division
Bureau of Insurance

Renee Wake, Manager
Government Relations, Market Conduct
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Richmond, VA 23218

530057

RE: Alleged Violations of the Unfair Trade Practices Act, specifically §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 3, 38.2-510 A 5, 38.2-510 6, 38.2-510 A 14 and 38.2-514 B of the Code of Virginia as well as §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-3407.1 B, and 38.2-3407.4 A of the Code as well as 14 VAC 5-120-50 9, Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies, 14 VAC 5-170-130 A, Rules Governing Minimum Standards for Medicare Supplement Policies, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-50 D, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 A, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D, Rules Governing Unfair Claim Settlement Practices.

Dear Ms. Battle:

This will acknowledge receipt of the Deputy Commissioner's letter dated October 6, 2010, concerning the above-captioned matter.

Conseco Life Insurance Company, on behalf of Conseco Senior Health Insurance Company, wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of $35,000 payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement; it is entitled to a hearing in this matter and waives its right to such a hearing; agrees to cease and desist from future violations of §§ 38.2-514 B, 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5, 38.2-510 A 6, 38.2-510 A 14, 38.2-3407.1 B and 38.2-3407.4 A of the Code of Virginia as well as 14 VAC 5-120-50 9, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D; and agrees to comply with the Corrective Action Plan contained in the Market Conduct Examination Report as of March 31, 2008.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Yours very truly,

Company Representative

10-14-2011
Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, OCTOBER 31, 2011

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2010-00203

CONSECO SENIOR HEALTH INSURANCE COMPANY
and
CONSECO LIFE INSURANCE COMPANY,

Defendants

SETTLEMENT ORDER

Based on a market conduct examination performed by the Bureau of Insurance, it is alleged that Conseco Senior Health Insurance Company ("Conseco Senior"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia, in certain instances, has violated §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, and 38.2-3407.4 A of the Code of Virginia by failing to comply with policy and form filing requirements; violated §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5, 38.2-510 A 6, and 38.2-510 A 14 of the Code of Virginia, as well as 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-50 D, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 A, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D, by failing to properly handle claims; violated § 38.2-514 B of the Code of Virginia by failing to make disclosures; violated § 38.2-3407.1 B of the Code of Virginia by failing to pay interest in accordance with requirements; violated 14 VAC 5-120-50 (9) by failing to comply with general policy requirements of the Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies; and

violated 14 VAC 5-170-130 A by failing to comply with policy provision of the Rules Governing Minimum Standards for Medicare Supplement Policies.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code of Virginia to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke the Defendants' licenses upon a finding by the Commission, after notice and opportunity to be heard, that Conseco Senior has committed the aforesaid alleged violations.

Conseco Life Insurance Company ("Conseco Life"), on behalf of Conseco Senior, has been advised of Conseco Senior's right to a hearing in this matter, whereupon, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein Conseco Life has tendered to the Commonwealth of Virginia the sum of Thirty-five Thousand Dollars ($35,000), waived its right to a hearing, agreed to the entry by the Commission of a cease and desist order, and agreed to comply with the Corrective Action Plan contained in the Market Conduct Examination Report as of March 31, 2008.

The Bureau of Insurance has recommended that the Commission accept the offer of settlement of the Defendants pursuant to the authority granted the Commission in § 12.1-15 of the Code of Virginia.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendants, and the recommendation of the Bureau of Insurance, is of the opinion that the Defendants' offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendants in settlement of the matter set forth herein be, and it is hereby, accepted;

(2) The Defendants cease and desist from any future conduct which constitutes a violation of §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5, 38.2-510 A 6, 38.2-510 A 14, 38.2-514 B, 38.2-3407.1 B, or 38.2-3407.4 A of the Code of Virginia, or 14 VAC 5-120-50 (9), 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B, or 14 VAC 5-400-70 D; and

(3) The papers herein be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Renee Wake, Manager, Government Relations, Market Conduct, Conseco Senior Health Insurance Company, 11825 North Pennsylvania Street, Carmel, Indiana 46302; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Althelia Battle.

A True Copy
Teste: Joel H. Peck
Clerk of the
State Corporation Commission