MULTI-STATE MARKET CONDUCT EXAMINATION
OF
THE HEALTHMARKETS, INC. INSURANCE COMPANIES
(Formerly Known As UICI)

The MEGA Life and Health Insurance Company

Mid-West National Life Insurance Company of Tennessee

and

The Chesapeake Life Insurance Company

9151 Boulevard 26

North Richland Hills, Texas 76180-5605

EXAMINATION PERIOD

January 1, 2000 through December 31, 2005

December 20, 2007

The Honorable Linda S. Hall, CPCU, CIC
Director, Division of Insurance
State of Alaska
Department of Commerce, Community and Economic
Development Robert B Atwood Building
550 West 7th Avenue, suite 1560
Anchorage, AK 99501-3567

The Honorable Mike Kreidler
Insurance Commissioner
Office of the Insurance
Commissioner State of
Washington
5000 Capitol Boulevard
Tumwater, WA 99501

Subject: Multi-State Market Conduct Examination
HealthMarkets, Inc. Insurance Subsidiaries (formerly known as UICI, Inc.)

Dear Commissioners Hall and Kreidler:

As charged by the Market Analysis Working Group (MAWG) of the National Association of Insurance Commissioners (NAIC), a multi-state examination of the market conduct affairs of the insurance subsidiaries of HealthMarkets, Inc (formerly known as UICI, Inc.) has been performed. Entities examined during the course of this examination include:

Mega Life and Health Insurance Company, NAIC 97055
Mid-West National Insurance Company of TN, NAIC #66087
Chesapeake Life Insurance Company, NAIC #61832

This examination was completed on the part of the lead states of Washington and Alaska, and in conjunction with 34 other jurisdictions who signed a Memorandum of Understanding electing to participate in this process. The examination was performed on behalf of the participating states by the examination contracting firm of RSM McGladrey, Inc.

A list of the examination statutes for each of the participating states can be found in Appendix A of this report. This examination was conducted in accordance with the statutory authorities listed in the Appendix and in ccordance with procedures set forth in the NAIC Market Conduct Examiners Handbook.

This report of examination is respectfully submitted.

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CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with National Association of Insurance Commissioners market conduct examination procedures. This examination was performed under the supervision of the Washington Office of Insurance Commissioner, the Alaska Division of Insurance and under direction of the Market Analysis Working Group of the National Association of Insurance Commissioners. The contracting examination firm, RSM McGladrey, Inc., performed this examination under a contractual arrangement with the State of Alaska. Jann Goodpaster, Director, managed the examination team for the contractor.

The examiners wish to express appreciation for the courtesy and cooperation extended by the officers and employees of HeathMarkets, Inc. (formerly known as UICI, Inc.) during the course of this market conduct examination.

We certify that this document is the report of the examination, that we have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by all parties, and that this report is true and correct to the best of our knowledge and belief.

Leslie A. Krier, AIE, FLMI
Market Conduct Oversight Manager
Office of the Insurance Commissioner
State of Washington

Ted Lehrbach
Chief Market Conduct Examiner
Division of Insurance
State of Alaska

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Jann L. Goodpaster, CIE, CPCU
Director
RSM McGladrey, Inc

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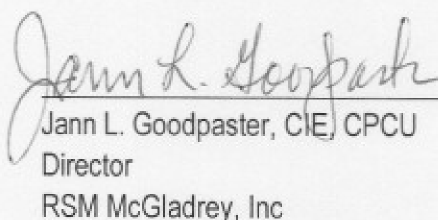


Jann L. Goodpaster, CIE, CPCU
Director
RSM McGladrey, Inc

EXECUTIVE SUMMARY

Background

For several years preceding this multi-state examination, the insurance companies that comprise UICI, now known as **HealthMarkets, Inc.**, (**The MEGA Life and Health Insurance Company (MEGA)**, **Mid-West National Life Insurance Company of Tennessee (MW or Mid-West)**, **The Chesapeake Life Insurance Company (CLICO))** and their predecessors, collectively "the Company" were monitored closely by state insurance regulators for the following reasons:

- Complaint indices were higher than normal in many states.
- Complaint trends showed that many complaints were directly or indirectly related to point-of-sale disclosures, or lack thereof. Specifically, consumers did not fully understand the products they purchased and there were indications of unfulfilled expectations from policyholders.
- UICI was the target of multiple lawsuits by consumers and others, some with issues consistent with the concerns of state regulators.
- The founder of UICI and primary stockholder, Ronald Jensen, was also the target of lawsuits and allegations that he had established channels of multiple streams of income for himself, family members, other stockholders, agents and executives of the Company, at the expense of policyholders.
- There was a lack of understanding and clarity regarding the relationship between the Company and the membership associations.
- Several states performed market conduct examinations and investigations. Although violations were identified during the market conduct examinations and fines were levied, the Company's actions and complaint indices did not significantly improve.
- The Company had a reputation among regulators for not being cooperative.

Examination Objectives

On March 15, 2005, under the direction of the **National Association of Insurance Commissioners (NAIC) Market Analysis Working Group (MAWG),** the States of Washington and Alaska issued a call letter to UICI for a multi-state examination with the following stated examination objectives:

A. Determine the Company's adherence to the Confidential National Compliance Plan created by the Company, dated November 30, 2004.
B. Determine if there are general policies and procedures in place to ensure that management maintains appropriate oversight of insurance operations.
C. Determine the types of policies sold by the insurance companies in the various jurisdictions.
D. Review UICI's claims settlement practices to determine if they comply with applicable statutes, rules and regulations.
E. Determine the distribution systems used for each product type.
F. Review UICI's marketing practices to determine if they comply with applicable statutes, rules and regulations.
G. Determine the nature of the associations affiliated with UICI and their role in the insurance operations of the Company.

From information ascertained during the initial months of the examination, concerns were raised about the Company's lack of transparency with regard to its relationships with the membership associations and other UICI entities. Due to the concerns regarding transparency and the complexity of the relationships between the Company, its affiliates and the membership associations, the scope of the examination was expanded to include an in-depth review of those relationships. Additionally, it was decided that targeted attribute testing would be performed to determine if the Company was in compliance with procedures described to the Examiners during the initial months of the examination, as well as with the Confidential National Compliance Plan. Therefore, the lead states of Washington and Alaska expanded the scope as follows:

H. Expand the review of inter-company relationships to include all UICI subsidiaries for the five-year period ending December 31, 2004 to understand the Company's legal and financial organizational structure.
I. Review the flow of funds between UICI companies and the membership associations as represented by Company-prepared flow charts to validate their completeness and accuracy.
J. Conduct targeted attribute testing of Complaints/Grievances, Underwriting and Claims Handling standards.

Examination Approach

The Examiners commenced the examination using a risk-focused approach. Interviews were conducted with 11 members of senior management and 30 key personnel from throughout the Company with an emphasis on procedures, communication, training and compliance controls. From the initial interviews and other investigation techniques, the Examiners identified the following compliance risk areas that required further review and analysis:

a. Compliance infrastructure and controls
b. Company operations and management
c. The financial structure of the Company, including inter-company relationships, the flow of funds between the entities and transparency of such relationships to stakeholders
d. Agent training, communication, oversight and monitoring procedures
e. Marketing and sales practices
f. Complaint/Grievance handling
g. Underwriting practices
h. Claims handling

The examination approach and work plan developed for the multi-state examination included various examination techniques. The Examiners used the NAIC Market Regulation Handbook as a guide to assist in identifying potential issues and to suggest examination methodology. The methodology included interviews with leadership, key home office personnel, field management and agents. As indicated in the examination scope, interviews covered the Company's structure and operations. The Examiners requested and received information regarding

these areas. Company responses were reviewed to determine compliance with the NAIC examination standards deemed by the examination team to be appropriate for this examination. Targeted attribute testing was conducted, and sampling methodologies described in the NAIC Market Regulation Handbook were followed. The report for this examination is a report by test.

Additional interviews were conducted with 51 field leaders and agents.

Findings and Required Actions

The Examiners noted deficiencies and issues with the Company's oversight, communication, monitoring and training of agents, claims handling practices, complaint handling practices, policyholder treatment and transparency related issues relative to its relationships with the membership associations. The most significant issues identified during the examination process are noted below in order of priority.

Finding # 1: The Company did not provide sufficient training to their agents and did not provide proactive oversight of their activities.

A. Between January 1, 2005, and June 30, 2005, Mega and Mid-West combined accounted for 931 complaints covering 1,199 issues. 397 of the total issues (33.1%) involved aspects of agent activities, including agent presentation issues, fraud and forgery. There were many other complaints about claims handling, such as denial and benefit disputes. These numbers indicate a lack of sufficient training of agents, particularly new agents, both in product specific and general health insurance areas.
B. There was a lack of sufficient quality assurance procedures over agent activities such as monitoring and auditing the activities of agents and agency management. Regional directors, division managers and district managers were not held accountable for the lack of compliance activities of the agents for which they were responsible.

Required Action #1: The Company must modify its agency program to expand and improve its agent training, particularly with new agents. The training program must include modules on industry knowledge, ethics, product presentation, proper disclosures, consistent delivery across agencies and a robust structure, among other enhancements, as follows:

A. To ensure agents and consumers thoroughly understand the product they are selling/buying and appropriate disclosures are made at the point of sale, the Company must:

1. Strengthen the training program for new agents by including health insurance industry information and more emphasis on state specific product information.
2. Provide agent training more frequently based upon average agent retention statistics, such as every six months rather than annually.
3. Develop a standard but progressive curriculum for agents based upon experience level with the Company.
4. Strengthen the training program for existing agents, particularly in the areas of product information, ethics and point-of-sale presentations.
5. Develop centralized standards and controls to manage agents and train agency management in appropriate controls and monitoring of agent and agency activities. Develop tools and metrics for measuring the effectiveness of training (e.g., reduction of complaints, reductions in cancellations, etc.).
6. Develop additional methods to help consumers have a better understanding of the Company's products during the sales process.
7. Train Benefit Confirmation Program (BCP) staff to be assertive in reviewing coverages with clients to ensure more calls are successfully completed.

B To provide adequate monitoring of agents and agent activities, the Company must:

1. Implement quality assurance procedures over agent activities including monitoring procedures and periodic audits.
   - The Company must enhance the monitoring of agents' training by requiring monitored testing and monitoring the delivery of the training presentations by the field managers.
   - The Company must implement a plan to monitor agents' actions using tools such as comprehensive field audits, phone interviews with recent customers, secret shoppers and trending of agent and agency related information, such as complaint statistics, cancellations, product upgrades and other agent monitoring tools.
   - The Company must provide additional point-of-sale materials such as scripts and checklists

for agent's use and ensure that all materials include appropriate disclosures.

Investigate all agents with unusual trend statistics and all complaints regarding claims that allege that agents misrepresented the product at the point-of-sale. Any agent found to be misrepresenting the product at the time of sale should be retrained, disciplined or dismissed as appropriate for the circumstances. Field management, such as regional and district managers and above, must be held accountable for the actions of each agent under their direction. The manager's performance assessment and overall compensation program should be directly tied to the level of complaints, cancellations and other indications of inappropriate agent activities experienced by the agents they supervise. Incentives should also be developed which reward regional managers who demonstrate effective accountability and management of their agents with respect to compliance requirements and performance.

Subsequent developments reported by the Company but not validated by the Examiners can be found in Report of Examination, Section F, page 53.

Finding #2: Many deficiencies were noted in the Company's claims handling practices as noted below:

A. In certain situations, the Company changed the diagnosis code or CPT code in the course of adjudicating a claim.

B. If a claim form had multiple lines of procedure codes that exceeded the file content capacity, it resulted in multiple claim numbers for one claim form.

C. Delays in claim settlements were the result of pending new claims while awaiting the receipt of medical information requested on a previous claim. No information regarding the delay was communicated to the consumer regarding the status of the new claim.

D. Claims acknowledgement letters were being used to inform claimants of claims settlement delays however, the letters did not always contain a reason for the delay. The Company did not consistently send "delayed claim settlement" letters.

E. **Explanation of Benefit (EOB)** forms did not contain deductible information.

F. The Examiners found instances where the Company did not adjudicate claims in the correct insurance entity.

G. During the examination period, the Company did not have a claims manual or written claims procedures.

H. There was no routine and recurring independent audit of claims handling procedures to ensure compliance with laws and regulations of the appropriate jurisdiction. Audits allow the Company to identify trends and root causes of mishandled claims by focusing attention on identifying training needs and problem claims adjusters.

Required Action #2: The following actions are required of the Company:

A. In regards to the CPT codes for each claim, the Company must:

1. Adjudicate each claim independently. The Company's practice of pending claims while waiting for information on other claims must cease.
2. Identify and re-adjudicate any claims for which diagnosis and CPT codes were altered because of the risk that the claim may not have been paid correctly as a result of the code change. The Company must cease to alter diagnosis and CPT codes submitted by providers on claims.

B Each claim must be adjudicated independently and assigned one claim number per claim form. The Company should evaluate the cost/benefit of replacing its current claims system due to limitations with the current system.

C. All claims should be adjudicated in a timely manner according to the jurisdiction in which the claim is made.

D. When claims settlement is delayed, the Company must send a "delayed claim settlement" letter and clearly set forth the reason for the delay. The format and content of delay letters must be in compliance with the applicable jurisdiction covering the transaction. The Company must ensure that all delayed claims letters are sent in all instances in which claim settlement is delayed.

E. All **EOB** forms should include the deductible information pertinent to the claim.

F. All claims must be filed with the Company in which the claim is being made.

G. The Company must develop and maintain a Claims Procedures Manual which includes comprehensive written claims adjudication procedures that are updated on an ongoing basis.

H. On a regular basis, the Company must perform claim audits of claims handling procedures to determine adherence to the Claims Procedures Manual. The results of such audits must be analyzed by compliance personnel to identify trends and root causes of claims mishandling, areas for training emphasis, problem claims adjusters and the need for disciplinary action for recurring errors by specific claims adjusters.

Subsequent developments reported by the Company but not validated by the Examiners can be found in Report of Examination, Section D, page 49..

Finding #3: The Company's process for disclosing to consumers and policyholders their relationships with the membership associations was insufficient. Transparency of activities, relationships and financial arrangements between various UICI affiliates and their interaction with the associations and other UICI affiliates was insufficient.

Required Action #3: The Company must provide sufficient information, oral and written, to consumers and policyholders regarding the Company's relationship with the associations and other UICI affiliates as applicable. This includes the following:

A. The Company must change its procedure such that the insurance payments and the association payments are received as two separate payments.

B. The Company needs to clearly disclose to regulators how the **Policy Fees** and the association **New Member Admin Fees** are allocated between the insurance company and the associations. This will assist the Company in providing to the regulators an accurate accounting for premium tax purposes and for the proper accounting for premium refunds to insureds.

C. The Company must prepare separate financial information for **Performance Driven Awards, Inc. (PDA)** and **Success Driven Awards, Inc. (SDA)** on at least an annual basis and have it available for domestic regulators upon request.

D. The Company needs to remain vigilant that its relationships with all entities are cost effective and do not adversely impact the cost of insurance to consumers/policyholders.

E. The Company must provide to regulators authoritative accounting support for its treatment of the agent's stock benefit match recorded in two of its non-insurance company affiliates.

Subsequent developments reported by the Company but not validated by the Examiners can be found in Report of Examination, Section G, page 56.

Finding #4: Many deficiencies were noted in the handling of complaints and grievances:

A. Complaints were not recorded in the required format on the Company's complaint register.
B. The Company did not take adequate steps to finalize and dispose of complaints in accordance with applicable statutes, rules and regulations, and contract language.
C. The timeframe within which the Company responded to complaints was not in accordance with applicable statutes, rules and regulations.
D. Written complaints submitted by or on behalf of a covered person were not treated as a grievance in states where separate grievance laws apply.
E. When complaints were received, the Company did not determine if the communication was a complaint or a grievance. Therefore, the Examiners could not determine if the Company handled the complaint appropriately.
F. For complaints involving agent's actions, the Company did not always request an agent statement. In addition, there was inconsistent evidence that disciplinary actions were taken against agents involved in the complaints.
G. The Company's **Complaint Action Team (CAT)** focused solely on complaints in an effort to identify actions designed to reduce the number of complaints. Once the complaint issue was released to the manager of the area responsible for the complaint, there was no apparent follow-up to ensure that the issue has been handled appropriately.

Required Action # 4: In order for complaints and grievances to be handled appropriately, the Company must take the following actions:

A. The Company must record and log all complaints in compliance with states' laws and the Company's policies and procedures.
B. The Company must ensure that all issues raised in a complaint/grievance are investigated,

finalized and disposed of in accordance with applicable statutes, rules and regulations, and contract language.

C. The Company must comply with the timeliness of response and timeliness of resolution of complaint/grievance as required by applicable statutes, rules and regulations.
D. The Company must identify states with separate grievance laws and recognize which complaints are considered as grievances under these laws.
E. The Company must request an agent statement for all complaints involving agent's actions.
F. The Company must maintain better oversight of complaints by:
    1. Preparing a report outlining the business practice reforms it implemented along with supporting documentation as to the adequacy of the reforms. This report should be used in creating a workplan for a follow-up examination.
    2. Implementing a process and log by which complaint issues are discussed by the **CAT** are tracked. This log should include, but not be limited to, the complaint issue, the area of the Company responsible for the issue raised in the complaints and steps being taken to avoid this issue in the future.

Subsequent developments reported by the Company but not validated by the Examiners are included in *Report of Examination, Section B, Review of Insurance Operations, page 41.*

Finding #5: The Company did not have a formal corporate compliance plan in place until November 2004. In addition, it did not have a centralized corporate compliance department in place until mid-2005. For the majority of the examination period, there was no centralized compliance function, no "compliance controls champion" or compliance infrastructure to facilitate the identification of compliance control risks, remediation of deficiencies, ongoing monitoring of the Company's compliance with laws and regulations and reporting of compliance deficiencies to governance boards and committees with accountability. Significant compliance control deficiencies existed during the examination period as supported by the high volume of complaints, nature of complaints and complaint trends, among other factors.

Required Action #5: The Company's adherence to its Compliance Plan and compliance program enhancements must be independently evaluated at periodic intervals and should be re-examined in the next 12 to 18 months. The Company must inform regulators on a timely and periodic basis concerning

the program's enhancements and changes to its compliance procedures.

Conclusion

To address the concerns identified throughout this report, the Company must take immediate action to significantly improve the training, communication, oversight and monitoring of agents and agencies. It must take the actions identified above to reduce complaint levels significantly and remediate deficiencies in its complaint handling and claims handling procedures. The Company needs to take immediate action to provide disclosure of its relationships with the associations to consumers and policyholders. The Examiners strongly recommend that the Company's compliance with the above required actions, particularly those relating to agent oversight, training and claims handling, be re-examined within 12 to 18 months of the issuance of this report.

At various times during the examination process, the Company indicated to the Examiners that changes to policies and procedures were implemented in response to examination findings. These changes are included in the respective sections of the Report of Examination in this report. Because some of these changes occurred after the examination period, the Examiners were not able to validate or support these changes. Review of these changes may be the subject of follow-up activities.

INTRODUCTION

This examination report presents the approach, findings, observations and required actions of the examination of the insurance operations of UICI, Inc. (the "Company") performed by RSM McGladrey, on behalf of Washington Office of the Insurance Commissioner, the Alaska Division of Insurance and 34 participating jurisdictions.

In addition to Washington and Alaska, participating jurisdictions include: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, Wyoming and the District of Columbia.

The report is structured in the following manner:

Executive Summary
Introduction
Glossary
Scope of Examination
Company Profile
Report of Examination
Examination Background
Examination Approach
Report on Examination Objectives
Findings and Required Actions
Results of Attribute Testing
Subsequent Developments
Certification and Acknowledgements

Appendices

A. Participating States

B. Confidential National Compliance Plan

Exhibits

The majority of the examination was performed on site at a satellite office provided by the Company in Hurst, Texas. Interviews with agents were conducted in many states across the country.

The Company provided access to its records, both electronic and paper, including its computer systems. The Company also facilitated interviews with their agents and with certain business associates as requested by the Examiners.

GLOSSARY

Term	Acronym	Description
Agency Marketing Group	AMG	A UICI division, created in 2004 that oversees the two marketing units – Cornerstone America and UGA. The agencies are operated independently of one another.
Alliance for Affordable Services	AAS	One of the associations that makes available to their members UICI's health insurance products through CSA/Mid-West agents. It had approximately 150,000 members at the time of the examination.
Americans for Financial Security	AFS	One of the associations that makes available to their members UICI's health insurance products through UGA/MEGA agents. It had approximately 25,000 members at the time of the examination.
Benefits Administration for the Self Employed	BASE or BASE 105	A benefit-administrator division, not wholly-owned by UICI, that provides Health Reimbursement Arrangements (HRAs) that qualify members for tax deductions for medical expenses under IRS Section 105.

Term	Acronym	Description
The Blackstone Group	N/A	A private investment and advisory firm focusing on alternative asset investing. In addition to private equity investing, their core businesses are private real estate investing, corporate debt investing, marketable alternative asset management, corporate advisory, and restructuring and reorganization advisory. Effective April 5, 2006, HealthMarkets (formerly UICI) merged with affiliates of The Blackstone Group, Goldman Sachs Capital Partners and DLJ Merchant Banking Partners.
The Chesapeake Life Insurance Company (a Wholly owned subsidiary of MEGA.)	CLICO	One of three UICI insurance entities examined.
Complaint Action Team	CAT	One of two internal committees within Self-Employed Agency (or Self-Employed Unit) (SEA) with compliance focus. The CAT, chaired by the SEA division head of consumer affairs, focuses solely on complaints in an effort to identify actions designed to reduce the number of complaints. Each team consists of officers and key staff members of SEA, as well as in-house and outside counsel. These teams operated independently of each other with no general oversight during the examination period.

Term	Acronym	Description
Cornerstone America	CSA	One of two sales agencies which are owned by UICI. Sells Mid-West products.
Department of Insurance	DOI	Insurance Department within each state.
Enterprise Document and Record Retention Program	DRR	The Company's Document and Record Retention Program which began implementation in May 2005 and is expected to be completed by July 2007.
Field Service Representative	FSR	Agent sales force including local sales managers.
HealthMarkets	N/A	Effective April 5, 2006, HealthMarkets (formerly UICI), merged with affiliates of The Blackstone Group, Goldman Sachs Capital Partners and DLJ Merchant Banking Partners, each of which is a private equity firm. Following the merger, the stockholders of HealthMarkets include members of management, HealthMarkets' dedicated insurance agents associated with the UGA-Association Field Services or Cornerstone America marketing divisions and the investment affiliates of the private equity firms.

Term	Acronym	Description
Market Analysis Working Group	MAWG	NAIC working group that identifies and reviews insurance companies, which are, or may exhibit characteristics of a current or potential market regulatory issue for multiple jurisdictions. MAWG also determines if regulatory action is being taken and supports collaborative actions in addressing problems identified.
The MEGA Life and Health Insurance Company	MEGA	One of three UICI insurance entities examined.
Memorandum of Understanding	MOU	The document created by MAWG and lead states which outlines the multi-state issues and objectives of this examination.
Mid-West National Life Insurance Company of Tennessee	MW or Mid-West	One of three UICI insurance entities examined.
National Association of Insurance Commissioners	NAIC	An association of insurance commissioners of which every state is a member and which coordinates insurance regulation on a national level.

Term	Acronym	Description
National Associations of Self-Employed	NASE	One of the associations that makes available to its members UICI's health insurance products through UGA/MEGA agents. NASE was founded in 1981. Ronald Jensen and his spouse, Gladys, served on the NASE Board of Directors from December 22, 1982 until May 31, 1985. Mr. Jensen was President of NASE for some or all of that time. It had approximately 250,000 members at the time of the examination.
New Member Admin Fee	N/A	One-time fee charged to members who join an association. Through December 31, 2005, the fee was $25 when insurance was not purchased and $120 - $125 when insurance was purchased in states that require membership in order to be eligible to purchase insurance.
Oklahoma Life	OKC or LifeOKC	A functional division (Term Life) of UICI not included in the scope of the examination.

Term	Acronym	Description
Performance Driven Awards, Inc.	PDA	A wholly owned subsidiary of UICI incorporated in Texas on May 14, 1997. PDA provides services to certain of the independent associations (NASE and AFS) that make available to their members UICI's health insurance products, including enrollment of new members. PDA in turn contracts with independent field services representatives to provide such services to the associations. PDA also has an agreement with MEGA for management services, most of which relate to associations. Associations remit commissions to PDA monthly for dues collected in that month and additional incentive paid for new members.
Policy Fee	N/A	Flat dollar amount added to the basic premium rate for policies issued in states in which the applicant is not required to join the association in order to purchase insurance (referred to as "individual" states).
Regulatory Action Team	RAT	One of two internal committees within SEA with compliance focus. The RAT, chaired by the chief compliance officer of the SEA division, focuses on all regulatory and compliance issues. Each team consists of officers and key staff members of SEA, as well as in-house and outside counsel. These teams operate independently with no general oversight.

Term	Acronym	Description
Sales Review Team	N/A	An internal team that meets monthly and recommends re-training and other corrective actions including termination of the agent based on complaints which are tracked and monitored on a regular basis.
Self-Employed Agency (or Self-Employed Unit)	SEA or SEU	A division of UICI. Its focus is to provide health insurance and related insurance products to the self-employed market. These products are distributed through UICI's two marketing divisions: UGA and Cornerstone America. SEA is the largest insurance related division within UICI and the majority of insurance products sold by the agency force are administered by SEA. SEA consists of the Insurance Center in North Richland Hills, TX and HealthMarkets in Norwalk, CT.
Specialized Association Services	SAS	SAS has an agreement with the associations to provide certain administrative services, including billing, administrative delivery of membership materials, and benefit procurement services. SAS is controlled by Ronald Jensen's adult children.
Star Health Resources Group	Star HRG	A functional division which administers voluntary and limited benefit health plans for high-turnover hourly, entry-level, or part-time employees. On July 11, 2006, CIGNA acquired Star HRG and its employees.

Term	Acronym	Description
Student Insurance Division	SID	A functional division (Student Health) of UICI.
Success Driven Awards, Inc.	SDA	A wholly owned subsidiary of UICI incorporated in Texas on October 31, 2003. SDA provides services to one of the independent associations (Alliance for Affordable Services) that make available to their members UICI's health insurance products, including enrollment of new members. SDA in turn contracts with independent field services representatives to provide such services to the association. SDA also has an agreement with Mid-West for management services, most of which relate to associations. The association remits commissions to SDA monthly for dues collected in that month and additional incentive paid for new members.
Training, Testing, Audit, Complaints & Compliance	TTACC	The training program developed by UICI for UGA and CSA. Formal training materials are collectively developed and maintained by the Training Group at AMG and UICI's Compliance Department. Implemented nationwide in 2003, training is conducted by the 2nd and 3rd Tier managers in UGA and CSA. There are versions of TTACC for each state where it operates that includes generic modules and some state-specific information and/or requirements. Training culminates with a test. All prospective agents are required to pass with an 80% score. It is an open-book, multiple-choice test. Manager-level individuals must score a 90% to pass the examination. Annual re-testing is required.

Term	Acronym	Description
United Group Association, Inc. or UGA – Association Field	UGA	One of two sales agencies which are owned by UICI. Sells MEGA products.
ZonRE	ZonRe	A functional division (Accident Reinsurance) of UICI not included in the focus of the examination.

SCOPE OF EXAMINATION

In 2003, the **National Association of Insurance Commissioners (NAIC)** formed the **Market Analysis Working Group (MAWG). MAWG's** initial charge was to identify insurers with market conduct issues in more than one state and to develop multi-state solutions. One of the companies perceived to have issues in multiple jurisdictions was **The MEGA Life and Health Insurance Company**. **MAWG** invited UICI to attend a National **NAIC** quarterly meeting and discuss with regulators their plan to become compliant with the common issues raised by **MAWG.** The Company initially declined **MAWG's** invitation. Company representatives ultimately met with regulators at the Fall National meeting in September 2004 and presented a plan that concentrated on agent training but did not address the other compliance issues noted by regulators. As a result, on March 15, 2005, under the direction of **MAWG,** the States of Washington and Alaska issued a call letter to UICI for a multi-state examination.

Each participating state was asked to sign a **Memorandum of Understanding (MOU).** As of the report date, a total of 36 jurisdictions were participating in this multi-state effort. The original **MOU** contained the following examination objectives:

A. Determine the companies' adherence to the Confidential Compliance Plan created by the companies dated November 30, 2004 (Confidential National Compliance Plan).
B. Determine if there are general policies and procedures in place to ensure that management maintains appropriate oversight of insurance operations (Review of Insurance Operations).
C. Determine the types of policies sold by the companies in the various jurisdictions (Types of Policies Sold).
D. Review UICI's claims settlement practices to determine if they comply with applicable statutes, rules and regulations (Review of Claims Settlement Practices).
E. Determine the distribution systems used for each product type (Product Distribution Systems).
F. Review UICI's marketing practices to determine if they comply with applicable statutes, rules and regulations (Review of Marketing Practices).
G. Determine the nature of the associations associated with UICI and their role in the insurance operations of the companies (Association and Affiliate Relationships).

SCOPE OF EXAMINATION

From information ascertained during the initial months of the examination, concerns were raised about the Company's lack of transparency with regard to its relationships to the membership associations and other UICI entities. Due to the concerns regarding lack of transparency and the complexity of the relationships between the Company, its affiliates and the membership associations, the scope of the examination was expanded to include an in-depth review of those relationships. Additionally, attribute testing was added to the scope to determine if the Company was in compliance with procedures described to the Examiners during the initial months of the examination, as well as with the Confidential National Compliance Plan. Therefore, the lead states of Washington and Alaska expanded the scope as follows:

H. Expand the inter-company relationship review to include all UICI subsidiaries for the five-year period ending December 31, 2004 to understand the Company's legal and financial organizational structure (Financial Overview).
I. Review the flow of funds between UICI companies and the associations as represented by Company-prepared flow charts to validate their accuracy (Flow of Funds).
J. Select samples and conduct attribute testing of Complaint/Grievances, Underwriting and Claim files (Results of Attribute Testing).

The call letter stated the examination period was for the five-year period from 2000 through 2004. Attribute testing was performed covering the period from January 1, 2005, through June 30, 2005. Agent interviews were formally concluded in December 2005. A few former agents were interviewed in early 2006; however, their formal relationship with the Company had terminated prior to December 31, 2005. To provide consistency and continuity throughout the report to the examination objectives outlined above, each objective has been given an Examination Objective title, which is noted in parenthesis above. The Examination Objective titles noted above are used as headings throughout the Report of Examination to link the examination objectives to discussion of the work performed and the results noted.

COMPANY PROFILE

Historically, UICI offered health insurance, life insurance products and selected financial services to niche consumer and institutional markets throughout the United States and Puerto Rico. Its insurance subsidiaries distributed the products primarily through the Company's two dedicated agency field forces: **United Group Association, Inc. or UGA-Association Field Services (UGA)** affiliated with **The MEGA Life and Health Insurance Company (MEGA), and Cornerstone America (CSA)** affiliated with **Mid-West National Life Insurance Company of Tennessee.**

Prior to the start of the examination, UICI had exited multiple lines of business to refocus on its core operations. These exited lines of business include sub-prime credit card, national motor club, workers' compensation, third party administration and special risks business. In addition, the College Fund Life Division's College First Alternative Loan Program stopped issuing new life insurance policies as of May 31, 2003. UICI indicated its on-going mission would be to generate long-term shareholder wealth as a leading provider of health and life insurance and related products, and to serve the self-employed individual, senior citizen and student markets through dedicated distribution channels.

At the time of the examination, UICI's domestic insurance companies included **The MEGA Life and Health Insurance Company (MEGA), Mid-West National Life Insurance Company of Tennessee (Mid-West) and The Chesapeake Life Insurance Company (CLICO). MEGA** is domiciled in Oklahoma and is licensed to issue health, life and annuity insurance policies in all states except New York. **Mid-West** was domiciled in Tennessee and was licensed to issue similar policies in Puerto Rico and all states except Maine, New Hampshire, New York and Vermont. During the examination, **Mid-West** was re-domiciled to Texas. **CLICO**, a subsidiary of **MEGA,** is domiciled in Oklahoma and is licensed to issue health and life insurance policies in all states except New Jersey, New York and Vermont. Please refer to Chart 1 on page 31 for the legal entity structure of the Company as of December 31, 2005.

UICI also maintained three offshore reinsurance companies: United Group Reinsurance, Inc., Financial Services Reinsurance Ltd. and U. S. Managers Life Insurance Company. The volume of underwriting risk transferred to these offshore reinsurers was not significant in relation to UICI's total book of business.

During the examination period, UICI managed its business through three business segments referred to as Insurance, Financial Services and Other Key Factors. The Insurance segment, which provides the majority of UICI's revenues and net income, includes revenues from the sale of individual and group health policies as well as life insurance policies. During the examination period, this segment included five divisions, which are shown in Chart 2 on page 32.

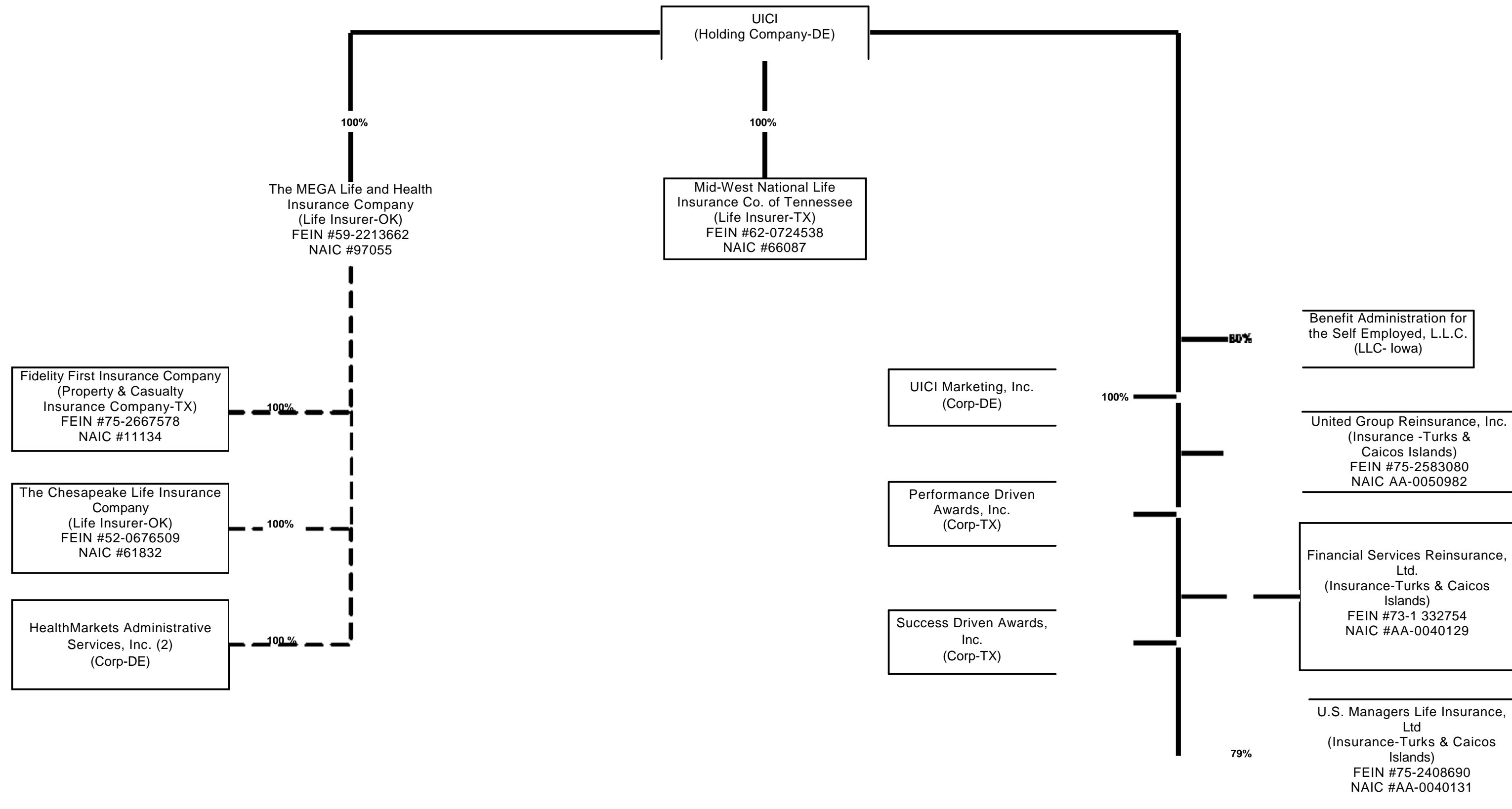
The **Self-Employed Agency (SEA)** Division, which is the largest division, offers a portfolio of traditional indemnity and PPO health insurance products to self-employed individuals in 43 states and the District of Columbia. The traditional indemnity health insurance products are designed to limit coverage to the occurrence of significant events requiring hospitalization. However, each policy offered coverage modifications so the insurance could be tailored to meet the individual policyholder's needs.

SEA's PPO products provide more flexibility for insureds than the traditional product. This product provides two levels of benefits – a higher level if the insured chose in-network providers or a lower level if the insured chose out-of-network providers. UICI contracted with three non-proprietary, national, preferred provider networks and 17 regional PPO organizations to service its managed care membership. In order to purchase these products, membership in one of the associations was required in those states in which association group coverage was offered. During the Examination period, association group coverage was offered in the majority of the states. For **MEGA** products, the aligned association was the **National Association for the Self-Employed (NASE)** and **Americans for Financial Security (AFS).** For **Mid-West,** the association was the **Alliance for Affordable Services (AAS).** If the insured was not a member at the time of solicitation, the agents enrolled them in the appropriate association as part of the application process. Once the insurance policy was issued, the insured could cancel the association membership.

UICI's **Student Insurance Division (SID)** and the **Star Health Resources Group (Star HRG)** Division offered group insurance products. The **SID** marketed health insurance coverage to students attending colleges and universities in the United States and Puerto Rico. UICI purchased **Star HRG** in February 2002. This Division marketed and administered limited benefit plans, such as medical, life, disability and dental for entry level, high turnover and hourly employees. Both of these Divisions were sold in 2006.

The primary stockholders during the examination period were Ronald L. Jensen and his family members. Mr. Jensen was also the Chairman of the Board of Directors and was actively involved in the day-to-day management of the company. His involvement is discussed in more detail in the Report of Examination, section B.

UICI ORGANIZATIONAL CHART OF INSURANCE ENTITIES AS OF DECEMBER 31, 2005

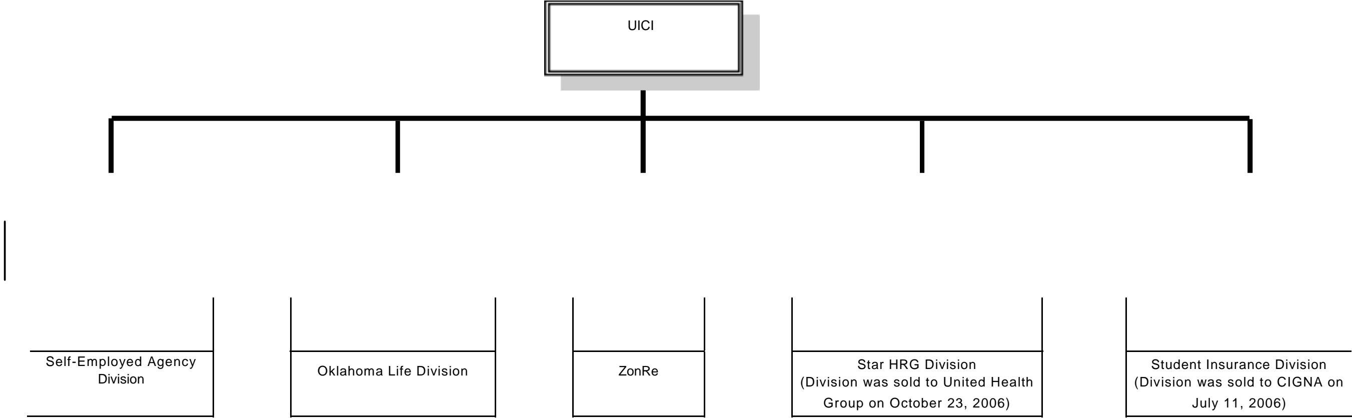


This document is an organizational chart of only insurance-related entities based on information submitted by the Company in its 2005 Annual Statement

CHART 1

UICI ORGANIZATIONAL CHART OF BUSINESS

DIVISIONS AS OF DECEMBER 31, 2005



This document is an organizational chart of UICI's insurance-related divisions based on information provided by the Company.

CHART 2

REPORT OF EXAMINATION

Examination Background

The following time periods were established as the scope of the examination:

- To understand the Company's legal organization and financial structure, the five-year period ending December 31, 2004, was used. Some historical elements from earlier periods were reviewed if the Examiners determined it was pertinent to the examination.
- The attribute testing was performed covering the time period from January 1, 2005, to June 30, 2005.
- Agent interviews were formally concluded in December 2005. A few former agents were interviewed in early 2006; however, their formal relationship with the Company had terminated prior to December 31, 2005.

The Examiners noted the following conditions at the onset of the examination:

- The Company was in the process of changing many operations as well as changing the compliance function structure while the Examiners were on site. Because some of these changes occurred outside the examination period, the Examiners have reported relevant facts as they became aware of them. Validation of subsequent changes reported by the Company was not within the scope of this examination but is the subject of a required action for future review by regulators.
- There were several open single state market conduct examinations.
- The Company was agency driven. Most operations were driven by agent needs rather than customer needs.
- The legal structure of the insurance entities varied significantly from the operational structures. The operational structure of the Company was complex and similar functions were often divided into various operational units.
- Complaint ratios were higher than average nationally and in many states.

- The Company did not have a centralized compliance program. Rather, compliance was a function of each business division and there was a lack of consistency and formal structure in the compliance programs.
- Due to the decentralized operational structure, there was a lack of management oversight, especially with regard to the agency management and marketing units.
- Some agent supports are provided by **PDA** and **SDA**, which are entities owned by UICI that oversee **MEGA** agents and **Mid-West** agents, respectively.
  - Each agency created its own agent training programs.
  - Each agency handled compliance functions on its own, and did not always communicate the same information to agents.
  - Agent contracts in **PDA** and **SDA** did not have the same provisions.
  - Each agency worked with a specific association.
- Oversight of agents was performed at the district manager level. The Home Office was minimally involved with agent training, performance and quality assurance as agents were considered independent contractors, not employees of UICI.
- The associations and the Company were dependent upon each other, but there was no evidence to indicate that the associations were under the control of UICI.
- Collecting and processing insurance premiums was co-mingled with collection and processing of association fees through an intermediary service, **Specialized Association Services (SAS).** As a single check was usually written to cover association fees and initial premium, there was no clear indication to applicants which company was providing which services.
- Attribute testing of the Company's processes and procedures identified numerous exceptions in key compliance and operational areas examined, such as claims/grievance handling and complaint handling. These exceptions are discussed further in this section of the report and in the Results of Attribute Testing section.
- The **DRR** (record retention) program was newly implemented on May 20, 2005.

On November 30, 2004, the Company submitted a voluntary compliance program to the states via **MAWG.** This program was a comprehensive plan to improve company operations and compliance with statutory requirements of the

states. When this examination began in May 2005, the Company had initiated several re-engineering programs for the insurance operations. On the non-operational side, the Company moved both **UGA** and **CSA** under the same management and was beginning to move oversight for all compliance into one corporate level unit.

Examination Approach

The examination was performed in accordance with the States of Washington and Alaska's examination procedures, and under the contract between the State of Alaska and RSM McGladrey, Inc.

The unique multi-state aspect of the examination required the Examiners to employ interviewing and investigation techniques in addition to the examination processes and sampling methodologies described in the **NAIC** Market Regulation Handbook.

A detailed workplan was established to ensure that each examination objective was addressed. The ten examination objectives were as follows:

A) Confidential National Compliance Plan (See Appendix B)

- Review the Confidential National Compliance Plan presented to the Alaska **Department of Insurance (DOI)** in November 2004.
- Determine if the Company has complied with the program presented.

B) Review of Insurance Operations

- Interview all senior members of management responsible for various divisions such as **SEA, SID, Star HRG** and the **Oklahoma Life Division (OKC or LifeOKC).**
- Interview compliance and operations personnel in **SEA.**
- Review written policies and procedures including compliance, underwriting, claims, marketing and agency management within **SEA.**

C) Types of Policies Sold

- Conduct interviews with agents.
- Review **TTACC** materials to determine if information related to the Company, the policies and the associations are complete.

D) Review of Claims Settlement Practices

- Conduct interviews of claims personnel.
- Review written policies and procedures for completeness.
- Conduct attribute testing to determine if the Company's policies and procedures are being administered in compliance with **NAIC** standards.

E) Product Distribution Systems

- Gain an understanding of what comprises the **Agency Marketing Group (AMG).**
- Conduct a review of the field force structure.
- Conduct a review of how the agents represent the associations.
- Gain an understanding of how agents are compensated.
- Gain an understanding of the agent recruiting process.
- Gather information as to how agents obtain leads and how the Company distributes leads.

F) Review of Marketing Practices

- Review agent training materials to determine if the content was complete and accurate.
- Review processes used for administering training programs.
- Interview agency managers and agents to determine if the Company maintained an active program of agent oversight including sales processes and on-going training. Interviewees were chosen randomly from the total population of active agents and managers around the country.
- Conduct interviews with former agents who expressed willingness to regulators to discuss training and sales processes.

G) Association and Affiliate Relationships

- Perform interviews with key personnel within UICI and the associations to determine how each organization interacted and worked together (insurance operations, **UGA, CSA, SAS,** associations, etc.).

H) Financial Overview

- Review annual statements and financial transactions for the five-year period ending December 31, 2004, with an emphasis on acquisitions, sales of assets, dividends and streams of income.

I) Flow of Funds Between Company and the Associations

- Review management agreements between entities and trace the flow of funds between the Company and the associations.
- Select a judgmental sample of policies and trace the financial transactions as they were transferred through the various entities.

J) Results of Attribute Testing

- Perform attribute testing to verify compliance with policies and procedures by comparing Company performance against the standards set forth in the **NAIC** Market Regulation Handbook. The areas tested were Complaints/Grievances, Claims and Underwriting.
- Conduct testing through direct review of random samples of files using the sampling methodology described in the **NAIC** Market Regulation Handbook. For statistical purposes, use an error tolerance of 7% for claims and 10% for complaints and underwriting samples. The sampling techniques are based on a 95% confidence level.
- The sampling methodology described in the **NAIC** Market Regulation Handbook generally calls for a sample of 50 files when the file population being sampled is less than 5000 and a sample of 100 files when the file population being sampled exceeds 5000.
- **CLICO** did not write any of the products targeted for review. As a result of a lawsuit, a limited number of accident and health policies were issued to some **MEGA** and **Mid-West** customers. Conduct a sample of such claims.

Report on Examination Objectives

The record of work performed and overall assessments for each of the ten examination objectives outlined in the scope are as follows:

A) Confidential National Compliance Plan

On November 30, 2004, the Company presented a Confidential National Compliance Plan to Director Linda Hall, State of Alaska Insurance Division. The Plan was comprised of the following four areas: Marketing and Sales, Claims – **MEGA** and **Mid-West** Self Employed Divisions, Claims – **MEGA's** Student Division and Producer Oversight.

Overall Assessment of the Confidential National Compliance Plan:

The Plan emphasized the training of agents and enhancement of claims programs. Several of the procedures listed were already in beta testing stages at the time the Plan was presented to Director Hall. The Examiners determined that the Plan, while a start, was not as comprehensive as it should be. It was missing many components of insurance corporate compliance programs that would make it an effective plan. In particular, the Examiners noted the following:

- The Company developed nine key training criteria for agents. Most of the areas were sufficiently covered but the topics of ethics, trust, honesty and responsibility were not as prominently covered in the training material. In addition, the training lacked health insurance and general insurance training, appropriate product-specific information, appropriate sales presentations and disclosures, among other deficiencies. This subject is addressed in more detail in a latter part of this report section.

- The Plan called for all training to be performed by the field hierarchy and for all training to be consistent with the training guideline. The Company tested the agents at the end of training with a standardized, open book, unmonitored test. With the exception of the test, the Company did not demonstrate quality assurance over the training of the agents. By conducting minimal field audits, there was limited validation that the information included in the training was being used by agents during consumer presentations. Validation that the training

the training provided the appropriate information and that the information included in the training was being used by agents in consumer meetings was crucial to understanding whether the training is sufficient.

B) Review of Insurance Operations

Based on the states' communications with Company personnel at all levels, it was apparent that there was no central point for compliance issues to be addressed in the insurance operations area. Although the Company indicated that they were adding staff in this area, there were still complaints from states that they were having problems getting responses from the Company. Little change was seen in the frequency and type of complaints being received by various jurisdictions. Also, there were reports that the Company failed to cooperate with regulators during examinations. In 2004, in response to state specific examination findings, the Company began making changes to its structure and operational processes. These included the following:

- In 2004, the Company engaged a consulting firm to review all of its processes and make recommendations for improvements.
- While the Examiners were on site and subsequently, the Company implemented a series of improvements in its insurance operations departments.
- While the Examiners were on site and subsequently, the Company re-organized its compliance department.
- In April 2005, the Companies adopted an additional method of monitoring agent sales activity and obtaining further assurance that customers understand their health insurance coverage. They began contacting new customers by telephone within the first three to four weeks after the policy has been delivered to verify their understanding of the products they had purchased. This Benefit Confirmation Program ("BCP") includes a review of the customer's coverage benefits and limitations and provides the customer an opportunity to ask for clarification or pose questions. The BCP was initially implemented for customers who had purchased one of the Company's scheduled health plans.
- The interviews conducted by the Examiners and the attribute testing of underwriting files under **NAIC** Underwriting Standard COM-6 revealed that the Company did not have an adequate policy of record retention prior to May 20, 2005.

Overall Assessment of Insurance Operations:

The Company must implement significant improvements to achieve this examination objective based upon the following:

- The number of complaints indicates that a large percentage of policyholders do not understand their policies, type and the manner in which claims are adjudicated. See Chart 1 on page #46.

- As a result of attribute testing, the Examiners concluded that the complaint and claims functional areas have many failures requiring immediate action. Please refer to the Results of Attribute Testing and the Findings and Required Actions sections of the report for additional information regarding these failures.

- The record retention program implemented on May 20, 2005, was being phased in. The completion date was planned for June, 2007. The plan the Company outlined appeared appropriate, but adherence to the Company's record retention program should be monitored in a follow-up examination.

- During the examination period, the Company had inadequate controls in place to ensure that the Company was in compliance with certain or specific market conduct laws and regulations. Significant improvements, to the extent not already done, are necessary to achieve more effective controls.

Subsequent developments reported by the Company but not validated by the Examiners are noted below:

- *The Company created a centralized compliance department to act as a single focal point for regulators and to ensure all divisions of the Company interpreted laws and regulations in a uniform manner.*

- *The Company indicated that, since the consolidation of the complaint units, procedures have been implemented to ensure complaints remain in an open status until the action promised to the customer is delivered and all communications with the complainant are logged on the complaint register.*

- *The Companies have consolidated their compliance functions in a centralized, enterprise-wide compliance program under the direction of a Chief Compliance Officer, Kay Doughty Phillips, and the Companies' General Counsel, Michael A. Colliflower.*

- *The Consumer Affairs Department completed re-training of its investigators to ensure all documentation is included in the complaint file.*

- *The Company represents that it established new procedures for investigators to follow-up on any promises made by the Company to the customer. In addition, the Company now audits complaint files to ensure that follow-up work is completed.*

- *In regard to the Company's handling of claims, the Company indicated that it is committed to designing a process for monthly audits of systems and procedures to ensure consistency with the receipt date capturing process.*

- *The Company recognized the need to update and document their record retention program. They implemented **DRR** with an expected completion date of June 2007.*

- *The Company states that, effective July 2005, investigators were required to request an agent statement for all agent-related complaints whether the agent was active or terminated. Failure to adhere to this requirement will be addressed in each investigator's quarterly audit reports.*

- *All **DOI** complaint responses are handled by the Consumer Affairs Department and subject to timeliness requirements reinforced by an audit process. Training of investigators took place in October 2005 addressing these requirements.*

- *In response to the Examiners' concerns, the bank draft letters were changed as of October 29, 2005, to include language that explained the grace period and requirements to reinstate.*

- *The Company consolidated information for all units into a single complaint register overseen by a single entity within the Company.*

- *An audit process was implemented in December 2005 to ensure that:*

  a. *Complaint procedures are followed and the response addresses all issues raised in a complaint;*
  b. *Responses to consumers and the **Department of Insurance (DOI)** are timely;*
  c. *Complaints are logged with the correct receipt and response dates; and*

d. The Company maintains a complete complaint file.

- *In December 2005, complaint identification training was conducted company-wide to ensure all complaints received by any area within the Company are forwarded to the Consumer Affairs Department to log and respond.*

- *In response to the Examiners' recommendations, the Company indicated that the **New Member Admin Fee** structure was standardized as of January 1, 2006.*

- *Automatic bank draft letters were changed as of October 29, 2005, to include notification of a grace period in the event of the nonpayment of premium.*

- *The Company created a Corporate Compliance Department. The Company believes this reorganization will alleviate multiple interpretations of laws and the lack of coordination between divisions.*

- *A Regulatory Advisory Panel was formed in August 2006 and is composed of respected former regulators Susan Stead, Jose Montemayor, Audrey Samers, and Tommy Thompson, former Secretary of Health and Human Services, all of whom have direct access to senior Company management and the Board of Directors and who provide the viewpoint of regulators when advising the Companies.*

- *In January 2007, the BCP was modified to include the Companies' health plans. In addition, they added a number of point-of-sale questions which enabling them to obtain timely feedback on the activities of sales agents. Information identified during customer calls is fed back to the Companies' management so that individual issues or those of a broader nature can be addressed. Any expressions of dissatisfaction with the products, Companies or agents are logged as verbal complaints.*

- *The Company created a team composed of members from the compliance, legal and business units and **AMG** to conduct monthly reviews of agent complaints. The name of the team is the Sales Practice Review Team ("SPRT"). SPRT was developed in 2005, and it operates in addition to the Companies' Complaint Action Team to formally review complaint trends and complaints against agents. These complaints include formal DOI complaints, written complaints and any verbal complaints received by the Companies. The Companies' "High Complaint Report" is the primary data document used in these reviews. This report lists every agent who has had five or more complaints in a rolling twelve-month period. Other complaints identified by the Companies'*

Consumer Affairs Division or other operational areas involving allegations against agents are also addressed by SPRT or the Companies' management. Discussions concerning the number, type and severity of complaints against agents lead to disciplinary actions ranging from retraining to termination. The disciplinary actions taken are monitored by SPRT from implementation through conclusion.

- *Complaint reporting has been centralized and now form the basis of their early warning system, which identifies items for consideration by the Companies' management. Enhancements are scheduled for implementation by year-end 2007 that will enable Compliance and the Companies' management to identify patterns as they are developing and to address developing issues in a timely and effective manner.*

- *The Companies recently created a new department within the Administrative Services Group ('ASG") named Operational Compliance. This department is responsible for compliance-related oversight by working with the operational departments within ASG to design and implement compliance-related initiatives and enhancements in response to new laws and regulations, commitments made to regulators as part of market conduct exams and state investigations, settlement agreements and corrective actions. In addition, the department is also responsible for monitoring the ongoing compliance of the operation. This monitoring effort: (1) utilizes the results of the Quality Assurance function within the operational units to assess issues and trends in processing performance, and (2) utilizes the audit findings generated by Compliance Audit to determine whether corrective actions are operating appropriately. Based on conclusions reached through monitoring efforts, Operational Compliance will recommend additional remedial action where necessary. As such, this effort works in conjunction with the monitoring and analysis taking place within the Claims department, and the periodic audits performed by Compliance Audit.*

- *In October 2006, the Executive Compliance Committee was created to bring compliance issues to the Companies' senior executives for their consideration. The Committee meets weekly and includes the CEO, CFO, General Counsel, Chief Compliance Officer, Chief Information Officer, representatives from **AMG**, ASG, and Compliance Audit, among other senior executives of the Companies. This committee discusses compliance issues and makes decisions regarding compliance direction and focus.*

- *Complaint oversight and management was centralized in the Compliance Department's Complaint Oversight and Reporting Unit as of January 1, 2006. Complaint logs are maintained by this Unit.*

- *Since December 2005, periodic training sessions have been conducted for all employees to ensure complaints*

were appropriately identified and routed correctly for logging and tracking. Complaint handling training sessions have been conducted every six months with employees who had direct contact with customers. All other employees received annual training. The most recent complaint training was conducted in August 2007.

- *Agents received complaint training through TTACC.*

- *A new Complaint Handling System ("CHS") has been developed and implemented as of June 2007. With the establishment of this new system, workflows for complaints have also been reviewed and enhanced. All written complaints, including complaints from state regulatory departments, are still entered into the complaint logs through a centralized location in the Complaint Oversight and Reporting Unit. Verbal complaints are entered into the CHS by escalation teams in the Customer Care and Customer Advocacy Departments who are specially trained to handle verbal complaint calls. The CHS allows more reporting capabilities that were not available under the prior complaint tracking system in turn allowing the Companies to better manage complaint handling and to monitor complaints for trends and patterns that require corrective action.*

- *The Customer Advocacy Group ("CAG") maintains a Complaint Manual that provides guidance for response time, response content, investigator guidelines and complaint handling procedures. All of these procedures require that complaint responses must be answered timely and that all issues must be addressed. An audit process was implemented by CAG in January 2006 to review complaints and ensure that standards related to complaint handling are met. CAG has responsibility for investigating and responding to consumer complaints on behalf of ASG. Audits are routinely conducted to ensure that complaints are being responded to timely and in compliance with company and regulatory standards, which includes providing complete responses with all appropriate supporting documentation in response to a consumer complaint.*

- *The Companies'* ***Complaint Action Team ("CAT")*** *was reestablished during 2007. The* ***CAT*** *meetings are now the responsibility of, and chaired by, the head of the Complaint Oversight and Reporting Unit. The Chief Compliance Officer and Deputy Compliance Officer are part of the* ***CAT*** *meeting process. The responsibilities of* ***CAT*** *are being refined and additional information will be provided under the Companies' Continuous Improvement Plan.*

- *As of February 2007, all of the Companies' compliance initiatives were centralized under the Compliance Department to promote consistency and accuracy across all business units.*

CHART 1:

CATEGORIES COMPANY PUT COMPLAINTS INTO (1 COMPLAINT COULD BE IN 1, 2, or 3 CATEGORIES)	COMPANIES		Total	% of Total
	Mega	Mid-West		
A1-Company Underwriting	1			
A6-Premium & Rating	5	3		
A7-Delays	5	2		
A8-Refusal to Insure	17	5		
A9-Other	2	2		
AB-Endorsement/Rider	10	4		
Sub-section totals	**40**	**16**	**56**	**4.7%**
B1-General Advertising	1	2		
B2-Mass Advertising	1			
B3-Agent Handling	32	23		
B7-Agent Presentation	173	86		
B8-Other	3	1		
B9-Misleading Advertising	3	1		
BC-High Pressure	1			
BD-Misstatement on Application	1	1		
BE-Fraud/Forgery	31	37		
Sub-section totals	**246**	**151**	**397**	**33.1%**
C2-Delays	24	14		
C3-Unsatisfactory Settlement	21	2		
C4-Unsatisfactory Settlement Offer	20	6		
C5-Claim Denial	119	76		
C6-Other	3	5		
C7-PPO Dispute	1			
C8-Claim Denial (Third Party)	13	11		
C9-Denial of Claim (Pre-X)	21	10		
CG-Benefit Dispute	78	32		
Sub-section totals	**300**	**156**	**456**	**38.0%**
D3-Other	2	1		
D4-Company Handling	3	1		
D5-Premium Refund	47	33		
D6-Continuation	1			
D7-Cancellation	20	10		
D8-Information Requested	5	2		
D9-Coverage Question	6			
DA-Dissatisfied with Service	28	18		
E1-Other	1	1		
E2-Vendor Service	5	3		
F3-Rate Increase	41	13		
F5-Billing/Premium Notice	16	3		
G1-Return of Dues (Cancellation)	11	14		
G2-Return of Dues (Decline)	1	2		
G3-Benefit Dispute (Other)	1			
Health		1		
Sub-section totals	**188**	**102**	**290**	**24.2%**
Totals	**774**	**425**	**1199**	**100.0%**

C) Types of Policies Sold

While the majority of all complaints were directly related to claims, there is an indirect relationship between the product and benefits that consumers thought they purchased and what was actually purchased. In addition, the single highest area of complaints was related to agent presentations about the product during the sales process. The following was noted:

- The products were approved by all states that required prior approval. The Company appears to use only those policy forms that have been filed.
- The underwriting function was largely performed in the field by the agents.

Overall Assessment of Policies Sold:

The Company must implement significant improvements as it relates to this examination objective based upon the following:

- The review of correspondence from consumers disclosed that issues and lack of clarity continue to exist concerning the type of policy being sold, particularly in the self-employed market.
- Each state defines the type of coverage available through associations. Some states treat this business as individual coverage, some as large group and some as small group. Accordingly, laws governing this block of business must be researched and applied appropriately for each state in which the Company is doing business. While it appears that operational company personnel may understand these differences, the agents and other field personnel do not.

Subsequent developments reported by the Company but not validated by the Examiner are noted below:

- *In a meeting with the Company President and others in December 2006, the Company indicated it has entered into a contract with another carrier to offer a broader range of policies including a more comprehensive medical plan. The policies will not be issued on HealthMarkets paper.*

D) Review of Claims Settlement Practices

This examination objective was included in the original **MOU** and was a very important part of the examination due to the significant number of complaints in this area.

Overall Assessment of Claims Settlement Practices:

The Company must implement significant improvements in its claims handling procedures as there were many processes identified that need to be changed in order to administer claims in compliance with the **NAIC** standards and the contracts sold. The following issues were identified:

- The Company had an automated process whereby an acknowledgement letter is generated and issued if a claim had been pending for 15 days. If a claim was pended or not processed within 15 days, the Company indicated its system was programmed according to its Time of Service guidelines (individual state requirements, including the guidelines for electronic versus paper claim submissions). The Examiners noted claims in which an acknowledgement letter was sent later than 15 days.
- The Company had an automated process whereby delay letters were sent to both the insured and the provider within a specified time period. These automated delay letters did not provide specific reasons for the delay and appeared to be more of an acknowledgement letter.
- When processing a claim, the Company entered diagnosis codes into its claims system that were different from those submitted by the provider on the claim form. This was particularly true for the primary diagnosis code. The Company indicated the practice of its Claims Department was to change the diagnosis on one claim to match the diagnosis of an already existing claim (e.g., allergic reaction with an accident code may have been re-coded as an allergy to match an existing allergy claim vs. a new accident). The Company represented that the practice allowed the insured the greatest benefit by tying the claims together and therefore the insured would not incur a new deductible for a new claim.
- The UICI Association-Group Insurance Litigation settlement in the Fourth Quarter of 2004 resulted in the Company offering **Chesapeake** accident policies to insured class members of the litigation. Class members were offered four months of coverage at no cost, and renewal options for seven and 12 month periods. Some insured class members had an existing **MEGA** or **Mid-West** policy in-force and chose to enroll in the **CLICO** accident policy. As a result, some insureds had two policies with the Company - one with **Chesapeake** and

one with either **MEGA** or **Mid-West.** A review of the claims on those policies was performed and the following findings were noted:

- i. The Examiners noted instances where a claim was entered as a **CLICO** claim but was paid or denied under the insured's existing **MEGA** or **Mid-West** policy.
- ii. The Examiners noted that claims would be initiated under **CLICO** and an acknowledgement and delay letter would be sent to the provider or insured under **CLICO**. However, if benefits were not available under the **CLICO** accident policy, the Company closed the claim with a "no claim" remark code. The Company would then process the actual payment or denial for the claim under the insured's **MEGA** or **Mid-West** policy, whichever one was available or in-force and send an **EOB** statement under one of these two company's name instead of **CLICO**. Neither the physician or insured received notification that the **CLICO** claim had been closed, even if the **MEGA** or **Mid-West** policy was no longer in force. This was confusing to insureds.
- iii. The Examiners noted instances where claims were not processed under the Company in which the benefits were available. In certain instances, benefits were denied in one company and not investigated sufficiently to identify that benefits were available in one of the other companies.

- The Examiners noted that the Company denied claims that appeared to relate to a separate, previously pended claim. The previously pended claim was pended for additional information such as medical records, accident reports, etc. The following findings were noted:
  - i. The Company pended any subsequent claim whether or not it was related to the initial claim.
  - ii. According to the Company, subsequent claims were denied when the Company had a separate, previously pended claim still open due to information requests that had not yet been received.
  - iii. The above claims handling procedures are inappropriate and constitute unfair claims handling practices.
- The Company acknowledged that during the examination period, they did not have a claims procedures manual.
- The Company indicated that during the examination period, all training was on the job training and performed by the supervisor of each unit. This practice led to inconsistent claims settlement practices.

Prior to June 2005, the claim files chosen by the claims audit unit were judgmentally selected from a check register report; accordingly, it was not a randomly selected sample. The audit was conducted only after the claim was adjudicated. Beginning in June 2005, claims chosen for an audit were selected randomly through the use of a computer program which automatically selected four claims per month, per examiner, prior to the completion of the adjudication process and the generation of the **EOB** to the policyholder. The system selected

a paid, denied and pending claim as well as claims where charges were only applied to the deductible. If the auditor determined that corrections were necessary, the claim was returned to the responsible claims examiner. The claims examiner corrected the claim adjudication and returned it to the auditor for review and release of the adjudication decision and **EOB**. A monthly report was generated showing the audit results. In addition to the audits performed in the claims audit unit, audits were performed by the claims examination supervisors for each team. The supervisors and the audit unit reviewed the same attributes, such as prompt payment, interest calculation and payment, if applicable, and whether the claim was processed accurately. The Examiners scope of the engagement did not encompass the review of the results of audits conducted commencing in June 2005. Accordingly, the Examiners did not evaluate the adequacy or effectiveness of the procedures implemented.

Subsequent developments reported by the Company but not validated by the Examiners are noted below:

- *According to the Company, in January 2006 the Claims Department established a training unit. This unit included a training supervisor and two trainers who reported to the compliance manager. Additional enhancements were made to the claims audit team by adding two auditors.*
- *In a response memorandum, the Company maintained that the practice of changing diagnosis codes for any reason would cease and it will not change the diagnosis code from the way it was submitted by the provider. The Company will apply the appropriate benefits and payments according to the submitted coding. According to the Company, the training unit will write guidelines for these situations and face-to-face training will occur within 30 days of the date the Company drafted its response, which was on February 24, 2006.*
- *The examination revealed that CPT codes were being altered by claims adjusters. The Company notified the Examiners on July 17, 2006, that the practice of changing CPT codes must cease.*
- *According to the Company, it had revised the automated delay status letter as of February 24, 2006. The letter now indicates that the Company has requested certain items, such as medical records. Based on the code the Examiner uses, the system populates the reason, such as medical records and other insurance information.*
- *The Company is currently working on a training plan, which will document how and when new claims examiners and existing examiners will be trained.*
- *The Companies formalized, as written policies and procedures, the claims handling processes that were in*

place during the examination period.

- *The Company revised their **EOB** forms to include more deductible information pertinent to the claim, making it easier for their customers to understand. This practice started in one participating state and they continue to roll out this revision in all states, with completion targeted for the first quarter of 2008.*
- *In February 2007, the Company implemented a process to categorize procedure codes related to charges for like services into "Revenue Grouping Codes" (a recognized industry practice) for entry in the claims system.*

E) Product Distribution Systems

This examination objective focused on the field service operations and agent activities. The review concentrated on the **AMG,** a UICI division, with two marketing units (agencies), **UGA** and **CSA.** During our review, the Examiners gathered information related to agent compensation, affiliation with associations, the recruiting process and how leads are handled.

Overall Assessment of Product Distribution Systems:

The Company must demonstrate oversight and compliance of the product distribution system to achieve this examination objective. This conclusion is based upon the following facts:

- The marketing agencies operated independently of one another. Home office support is now in the early stages of transitioning to a centralized organization structure within **AMG.**
- The field force hierarchy of both agencies is similarly organized. The titles of the three management tiers differ.
- Agents for both agencies were enrollers for the associations.
- The Agents received separate compensation for insurance sales and for enrolling new members in the association. The Agents received "advance checks" from the Company which, in fact, are loans on which the Agents are charged 1% interest. Some agents did not know that these checks were loans. In addition, most agents could not explain whether the commissions for association enrollment were separate from insurance sales commissions or not.
- Recruiting was the responsibility of sales management in both agencies. Prior insurance experience was not required to become an Agent or Enroller. The large majority of agents and enrollers did not have experience upon being hired by the Company. The Company indicated that it is better to hire inexperienced agents as they are less likely to have poor selling techniques.

- **AMG** sold company-generated leads to the field. The leads were called "A" and "B" leads. "A" leads were the most valuable because they were newer; "B" leads were usually older, recycled leads.

Subsequent developments reported by the Company but not validated by the Examiners are noted below:

- *Beginning in December 2005, the titles of the various levels of hierarchies within **UGA** and **CSA** agencies were changed to be the same in each entity.*
- *As of June 1, 2006, a single department within **SEA** supports **UGA** and **CSA.** This contact point handles agent training, accounting, technology, marketing, compliance and product support for both agencies. The Company expects that this change will result in the two field forces being more closely aligned. The Insurance Center had supported the two field forces for several years with product implementation, customer support and compliance, and continues to do so.*
- *A new database, the Agency Management System ("AMS") provides a consolidated view of an agent's activity, including complaints, performance metrics, and results from the Benefit Confirmation Program and is intended to promote better oversight of agent activity. AMS information is available to field leadership on both an individual agent and team basis, and agents can review their own information.*

F) Review of Marketing Practices

The primary concern in this examination objective was to determine how agents were selling products for the companies and how actively the Company participated in oversight of agents. This area of emphasis was chosen because of the nature and number of complaints received by states across the nation. The two primary concerns identified in the complaints were product sales and claims administration. After reviewing complaints, it became apparent that claims were actually being paid in accordance with policy provisions, but that agents were often selling products without making full disclosure of the benefits being purchased. In addition, it also seemed that the Company was leaving all sales issues in the hands of district and regional managers and not taking an active role in agent oversight.

To understand how products were being represented to consumers, the Examiners performed the following relative to the marketing process:

- Reviewed training materials and procedure manuals including the Company built training program called **Training, Testing, Audit, and Complaints & Compliance (TTACC). TTACC** is a three-day instructional program

taught by regional managers. The agents are required to pass an on-line, unmonitored, open book examination before completing the training. Depending on the proficiency and training abilities of the regional manager, the agents' training value varied.

- Conducted interviews of active and former agents in various parts of the country.

Overall Assessment of Marketing Practices:

The Company must implement significant improvements to achieve this examination objective based upon the following:

- The agency system had long been bifurcated between **UGA** and **CSA.** This meant that agents selling **Mid-West** products through **CSA** and agents selling **MEGA** products through **UGA** were getting different information at different times about the same products and company strategies. While the Examiners were on site, the Company combined leadership of **UGA** and **CSA** to create a more uniform agency force.
- A review of the complaint data provided by the Company for the period January 1, 2005, through June 30, 2005, revealed that there were a total of 931 complaints between **MEGA** and **Mid-West.** Of those complaints, there were 1,199 complaint issues noted. Of the total complaints, 397 (33.1%) involved aspects of agent handling, including agent presentation issues and fraud and forgery. Approximately 456 (38.0%) complaints involved aspects of claims handling, such as denial and benefit disputes. These statistics indicate that a large percentage of policyholders had issues with the information provided by agents at point-of-sale and the manner in which claims were adjudicated. During the examination period, as apparent from the complaint statistics noted above, the Company lacked sufficient training for its agents, particularly new agents, both in product specific and general insurance information. A training program was established in 2003, referred to as the **TTACC** program. This program falls short of regulator expectations for a comprehensive and thorough training program due to limitations in its content. Examples of areas needing improvement or enhancement are: appropriate sales presentations; disclosures and practices; ethical standards; compliance requirements; and general health insurance and product specific training, consistency in training presentation by field managers, and the use of an open-book, unmonitored examination at the training program's conclusion.
- The Examiners did not see the same level of commitment to change in the agent/agency processes as was seen in the operational areas. The Company's long range plan was to do the same type of activity review on the agent/marketing side as occurred in the operational areas to ensure consistency throughout the organization. As of the writing of this report, some changes had occurred, but the overall picture had not changed significantly.

Subsequent developments reported by the Company but not validated by the Examiners are noted below:

- *The Company indicated it would add a step to the annual field audit procedures to confirm that changes in the Company's product portfolio, processes or marketing guidelines due to changes in laws and regulations are communicated to and implemented by the field. A procedure outlining the communication of these changes will be added to the Division Sales Leader Handbook. The projected completion date for this Handbook was July 2006.*
- *The Company was developing an audit program to target key compliance-related topics identified by triggers which were under development and scheduled for implementation in July 2006. The audit program targets field offices identified by a compliance monitoring team comprised of **AMG** Insurance Center and Corporate Compliance representatives. The Company indicated that in its initial phase of development, the system aggregated information including complaints. Beyond the initial phase, it identified metrics that will be used to determine field offices to be audited as part of an enhanced audit program. According to the Company, the plan strengthens field audit procedures by monitoring marketing guidelines that are communicated to and implemented in the field. Future phases will include results of Benefit Confirmation Calls, underwriting verification calls and other indicators of agent activity. This audit activity will be monitored by the UICI Corporate Internal Audit Department.*
- *When the current **TTACC** platform was created, each agency developed its own version of the training. Since September 2005, the **AMG** has been working to more closely align the training modules and content to be more consistent. In March 2006, the Company indicated that several enhancements were made to the training program and were released to the field. **AMG** plans to continue to enhance the training platform to create more alignment between the two entities. This project was anticipated to be completed by the Fourth Quarter of 2006.*
- *The Company was evaluating the feasibility of product trainers located throughout the country to assist in product training in field offices. The Company expected to have a plan for implementation by August 2006 and the project was to be completed by the end of the First Quarter 2007.*
- *During 2006, the Company indicated it would undertake a project to strengthen training not only for new agents but also for existing agents. This included requiring ongoing training for agents following initial **TTACC** training, providing trainers from the Insurance Center to train in local field offices and developing a continuing education program for their agents. The projected completion and roll-out date for these enhancements was the First Quarter of 2007.*
- *The responsibility for health insurance product training was brought in house in late 2006 by the creation of the National Product Training Team. The Training Team consists of 10 members, whose primary responsibility is to provide uniform, high quality product training to agents in each state where the Company writes business, as well as to the Companies' operational units.*

- *The Company plans to begin administering all TTACC testing in a monitored environment either at a division office, a satellite district field office or through a third-party test administrator by year-end 2007. In addition, effective September 2007, an 8- hour waiting period before an agent can re-take a failed TTACC test was imposed. During this period, additional training can be provided to ensure that the agent understands the material before attempting to pass the test again.*
- *A comprehensive field audit program, the Field Evaluation Program (FEP), was developed to enhance the monitoring and oversight of agents. The Company began testing the FEP in two divisional sales offices during August 2007 and will implement the program by year-end 2007 throughout the field.*
- *The Company worked with the field leaders of UGA and CSA to develop and approve point-of-sale scripts that provide an outline of information and topics to be covered during a sales presentation for agents in December 2005. The scripts are approved by the Compliance Department and are maintained on the marketing division's websites.*
- *The Company adopted an "Agent Due Process" procedure for the purpose of monitoring, reviewing and correcting agent activity with respect to sales and marketing issues. The process ensures that disciplinary actions against agents, up to and including termination, are processed in a consistent and orderly manner.*
- *Field leaders are provided with a comprehensive Field Leaders Manual to use as a resource in their field offices. The manuals are reviewed and updated by the Companies annually to keep them current with all company, statutory and regulatory requirements.*

G) Association and Affiliate Relationships

This examination objective focused on the Company's relationships with various associations. The Examiners were charged with studying the relationships between the Company, the various associations with which it does business and their affiliates. The Examiners determined that UICI and the associations that market its products have a complex relationship that includes the following components:

- The relationships between the Company and the associations had the appearance of independence. They had independent boards with no common board members. Each of them appeared not to have any explicit control over the other. They maintained vendor/customer contracts cancelable by either party.
- Associations were not treated as related parties in UICI's financial statements. According to the Company, the reason the associations were not considered related parties is because: "UICI does not possess the power to direct, or cause the direction of, the management policies of the associations. It had no voting power within

the associations or any ownership interest. The associations have a significant membership without insurance and the insurance companies have significant numbers of policyholders that were not members of these associations. UICI provides billing and cash collection services but provides no management, financial reporting or cash management services. Similar billing and cash collection services were readily available throughout the country and, therefore, we do not believe the rendering of these services constitutes a reliance relationship".

- UICI marketed the vast majority of its self employed insurance products through the associations. Because UICI was so dependent on this line of business, the Examiners asked the Company if it maintained any type of disaster recovery plan or alternative business arrangement proposal in case **NASE** or **AAS** decided to terminate their relationship with UICI. The Company did not maintain such a plan.
- Both UICI and the associations appeared to be an integral part of each other's business model. For example, the associations were involved with UICI agency meetings. As "enrollers" for the associations, **UGA** and **CSA** agents used the associations' websites extensively to do business. At the time of the examination, in all but one state (Washington), policyholders wrote a combined check for association dues and insurance premiums. As of August 2006, the Company indicated that it required separate checks for association-related dues and insurance premiums in all states.

- The associations were dependent on UICI for member recruitment. According to **NASE,** which was the largest association, between two-thirds and three-quarters of its members were recruited by UICI agents. The approximate membership numbers for the associations were: **NASE** – 250,000 members; **AAS** – 150,000 members; and **Americans for Financial Security (AFS)** – over 25,000 members.
- The associations framed the relationship they had with UICI as a business relationship. All of the associations had similar, fairly detailed, disclosures about this relationship on their websites. The information was consistent with the Company's description of its relationship with the associations. These disclosures stated that :
  - The association has no direct or indirect ownership in UICI.
  - The association has an agreement with the insurance company pursuant to which the insurance company makes available to association members certain insurance company products. This agreement can only be terminated by the association or the insurance company with not less than one year's notice.
  - Salespersons act as both licensed insurance agents for the insurance company and field service representatives for the association. They act on behalf of the insurance company when describing health insurance products and on behalf of the association when describing association benefits.
  - Health insurance premiums are paid to the insurance company and membership dues are paid to the association.
  - The association pays an affiliate of UICI for enrolling new members and pays the insurance company or affiliates for administrative services for association member benefits obtained from the insurance company or its affiliates.
  - Ronald Jensen and his immediate family own approximately 17% of UICI common stock.
  - **Specialized Association Services (SAS)** (which was controlled by Ronald Jensen's adult children) has an agreement with the association to provide certain administrative services, including billing, administration, delivery of membership materials and benefit procurement services. **SAS** has no ownership interest in the association.

Overall Assessment of Association and Affiliate Relationships:

The Company must implement additional transparency procedures, in addition to existing disclosures, to achieve this examination objective. Since the field work was concluded, the Company has represented that it continues to take steps to separate its actions from the associations. However, a close business relationship is still apparent. The Company's relationship with the associations should continue to be closely monitored.

Subsequent developments reported by the Company but not validated by the Examiners are noted below:

- *The Company indicated that effective January 1, 2006, in states where the purchase of insurance must be accompanied by the purchase of an association membership; the associations began to charge a single one-time **New Member Admin Fee** in the amount of $75.00. This fee is not refundable upon declination of insurance coverage or cancellation within the 10 day "free look" period. In states where the purchase of insurance is not required to be accompanied by the purchase of an association membership, the one-time **New Member Admin Fee** is $25.00. In both cases, a full refund of the one-time **New Member Admin Fee** would be made by the association if the member cancels his or her membership directly with the association within the first 30 days of membership and no association benefits have been used.*
- *In 2007, a sentence was added to the Association Disclosure form to make it clear that it is not necessary for a consumer to remain a member of the association in order to maintain insurance coverage.*

H) Financial Overview

The primary goal of this examination objective was to understand the Company's legal and financial structure during the five-year period ending December 31, 2004.

Based on the review of financial and company legal structure information for the period, it became apparent that:

- UICI was managed by business division as opposed to legal entity. Legal entities operate across division lines.
- UICI transitioned from a more diversified corporation in 2000 to a core insurance business focus by 2005.
- **PDA** and **SDA** were the principal intermediaries (subsidiaries) through which the association funds flowed.
- Insurance Operations, specifically **SEA**, drove profitability throughout the five-year period under review for this objective.
- UICI had a complex organizational structure. Although there were many dispositions of subsidiaries in the five-year period, the Company still had 22 subsidiaries on December 31, 2005, including 7 insurance subsidiaries.

Overall Assessment of Financial Overview:

The Examiners determined that this examination objective was satisfied. After the Examiners obtained a more in-depth understanding of the Company's legal and financial organizational structure in the early phases of fieldwork, additional examination objectives were established to review the flow of funds between the UICI companies and the associations (see Flow of Funds objective below).

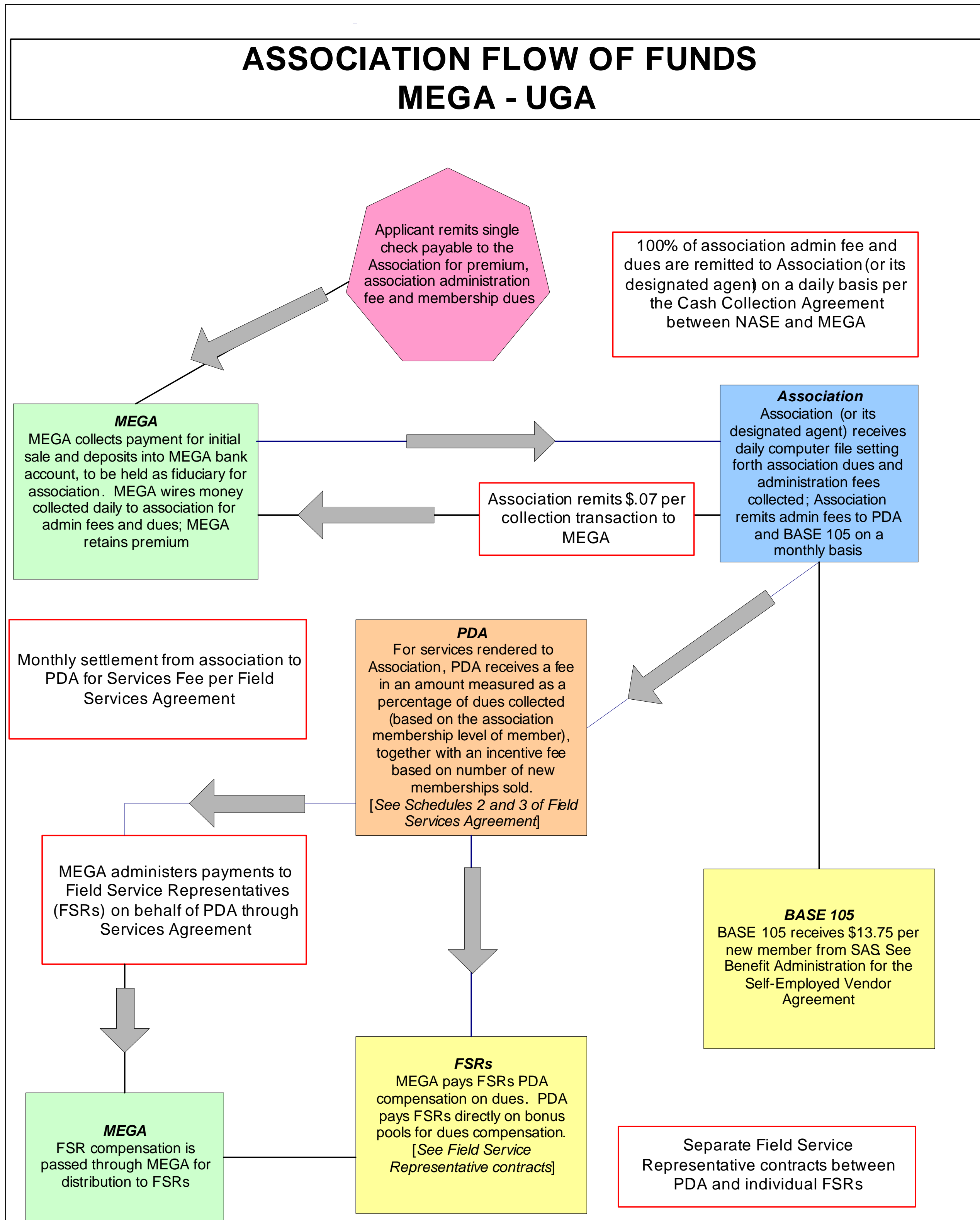
Subsequent developments reported by the Company but not validated by the Examiners are noted below:

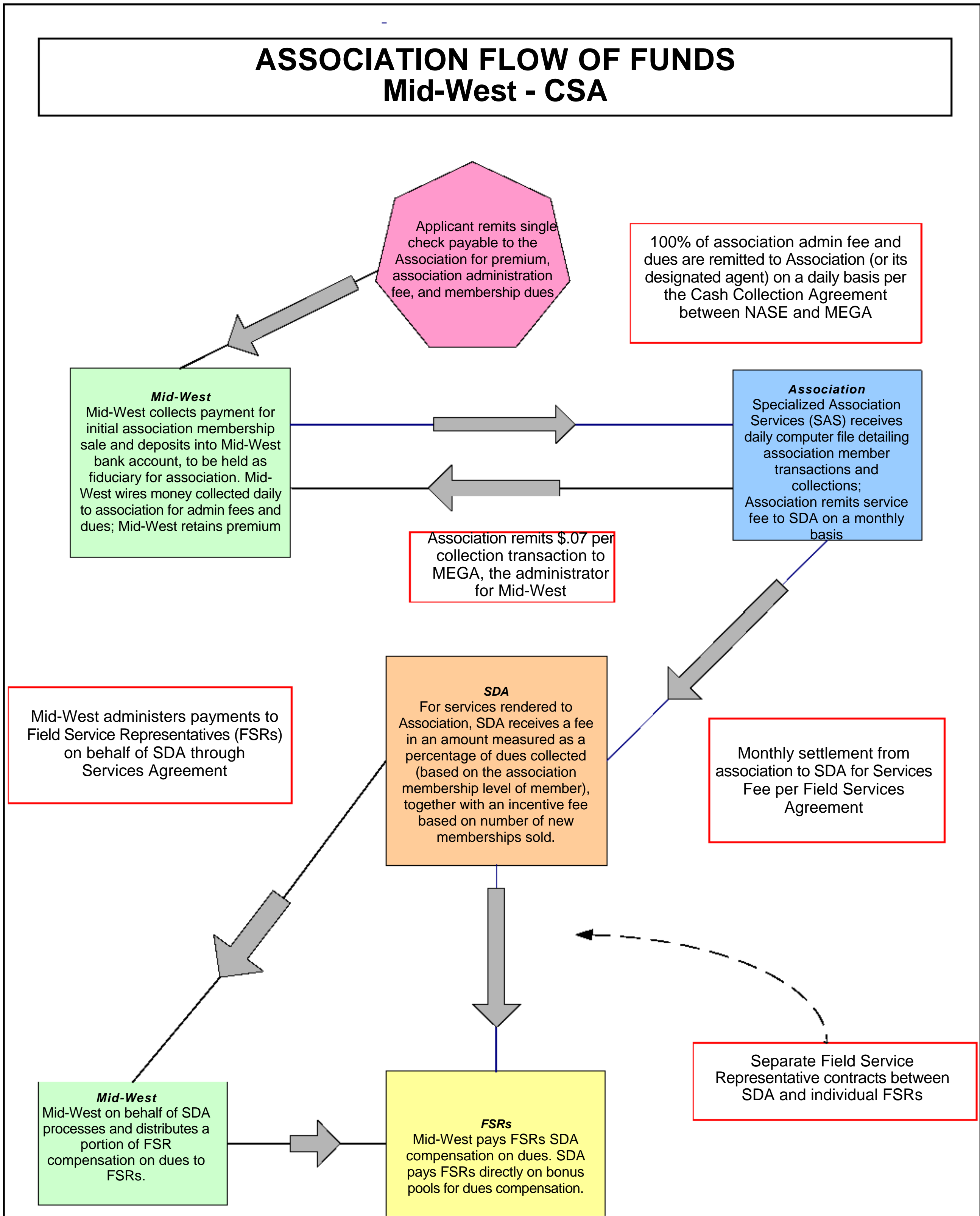
- *Beginning January 2007, the Company instituted procedures on a national basis to collect separate checks for association-related dues and insurance premiums at the time of application.*

I) Flow of Funds Between Company and Associations

The primary objective in this area was to verify that the Company-prepared flowcharts representing the flow of funds between the UICI companies and the associations were accurate. These flowcharts are included on pages 61 and 62.

- The insurance premium funds flow is not included in the flowcharts.
- **PDA** and **SDA** were the principal intermediaries (subsidiaries) through which the association funds flowed.
- Although the flowcharts indicate that the insurance companies **(MEGA and Mid-West)** wire funds collected to the associations on a daily basis, there was a delay in remitting the **New Member Admin Fees** until the insurance application cleared underwriting.
- Remittance of funds for association monthly dues was not subject to a delay as they are remitted immediately.
- Funds that flow back to **PDA** and **SDA** from the associations were received on a monthly basis only, based upon the percentage of dues collected and new memberships sold in the prior month.
- **FSR** compensation in the form of commissions on membership dues was paid by the insurance company **(MEGA or Mid-West)** for **PDA** and **SDA** on a regular basis. **FSR** compensation in the form of bonuses was paid by **PDA** and **SDA** on a periodic basis.


ASSOCIATION FLOW OF FUNDS
MEGA - UGA
Applicant remits single check payable to the Association for premium, association administration fee and membership dues
100% of association admin fee and dues are remitted to Association (or its designated agent) on a daily basis per the Cash Collection Agreement between NASE and MEGA
MEGA
MEGA collects payment for initial sale and deposits into MEGA bank account, to be held as fiduciary for association. MEGA wires money collected daily to association for admin fees and dues; MEGA retains premium
Association
Association (or its designated agent) receives daily computer file setting forth association dues and administration fees collected; Association remits admin fees to PDA and BASE 105 on a monthly basis
Association remits $.07 per collection transaction to MEGA
Monthly settlement from association to PDA for Services Fee per Field Services Agreement
PDA
For services rendered to Association, PDA receives a fee in an amount measured as a percentage of dues collected (based on the association membership level of member), together with an incentive fee based on number of new memberships sold.
[See Schedules 2 and 3 of Field Services Agreement]
MEGA administers payments to Field Service Representatives (FSRs) on behalf of PDA through Services Agreement
BASE 105
BASE 105 receives $13.75 per new member from SAS See Benefit Administration for the Self-Employed Vendor Agreement
MEGA
FSR compensation is passed through MEGA for distribution to FSRs
FSRs
MEGA pays FSRs PDA compensation on dues. PDA pays FSRs directly on bonus pools for dues compensation.
[See Field Service Representative contracts]
Separate Field Service Representative contracts between PDA and individual FSRs


ASSOCIATION FLOW OF FUNDS
Mid-West - CSA
Applicant remits single check payable to the Association for premium, association administration fee, and membership dues
100% of association admin fee and dues are remitted to Association (or its designated agent) on a daily basis per the Cash Collection Agreement between NASE and MEGA
Mid-West
Mid-West collects payment for initial association membership sale and deposits into Mid-West bank account, to be held as fiduciary for association. Mid-West wires money collected daily to association for admin fees and dues; Mid-West retains premium
Association
Specialized Association Services (SAS) receives daily computer file detailing association member transactions and collections;
Association remits service fee to SDA on a monthly basis
Association remits $.07 per collection transaction to MEGA, the administrator for Mid-West
Mid-West administers payments to Field Service Representatives (FSRs) on behalf of SDA through Services Agreement
SDA
For services rendered to Association, SDA receives a fee in an amount measured as a percentage of dues collected (based on the association membership level of member), together with an incentive fee based on number of new memberships sold.
Monthly settlement from association to SDA for Services Fee per Field Services Agreement
Separate Field Service Representative contracts between SDA and individual FSRs
Mid-West
Mid-West on behalf of SDA processes and distributes a portion of FSR compensation on dues to FSRs.
FSRs
Mid-West pays FSRs SDA compensation on dues. SDA pays FSRs directly on bonus pools for dues compensation.

Overall Assessment of Flow of Funds Between Company and Associations:

The Examiners' assessment relative to this examination objective is as follows:

- Company flowcharts were essentially accurate in representing the flow of funds between the Company and the associations.
- **PDA** and **SDA** were the principal intermediaries (subsidiaries) through which the association funds flowed.
- The flow of funds appears to be unnecessarily complex resulting in lack of clarity and transparency as to economic purpose and benefit to the policyholder. The multiple tiers in the flow of funds appears to add unnecessary cost to the process and raises questions as to the substance of the economics of the arrangements.

J) Results of Attribute Testing

Based on the high volume of data included as part of this examination objective, the details of the work performed and the testing results are included in the Examination Section titled "Results of Attribute Testing" which begins on page 77.

FINDINGS AND REQUIRED ACTIONS

The Company has been the subject of a number of single state examinations. These examinations were performed by testing attributes specific to the examining state and were met with varying degrees of company cooperation. Consumers, regulators, former agents and the media continue to inquire about, question and scrutinize the Company's practices and activities regularly. During the examination period, questions continued to be raised concerning the management of the Company, particularly about the activities of then Chairman of the Board, Ronald L. Jensen, and his family. There were allegations that Mr. Jensen and some of his family members had developed various unnecessary streams of income primarily from the associations and affiliated entities. In addition, states were noting significant increases in the number of complaints concerning point-of-sale practices and claims handling.

The Examiners noted that significant evidence existed of unfulfilled expectations of clients, especially surrounding point-of-sale transactions. Company management's position was that it was an agency driven company; however, there was little evidence that adequate training and monitoring of agent activities was in place. It was also evident that the Company did not have an effective process in place to recognize and address differences in state requirements in some phase of operations.

During the examination, the Company discussed enhancements to their compliance program with the Examination team. The Company hired outside consultants to review their business operations and make recommendations for change. The Company indicated that they would create a plan to bring Company operations into compliance with all states' laws based upon the consultant's report. The Examiners requested a copy of the consultants' report; however, a completed report was not provided (see related finding and required action below).

The Examiners noted that the Company did not have adequate controls in place over its agents or their activities. The Company has developed training programs for certain agents. The **TTACC** training provides a starting point for agents' training. However, it is presented by field managers with varying levels of training abilities. The only quality assurance tool concerning the **TTACC** is the unmonitored test that the agents must pass.

The Examiners were also concerned about the limited oversight the Company demonstrated over the agents' activities. During the examination period, the Company did not have a program to monitor agent activities.

Finding #1: Regulators noted that the largest category of complaints was missing or inaccurate information during the initial contact between the agent and the customer..

It is the opinion of the Examiners that these issues will continue to persist until the Company strengthens the agents' oversight program. The Company needs to provide additional training, both product specific and general insurance knowledge, to agents. The Company needs to conduct a quality assurance agent audit of the actions of agents and agency management on a regular basis. Special attention should be paid to point-of-sale transactions.

Required Action #1: The Company must modify its agency program to expand and improve its agent training, particularly for new agents, by expanding its training program to include industry knowledge, ethics, product presentation, proper disclosures, consistent delivery across agencies and a robust structure, among other enhancements:

To ensure agents and consumers thoroughly understand the product they are selling/buying and appropriate disclosures are made at the point-of-sale and in follow-up contacts, the Company must:

a. Strengthen the training program for new agents by including health insurance industry information.
b. Provide agent training more frequently based upon average agent retention statistics, such as every three to six months rather than annually.
c. Develop a standard but progressive curriculum for agents based upon experience level with the Company.
d. Strengthen the training program for existing agents, particularly product information, ethics and point-of-sale presentations.
e. Develop centralized standards and controls to manage agents and train agency management in appropriate controls and monitoring of agent and agency activities. Develop tools and metrics for measuring the effectiveness of training (e.g., reduction of complaints, reductions in cancellations, etc.).
f. Develop additional methods to help consumers have a better understanding of the Companies' products during the sales process.
g. Train BCP staff to be assertive in reviewing coverages with clients to ensure more calls are successfully completed.

Finding #2: Quality assurance procedures over agent activities, such as monitoring and auditing the activities of agents and agency management, were insufficient. A review of the **TTACC** training and new product training confirmed the need to audit agents' actions in the field.

A. Since the examination period, an internal audit plan is being implemented, but agent activities and transactions are not included in the initial audit program. The Company has indicated that agent activities will be subject to audits "at a later date".

B. Any internal audit program must include information used at point-of-sale to ensure agents are correctly representing the products.

C. There is minimal, if any, accountability on the part of regional directors, division managers and district managers for the actions of agents under their supervision.

Required Action #2: To provide adequate monitoring of agents and agent activities, the Company must:

a. Implement quality assurance procedures over agent activities including monitoring procedures and periodic audits.

b. Enhance the effectiveness of agent training by requiring monitored testing and monitoring the delivery of the training presentations by the field managers.

c. Implement a plan to monitor agents' actions using tools such as comprehensive field audits, phone interviews with recent customers, secret shoppers and trending of agent and agency related information, such as complaint statistics, cancellations, product upgrades and the like.

d. Provide additional point-of-sale materials such as scripts and checklists for agents' use and ensure that all materials include appropriate disclosures.

e. Investigate all agents with unusual trend statistics and all complaints regarding claims alleging that agents misrepresented the product at the point-of-sale. Any agent found to be misrepresenting the products at the point-of-sale should be retrained, disciplined or dismissed as appropriate for the circumstances.

f. Hold field management, such as regional managers and above, accountable for the actions of each agent under their supervision. Field management performance assessment and overall compensation should contain a component that is tied to such performance measures as the number of complaints received about sales practices in the manager's territory, the number of cancellations and persistency of business written by the manager and his agents, and other actions that may be indicators of the overall performance of that manager's territory. Incentives should also be developed which reward regional managers who demonstrate effective accountability and management of their agents with

respect to compliance requirements and performance.

If done correctly and on an on-going basis, these measures will provide the Company with proactive tools to monitor and prevent inappropriate sales practices.

Finding #3: Issues concerning the handling of claims included the following:

#3A. Diagnosis and CPT Codes

If a second claim is received for on-going treatment of an illness or injury and it has a different primary diagnosis code, the claims adjudicator changes the diagnosis code on the second claim to match the first claim. The Company states that must be done so that a second deductible is not taken. The Examiners noted that the adjudication staff alters CPT codes as well.

The Company indicated that diagnosis codes entered into its claims system are not the decisive factor behind benefit payment calculations. This practice does not impact the benefit payments made to claimants. According to the Company, a benefit payment is determined by the "Cause Code" and "Benefit Code" selected by its claims examiner. The Company explained that claims are adjudicated using the "Cause Code" and "Benefit Code" assigned to the claim during the adjudication process, rather than the diagnosis code and CPT code billed by a provider and captured in its claims system. The Company maintains that its claims adjudication system utilizes a programming mechanism, the "Cause Code," to tie all relative deductibles, co-pays and co-insurance to a single cause in order to adjudicate claims consistent with the benefit schedules for its health plans. A "Benefit Code" for a claim is determined by the claims examiner and entered into the claims system to identify the type of service provided to the claimant (e.g., inpatient hospital charges, office visit, surgical, laboratory service, etc.). Therefore, the Company asserts that benefit payments are not impacted by the Company's practice of changing diagnosis codes submitted by a provider since the "Cause Code" and "Benefit Code" are the drivers for its claims adjudication.

The Examiners note that such a practice allows claims examiners to make judgmental determinations of the "Cause Codes" or "Benefit Codes" assigned to a submitted claim rather than the provider's determination. This presents the potential risk that benefit payments by the Company on a claim may be incorrect or inconsistent with what the provider indicated.

Required Action #3A: The Company must identify and re-adjudicate any claims for which diagnosis and CPT codes were altered. The Company must cease altering diagnosis and CPT codes submitted by providers on claims.

#3B. Claim Numbers

The Company assigned additional consecutive claim numbers to a single claim if there were more than four CPT codes on the claim. The claims processing screen limits the number of CPT codes that can be entered/processed under a single claim number. It allows a maximum of eight lines of text on the screen and, during claims processing, a CPT code can be entered twice to break out its allowable and disallowable charges. As a result, if a claim submitted on a claim form is billed with more than four CPT codes, that claim will be assigned two claim numbers in consecutive order. This practice results in multiple claim numbers for a single occurrence or service and distorts the Company's claim count. This results in reporting incorrect data in relation to the number of claims received and processed.

Required Action #3B: The Company must make changes to the claims adjudication system that will allow an entire claim to be entered into the system as a single claim.

#3C. Claim Delays

The Examiners reviewed a sample of paid and denied claims processed during the examination period. They found that the Company would pend all claims while waiting for information on any related claim. Claim delay letters were not always sent, used acknowledgement letters in practices did not meet many states' Unfair Claim Settlement Act (UCSA) requirements. Because the Company was inconsistent in handling of claims, providers and insureds would resubmit claims because they were not sure the original had been received. This increased the number of claims and handling problems as well.

Required Action #3C: All claims must be adjudicated in a timely manner as required by statute or rule in the appropriate jurisdiction, based on claim submission location. All delayed claim letters must include a reason for the delay. The Company's practice of pending claims while waiting for information on other claims must cease.

#3D: Explanation of Benefits

The Company's **EOB** forms do not include information regarding the deductible applied to the claim. The lack of complete information on **EOB** forms makes it impossible for consumers and providers to determine if claims are

properly paid.

Required Action #3D: All **EOB** forms must include the deductible information pertinent to the claim.

#3E: Independent Claims Audits

During the examination, it was noted that there was no routine and recurring independent audit of claims handling procedures to ensure that the handling of claims is in compliance with laws and regulations and to ensure that the Company is identifying trends and root causes of mishandled claims and focusing on identifying training needs and problem claims adjusters.

Required Action #3E: The Company must perform independent routine and ongoing audits of claims to determine adherence with the Claims Procedures Manual and applicable laws and regulations. The results of such audits must be analyzed by compliance personnel to identify trends and root causes of claim mishandling, areas for training emphasis and problem claim adjusters. Audits must result in action by the Company to correct those areas found to be problematic or deficient.

Finding #4: At the commencement of this multi-state market conduct examination, the Company did not have a Claims Procedures Manual.

Required Action #4: The Company will develop and maintain a Claims Procedures Manual.

Finding #5: The UICI Association Group Insurance litigation settlement in the Fourth Quarter of 2004 resulted in the Company agreeing to offer **CLICO** accident policies to insured class members of the litigation. Class members were offered four months of coverage at no cost, and renewal options for seven and twelve month periods. Oftentimes, the insured class members that applied for this accident policy would already have a **MEGA** or **Mid-West** policy in-force or membership in one of the associations during the examination period. As a result, an insured could have two policies with the Company; one with **CLICO** and one with either **MEGA** or **Mid-West.**

In reviewing **CLICO** claims, the Examiners would often see a claim that had been initiated under **CLICO,** and an acknowledgement and delay letter would be sent to the provider or insured under this company name. However, if benefits were not available under the **CLICO** accident policy, the Company would utilize a "no claim" remark code to close the claim internally and then process the actual payment or denial for the claim under the insured's **MEGA** or

Mid-West policy (whichever one was available or in-force). They used the **EOB** statement to advise the insured of this action. This would be the only notification to the insured or the provider concerning the change of Company. The insured was never given the opportunity to question the denial of the **CLICO** claim.

Required Action #5A: All claims should be adjudicated under the Company in which the claim is being made.

Required Action #5B: Anytime a claim is denied, appropriate notification must be sent.

Required Action #5C: All claims must be documented correctly by being filed with the Company in which the claims is being made.

Finding #6: The manner in which the Company and the association operate is not fully disclosed to those purchasing UICI insurance products.

A. During the examination period, the Company allowed agents to collect, at point-of-sale, a single check payable to a third party to pay the association dues and initial insurance premium. The amount collected could also include **Policy Fees, New Member Admin Fees** and other fees, some of which are remitted to the association and some of which are retained by the insurer. Little to no disclosure was made to the client concerning how the funds would be split. In some states, any amounts collected by the insurer in a single check or remittance may constitute "premium" and be subject to premium tax. The Company did not account for such statutory differences in their accounting for premium taxes.

B. Agents are both sales representatives for the insurance company and enrollers for the association. This causes confusion for new members and may be in conflict with the best interests of the consumer.

C. A **Policy Fee** was charged to consumers who reside in individual (non-association) states while no **Policy Fee** was charged if the consumer resides in an association group state. The Company did not clearly disclose to regulators how the **Policy Fees** and the association **New Member Admin Fees** are allocated between the insurance company and the associations. The Company represented that the **Policy Fee** reflects the cost of issuing a policy, establishing the required records, sending premium notices and other related expenses. The Company also represented in writing that the **Policy Fee** is subject to premium tax. No **Policy Fee** is added to policies issued in states where the applicant must join the association to buy insurance (referred to as "association group" states).

D. The Examiners noted significant changes in the structure of the Company during the examination period.

The Company divested itself of many of the peripheral affiliations with other non-insurance entities that may have impacted the cost of the insurance to consumers/policyholders.

Required Action #6: The Company must provide sufficient transparency information based on the complexity of the Company's relationship with the associations and its own affiliates. This includes the following:

A. The Company must change its procedures so that the insurance payments and the association payments are received as two separate payments. The Company must identify states in which the definition of premium includes all amounts collected by the insurer and must advise those states of the possibility that the Company may need to amend premium tax filings. The Company must work with the affected regulatory jurisdictions to correct prior year filing errors.
B. The Company must disclose, with emphasis and clarity, to consumers and policyholders the relationship between the Company and any associations it uses for marketing products.
C. The Company needs to clearly disclose to regulators how the **Policy Fees** and the association **New Member Admin Fees** are allocated between the insurance company and the associations. This will assist the Company in providing to the regulators an accurate accounting for premium tax purposes and for the proper accounting for premium refunds to insureds.
D. The Company needs to remain vigilant that its relationships with all entities are cost effective and do not adversely impact the cost of insurance to consumers/policyholders.

Finding #7: The handling of complaints and grievances included the following findings based upon our attribute testing:

A. Complaints were not recorded in the required format on the Company complaint register.
B. The Company did not take adequate steps to finalize and dispose of complaints in accordance with rules and regulations, applicable statutes and contract language.
C. The timeframe within which the Company responded to complaints was not in accordance with applicable statutes, rules and regulations.
D. The Company did not treat all written complaints submitted by, or on behalf of, a covered person as a grievance in states where separate grievance laws apply.
E. For Complaints involving agent's actions, the Company did not request an agent statement in all instances. In addition, there was inconsistent evidence that disciplinary actions were taken against agents involved in the complaints.

F. The Company's **CAT,** chaired by the **SEA** division head of consumer affairs, focuses solely on complaints in an effort to identify actions designed to reduce the number of complaints. This team operated independently with no executive management oversight. If compliance related issues arose from these meetings, it was the responsibility of various managers to see that each issue was addressed. Once the issue had been released to the manager, there was no follow-up to ensure that the issue was handled appropriately.

Required Action # 7: For complaints and grievances to be handled appropriately, the Company must take the following actions:

A. All complaints must be recorded and logged correctly in compliance with states' laws and the Company's stated procedure.

B. The Company must ensure that all issues raised in a complaint/grievance are acknowledged, investigated and finalized/disposed of in accordance with applicable statutes, rules and regulations, and contract language.

C. The Company must comply with the timeliness of response and timeliness of resolution of each complaint/grievance as required by applicable statutes, rules and regulations.

D. The Company must identify those jurisdictions that have statutes or regulations defining a grievance.
   1. The Company must train appropriate personnel to identify grievances upon receipt.
   2. The Company must develop procedures for staff to follow when handling grievances. These procedures must be state specific.

E. The Company must request an agent statement for all complaints involving an agent's actions.

F. The Company must improve its complaint handling controls and establish strong oversight of the complaint handling process by:

   1. Preparation of a report to regulators which outlines the complaint-related business practice reforms the Company has implemented to date which address the many concerns expressed in complaints. Included with the report should be documentation to evidence and support the adequacy of such reforms. This report can be used by regulators in developing a workplan for a follow-up examination.
   2. Creation of a tracking log for issues forwarded to **CAT** and establishing a procedure to ensure that there is ownership and accountability for the process.

Finding #8: The examination of underwriting practices disclosed that Policyholders who paid their premium via direct bill received advanced notice that their coverage was going to expire. The notice also explained that a grace period existed for 30 days after coverage ended. During this time, the premium could be paid and coverage could be maintained. Policyholders paying via an automatic bank draft did not receive a notice that explained the grace period. This practice is discriminatory.

Required Action # 8: Cancellation, non-renewal and discontinuance notices must be handled consistently for all policies and must comply with policy provisions and state laws. This includes information about the availability of a grace period provided to the insured and other parties to the contract.

Finding #9: The Examiners completed a review of UICI's compliance program.

A. UICI did not have a central compliance department to oversee compliance for all companies, divisions and affiliates. Each division or functional unit was responsible for managing its own compliance program
B. **SEA** was the only functional unit with a substantial compliance program at the time of the field work. All divisions of the Company had some type of compliance structure in place to address issues but there was no consistency between divisions.

Required Action #9: The Company must centralize the compliance program to promote consistency in all business units. The Company's adherence to its Compliance Plan and compliance program enhancements must be independently evaluated at periodic intervals and should be re-examined in the next 12 to 18 months. The Company must inform regulators on a timely and periodic basis concerning the program's enhancements and changes to its compliance procedures.

Finding #10: PDA and **SDA** were not audited on a stand-alone basis. As wholly owned subsidiaries of UICI, they were presented as part of the consolidated UICI financial statements and their results are included in the combined results of the **SEA** division. These subsidiaries were integral to the insurance business, as most of the interdependent activity between the associations and the insurers was performed through these entities. In the period under review, **PDA** and **SDA** have become profitable and are thus contributing to the overall profitability of the insurance business. The association transaction is an integral part of the total purchase transaction. Because **PDA** and **SDA** were so embedded into UICI's insurance operations, financial information about these companies is relevant to regulators in their oversight of Company insurance products. The Company has

indicated a willingness to provide such reliable, stand-alone **PDA** and **SDA** financial statements to regulators in the future upon request.

Required Action # 10: The Company should prepare separate financial information of **PDA** and **SDA** on an annual basis and have it available to domestic regulators upon request.

Finding #11: The Company had a matching stock benefit for its agents/**FSRs** who were members of the agent stock plans. Under these plans agents/**FSRs** were allowed to purchase UICI common stock out of a portion of their commissions. The agents/**FSRs** shares were matched by the Company up to a certain maximum over a 10 year vesting period. The determination of the amount of the match was based upon both association enrollment sales and insurance product sales. The compensation expense for the stock match was incurred by **PDA/SDA** based on an agreement between the **FSR** and **PDA/SDA** and none of this compensation match was recorded in the insurers' **(MEGA or Mid-West)** statutory annual statements as agent compensation. The Company had indicated that it had historically recorded the compensation expense related to the matching feature on **PDA's** and **SDA's** books, since **PDA** and **SDA** are the legal entities that, in accordance with the terms of the Agent Plan documents, have the legal obligation to pay such compensation. In the calculation of the matching credits, **PDA** and **SDA** have chosen to use the metric of commission for insurance sales in the numerator of the matching credit calculation. This metric was used to calculate the number of matching credits. The substance of this benefit, given its determination, was based on insurance sales and gives the appearance that the substance of this benefit to the agents was commissions or agent compensation related to the insurance business.

Required Action #11: The Company should provide to regulators authoritative accounting support for its treatment of the agent's stock benefit match.

Finding #12: While the examination was in process, the Company engaged an outside consulting firm to review areas under examination based on prior market conduct examination findings. The Examiners requested a copy of the report prior to the examination to help identify areas of concern. The Companies declined to share the report with the Examiners indicating the review was not complete. On November 15, 2005, the Company presented a progress report to the Examiners and regulators in the form of a PowerPoint presentation. In subsequent discussions with the Company after their presentation, they asserted the report fell under attorney-client and work-product protections and declined to provide additional information regarding the review. By law in every state, companies are compelled to share information that is pertinent to the examination process.

Required Action #12: The Company must provide a copy of the consultant's report or an overview of the report for review by the regulators.

Finding #13: As noted in the Subsequent Developments section of this report, the Company has represented that many improvements and changes in their practices and procedures were implemented subsequent to the examination time period and subsequent to the completion of the Examiners field work.

Required Action #13: The Company must prepare a report to regulators outlining concisely by examination area all business reforms, improvements and changes to policies and procedures implemented through a current date.

RESULTS OF ATTRIBUTE TESTING

The Examiners performed attribute testing to validate the policies and procedures provided to the Examiners by the Company. The following three areas were tested as applicable to the three insurance entities: Complaints/Grievances, Underwriting and Claims. The Examiners used the testing standards found in the **NAIC** Market Regulation Handbook.

The Examiners generated randomly selected samples from the examination period. The sample items were tested against selected **NAIC** Market Regulation Handbook standards to determine the Company's compliance in the areas determined to be the most relevant to the scope of the examination.

If there were no exceptions found for a particular standard, then there are no comments about that particular standard.

Overview of Results

The complaint handling processes were inadequate and lacked centralized control. The total complaint population of 925 complaints included 1,199 complaint issues of which 397, or 33.1%, involved aspects of agent handling including agent presentation issues, fraud and forgery. A larger number of complaints, 456, or 38.0%, involved aspects of claims handling, such as denial and benefit disputes. These statistics indicate that a large percentage of policyholders had issues with the information, or lack thereof, provided by agents at the point-of-sale and the manner in which claims were adjudicated. As complaints were not handled by a centralized department, the identification of complaints was not consistent throughout the Company. In addition, the Company did not maintain separate complaint and grievance logs. Since the Company did not differentiate between a complaint and a grievance, they are unable to analyze and trend grievance related issues.

In regards to analyzing complaint data, the Company did not trend complaints within each division or across the Company. The **SEA** was the only division the Examiners found that was gathering complaint data, but the reports generated by this division were only used to determine whether an agent's actions contributed to the complaint and not for trending all issues related to complaints.

Also in the area of complaint handling, attribute testing indicated that the Company was not responding to complaints in a timely manner. When questioned, the Company indicated that situations such as misidentification of the complaints, lost complaints and archiving a complaint before it was resolved were some of the reasons given for delays.

The Examiner's review of complaints indicates that the Company needs to provide ongoing training to all staff regarding the identification of complaints and the process in which complaints should be handled. In addition, there were instances in which complaints were inaccurately recorded in the log, were not handled according to the Company's procedures and/or handled under the wrong company. All of these problems indicate that the Company needs to implement a stronger compliance monitoring and audit program to ensure that all complaints are handled correctly and consistently according to the Company's complaint handling procedures and the applicable state laws and regulations.

The underwriting area yielded the fewest errors. Most of the underwriting was conducted in the field. By the time the application was submitted to the underwriting staff, most issues had been resolved. It was disclosed that grace period notices were not provided to customers who paid their premiums and fees through automatic bank drafts. It was also noted in the review of underwriting standards that in some instances, applications were not submitted in a timely manner to the Company by agents. Differing practices relating to the return of unearned premium and fee remittances were noted to be used by the Company, some of which may not be in compliance with certain state's laws governing this subject. The Company also did not have a formal record retention program in place for the majority of the examination period.

The review of the Company's claims handling procedures yielded many concerns. The Examiners review disclosed that the Company's **EOB** forms did not include information regarding the deductible applied to the claim. The lack of this information on the **EOB** makes it impossible to determine if claims were properly paid. Claims acknowledgements were not timely. Claims investigations were not conducted in a timely manner. Delay letters were either not sent, untimely sent or did not include the reason for the delay. Additionally, acknowledgement letters were used as delay letters; however, they did not include the reason for the delay. Many claims were not settled in a timely manner. Claims file documentation was noted to be inadequate or incorrect in many instances. Also, there were many instances noted whereby the initial or ultimate settlement of the claim resulted in an incorrect claim denial.

In addition to the test work performed using **NAIC** Claims standards, the Examiners observed that the Company did not assign a common claim number to a single claim submitted if the number of procedure codes being billed exceeds the maximum number of procedure code lines allowed to be recorded in its claims processing screen. Therefore, a single claim can be assigned multiple claim numbers in consecutive order if it requires more than one claims processing screen to capture all procedure codes billed on it. This type of practice made it difficult for a reviewer or provider to follow and track a claim. In addition, it distorts the Company's claim count.

Complaints and Grievances

Complaint Standards

Pursuant to the **NAIC** Market Regulation Handbook, the Examiners selected a random sample of 50 complaints from a total population of 586 for **MEGA** and a random sample of 50 complaints from a total population of 339 for **Mid-West** during the period January 1, 2005, through June 30, 2005. These were tested against the four Complaint Handling standards listed in the **NAIC** Market Regulation Handbook in effect during the examination period. It should be noted that the Company reported no complaints were received for **CLICO** during the examination period. Therefore, attribute testing was not completed for **CLICO.** The table below summarizes the sample used for this section of the examination:

Standard #	Company	Population Size	Sample Size	# Violations	% In Violation of Standard
1	MEGA	586	50	5	10.0%
	Mid-West	339	50	2	4.0%
3	MEGA	586	50	3	6.0%
	Mid-West	339	50	3	6.0%
4	MEGA	586	50	4	8.0%
	Mid-West	339	50	2	4.0%

Complaint Standard #1: All complaints are recorded in the required format on the regulated entity complaint register.

The Examiners found seven files that were not in compliance with this standard. The errors found in this section include the following:

- The receipt and response dates were incorrectly recorded in the complaint log. (1 **MEGA)**
- The original complaint was never recorded in the complaint log. (2 **MEGA)**
- The resolution date was incorrectly recorded in the complaint log. (1 **MEGA**, 1 **Mid-West)**
- The receipt date was incorrectly recorded in the complaint log. (1 **MEGA**, 1 **Mid-West)**

In addition to the above, other observations noted during the review of complaint files are as follows:

- A complaint was logged in the register correctly but none of the documentation was scanned. (1 **MEGA)**
- The Examiners found a complaint in the register that started out as a complaint, but was later determined to be an inquiry only. This should have been removed from the register when this was discovered. (1 **MEGA)**
- The Examiners noted that correspondence for one complaint was not logged into the complaint tracking system. (1 **Mid-West)**

NAIC Market Regulation Handbook Complaint Standard #3: The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with rules and regulations, applicable statutes and contract language.

The Examiners found six files that were not in compliance with this standard. The errors found in this section were as follows:

- The complaint was not forwarded to Consumer Affairs to be entered into the complaint log. (1 **MEGA)**
- The information supplied to the complainant was insufficient and did not provide appropriate detailed information concerning Company actions. (1 **MEGA)**
- Correspondence used the incorrect company name and association. This resulted in incorrect policy information being used in the resolution letter. (1 **MEGA**, 1 **Mid-West)**
- As a result of a complaint, if the Consumer Affairs Department determines that a claim needs to be reprocessed, there was no follow-up to ensure that the work was done. (1 **Mid-West)**
- Company procedures state that for some complaint types, an agent statement must be included in the response. This process was not consistently followed. (1 **Mid-West)**

Other observations were noted during the review of complaint files. Those observations are as follows:

- The Company did not communicate effectively with complainants in situations where system-generated correspondence was not produced. This same comment applies to claims. (1 **MEGA)**
- The Company did not retain all documents related to a complaint in a common location, which resulted in a greater likelihood that information could be lost and irretrievable. (1 **Mid-West)**
- In handling the complaint, it is unclear whether the Company followed its pro-rata refund procedures. (1 **Mid-West)**
- A portion of initial premium shown as paid by the applicant appears to have been paid by the agent. (1 **Mid-West)**

NAIC Market Regulation Handbook Complaint Standard #4: The timeframe within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

The Examiners found six files that were not in compliance with this standard. The errors found in this section are as follows:

- The Company's Underwriting Department received correspondence that was not forwarded to Consumer Affairs to log and respond to. Acknowledgement and resolution of the complaint took 137 days. (1 **MEGA)**
- The associates did not respond to a **DOI** inquiry until a follow-up letter was received. Resolution of the complaint took 52 days from the date the initial complaint was received. (1 **MEGA)**
- A Company's complaint log indicated that a complaint was resolved and closed earlier than was documented in the file. (1 **MEGA)**
- A complaint was archived without a response and resolution of the complaint took 35 days. (1 **MEGA)**
- The complaint was archived without a response and resolution of the complaint took 140 days. (1 **Mid-West)**
- Acknowledgement of a complaint took 15 days and resolution of the complaint took 31 days. There was no documented reason for the delays. (1 **Mid-West)**

The Examiners also noted as an observation that two complaints were handled properly but the Company did not meet the 15-day timeframe established in the department's correspondence. (2 **Mid-West)**

Grievance Standards

The Examiners requested the total population of grievances for the examination period and were informed by the Company that they did not track grievances separately from the complaint population nor did they retain a separate log of grievances.

As a result of this finding, and as all states do not have grievance laws, the Examiners determined that the most efficient method to select a sample would be to use the same sample used for testing complaint standards. The Examiners identified complaints in the complaint sample in which grievance laws were applicable. Since complaints and grievances are not recorded separately, one complaint/grievance could have the same violation under the complaint standard and the grievance standard (e.g., timeliness). The following table shows the results of this review:

Standard #	Company	Population Size	Complaint Sample Size	Grievance Sample Size	# Violations	% In Violation of Standard
1	MEGA	586	50	28	2	7.1%
	Mid-West	339	50	12	2	16.7%

NAIC Market Regulation Handbook Grievance Standard #1: The health carrier treats as a grievance any written complaint submitted by or on behalf of a covered person regarding; 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; 2) claims payment, handling or reimbursement for health care services; or 3) matters pertaining to the contractual relationship between a covered person and the carrier.

The Examiners found four files that were not in compliance with this standard. The errors found in this section are as follows:

- The grievance was not properly handled as the Company failed to send an acknowledgement letter to the consumer within 14 days of receipt and the Company failed to issue a written decision within 30 days. (1 **MEGA)**
- The grievance was not forwarded to the Consumer Affairs Department. As a result, the grievance was never logged into the register. (1 **MEGA)**
- The grievance was archived without a response and as a result it was not handled in a timely manner. (1 **Mid-West)**
- Acknowledgement and resolution of the grievance took longer than required. There was no documented reason for the delay. (1 **Mid-West)**

Underwriting

The underwriting attribute testing involved samples from **MEGA** and **Mid-West** in the following categories: issued, terminated and declined. **CLICO** does not issue health coverage and was, therefore, excluded from the attribute testing. The sample for each company was 100 cases, or 200 in total, randomly selected using ACL.

The Examiners were provided access to UICI's various systems in which underwriting information resides. The most frequently accessed systems were the RUMBA main frame system; Notepad, which is primarily used to create a written record of telephone conversations; and Work Desk, which contains imaged copies of various forms.

Prior to and during the attribute testing, the Examiners requested various underwriting and/or new business information from the Company. This information explained the Company's policies and procedures in this area and was used during the attribute testing. The specific information provided is explained in each standard below as applicable.

To conduct the attribute testing in the Underwriting area, the Examiners selected random samples of issued, declined and terminated (cancelled) policies during the examination period of January 1, 2005, through June 30, 2005. The table below summarizes the **NAIC** Market Regulation Handbook Underwriting standards in effect during the examination period that were selected for testing. Fourteen **NAIC** standards were selected for testing. The samples used and the test results are outlined on pages 84 through 107:

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Policyholder 2	MEGA	Issued	157,154	100	0	0%
	Mid-West	Issued	80,010	100	0	0%
	MEGA	Declined	16,311	100	0	0%
	Mid-West	Declined	10,651	100	0	0%
	MEGA	Terminated	165,705	100	0	0%
	Mid-West	Terminated	70,554	100	0	0%

NAIC Policyholder Standard #2: Policy issuance and insured requested cancellations are timely.

The Company generally issues policies within 30 days of receiving the application. The issue time lengthens if the underwriter determines that additional information is needed to complete underwriting. The attribute testing tracked when the application was signed by the applicant, when it was received by the Company and when the policy was issued. If additional information such as medical records is needed to process the application, the Company's procedure is to send a "delay" letter to the applicants. This letter is generally mailed within seven days of when the Company received the initial application.

In general, applications are submitted to the Company weekly by agents. The Examiners found three instances where the application was not submitted for 19, 21 and 36 days, respectively, after being signed. In response to the Examiners' inquiry, the Company explained that it accepts applications that are up to 30 days old. One of these applications was received in excess of 30 days after signature.

The Company provided detailed written procedures of the process used to assemble policies and to ensure the correct forms were used. The Company has a quality control process to spot-check policies as they are assembled.
The Company provided a written description of its cancellation procedures and examples of the cancellation letters sent

to policyholders. Pursuant to provisions in the certificate/policy, the coverage stays in effect through the policy month. For instance, coverage paid via an automatic deduction from a bank account that is cancelled in mid-policy month will stay in effect through that policy month.

During the attribute testing, the Examiners recorded the date of the policyholder's request to cancel, the date the Company acknowledged the request and the actual cancellation date. There were no exceptions to the Company's procedures or delays in processing the cancellations noted in either the **MEGA** or **Mid-West** terminated or declined samples.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 1	MEGA	Issued	157,154	100	0	0%
	Mid-West	Issued	80,010	100	0	0%

NAIC Underwriting Standard #1: The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the Company rating plan.

Applications fall into one of three underwriting categories: guarantee issue, accept/reject and full underwriting. Once the category has been determined, the underwriting staff follows procedures established for that category. The Company maintains a file that lists underwriting requirements for each state. Applications are checked against this file when received to ensure that state specific requirements are met.

For each policy in the "issued" sample, the Examiners tested for compliance with state requirements. No exceptions were noted in either the **MEGA** or **Mid-West** samples.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 2	MEGA	Issued	157,154	100	0	0%
	Mid-West	Issued	80,010	100	0	0%
	MEGA	Declined	16,311	100	0	0%
	Mid-West	Declined	10,651	100	0	0%
	MEGA	Terminated	165,705	100	0	0%
	Mid-West	Terminated	70,554	100	0	0%

NAIC Underwriting Standard #2: All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations.

In response to the Examiners requests, the Company provided lists and copies of specific state required disclosures and forms. These included complaint notices and guaranty association notices, which are given to the insured when the policy is issued. Some states have specific requirements about the information to be included in the letters provided to applicants when they are declined for coverage. The Company provided copies of the state specific letters used by **MEGA** and **Mid-West.** In addition, the Company provided an overview of the internal process used to identify and update various state requirements. These stated procedures were confirmed during attribute testing.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 5	MEGA	Issued	157,154	100	0	0%
	Mid-West	Issued	80,010	100	0	0%
	MEGA	Declined	16,311	100	0	0%

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
	Mid-West	Declined	10,651	100	0	0%
	MEGA	Terminated	165,705	100	0	0%
	Mid-West	Terminated	70,554	100	0	0%

NAIC Underwriting Standard #5: The Company's underwriting practices are not to be unfairly discriminatory. The Company adheres to applicable statutes, rules and regulations, and Company guidelines in the selection of risks.

The examination work for this standard required the Examiners to determine whether the Company issued policies according to the underwriting category applicable to each state (e.g., guarantee issue, accept/reject and full underwriting). The Company provided its Underwriting Resource Guide, which is a procedure manual. The manual also includes an overview of training processes, including state specific training. No exceptions were noted relative to these guidelines in the attribute testing.

The Company's Underwriting Resource Guide lists occupations that require "special consideration", and included in this list are medical practitioners and attorneys. The list is included in all underwriting guidelines including states with guarantee issue. The Examiners did not find any files that were declined due to occupation, but former agents represented that they were not permitted to quote medical practitioners or attorneys.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 7	MEGA	Issued	157,154	100	0	0%
	Mid-West	Issued	80,010	100	0	0%

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
	MEGA	Declined	16,311	100	0	0%
	Mid-West	Declined	10,651	100	0	0%
	MEGA	Terminated	165,705	100	0	0%
	Mid-West	Terminated	70,554	100	0	0%

NAIC Underwriting Standard #7: File documentation adequately supports decisions made.

No exceptions were noted by the Examiners in the testing of this standard.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 8	MEGA	Issued	157,154	100	0	0%
	Mid-West	Issued	80,010	100	0	0%

NAIC Underwriting Standard #8: Policies, riders and endorsements are issued or renewed accurately, timely and completely.

Unless additional information such as a request for medical records is made, as noted previously, the Company generally issues policies within 30 days of receiving the application. The attribute testing tracked when the application was signed, when it was received by the Company and when the policy was issued. If additional information, such as medical records, was needed to process the application, the Company's procedure was to send a "delay" letter to the applicants. This letter was generally mailed within seven days of when the Company received the application. No exceptions were noted by the Examiners. However, please see relevant comments under NAIC Policyholder Standard #2 presented earlier in this section.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 10	MEGA	Terminated	165,705	100	See explanation below	See explanation below
	Mid-West	Terminated	70,554	100	See explanation below	See explanation below

NAIC Underwriting Standard #10: Cancellation, non-renewal and discontinuance notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

As part of the attribute testing, the Examiners reviewed a sample of policies/certificates in which the policyholder initiated the cancellation and a sample of policies that lapsed for nonpayment of premium. The Company may cancel coverage for the following reasons: (1) nonpayment of premium, (2) health misstatements on an application and (3) at the request of the policyholder. During the examination period, policyholders who paid the premium via direct bill received advance notice that their coverage was about to expire, and that a grace period existed for 30 days after coverage ended. During this time, the premium could be paid and coverage would continue. Policyholders paying by an automatic bank draft did not receive a notice that explained the grace period. Although the specific policies selected in the sample were not in violation of the standard, the practice relating to the automatic bank drafts resulted in an inappropriate business practice and therefore the Company was in violation of this standard.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 11	MEGA	Terminated	165,705	100	0	0%
	Mid-West	Terminated	70,554	100	0	0%

NAIC Underwriting Standard #11: Cancellation practices comply with policy provisions, HIPAA and state laws.

No exceptions were noted in the testing of the Company's cancellation practices.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 12	MEGA	Terminated	165,705	100	See explanation below	See explanation below
	Mid-West	Terminated	70,554	100	See explanation below	See explanation below

NAIC Underwriting Standard #12: Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

When a policyholder cancels coverage, the policy stays in force until the end of that policy month. If a longer payment mode is utilized (semi-annual and annual), any premium paid beyond the last policy month is refunded. In the testing of policy cancellations, the Examiners noted whether unearned premium was returned. No exceptions to the Company's policy were noted by the Examiners. The Company also provided a written explanation of its process to identify and track any particular state requirement related to the return of unearned premium.

Regarding the free-look period, the Company's general policy during the examination period was to return the entire amount initially paid by the applicant, absent a request to maintain association membership, including any monies associated with association membership (e.g., the health premium, **New Member Admin Fee** and association dues and benefits, if any). However, the Company also indicated that it was not the Company's policy to pay interest on refunds of unearned premium as a general course of action. This would not be in compliance with states that require the payment of interest after a specific time period had elapsed once a consumer cancels the policy or takes advantage of the free look policy period.

Customer Cancellation of Coverage During the Free-Look Period After Issue

The stated free-look period is 10 days. For administrative purposes, 30 days from the effective date is used to determine the free-look period. Cancellations were accepted via telephone or correspondence from the policyholder. In the absence of a request from the policyholder to maintain association membership, the entire amount of cash collected from the applicant is refunded (health premium, association admin fee, association dues and any association benefits). The States of Washington, New Hampshire and New Mexico are an exception to this procedure. In these states, the health premium was refunded and the association admin fees, dues and any other

states, the health premium was refunded and the association admin fees, dues and any other association benefits were kept in force. The member must contact the associations directly to cancel one's membership.

Applicants whose applications are declined or whose underwriting process was terminated because of an incomplete application did not automatically receive a refund of the association monies paid. For association group states, the refund was comprised of the health premium and the association **New Member Admin Fee.** For individual states, the refund was comprised of the health premium and the **Policy Fee.** In this instance, the member must contact the association directly to be refunded the association dues and any association benefits received. In response to findings on this issue, the Company stated that this practice was not an apparent violation of any insurance law or regulation. However, to the Examiners, this practice demonstrates the complexities of the Company/association relationship and may not be compliant with certain state's laws and regulations.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 14	MEGA	Issued	157,154	100	0	0%
	Mid-West	Issued	80,010	100	0	0%
	MEGA	Declined	16,311	100	0	0%
	Mid-West	Declined	10,651	100	0	0%

NAIC Underwriting Standard Health #14: Pertinent information on applications that form a part of the policy is complete and accurate.

The examination procedures performed for this standard included reviewing the documentation provided by the Company to determine whether a documented underwriting/new business issue process was in place. A detailed flow chart that describes the Company's process from the time the application was received to when the policy was issued was reviewed and confirmed. The process used by the Company to assemble the policies for mailing to the policyholder was also reviewed.

The Examiners reviewed the Company's process for correcting errors or omissions on the initial application. If an

incomplete application was received and information had to be added or changed, the Company did not return it to the applicant. Instead, the applicant was notified via a telephone call and an endorsement was issued with the policy.

The Company also prepared a chart of the different underwriting standards by state: guarantee issue, accept/reject and fully underwritten. This information was confirmed with the states participating in the examination. The Examiners also confirmed that each policy/certificate was issued according to the specific state requirements. There were no exceptions noted.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 16	MEGA	Issued	157,154	100	0	0%
	Mid-West	Issued	80,010	100	0	0%
	MEGA	Declined	16,311	100	0	0%
	Mid-West	Declined	10,651	100	0	0%
	MEGA	Terminated	165,705	100	0	0%
	Mid-West	Terminated	70,554	100	0	0%

NAIC Underwriting Standard #16: The Company complies with proper use and protection of health information in accordance with applicable statutes, rules and regulation.

The Company provided documentation that adequately describes its process and procedures for protecting private information of applicants and policyholders (an excerpt appears below):

The Company did have a Privacy Procedure that was in place pertaining to the retention and disposal of all Privileged and Protected Health Information (PPI and PHI) as defined by HIPAA and GLBA.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 18	MEGA	Issued	157,154	100	0	0%
	Mid-West	Issued	80,010	100	0	0%
	MEGA	Declined	16,311	100	0	0%
	Mid-West	Declined	10,651	100	0	0%

NAIC Underwriting Standard #18: The Company does not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of HIPAA.

MEGA markets have guarantee-issue coverage in the following states: Maine, Massachusetts, Oregon and Washington. **Mid-West** markets have guarantee-issue coverage in Massachusetts and Washington. The attribute testing included a sample of declined applications, none of which came from the above states.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting 19	MEGA	Declined	16,311	100	0	0%
	Mid-West	Declined	10,651	100	0	0%

NAIC Underwriting Standard #19: The Company issues coverage that complies with the guarantee-issue requirements of HIPAA and related state laws for groups of two to 50.

During the examination period, small group plans were offered by both **MEGA** and **Mid-West**. The type of plan offered depended on the state. The companies provided the Examiners with a list showing which company offered products in which states. For both Companies, the agents were required to submit a “Statement of Eligibility” with

each application. The blank form was part of the new business packet which included the small group application form to be used in lieu of the usual individual application form. The Examiners did not find instances where the incorrect product was issued.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
Underwriting COM-6	MEGA	Issued	157,154	100	0	0%
	Mid-West	Issued	80,010	100	0	0%
	MEGA	Declined	16,311	100	0	0%
	Mid-West	Declined	10,651	100	0	0%
	MEGA	Terminated	165,705	100	0	0%
	Mid-West	Terminated	70,554	100	0	0%

NAIC Underwriting Standard COM-6: Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

The interviews conducted by the Examiners and the attribute testing of underwriting files under **NAIC** Underwriting Standard COM-6 revealed that the Company did not have record retention policy prior to May 20, 2005. The exception to this was for privacy related information. In response to the Examiners' inquiry, the Company provided the following information:

> "Prior to June 30, 2005, the Company did not have any plan or project documents for the **Enterprise Document and Record Retention Program (DRR).** All project documents were in the process of being compiled and drafted. The only item completed by that time was the selection of and training on the tool that was going to be used to implement and maintain the process."

Claims

For attribute testing in the Claims area, the Examiners selected random samples of paid and denied claims during the examination period of January 1, 2005, through June 30, 2005. These samples were tested against eleven selected **NAIC** Market Regulation Handbook claims standards. Also, two additional standards were tested on a company-wide basis based upon interviews and reviews of Company documentation. The table below summarizes the standards, samples and results of the testing performed.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
1	MEGA	Paid	606,832	100	0	0%
	Mid-West	Paid	253,183	100	3	3%
	CLICO	Paid	50	50	2	4%
	MEGA	Denied	339,719	100	1	1%
	Mid-West	Denied	147,408	100	0	0%
	CLICO	Denied	80	50	1	2%

NAIC Claims Standard #1: The initial contact by the Company with the claimant is within the required timeframe.

The Company required initial contact within 15 days which matches the requirements of the Unfair Claims Settlement Act Model Law. If a state had a more restrictive time standard, the Company followed that standard. The Examiners found seven files that were not in compliance with this standard. The errors found in this section are as follows:

Paid Claims:

- It took the Company 27 days to acknowledge a paid claim from the receipt date. (1 **Mid-West**, 1 **CLICO)**
- It took the Company 18 days to acknowledge a paid claim from the receipt date. (1 **Mid-West**, 1 **CLICO)**
- It took the Company 17 days to acknowledge a paid claim from the receipt date. (1 **Mid-West)**

Denied Claims:

- It took the Company 56 days to acknowledge a denied claim from the receipt date. (1 **MEGA)**
- It took the Company 21 days to acknowledge a denied claim from the receipt date. (1 **CLICO)**

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
2	MEGA	Paid	606,832	100	0	0%
	Mid-West	Paid	253,183	100	4	4%
	CLICO	Paid	50	50	2	4%
	MEGA	Denied	339,719	100	1	1%
	Mid-West	Denied	147,408	100	4	4%
	CLICO	Denied	80	50	0	0%

NAIC Claims Standard #2: Investigations are conducted in a timely manner.

The Examiners found eleven files that were not in compliance with this standard. The errors found in this section are as follows:

Paid Claims:

- It took the Company 275 days from the receipt date to pay a claim. There was no request for medical records under this claim. There was another claim pended with the same date of service for which information had been requested. No delay letter was sent. (1 **Mid-West)**
- It took the Company 114 days from the receipt date to pay a claim. There was another claim pended with the same date of service for which information had been requested. There was no request for additional information under this claim. There was another claim pended with the same date of service for which information had been requested. No delay letter was sent. (1 **Mid-West)**
- It took the Company 82 days from the receipt date to pay a claim. Claim was pended for underwriting review; however, this was never relayed to the provider or insured. No delay letter was sent. (1 **Mid-West)**
- It took the Company 34 days from the receipt date to pay a claim. No delay letter or request for additional information was sent to the provider or insured regarding this claim. (1 **Mid-West)**
- Two claims were opened in CLICO in error and acknowledgement letters were sent to the provider and insured. However, a final notice was never sent. (2 **CLICO)**

Denied Claims:

- It took the Company 65 days from the receipt date to deny a claim. The claim had been pended for underwriting review; however, there was no request for information or accident details for this claim. There was another claim pended with the same date of service for which information had been requested. (1 **MEGA)**
- It took the Company 148 days from the receipt date to deny a claim. There was no request for additional information under this claim. There was another claim pended with the same date of service for which information had been requested. No delay letter was sent. (1 **Mid-West)**
- It took the Company 80 days from the receipt date to deny a claim. There was no request for additional information under this claim. There was another claim pended with the same date of service for which information had been requested. No delay letter was sent. (1 **Mid-West)**
- It took the Company 61 days from the receipt date to deny a claim. No delay letter was sent. (1 **Mid-West)**

- It took the Company 53 days from the receipt date to deny a claim. There was no request for additional information under this claim. There was another claim pended with the same date of service for which information had been requested. (1 **Mid-West)**

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
3	MEGA	Paid	606,832	100	0	0%
	Mid-West	Paid	253,183	100	4	4%
	CLICO	Paid	50	50	2	4%
	MEGA	Denied	339,719	100	2	2%
	Mid-West	Denied	147,408	100	4	4%
	CLICO	Denied	80	50	4	8%

NAIC Claims Standard #3: Claims are settled in a timely manner as required by statutes, rules and regulations.

The Examiners found sixteen files that were not in compliance with this standard. The errors found in this section are as follows:

Paid Claims:

- It took the Company 275 days from the receipt date to pay a claim. No delay letter or request for information was sent. (1 **Mid-West)**
- It took the Company 114 days from the receipt date to pay a claim. No delay letter or request for information was sent. (1 **Mid-West)**

- It took the Company 82 days from the receipt date to pay a claim. No delay letter or request for information was sent. (1 **Mid-West)**
- It took the Company 34 days from the receipt date to pay a claim. No delay letter or request for information was sent. (1 **Mid-West)**
- Two claims were opened in this Company in error and acknowledgement letters were sent to the providers and insureds. However, a final notice was never sent. (2 **CLICO)**

Denied Claims:

- It took the Company 53 days from the receipt date to deny a claim. No delay letter or request for information was sent. (1 **MEGA)**
- It took the Company 65 days from the receipt date to deny a claim. No delay letter or request for information was sent. (1 **MEGA)**
- It took the Company 148 days from the receipt date to deny a claim. No delay letter or request for information was sent. (1 **Mid-West)**
- It took the Company 80 days from the receipt date to deny a claim. No delay letter or request for information was sent. (1 **Mid-West)**
- It took the Company 61 days from the receipt date to deny a claim. No delay letter or request for information was sent. (1 **Mid-West)**
- It took the Company 53 days from the receipt date to deny a claim. No request for information was sent but a delay letter was sent after 30 days. (1 **Mid-West)**
- It took the Company 56 days to deny a claim from the receipt date and more than 30 days to send the first delay letter. (1 **CLICO)**
- It took the Company 46 days to deny a claim from the receipt date. The claim was submitted with a **MEGA** policy number, but it was processed under **CLICO** instead. The claim was never processed under **MEGA** prior to this examination. (1 **CLICO)**
- It took the Company 68 days to deny a claim from the receipt date. (1 **CLICO)**
- It took the Company 31 days to deny a claim from the receipt date. (1 **CLICO)**

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
4	MEGA	Paid	606,832	100	0	0%
	Mid-West	Paid	253,183	100	0	0%
	CLICO	Paid	50	50	0	0%
	MEGA	Denied	339,719	100	0	0%
	Mid-West	Denied	147,408	100	0	0%
	CLICO	Denied	80	50	0	0%

NAIC Claims Standard #4: The Company responds to claim correspondence in a timely manner.

No errors were noted by the Examiners.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
5	MEGA	Paid	606,832	100	0	0%
	Mid-West	Paid	253,183	100	2	2%
	CLICO	Paid	50	50	1	2%
	MEGA	Denied	339,719	100	3	3%
	Mid-West	Denied	147,408	100	7	7%

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
	CLICO	Denied	80	50	21	42%

NAIC Claims Standard #5: Claim files are adequately documented.

The Examiners found 34 files that were not in compliance with this standard. The errors found in this section are as follows:

Paid Claims:

- The receipt date recorded by the Company in its claims system did not match the receipt date on the paid claim. (1 **Mid-West)**
- The date recorded by the Company in its claim system and the date of the acknowledgement letter did not match. (1 **Mid-West)**
- The Company paid a claim under the incorrect policy number. (1 **CLICO)**

Denied Claims:

- The receipt date recorded by the Company in its claims system did not match the receipt date on the denied claim. (3 **MEGA)**
- The Company denied four claims for "information previously requested not received". These requests were made on other claims with a related date of service and not on these specific claims. No delay letters were sent. (4 **Mid-West)**
- The Company initially denied two paid claims for "information previously requested not received". These requests were made on other claims with a related date of service. (2 **Mid-West)**
- The Company initially denied a paid claim for additional information; however, the request for additional information was not made on this paid claim. (1 **Mid-West)**

- Nine denied claims were submitted to the Company with information indicating a possible **MEGA** policy; however, they were processed under **CLICO** instead. Some of these claims were not processed under **MEGA** until this examination. (9 **CLICO)**
- Three denied claims were submitted to the Company with a **Mid-West** policy number; however, they were processed under **CLICO** instead. Some of these claims were not processed under **Mid-West** until this examination. (3 **CLICO)**
- The Company could not provide an imaged copy of two claims. (2 **CLICO)**
- The Company created two claims under **CLICO,** but never notified the provider or insured regarding its final determination for the claim. (2 **CLICO)**
- The Company processed a denied claim with the incorrect billed amount. (1 **CLICO)**
- The Company recorded the incorrect receipt date in its claims system for four denied claims. (4 **CLICO)**

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
6	MEGA	Paid	606,832	100	3	3%
	Mid-West	Paid	253,183	100	7	7%
	CLICO	Paid	50	50	4	8%

NAIC Claims Standard #6: Claim files are handled in accordance with policy provisions, HIPAA and state law.

The Examiners found 14 files that were not in compliance with this standard. The errors found in this section are as follows:

Paid Claims:

- The Company initially denied a paid claim for additional information previously requested; however, this was the first submission for the claim. (1 **MEGA)**
- The Company initially denied a paid claim for a routine PAP test. This benefit was a state mandate and should

have been paid. (1 **MEGA)**

- The Company excluded payment of an eligible lab charge. (1 **MEGA)**
- The Company incorrectly denied five claims because one of the claims was pended for additional information. No delay letters were sent. The Company changed the billed diagnosis code. (5 **Mid-West)**
- The Company changed the billed diagnosis in its claims system. (1 **Mid-West)**
- The date recorded by the Company in its claims system and the date of the acknowledgement letter did not match. (1 **Mid-West)**
- The Company processed a paid claim under the wrong policy number. (1 **CLICO)**
- The Company created three claims under **CLICO** in error and never sent a final determination to the provider or insured regarding them. (3 **CLICO)**

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
7	MEGA	Paid	606,832	100	See explanation below	See explanation below
	Mid-West	Paid	253,183	100	See explanation below	See explanation below
	CLICO	Paid	50	50	See explanation below	See explanation below
	MEGA	Denied	339,719	100	See explanation below	See explanation below
	Mid-West	Denied	147,408	100	See explanation below	See explanation below
	CLICO	Denied	80	50	See explanation below	See explanation below

NAIC Claims Standard #7: Company claim forms are appropriate for the type of product.

The Examiners noted that the Company's **EOB** forms did not include information regarding the deductible applied to the

claim. The lack of deductible information on **EOB** forms makes it impossible for consumers and providers to determine if the claim is properly paid. As such, the Company was in violation of this standard.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
9	MEGA	Denied	339,719	100	3	3%
	Mid-West	Denied	147,408	100	6	6%
	CLICO	Denied	80	50	2	4%

NAIC Claims Standard #9: Denied and closed-without-payment claims are handled in accordance with policy provisions, HIPAA and state law.

The Examiners found 11 files that were not in compliance with this standard. The errors found in this section were as follows:

Denied Claims:

- The Company incorrectly denied a claim for a prostate screening and testing when there was a state mandate to provide this benefit. (1 **MEGA)**
- The Company excluded payment for an ambulance claim until this examination. (1 **MEGA)**
- The Company partially processed only the second page of a submitted claim. (1 **MEGA)**
- It took the Company 148 days to deny a claim. It was an incorrect denial and no delay letter was sent. (1 **Mid-West)**
- It took the Company 87 days to deny a claim 43 days after its receipt of requested information. (1 **Mid-West)**
- It took the Company 80 days to deny a claim. It was an incorrect denial. An incorrect receipt date was also recorded by Company in its claims system. No delay letter was sent. (1 **Mid-West)**
- It took the Company 61 days to deny a claim. No delay letter was sent. (1 **Mid-West)**
- The claim was initially denied in error as the insured had eligible benefits for the service denied. (1 **Mid-West)**
- It took the Company 46 days to deny a claim and the delay letter did not provide reason. Billed diagnosis was changed by the Company. (1 **Mid-West)**
- The claim was submitted under a **Mid-West** policy; however, the Company processed it under **CLICO** instead. The claim was not processed under **Mid-West** until this examination. **(1 CLICO)**
- The Company created a claim under **CLICO** in error and did not process it under the correct Company within the time service of requirement (31 days). **(1 CLICO)**

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
11	MEGA	Paid	606,832	100	0	0%
	Mid-West	Paid	253,183	100	0	0%
	CLICO	Paid	50	50	0	0%
	MEGA	Denied	339,719	100	0	0%

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
	Mid-West	Denied	147,408	100	0	0%
	CLICO	Denied	80	50	0	0%

NAIC Claims Standard #11: Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than amount due under the policy.

No exceptions were noted by the Examiners.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
12	All	See explanation below	See explanation below	See explanation below	See explanation below	See explanation below

NAIC Claims Standard #12: The Company complies with the requirements of The Newborns' and Mothers' Health Protection Act.

This standard was tested by review of policy and procedures for all three companies. As previously noted, the Companies did not have a claims manual during the examination period. Therefore, the Examiners asked the Company to tell them how they ensured compliance with the newborns' and Mothers' Health Protection Act which requires that carriers not restrict benefits for a hospital stay to less than 48 hours following childbirth.

The Companies' response was that this is included in the maternity rider. The Companies' position is that there is nothing in the rider that would limit benefits in a manner that would be non-compliant with this law. Benefits were only restricted to the benefit amount in the rider and not by length of stay for maternity care.

It is the opinion of the Examiners that although the Companies did not limit benefits in a manner that would be non-compliant, the limitation that benefits may not be available based on a dollar maximum could be cost prohibitive to the new parents.

Standard #	Company	Sample	Population Size	Sample Size	# Violations	% In Violation of Standard
13	All	See explanation below	See explanation below	See explanation below	See explanation below	See explanation below

NAIC Claims Standard #13: The group health plan complies with the requirements of the Mental Health Parity Act of 1996.

This standard was tested by review of policy and procedures for all three companies. As previously noted, the Companies did not have a claims manual during the examination period. Therefore, the Examiners asked the Company to tell them how they ensured compliance with the Mental Health Parity Act of 1996 (MHPA).

The Companies' response stated that this applies only to plans offered in the Large Group market (51 + employees). Although **MEGA** and **Mid-West** do not offer products in this market, many states consider association business to be part of the large group market and therefore require the Companies to provide benefits in compliance with MHPA. The Companies stated that where necessary, they will amend certificates to ensure compliance.

SUBSEQUENT DEVELOPMENTS

During the examination of UICI, the Company's leadership and organizational structure continued to evolve. The Examination team noted leadership and organizational changes that affected the corporation as a whole, and was made aware of changes to processes and procedures which, as represented by the Company, were intended to address the issues raised by regulators. The changes to processes and procedures were not validated by the Examination team as those changes occurred subsequent to the examination period.

The subsequent developments identified throughout the examination report are grouped according to their relationship to the objectives identified in the **MOU.** Events that were outside the objectives identified in the **MOU,** but were significant to the organization, are listed in this section and are as follows:

1. On September 2, 2005, Ronald L. Jensen was killed in an automobile accident.
2. After Mr. Jensen's death, officials at UICI announced that **Blackstone** would acquire UICI and that the preliminary work had been completed prior to Mr. Jensen's death. The purchase was completed on April 5, 2006, and the Jensen family divested all of their interest in UICI.
3. On April 14, 2006, UICI announced that it had changed its corporate identity to **HealthMarkets, Inc. Insurance Companies (HealthMarkets).**
4. **Star HRG** was sold to CIGNA on July 11, 2006, and Student Resources Life was sold to UnitedHealth Group on October 23, 2006.
5. On November 13, 2006, **HealthMarkets** announced it was creating a Regulatory Advisory Panel. The panel consists of Tommy Thompson, former Secretary of the U.S. Health and Human Services, Audrey Samers, former Deputy Superintendent and General Counsel of the New York State Insurance Department, Susan Stead, a former Ohio Department of Insurance Assistant Director who has served in key roles at the **National Association of Insurance Commissioners,** and José Montemayor, former Texas Insurance Commissioner. Currently, Susan Stead serves as the panel's Chairwoman.
6. On May 21, 2007, **HealthMarkets** announced a new HSA-Compatible Plan for Alabama Residents.

As noted previously, this section of the report is based on information provided and/or represented by the Company and has not been subjected to examination procedures to verify its accuracy or the effectiveness of such changes in procedures and operations. A follow-up examination will be performed to validate the progress made by the Company in implementing effective compliance procedures and in monitoring compliance with such procedures.

APPENDIX A

LIST OF PARTICIPATING STATES AND EXAMINATION AUTHORITY

State	Exam Authority
AL	Code of Alabama, 1975, Section 27-2-21
AK	AS 21.06.120 through AS 21.06.230
AZ	ARS §§ 20-142 and 20-156
AR	Arkansas Code Ann. 23-61-201 through 23-61-208
CA	CIS 730 and 790.04
CO	C.R.S. 10-1-203
CT	CGS 38A-15
DC	Washington DC Official Code 31-1402
FL	FS 624.3161
ID	IC §41-219(1)
IN	IC27-1-3.1
IA	ICS 507.2
KY	KRS 304.2-100 KRS 304.2-210
LA	LSA R.S. 22:1215, 22:1301 Et. Seq.
ME	24-A M.S. RA §221
MD	2-205 and 2-206 Insurance Articles of Maryland
MA	M.G.L. Chapter 175 Section 4
MI	M.I.C. R500.210 & R500.222
MO	374.205 RSMo
MT	MCA 33-1-401
NV	NRS 479B.230
NH	RSA 400-A:37
NC	NCGS 58-2-131
OH	RC 3901.48
OK	Title 36 O.S.§309.1 and O.S.§309.7
OR	ORS 731.300 - 731 .312
PA	Insurance Department Act Section 903 (40 P.S. Subsection 323.3)
SD	SDCL 58-3-1
TN	Tennessee Code 56-1-409
TX	Article 1.15 TX Ins Code, Article 21.21, Section 5 TX Ins Code
UT	Title 31A Insurance Code, Chapter 2, Section 203
VA	§38.2-1 318 Code of Virginia
WA	§48.03, RCW
W. Va.	West Virginia Code §33-2-9(c)
WI	§601.43, Wisconsin Statute
WY	Wyoming Statue §26-2-116

APPENDIX B

CONFIDENTIAL NATIONAL COMPLIANCE PLAN

The Confidential National Compliance Plan for **The MEGA Life and Health Insurance Company** and **Mid-West National Life Insurance Company of Tennessee** is available to state regulators upon request.

HealthMarkets®
Keeping the Promise of Affordable Coverage

Kay D. Phillips, J.D.
Vice President, Chief Compliance Officer
and Associate Counsel
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P 817-255-5513
F 817-255-5392

December 10, 2007

Mr. James T. Odiorne, CPA, JD
Office of the Insurance Commissioner
5000 Capitol Boulevard
Tumwater, WA 98501

Sent Via E-Mail and Overnight Delivery

Re: The MEGA Life and Health Insurance Company, NAIC #97055,
Midwest National Life Insurance Company of Tennessee, NAIC #66087,
The Chesapeake Life Insurance Company, NMC #61832

Dear Mr. Odiorne:

I am pleased to enclose the response of The MEGA Life and Health Insurance Company, Mid-West National Life Insurance Company of Tennessee and The Chesapeake Life Insurance Company (collectively, the Companies) to the multi-state market conduct examination Draft Report.

We are submitting our Executive Summary and our Responses to Draft Report Findings and Required Actions, along with our Responses to the Results of Attribute Testing. Our response detail identifies areas where we disagree with the findings and the reasons for our disagreement. Where corrective actions for problem identified in the draft report are already in place those actions are fully described.

Thank you for your consideration and I look forward to hearing from you at your convenience.

Sincerely,

Kay D. Phillips
Chief Compliance Officer

cc: Leslie Krier
Ted Lehrbach
Kara Baysinger
Mike Colliflower

RESPONSE TO THE

MULTI-STATE MARKET CONDUCT EXAMINATION DRAFT REPORT
OF
THE HEALTHMARKETS, INC. INSURANCE COMPANIES

(Formerly Known As UICI)

The MEGA Life and Health Insurance Company

Mid-West National Life Insurance Company of Tennessee

and

The Chesapeake Life Insurance Company

9151 Boulevard 26

North Richland Hills, Texas 76180-5605

EXAMINATION PERIOD

January 1, 2000 through December 31, 2004*

***Examination period extended to December 31, 2005 to include attribute testing and agent interviews.**

December 10, 2007

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SECTION 1 – EXECUTIVE SUMMARY

Introduction

The MEGA Life and Health Insurance Company, Mid-West National Life Insurance Company of Tennessee and The Chesapeake Life Insurance Company (collectively, the Companies) wish to express their appreciation to the Washington Office of the Insurance Commissioner and the Alaska Division of Insurance (the Lead States) for the opportunity to respond to the Draft Report sent to the Companies on November 20, 2007. We are appreciative of the inclusion in the body of the Draft Report of many of the initiatives and enhancements the Companies have undertaken both during and after the examination period. We believe that, with only certain noted exceptions, the Draft Report presents an accurate picture of the Companies' efforts to improve their operations, compliance programs, agent training and oversight in the home office and the field, both during and after the examination period.

The Companies also believe they have effectively addressed or are addressing the findings identified in the Draft Report. Many of those enhancements have been in place for some time, while others are underway. Many of these enhancements are discussed more fully in Section II, the main body of this Response.

Our compliance program enhancements and improvements are a daily part of our Companies' commitments and operations, and are therefore, an ongoing and expanding part of what we do and who we are today as HealthMarkets companies. We appreciate the opportunity to discuss these compliance program enhancements and improvements in this Response, so that the Lead States, Participating States and the rest of the regulatory community have the most current information related to these ongoing efforts.

The Companies are committed to (1) offering health insurance at an affordable price to consumers who must pay the total costs of coverage on their own; (2) holding compliance as an enterprise-wide top priority; and (3) building open and trusting relationships with regulators through regular meetings and proactive interaction. The following improvements evidence our dedication to these goals:

1. Enhanced, comprehensive agent training and oversight implemented beginning in 2003, with efforts to enhance and improve agent training that continue today. The core of this expanded effort is our agent training program that is called “Training, Testing, Auditing, Complaints and Compliance” or TTACC.

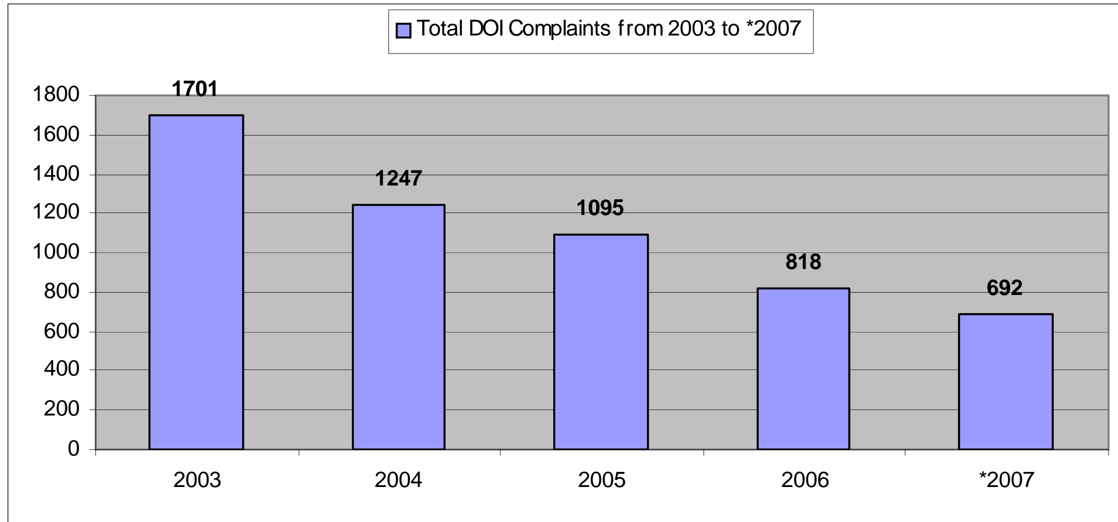
2. Expand our existing program of agent oversight, through a newly-developed process called the Field Evaluation Program (“FEP”), to be kicked off during the first quarter of 2008. The FEP will include regular comprehensive field audits of the sales offices of each marketing division, and targeted audits when issues requiring prompt attention are identified. These audits will be done by Field Auditors within the Compliance Department, under the guidance of the Chief Compliance Officer.

3. Since September 2004, disclosure forms fully describing the relationship between the Companies and the associations have been used nationwide. The language in these disclosure forms have been approved by a Federal Court.

4. A post-sale Benefit Confirmation Call Program was implemented in April 2005 to confirm that purchasers of the Companies' base health insurance plans understand the benefits and limitations of their coverage.

5. More comprehensive insurance products were introduced in 2006 as an alternative to the Companies' scheduled benefit plans. We continue to focus on product needs of consumers in product development.

These changes and others currently underway have increased customer understanding and satisfaction with our products and services, as shown by a significant reduction in complaints and litigation against the Companies. Specifically, over the last three years, Department of Insurance complaints declined 52% and this downward trend has continued in 2007. Our records show that through November 30, 2007, DOI complaints are down nearly 9% from the prior year period. In addition, litigation against the Companies is down approximately one-half nationally since 2005.



* 2007 MEGA, Mid-West and CLICO DOI count as of 11/30/07

Comments and Concerns

The Companies are concerned about several issues and findings in the Draft Report.

1. Consumer Understanding: In the normal course of our business today, we make concerted efforts to assure that our customers understand the products they have purchased from our Companies. At the point of sale, our agents use detailed product brochures approved by our Compliance Department that thoroughly describe the product(s) we sell. At the end of the sales presentation, our agents are required to leave behind a product brochure that lists the benefits and limitations of the product the customer has purchased. After the sale is completed and the policy is issued, we make several telephone calls under our Benefit Confirmation Program (BCP) to our new customer to go over their plan with them. During those calls, we review the benefits and limitations of the policy they have purchased, and also confirm with them that our plans are not major medical or comprehensive health insurance policies.

If we do not connect via the telephone on the BCP call, we send a letter to the new insured. This letter contains a statement that this coverage is "not a comprehensive major medical plan." A copy of the form of letter is attached as Exhibit 1.

We understand the concerns expressed in the Draft Report and we commit to the Lead States that we will work collaboratively with them to develop additional methods to help consumers have a better understanding of the Companies' products.

2. Association Disclosure: The Companies are concerned about Finding #3, which states: *"The Company discloses their relationship with the associations to consumers and policyholders, both orally and in writing. The Examiners found these disclosure methods insufficient."* In 2004, the Companies began to provide written disclosures at the point of sale that clearly delineate the relationship between the Companies and the associations. The Association Disclosure form was developed during the settlement of national litigation involving the Companies and was approved by a Federal Court. The Disclosure form cannot be changed without the approval by the Federal Court.

The Companies believe that their disclosure methods are sufficient based on the information provided above. In addition, the Companies are unaware of any statute or regulation that requires the use of such a disclosure form in the sale of association group insurance. We request that the language of this finding be deleted or modified, or that we be given the opportunity to discuss what other measures would satisfy the concerns expressed in the Draft Report. The Association Disclosure form is attached as Exhibit 2.

3. Dual Role of Agents: A third concern relates to the finding that our agents are sales agents for the Companies' health insurance plans, as well as enrollers for the associations. It is standard practice in the association group insurance market, rather than the exception, for agents to act in this dual capacity. Our agents are trained regarding their dual capacity and the need for them to clearly disclose their capacity when talking to prospects. In addition, we have undertaken to completely separate collection of the association dues and insurance premium payments at the point of sale and throughout the life of the policy. We obtain two checks during the sales process, and thereafter, either bill or draft separately for the association membership dues amount and the insurance premium. We submit that this separation should be sufficient when coupled with the agent training and the Association Disclosure form referenced in Item 2 above.

4. Attribute Testing: While the Draft Report noted deficiencies in the handling of complaints and grievances, we respectfully point out that the Companies complaint handling practices were within the NAIC Market Regulation Handbook's (the NAIC Handbook) stated error

tolerance levels for every aspect of the attribute test standards listed in the Draft Report. The single exception was Grievance Standard 1, where two violations were noted for Mid-West among a sample size of twelve, which is a very small sample size.

The following table summarizes[1] the results of the Companies' attribute testing in the Draft Report. Please note that the overall results of these tests clearly indicate that the Companies successfully met the stated error tolerance level for all but four[2] of fifty tested attribute standards.

	% in Compliance with Standard									
	MEGA				Mid-West				CLICO	
Standards	Complaint	Grievance	Claims (Paid)	Claims (Denied)	Complaint	Grievance	Claims (Paid)	Claims (Denied)	Claims (Paid)	Claims (Denied)
1	90%	93%	100%	99%	96%	83%	97%	100%	96%	98%
2	N/A	N/A	100%	99%	N/A	N/A	96%	96%	96%	100%
3	94%	N/A	100%	98%	94%	N/A	96%	96%	96%	92%
4	92%	N/A	100%	100%	96%	N/A	100%	100%	100%	100%
5	N/A	N/A	100%	97%	N/A	N/A	98%	93%	98%	58%
6	N/A	N/A	97%	N/A	N/A	N/A	93%	N/A	92%	N/A
9	N/A	N/A	N/A	97%	N/A	N/A	N/A	94%	N/A	96%
11	N/A	N/A	100%	100%	N/A	N/A	100%	100%	100%	100%

Section II of Response

Section II of this response is devoted to a detailed response to the findings and required actions in the Draft Report. In summary, Section II includes requests for clarification or deletion of findings and/or required actions, additional information concerning the Companies' operations and examples of how identified issues have already been addressed, as the following highlights:

- Description of key enhancements accomplished with respect to organizational structure, field training and field monitoring activities since 2003 (Finding #1 and Finding #2);

- Explanations and requests related to Claims Handling (Finding #3), regarding:

[1] Excludes attribute testing results for Underwriting because the Draft Report does not identify any violations of the tested Underwriting standards.
[2] Three of the four tested standards that exceed the stated error tolerance levels relate to claim settlement practices for The Chesapeake Life Insurance Company, and make up .0096% of the total claims processed during the tested timeframe of 1/1/2005 through 6/30/2005.

    - The Companies' use of diagnosis and CPT codes (Finding #3A);
    - Consecutive claim number issue and its resolution in December 2004 (Finding #3B);
    - Revisions to Explanation of Benefit ("EOB") forms to include deductible information (Finding #3D);
    - Quality assurance and independent internal audit processes to assure claims adjudication is compliant (Finding #3E);

- Companies' development and completion of a Claims Procedure Manual (Finding #4);

- Explanations and requests related to the Companies' and the Associations' operations (Finding #6) as follows:

    - Remittance of the initial and renewal payments for the Companies and the Associations (Finding #6A);
    - Use of a detailed disclosure form regarding the business relationships between the Companies and the Associations beginning in September 2004 (Finding #6B);
    - Handling of the Association administration fees (Finding #6C);

- Explanation that the results of the Attribute Testing on complaints and grievances indicate the errors were virtually all within the allowable 10% error tolerance level pursuant to NAIC standards and requests that these results be applied to findings and required actions (Findings #7.A.-7.F.);

- Explanation of the strides made by the Companies in creating a comprehensive, centralized compliance program to promote consistency throughout the entire enterprise (Finding #9); and

- The Companies' request for reconsideration of an alternative means of satisfying the examiners concerns related to the outside consultant's report (Finding #12).

Overview of Compliance Initiatives

The Companies have taken significant action in the last four years to develop a strong, sustainable compliance program that will enable them to enhance improvements achieved to date and to demonstrate effective compliance controls to the regulatory community.

- Beginning in late 2004, the Companies restructured the historically decentralized compliance efforts to create a comprehensive, centralized compliance structure with reporting directly to the Chief Executive Officer (CEO), the General Counsel and, ultimately, the Board of Directors of HealthMarkets, Inc.

- In early 2007, the Compliance Program was centralized into the Compliance Department under the direction of the Chief Compliance Officer (CCO). The CCO has unfettered access to the Chief Executive Officer (CEO), the Chief Operating Officer (COO), and other senior management personnel throughout the organization. In addition, the CCO interacts with and provides regular reports to the Compliance and Governance Committee of the HealthMarkets, Inc. Board of Directors. This centralization of compliance functions that had been spread throughout various departments and business units of the Companies has improved communication and coordination of the Companies' compliance goals, and has helped ensure a consistent interpretation of new laws and regulations across the enterprise.

- In early 2006, the Companies developed an internal Compliance Audit group that is charged with conducting follow up audits on remediation efforts and actions taken in response to market conduct examination commitments and with auditing the implementation of new laws and regulations by our business units. This group reports directly to the Compliance and Governance Committee of the Board of Directors.

- A Regulatory Advisory Panel (RAP) composed of respected former insurance regulators and other respected government officials was formed in August 2006. The RAP is independent and provides objective advice and guidance to the Companies regarding regulatory and compliance issues, trends and initiatives.

- In October 2006, the Executive Compliance Committee (ECC) was created, to bring compliance issues to the Companies' senior executives for their consideration. The

ECC meets regularly, and includes the CEO, Chief Operating Officer (COO), CFO, General Counsel, Chief Information Officer (CIO), the CCO, and senior management from the marketing division, AMG, the business processing center, Administrative Services Group (ASG), and Compliance Audit.

- The Companies recently created a department within ASG that is charged with compliance-related oversight. In coordination with the Companies' CCO, this new department, Operational Compliance, works with the operational departments within ASG to implement compliance-related enhancements in response to enacted new laws and regulations, and commitments made to regulators. In addition, Operational Compliance is also charged with monitoring the ongoing compliance of the operations within ASG.

The Companies are committed to working with the Lead States, our Domestic Regulators, and the Participating States on completion of the report. The Companies respectfully submit that we have addressed those concerns and criticisms in a wide variety of effective enhancements and improvements to our policies and procedures and our organization.

The Companies believe that they have made and are continuing to make extraordinary strides in improving our compliance with all laws and regulations that relate to our business. Fuller explanations of the many enhancements made in recent years, as well as responses to each of the Findings in the Draft Report are included in Section II of our Response.

SECTION II – RESPONSES TO DRAFT REPORT FINDINGS AND REQUIRED ACTIONS

This Section of the response supplements the information set forth in the Executive Summary. The Companies have carefully reviewed the Findings and Required Actions described in the Draft Report together with the other sections of the Draft Report and respectfully submit the following comments and information for consideration. This Section of the Companies' response includes summary information regarding key initiatives completed by the Companies that are responsive to the Findings and Required Actions expressed in the Draft Report. The Companies continue to develop and implement additional planned actions to supplement the key enhancements that have already been implemented by the Companies. This response information also includes requests to change some of the report findings and required actions.

The Companies' Responses to the Findings and Required Actions are provided below in sequential order with the Draft Report:

Finding #1: *Regulators noted that a majority of complaints stemmed from missing or inaccurate information during the initial contact between the agent and the customer. While the Company has devoted resources to refine internal operations, the agency program had not changed significantly. These issues will continue to persist until the Company becomes more involved in oversight of agents.*

The Companies have changed the agency program significantly and considerable enhancements have occurred with respect to agency operations, with much effort devoted to enhancing agent training and oversight. The Companies continue their long-time commitment to ensure that their customers receive complete and accurate information during the sales process. Key enhancements accomplished with respect to organizational structure, field training and field monitoring activities since 2003 include:

- **Agency Marketing Group.** The Agency Marketing Group ("AMG") was established in 2004 to provide centralized oversight of UGA (the marketing division of MEGA) and Cornerstone America ("Cornerstone," the marketing division of Mid-West) in a consistent manner. Compliance staff was dedicated to oversee agent training and monitoring programs in March 2005.

- **TTACC Training Program, 2003.** A comprehensive, company-wide agent training platform entitled the “Training, Testing, Auditing, Compliance and Complaints” or “TTACC” program was introduced beginning in 2003. TTACC is a mandatory agent training program that covers a variety of insurance, sales and compliance related topics including, but not limited to, marketing guidelines, advertising guidelines, unfair trade practices, general sales presentation guidelines, proper disclosures, disciplinary policy and detailed product training. Training regarding ethics and sales practice standards are embedded throughout the TTACC training materials. State-specific training modules are designed to address the unique requirements that exist in each state, including products and mandated benefits.

  At the initial implementation of TTACC in 2003, all appointed agents in each state were required to complete the TTACC training program for their state and pass a test covering the training materials with at least an 80% grade, or 90% in the case of Field Leaders. Since its inception, all new agents have been required to complete TTACC training and testing before they can write business for the Companies. All existing agents must also complete TTACC testing annually. As of November 2004, the Companies would not accept any business from an agent who has not completed the required training and testing. There are no exceptions to this rule.

  While the basic objectives have not changed, TTACC has undergone numerous revisions since its initial rollout to improve the quality and effectiveness of the training provided to all of the Companies’ agents. These revisions have moved UGA and Cornerstone (our two dedicated sales divisions) to a single training platform, which ensures consistency of training across the two sales organizations. Over the years, the Companies have added sections to the training modules to address issues identified in internal audits or through a pattern of complaints, as well as the addition of new questions to the TTACC tests to ensure that agents understand the new training materials. We continue to review and improve TTACC, both in scope and specificity, as new products are introduced or new regulatory or statutory requirements are implemented. Several states, including Arizona, Delaware, Iowa, Massachusetts, Oregon, Washington, and Wisconsin, have sent representatives to attend agent training sessions, and the Companies have received favorable feedback from these states. The

Companies have made modifications to the training based on feedback from those states as part of our commitment to improve our agent training.

- **National Product Training Team, beginning December 2006.** A National Product Training Team ("the Training Team") was established in late 2006 to conduct comprehensive product training sessions at field offices. While Field Leaders have responsibility for TTACC new agent training in accordance with the Companies' approved TTACC materials, the Training Team conducts continuing education for existing products and delivers all training for new products and initiatives. In addition, the Training Team provides targeted training courses for products and compliance issues.

  This team of professional trainers is overseen by the Vice President in charge of product training and development. This Vice President has a direct reporting relationship to the head of the Companies' operations. The Training Team is currently staffed with 12 members, including ten (10) traveling trainers and two (2) compliance support members. The Training Team has conducted 70 training sessions this year, including 47 refresher courses, at field offices.

- **Other Training Opportunities (ongoing):** Other training opportunities are continually provided to the agents, including but not limited to:

  - Field leaders hold weekly meetings with their field force, and a portion of these meetings is usually dedicated to compliance training. Field leaders may use training materials or other compliance information developed and provided by the Companies, or they may address issues of concern that have been identified within their field office. The field leaders continue to reinforce product knowledge and important compliance information during these weekly sessions.

  - The Companies conduct regular field leader meetings to provide essential training and to communicate important company strategies, including compliance-related information. The field hierarchy includes Regional, Divisional and District sales leaders who oversee the activities of the agents in their

respective regions. During these sessions, the Companies provide presentations on leadership skills to help field leaders develop their own skills and those of their agents as part of Field Leadership Training sessions, held since 2004. Compliance, financial responsibility, and peer-to-peer training on job-specific responsibilities are topics that are typically covered at each of these training schools for the field leaders. In addition, the Companies receive feedback from the field leaders regarding ways the Companies can help their field force to better serve their customers as part of regular meetings with an advisory board called the Leaders' Congress. This group provides feedback and insight regarding future company initiatives, including compliance-related projects, as well as agent training and oversight programs.

- **Field Leader and Agent Handbooks, beginning June 2006.** Agents at every level of the hierarchy are provided with a Handbook, through which the Companies' standards related to ethical behavior are reinforced. Separate Handbooks were developed for the various levels of the field hierarchy, including writing Agents, District Leaders and Division Leaders, in order to ensure that all levels of the hierarchy are informed on guidelines pertinent to their responsibilities. The Handbooks cover a variety of topics related to compliance, including but not limited to, disclosures required regarding the relationship between the insurance company and the Association, complaint handling, sales presentation standards, basic insurance industry terms, advertising guidelines, and federal guidelines related to privacy, telephone do-not-call lists and anti-money laundering. Agents are required to sign an acknowledgement as certification that they have received and read the Handbook, and they are accountable for compliance with the guidelines in the Handbook. (Agents' accountability is discussed in further detail in the response to Finding 2h.) The Handbooks are available to examiners upon request.

- **AMG Advisor, beginning April 2005:** In addition to TTACC training, the Companies also send monthly "AMG Advisor" publications to the field force which provide refresher training information regarding various topics, such as advertising guidelines, HIPAA Guidelines, HIPAA Eligible Individual qualification, Telephone Do-Not-Call List requirements, and the Agency Management System ("AMS"). Field leaders are encouraged to use these publications as training materials at their regular weekly meetings. The AMG Advisors are also maintained on the marketing division websites as

resource information available to all agents. Examples of prior AMG Advisor publications are available to examiners upon request.

- **Point-of-Sale Scripts, December 2005**: In December 2005, the Companies worked with the field leaders of UGA and Cornerstone to develop and approve point-of-sale scripts that outline the information and topics to be covered during an agent's sales presentation. The scripts are approved by the Compliance Department and are maintained on the marketing divisions' websites so that they are readily available and easily accessible by the Companies' agents.

- **Agency Management System ("AMS"), July 2006**. The AMS captures information regarding agent activity, including but not limited to complaints, mix of business, Benefit Confirmation Program ("BCP") call and general performance metrics. This tool is available on-line to all field leaders and agents to view their respective hierarchy and personal information. The AMS is also used by the Companies' management as a source of information to monitor agents' activities.

- **Benefit Confirmation Program, beginning April 2005.** The Companies implemented a post-sale BCP in April 2005. Initially, the objective of this program was for the Companies to contact all consumers who had purchased a scheduled benefit health plan and ensure that the consumer understood the coverage they purchased. Such calls are made post-issue (within three (3) to four (4) weeks after the health insurance plan has been delivered), and customers who cannot be reached by telephone after three (3) attempts are contacted by letter. Phone messages and letters provided to insureds who cannot be reached include specific invitation to the insured to contact the Customer Care Department with any questions. In January 2007, the BCP was expanded so that all customers who purchase a health benefit plan from the Companies are contacted.

  During the BCP call, the Customer Service Representative reviews features of the insured's plan with him/her to ensure the insured understands the coverage purchased, including but not limited to the following features:

  - Type of coverage selected (for example, Basic Hospital/Medical Surgical Expense Plan) and, for scheduled plans, that the coverage differs from a comprehensive major medical and catastrophic plan;

- The deductibles of the plan and how the deductibles are applied;
- The aggregate and lifetime maximum amounts of the plan;
- The benefits provided by the base plan and any optional benefit riders. The Customer Service Representative also confirms any optional benefit riders that were not selected; and
- Any adverse underwriting action that may have been taken.

The benefits and limitations of the insurance plan are also presented by the agent at the time of sale and this presentation is acknowledged in writing by the customer at that time.

Any issues brought to the Companies' attention by an insured during the BCP call regarding allegations of agent misconduct are logged and investigated as verbal complaints through the Companies' complaint handling processes. Agents with high complaints (more than five (5) in a rolling 12-month period) are reviewed by the Sales Practice Review Team (described below).

Summary reports are reviewed and analyzed by the Companies' senior management for trends to assist in further editing BCP scripts to achieve the highest level of customer understanding of their health coverage.

In October 2006, a number of questions were added to the BCP script to assist the Companies' management in monitoring agent actions. Those questions address "point-of-sale" issues, such as whether the agent properly explained the benefits and limitations of the proposed policy, whether he/she left a brochure with the customer, whether he/she answered questions the prospect had, and whether the customer found the sales materials helpful.

- **Sales Practice Review Team, beginning in 2005**. Agents' complaint-related activity is reviewed through the Sales Practice Review Team ("SPRT") that meets on a monthly basis. Agents who receive five (5) or more complaints during a rolling 12-month period are reviewed during SPRT meetings. Senior level management from the Companies, including the Chief Compliance Officer and General Counsel or Deputy General Counsel, the UGA Executive Vice President of Sales, the Cornerstone Executive Vice

President of Sales, the AMG Vice President of Sales Compliance and management staff from the Customer Advocacy Group, are regular participants in these monthly meetings.

While the Companies have an established process to address complaints involving agents through SPRT, the Companies do not wait for an agent to appear on the SPRT high complaint report before taking action regarding allegations of agent misconduct. Allegations of misconduct by an agent are investigated through an established protocol by the Customer Advocacy Group. Following such an investigation, an agent may be subject to immediate disciplinary action including termination.

- **Agent Due Process, November 2005:** The Companies adopted an "Agent Due Process" procedure for the purpose of monitoring, reviewing and correcting agent activity with respect to sales and marketing issues. The process ensures that disciplinary actions against agents, up to and including termination, are processed in a consistent and orderly manner.

- **TTACC Audits, beginning in 2005:** The audit portion of TTACC became operational for UGA during 2003. Upon the establishment of the Agency Marketing Group ("AMG", described above), an enhanced and consistent audit program was implemented for both UGA and Cornerstone. This audit program is still in use today. A dedicated team of compliance staff audits field offices at least once every 12 months to ensure a consistent training message is delivered throughout all the Companies' field offices. The auditor observes a TTACC training session to ensure that all required components of training are covered. The auditor also reviews other facets of the field office, such as agent files, to determine if appropriate file documentation is being maintained, and whether communications regarding regulatory changes and compliance information are being made regularly to agents by the field leaders. In addition, point-of-sale materials (*e.g.,* product brochures) are reviewed to ensure that only current materials that have been approved by the Compliance Department are being used. The audit reports are provided to the Regional and Divisional Sales Leaders, the Executive Vice President of Sales and to the Chief Compliance Officer. If a division office fails an audit, the Regional Sales Leader takes steps to ensure that any corrective measures are completed, and the Companies typically re-audit the field office within the following 90 days to confirm that corrective actions were completed.

- **Audits by Independent Law Firm:** In certain cases, the Companies have engaged the services of an independent law firm to conduct targeted, in-depth field audits of field offices. Some of these field audits were scheduled due to the requirements of market conduct examination settlements, while others resulted from the identification of potential compliance issues by the Companies. Reports of these field audits are submitted to the Companies' management. These audit reports require development and implementation of action plans to address issues identified during the audit, to correct any deficiencies identified and to evaluate the appropriateness of disciplinary actions. Follow-up is conducted by field leaders and the Companies' management until the action plans are completed.

- **Field Evaluation Program ("FEP"):** The Companies are developing and implementing a Field Evaluation Program which will provide oversight and monitoring of field agents through a comprehensive field audit program. This program will include interviews with Agents and Field Leaders and review of files and sales materials in each field office on topics such as general field office activities and documentation; recruiting; new and ongoing agent training and education; sales presentations, and complaint identification and reporting. The Company anticipates that implementation of the FEP will begin during the first quarter of 2008.

- **Complaint Monitoring:** The Companies regularly monitor complaint ratios and patterns of complaints through SPRT and within the Companies' operational units and the Compliance Department. Complaint statistics with an analysis of the reasons for complaints are reported quarterly to the HealthMarkets Board of Directors.

In addition to the enhancement of agent training and oversight described above, the Companies also introduced a new product portfolio, the CareOne product suite, beginning in February / March 2006. The Companies redesigned their products to provide more comprehensive insurance products as an alternative to the Companies' scheduled benefit plans. Many of the expanded benefits in our CareOne products were previously available only through optional benefit riders. Our customers can also elect additional benefits, depending on their needs and their cost concerns. The CareOne product suite has been

released in 36 jurisdictions to date, and will continue to be released in other jurisdictions as regulatory approvals are received.

The Companies believe that the changes to organizational structure, improved and enhanced agent training program, implementation of the BCP, and increased monitoring of agent activities as described above, as well as the introduction of the CareOne product portfolio, have significantly enhanced our customers' understanding of the health insurance plans offered by the Companies. The impact of these changes is reflected through the reduction in the number of complaints submitted to regulators since 2003. Department of Insurance complaints have declined 52% from 2003 to 2006 (from 1701 complaints in 2003 to 818 complaints in 2006). The Companies' records also show that complaints are down another 9% through November 30, 2007 (692 complaints), compared to the same period in 2006 (759 complaints).

Required Action #1: *The Company must modify its agency program to expand and improve its agent training particularly for new agents, by expanding its training program to include industry knowledge, ethics, product presentation, proper disclosures, consistent delivery across agencies, and a robust structure, among other enhancements, as follows:*

To ensure agents and consumers thoroughly understand the product they are selling/buying and appropriate disclosures are made at the point of sale and in follow-up contacts, the Company must:

a. *Strengthen the training program for new agents by including health insurance industry information.*
b. *Provide scheduled agent training more frequently based upon average agent retention statistics, such as every three to six months rather than annually.*
c. *Develop a standard but progressive curriculum for agents based upon experience level with the Company.*
d. *Strengthen the training program for existing agents, particularly product information, ethics and point-of-sale presentations.*
e. *Develop centralized standards and controls to manage agents and train agency management in appropriate controls and monitoring of agent and agency activities. Develop tools and metrics for measuring the effectiveness of training (e.g., reduction of complaints, reductions in cancellations, etc.).*

f. Develop additional methods to help consumers have a better understanding of the Companies' products during the sales process.

g. Train Benefit Confirmation Program (BCP) staff to be assertive in reviewing coverages with clients to ensure more calls are successfully completed.

Company Response: The Companies agree to continue the expansion and improvement of the TTACC training program for all agents as well as oversight activities. In addition to the extensive array of agent training and oversight initiatives already implemented (and addressed in the response to Finding #1), the Companies are evaluating methods to implement this Required Action with an emphasis on continued improvements to the TTACC program and monitoring activities, including the development and implementation of additional tools and metrics to assist in this process. The following initiatives are planned and in progress toward completion:

- The Companies are expanding and enhancing the training programs for new and existing agents to include modules covering basic health insurance industry information and ethics. Agents will be required to complete an on-line "e-learning" module covering these topics prior to their participation in the TTACC classroom training. TTACC tests will be revised to include tests items for basic health insurance industry and ethics information. The targeted completion date for these new TTACC modules and updated tests is December 31, 2007.

- The Handbooks for Agents, District Leaders and Division Leaders are being revised to include a section dedicated to ethics-related topics. Agents and Field Leaders will be required to annually acknowledge their receipt and understanding of the new ethics section and their agreement abide by its guidelines. The targeted completion date for the Handbook updates is December 31, 2007.

- The Companies will continue to deliver training to all field offices and expand the plan for training delivery to provide for a minimum of three (3) product training courses for field agents each year beginning in 2008. The Companies will also develop a plan and associated training strategies to address supplemental training for divisions where remedial and/or additional training may be needed on an "as needed" basis by Q2 2008.

- The Companies are working to develop a plan for a progressive curriculum for agents that will take a tiered approach to agent development, based on their tenure. Modules will be implemented as they are developed over the 12 months following completion of the plan. The targeted completion date for development of the plan is Q2 2008.

- The Companies have taken a number of steps to help consumers better understand the products they have purchased. At the point of sale, our agents use detailed product brochures approved by our Compliance Department that thoroughly describe the product(s) sold by the Companies. At the end of the sales presentation, our agents are required to leave behind a product brochure that lists the benefits and limitations of the product the customer has purchased. After the sale is completed and the policy is issued, the Companies make several telephone calls under our BCP program to our new customer to go over their plan with them.

  The Companies understand the concerns expressed in the Draft Report. The Companies commit to the Lead States that they will work collaboratively with the Lead States to develop additional methods to help consumers have a better understanding of the Companies' products.

- The Companies agree to develop a strategy with a goal toward increasing the successful completion of BCP calls.

Finding #2: *There was a lack of sufficient quality assurance procedures over agent activities such as monitoring and auditing the activities of agents and agency management. A review of the TTACC training and new product training confirmed the need to audit agents' actions in the field.*

A. An internal audit plan is being implemented, but agent activities and transactions are not included in the initial audit program. The Company has indicated that agent activities will be subject to audits "at a later date."

B. Any internal audit program must include information used at point-of-sale to ensure that agents are correctly representing the products.

C. There is minimal, if any, accountability on the part of the regional directors, division managers and district managers for the actions of agents under their supervision.

Company Response: The Companies have agreed to, and have implemented, a multi-faceted audit process for agent training that is designed to ensure that agents are being properly trained in accordance with the Companies' standards. This audit process, as well as additional agent oversight activities, is described in the response to Finding #1.

The Companies respectfully submit that the Field Leaders, including Regional Directors, Division Managers and District Managers, were held accountable during the examination period and continue to be held accountable for the actions of the agents working within their hierarchy. Issues within a Field Leader's hierarchy have typically been identified through complaints, BCP results, reports of other agents and audits of field offices. The Companies take any allegations of agent misconduct seriously and investigate such issues. Field Leaders have been held accountable for activities within their teams through disciplinary actions (such as counseling, demotion, or termination of the contractual relationship with the Field Leader).

Required Action #2: *To provide adequate monitoring of agents and agent activities, the Company must:*

a. *Implement quality assurance procedures over agent activities including monitoring procedures and periodic audits.*

   Company Response: The Companies agree and remain committed to continuing enhancements with respect to monitoring and oversight of agent activity. Key enhancements accomplished to date that relate to agent monitoring and oversight activities are described under Finding #1 above.

b. *Enhance the effectiveness of agent training by requiring monitored testing and monitoring the delivery of the training presentations by the field managers.*

   Company Response: The Companies agree that monitored testing and delivery of the training presentations is appropriate. As an interim step, the Companies began administering all TTACC testing in a monitored environment, either at a division or satellite district field office on November 26, 2007. The Companies are evaluating options for a long-term solution, including the effectiveness of the interim solution, and

will determine the approach for establishing on-going monitored agent testing by Q1 2008.

In addition, as of September 2007, the Companies imposed an eight (8) hour waiting period before an agent could re-take a failed TTACC test, during time additional training can be provided to ensure that the agent understands the material before again attempting to pass the test.

c. *Implement a plan to monitor agents' actions using tools such as comprehensive field audits, phone interviews with recent customers, secret shoppers and trending of agent and agency related information, such as complaint statistics, cancellations, product upgrades and the like.*

Company Response: The Companies have implemented processes and programs to monitor the activities of agents. The key enhancements are described under Finding #1 above. The Companies continue to evaluate other methods to enhance agent oversight activities, including the following:

- The Companies are implementing additional monitoring using enhancements to the Agency Management System ("AMS") software tool. AMS is being enhanced to include additional indicators for reporting that will identify patterns in agent activity that may require review and corrective action. The system will prompt review of an agent or field leader who exceeds thresholds for key indicators. The targeted date for completion of the enhancements is Q3 2008.

- The Companies are also expanding the Sales Practice Review Team ("SPRT") meeting to include the review of metrics for Field Leaders with regard to complaints attributed to the agents within their hierarchy by year-end 2007.

- The Companies agree to consider additional monitoring actions.

d. *Provide additional point-of-sale materials such as scripts and checklists for agent's use and ensure that all materials include appropriate disclosures.*

Company Response: The Companies have provided agents with approved point-of-sale materials, including product brochures and point-of-sale scripts, for use during a sales presentation. The Companies are developing enhanced and/or new point-of-sale scripts and presentation materials to further promote consistent communication during sales presentations and providing additional training to agents regarding the use of such materials. The Companies expect to have new and enhanced materials available to agents during Q2 2008.

e. Investigate all agents with unusual trend statistics and all complaints regarding claims that allege that agents misrepresented the product at the point of sale. Any agent found to be misrepresenting the products at the time of sale should be retrained, disciplined or dismissed as appropriate for the circumstances.

Company Response: The Companies have established processes to monitor complaint activity regarding agents. Those processes are described under Finding #1.

f. Hold field management, such as regional managers and above, accountable for the actions of each agent under their supervision. Field management performance assessment and overall compensation should contain a component that is tied to such performance measures as the number of complaints received about sales practices in the manager's territory, the number of cancellations and persistency of business written by the manager and his agents, and other actions that may be indicators of the overall performance of that manager's territory. Incentives should also be developed which reward regional managers who demonstrate effective accountability and management of their agents with respect to compliance requirements and performance.

Company Response: The Companies respectfully submit that the Field Leaders, including Regional Directors, Division Managers and District Managers, have been and continue to be held accountable for the actions of the agents working within their hierarchy.

With respect to current compensation models and accountability of Field Leaders, a "Taken Rate"[3] calculation is built into the calculations for compensation and qualifiers which measure the quality of business submitted by an agent. The Taken Rate is a key indicator of customer satisfaction and a key factor in our recognition and pay programs. The Taken Rate has significant financial implications related to the compensation that a Field Leader or agent might earn. The agent's Taken Rate is affected when an applicant cancels his/her insurance application and can indicate possible issues with an agent's submitted business. The Taken Rate will be used with other metrics that are captured in the Agency Management System (described on page 7) as a trigger to review an agent's performance when enhancements to the AMS are completed. An agent or Field Leader with a low Taken Rate will receive less remuneration than an agent with a higher Taken Rate.

The Companies are also evaluating additional methods of adjusting Field Leaders' compensation tied to specific compliance performance measures. The Companies' target date for determination of such program(s) is Q1 2008 with implementation of the program(s) to follow.

Finding #3 – Claims Handling

The Draft Report (under Finding #2, page 9) states that many deficiencies were noted in the Companies' claims handling practices and cites several different exceptions related to particular claims standards that were tested. The Companies recognize that their claims administration system has certain limitations that are reflected in some of the findings in the Draft Report. As a result, the Companies are formulating plans to address system-related claims issues on a long-term basis to further enhance their claims processing. These plans will be outlined by year-end 2007, with implementation to follow in 18-24 months. Despite the limitations of our current system, the Companies respectfully point out that their claims handling practices were within the 7% error tolerance level under the NAIC Market Regulation Handbook guidelines for each aspect of the Attribute Testing listed in the Draft Report with the exception of three (3) standards involving the extremely small number of accident claims processed by The Chesapeake Life Insurance Company (approximately

[3] The "Taken Rate" is a ratio of taken policies (*i.e.* those that are in force for at least one (1) month) compared to submitted policies and expressed as a percentage.

.0096% of the claims processed during the examination period). Further, the Companies believe that some of the deficiencies cited in the Draft Report were inadvertent errors, and did not violate any legal standards, and most importantly, did not result in harm to consumers. The Companies are, therefore, offering the below response separating those items the Companies feel were not in violation of any NAIC specific standards and those the Companies have addressed, with details of their resolution.

Finding #3A. Diagnosis and CPT Codes

When processing a claim, the Company enters diagnosis codes into its claims system that are different from what was submitted by the provider on the claim. This is performed with respect to the primary diagnosis code. The Company indicated it has been the practice of its claims department to change the diagnosis on one claim to match the diagnosis of an already existing claim (i.e., allergic reaction with an accident "E" code may have been re-coded as an allergy to match an existing allergy claim vs. a new accident). According to the Company, the practice was to give the insured the best benefit by tying that claim to an existing claim for the same diagnosis. By doing this, the insured purportedly would not incur a new deductible for a new claim. The Examiners also noted that the Company altered CPT codes submitted by the provider on the claim.

…

The Company indicated that diagnosis codes entered into its claims system are not the decisive factor behind benefit payment calculations and that ultimately, it does not impact the benefit payments made to claimants. According to the Company, a benefit payment is determined by the "Cause Code" and "Benefit Code" selected by its claims examiner. The Company explained that claims are adjudicated using the "Cause Code" and "Benefit Code" assigned to the claim during the adjudication process, rather than the diagnosis code and CPT code billed by a provider and captured in its claims system. The Company maintains that its claims adjudication system utilizes a programming mechanism, the "Cause Code," to tie all relative deductibles, co-pays, and co-insurance to a single cause in order to adjudicate claims consistent with the benefit schedules for its health plans. A "Benefit Code" for a claim is determined by the claims examiner and entered into the claims system to identify the type of service provided to the claimant (i.e. inpatient hospital charges, office visit, surgical, laboratory services, etc.). Therefore, the Company asserts that benefit payments are not impacted by the Company's practice of changing diagnosis codes submitted by a provider since the "Cause Code" and "Benefit Code" is the driver for its claims adjudication.

The Examiners note that such a practice allows for claims examiners to make judgmental determinations of the "Cause Codes" or "Benefit Codes" assigned to a submitted claim rather than the provider's determination. This presents the potential risk that benefit payments by the Company on a claim may be incorrect or inconsistent with what the provider indicated.

Required Action #3A: *The Company must identify and re-adjudicate any claims for which diagnosis and CPT codes were altered because of the risk that the claim may not have been paid correctly as a result of the code change. The Company must cease to alter diagnosis and CPT codes submitted by providers on claims.*

Company Response: The Companies do not alter diagnosis codes and CPT codes on claim forms submitted by providers. The Companies appreciate the acknowledgement in the Draft Report that the diagnosis codes and CPT Codes are not the decisive factor for benefit determination, but rather benefit determination is made based on the Cause Code and Benefit Code assigned in the claims system to the claims. A further explanation of how the diagnosis and CPT code information is captured and stored is represented in the attached claim process flow example. The example outlines the Companies' position that this finding does not lead to an indication of misuse of diagnosis or CPT codes resulting in improper claims adjudication outcomes to the detriment of any customer. Please refer to Exhibit 3.

Although there is some judgment on the part of the claim examiner to select the initial cause, there is consistency when claims are tied together using the same cause indicator. There are two key driver options for Cause Code, one for "sickness" and one for "accident" and there is a low likelihood that the claim examiner discretion will result in an incorrect choice. The other key piece of data known as the "Benefit Code" (which identifies the type of service such as office visit, surgical, laboratory service, etc.) is also selected and used to further determine the appropriate benefit package aligned with the "unaltered" primary diagnosis on the claim. In most mainstream claim adjudication systems, these factors are part of the benefit selection criteria and are used to drive benefit payments. The Companies administration system (Processor 1) has been in use for a long period of time and because of this has certain system limitations which are clearly reflected as part of this finding.

The Companies have analyzed all claims from the claims sample used for the Attribute Testing and have determined that no claims were paid incorrectly as a result of this structure. Detailed policies and procedures exist and are updated as needed. These procedures were recently revised when the new programming to lock down diagnosis fields was completed in early 2007. The Companies strongly believe that claims have been processed correctly under the current system and have no indication that this process has contributed to any deficient claim adjudication practices that would require a re-adjudication of any claims.

The Companies respectfully request that the Required Action to re-adjudicate claims be removed from the Draft Report.

In the alternative, the Companies respectfully request that the Required Action be revised. The only method the Companies have to identify claims where a diagnosis or CPT Code on a provider bill may have been recorded differently in the claims system is to complete a manual comparison of each provider bill to the entries in the computer system for the millions of claims received during the examination period. As a result, the Companies respectfully request that this Required Action be revised in a manner that satisfies the objectives of the Required Action while providing the Companies with an action that is attainable. To this end, the Companies request that Required Action 3A be reworded as follows:

> *The Company must identify the extent to which any claims were not adjudicated correctly as a result of a diagnosis or CPT code being altered. The Company will complete this identification of claims errors within the set of sample claims reviewed by the examiners during Attribute Testing. In the event that claims errors identified from the review of sample claims can be attributed to the alteration of a diagnosis or CPT code, and exceeds a 7% error level, then the Company will be required to conduct additional testing or corrective action as agreed by the Lead States.*

Finding #3B. Claim Numbers

The Examiners noted that the Company had a claims handling practice whereby it assigned an additional consecutive claim number to a submitted claim if there were more than four

procedures codes (CPT) billed on it…This practice results in multiple claim numbers for a single occurrence or service. This distorts the Company's claim count and results in reporting incorrect data in relation to the number of claims it received and processed.

Required Action #3B: *The Company must make changes to the claims adjudication system that will allow them to enter an entire claim into their system as a single claim.*

Company Response: The Companies respectfully submit that this issue was resolved in December 2004 through the use of a "Film Number" that ties all sub-claims together. This issue relates to the claims handling practice whereby the claims may be assigned multiple claim numbers for a single bill due to a system limitation in capturing the number of procedure codes that can be entered/processed at one time. The Companies' claim count and results are not compromised by this practice since a unique "film number" links all claims together for a single occurrence or service (single bill). The claim is counted as one claim yielding one Explanation of Benefits ("EOB") to the insured reflecting all billed charges. This is also demonstrated in the claims process flow example provided in Exhibit 3.

No consumer harm or violation of NAIC standards has resulted from this practice. However, the Companies are committed to enhancing our claims handling functions by implementing a claims administration system that addresses this limitation within the 18-24 month timeframe discussed above.

Finding #3C. Claim Delays

During the Examiners' review of a sample of paid and denied claims processed within the examination period, it was noted that investigations were not conducted in a timely manner. Additionally, when claims were delayed, claim delay letters used by the Company were not consistently sent, did not specify the reason for the claim delay and did not meet many state's claims handling requirements for claim adjudication delays due to investigations. It was also noted that the Company used acknowledgement letters as delay letters; however, the reason for the delay was not included.

Company Response: This statement appears to relate to "NAIC Claims Standard #2: Investigations are conducted in a timely manner," and to "NAIC Claims Standard #3: Claims are settled in a timely manner as required by statutes, rules and regulations." Attribute

testing results for NAIC Claims Standards #2 and #3 appear on pages 98 through 101 of the Draft Report. The Companies respectfully submit that they passed the attribute testing related to these NAIC standards and that Finding #3C should be revised to accurately reflect the results of the attribute testing. The first sentence of Finding #3C does not state the extent to which claims were found to be non-compliant with NAIC Claims Standard #2 and #3. This sentence could be improperly construed to indicate that no claims processed by the Companies were compliant with these NAIC Claims Standards for timely investigation of claims. The percentage of violations noted in the Attribute Testing for NAIC Claims Standards #2 and #3 were 4% or less which is well within the 7% error tolerance level set forth in the NAIC Market Regulation Handbook, with one exception. The exception related to CLICO denied claims for which the error level noted for attribute testing was 8%. Please note that the number of paid and denied claims processed by CLICO was an extremely small number within the total population of claims subject to the examination for the period of 1/1/05 to 6/30/05 (the CLICO claims count amounted to .00581% of the total claims population for paid claims (50 out of 860,065) and .01642% of the total claims population for denied claims (80 out of 487,207).

To add perspective to this issue, please note and consider that a total of 11 violations were found with respect to NAIC Claims Standard #2 out of a total of 500 sample files reviewed. With respect to NAIC Claims Standard #3, a total of 16 violations were noted out of a total of 500 sample files reviewed. Further, a total of seven (7) instances of failures to send delay letters are reported under NAIC Claims Standard #2 and a total of nine (9) instances of failure to send delay letters and two (2) instances of sending late claims delay letters late are reported under NAIC Claims Standard #3 out of a total of 500 sample files reviewed for each of these Standards.

The Companies respectfully request that this portion of the Finding and the related Required Action be reworded to indicate the results of the Attribute Testing.

Required Action #3C: *All claims must be adjudicated in a timely manner as required by statute or rule in the appropriate jurisdiction based on claim submission location.*

Company Response: The Companies agree with this Required Action and maintain that claims are currently processed according to each state's claims prompt payment

requirements. The Companies strive to ensure that each claim is processed timely, and have processes set up to include payment of interest on claims that are not processed timely in accordance with applicable state laws. The percentage of violations noted in the Attribute Testing for NAIC Claims Standards #2 and #3 were 4% or less which is well within the 7% error tolerance level set forth in the NAIC Market Regulation Handbook (with one exception of unique circumstance for which the error level noted for Attribute Testing was 8%).

All delayed claims letters must include a reason for the delay.

Company Response: The Companies send out letters to insureds when a claim is pending to advise that additional information being requested. To further improve this process and address the Required Action, the Companies have undertaken a project to evaluate solutions. First, the Companies are completing an analysis to determine the detailed requirements for claims-related correspondence to ensure that, in the event of a delay in claim processing, the associated letters contain the reason(s) for the delay. The letters will then be revised as appropriate, based on the results of the analysis. Development and implementation will begin once the requirements have been documented and approved. The date targeted for completion of the analysis is Q1 2008.

The Company's practice of pending claims while waiting for information on other claims must cease.

Company Response: During the examination period, the Companies' claims examiners discontinued the practice of pending claims that are unrelated to other claims being investigated. Claims are pended to request medical records or other information as necessary to ensure proper claims adjudication and as allowed by state law.

Finding #3D: Explanation of Benefits

The Company's ***Explanation of Benefits (EOB)*** *forms do not include information regarding the deductible applied to the claim. The lack of complete information on EOB forms makes it impossible for consumers and providers to determine if claims are properly paid.*

Required Action #3D: *All* ***Explanation of Benefit*** *forms must include the deductible information pertinent to the claim.*

Company Response: The Companies agree to revise their Explanation of Benefit ("EOB") forms. The Companies are in the process of updating the EOB to include more deductible information pertinent to the claim so it is easier for customers to understand. The Companies have revised their EOB form to reflect this enhancement in one Participating State and are continuing to make this revision effective in all states, with completion targeted for Q2 2008.

Finding #3E: Independent Claims Audits

Required Acton #3E: *The Company must perform independent routine and ongoing audits of claims to determine adherence with the Claims Procedures Manual and applicable laws and regulations. The results of such audits must be analyzed by compliance personnel to identify trends and root causes of claim mishandling, areas for training emphasis, and problem claim adjusters. Audits must result in action by the Company to correct those areas found to be problematic or deficient.*

Company Response: The Companies agree and have established quality assurance and independent internal audit processes to ensure that claims adjudication is compliant with the Companies' internal procedures as well as applicable laws and regulations, as follows:

Quality assurance audits are conducted by a dedicated staff of 13 as part of the Claims Department daily operations.

The Compliance Audit department conducts independent periodic (weekly, monthly, quarterly and annual) audits of compliance related activities within business units and functional areas.

Audit results and recommendations are discussed with and reported to business unit management. The head of the operating division also reviews the draft audit report and provides comments. A final report is produced that includes any corrective action that the business unit management will perform to correct any issues. Final reports are distributed to

the Compliance Department and senior leadership. Issues are communicated to the Compliance & Governance Committee during their quarterly meetings. Compliance Audit, and the newly formed Operational Compliance Department (discussed below), follow-up to ensure that corrective action plans have been implemented.

The Companies recently created a department within the Administrative Services Group ("ASG") that is charged with compliance-related oversight. ASG administers the association group and individual health insurance and ancillary coverages written by the Companies. In coordination with the Companies' Chief Compliance Officer and compatible with the Companies' central Compliance Department, this new department, Operational Compliance, works with the operational departments within ASG to design and implement compliance-related initiatives and enhancements in response to new laws and regulations as well as commitments made to regulators. In addition to compliance implementation oversight, Operational Compliance is also charged with monitoring the ongoing compliance of the operation. This monitoring effort 1) utilizes the results of the Quality Assurance function within the operational units to assess issues and trends in processing performance and 2) utilizes the audit findings generated by Compliance Audit to determine whether corrective actions are operating appropriately. Based on conclusions reached through monitoring efforts, Operational Compliance will recommend additional remedial action where necessary. As such, this effort dovetails with the monitoring and analysis taking place within the Claims Department, and the periodic audits performed by Compliance Audit.

Finding #4: *At the commencement of this multi-state market conduct examination, the Company did not have a Claims Procedures Manual.*

Required Action #4: *The Company will develop and maintain a Claims Procedure Manual.*

Company Response: The Companies have already remedied this deficiency by developing and implementing a comprehensive claims manual in 2006 that includes written policies and procedures for the claims handling process. As with all of our policies and procedures, the claim manual will be reviewed and revised regularly as the Companies' needs dictate or as changes to laws or regulations may require.

Finding #5: ***…****In reviewing a* ***CLICO*** *claim, the Examiners would often see a claim that had been initiated under* ***CLICO****, and an acknowledgement and delay letter would be sent to the provider or insured under this company name. However, if benefits were not available under the* ***CLICO*** *accident policy, the Company would utilize a "no claim" remark code to close the claim internally and then process the actual payment or denial for the claim under the insured's* ***MEGA*** *or* ***Mid-West*** *policy (whichever one was available or in-force). They used the* ***Explanation of Benefits (EOB)*** *statement to advise the insured of this action. This would be the only notification to the insured or the provider concerning the change of Company. The insured was never given the opportunity to question the denial of the* ***CLICO*** *claim.*

Required Action #5A: *All claims should be adjudicated under the Company in which the claim is being made.*

Required Action #5B: *Anytime a claim is denied, appropriate notification must be sent.*

Required Action #5C: *All claims must be documented correctly by being filed with the Company in which the [claim] is being made.*

Company Response: The Companies wish to note that this Finding stems from an isolated incident and is no longer an issue. The CLICO accident policy was issued to fulfill a specific purpose, namely, as part of the settlement of national litigation. The CLICO accident plans were issued beginning in January 2005. As of July 1, 2007, less than 100 accident plans remained in force. No consumers were harmed as a result of this issue as the actual benefit payments due were not affected. Please note that the number of paid and denied claims processed by CLICO was an extremely small number within the total population of claims subject to the examination for the period of 1/1/05 to 6/30/05 (the CLICO claims count amounted to .00581% of the total claims population for paid claims (50 out of 860,065) and .01642% of the total claims population for denied claims (80 out of 487,207).

The Companies further note that Finding #5 and the related Required Actions relate to "NAIC Claims Standard #5: Claim files are adequately documented." Attribute testing results for NAIC Claims Standard #5 appear on pages 103 through 104 of the Draft Report.

The Companies respectfully submit that Finding #5 of the Draft Report should be revised to accurately reflect the results of the attribute testing.

Finding #6: *The manner in which the Company and the association operate is not fully disclosed to those purchasing UICI insurance products.*

A. During the examination period, the Company allowed agents to collect, at point of sale, a single check payable to a third party to pay the association dues and initial insurance premium. The amount collected could also include ***Policy Fees, New Member Admin Fees*** *and other fees, some of which are remitted to the association and some of which are retained by the insurer. Little to no disclosure was made to the client concerning how the funds would be split. In some states, any amounts collected by the insurer in a single check or remittance may constitute "premium" and be subject to premium tax. The Company did not account for such statutory differences in their accounting for premium taxes.*

Required Action #6A: *The Company must change its procedures so that the insurance payments and the association payments are received as two separate payments. The Company must identify states in which the definition of premium includes all amounts collected by the insurer, and must advise those states of the possibility that the Company may need to amend premium tax filings. The Company must work with the affected regulatory jurisdictions to correct prior year filing errors.*

Company Response: The Companies and the Associations agreed to make revisions to the manner in which initial payments and renewal payments are remitted for Association fees/dues and insurance premiums. As of January 1, 2007, the Field Service Representative / Agent collects two separate payments at the time of application – one payment for the Association dues/fees which is made payable to the Association and separate payment for insurance premiums which is made payable to the Companies. The Companies are in the process of completing a project to split renewal billings and bank drafts so that separate billings and bank drafts are generated for association dues payments and insurance premiums. This project is in progress with an expected completion date during Q1 2008.

In response to the Finding and Required Action related to the definition of premium and tax filings, the Companies respectfully submit the following. The Companies executed service agreements with the Associations that provide the Companies with the power and authority to collect Association fees and remit those fees to the Association. Based upon the agreements in place and as a convenience to consumers, the Companies and the Associations allowed Agents / Field Service Representatives to collect one initial payment from a consumer who applied for both an Association membership and an insurance plan at the same time. The initial payment included the Association administration fee (*i.e.,* noted by the examiner as the "New Member Admin Fee"), the Association dues, any amounts for other Association benefits, and the insurance premium including any policy fees, as applicable.

The initial payment made by the consumer was submitted to the Companies for processing. The total amount of funds submitted by the consumer for Association fees and dues was remitted to the Association (or Specialized Association Services on behalf of the Association) pursuant to service agreements between the entities. The Companies did not/do not retain any portion of the Association fees or dues that was/is collected. The Companies retain only the premium amount submitted by the consumer for an insurance product underwritten by the Companies (including any policy fees). As further support of this statement, please note the following statement in the Draft Report: "The Examiners found that the information contained in the Company-prepared flow charts depicting the flow of funds between UICI companies and the associations was accurate." (reference page 60 under "Overall Assessment of Flow of Funds Between Company and Associations)

The Companies respectfully submit that the remittance of Association fees / dues and insurance premiums in a single check does not determine that the Association fees / dues constitute "premium." The Association fees and dues were not submitted as consideration for an insurance product underwritten by the Companies. Such Association fees and dues were submitted as consideration for Association Membership and were remitted in their entirety to the respective Association (or Specialized Association Services on behalf of the Association) according to the service agreements in effect. Accordingly, the Association fees and dues do not constitute "premium" under the insurance laws of any state.

The Companies respectfully submit that premium taxes have been appropriately accounted for and correctly paid to all state insurance departments with respect to this issue. Accordingly, the Companies request that the Finding and Required Action related to the question of whether Association fees / dues constitute premium for tax purposes be removed from the Draft Report.

Finding #6B: *Agents are both sales representatives for the insurance company and enrollers for the association. This causes confusion for new members and may be in conflict with the best interests of the consumer.*

In addition, ***Finding #3 (from the Executive Summary of the Draft Report)*** *states: The Company discloses their relationship with the associations to consumers and policy holders both orally and in writing. The Examiners found these disclosure methods insufficient. Additionally, transparency of activities, relationships and financial arrangements between various UICI affiliates and their interaction with the associations and other UICI affiliates is insufficient.*

Required Action #6B*: The Company must disclose, with emphasis and clarity, to consumers and policyholders the relationship between the Company and any associations it uses for marketing products.*

Required Action #3 (from the Executive Summary of the Draft Report): *The Company must provide sufficient information, oral and written, to consumers and policyholders regarding the Company's relationship with the associations and other UICI affiliates as applicable.*

Company Response: In September 2004, the Companies implemented the use of a detailed disclosure at the point of sale regarding business relationships between the respective insurance company and association in September 2004 (referred to as "Association Disclosure") during the examination period. The Association Disclosure was developed during the settlement of national litigation involving the Companies and approved by a Federal Court. Any changes to the Association Disclosure require approval by the Federal Court.

The Association Disclosure clearly explains the relationship between the Companies and the Associations, including the following key information:

- Organizational information about the Association and the insurance company, including the fact that the Association is a separate entity from HealthMarkets and its affiliates and subsidiaries, with the entities having no direct or indirect ownership in each other.
- The fact that Association members are required to pay monetary dues for membership.
- Salespersons serve a dual role as both a licensed insurance agent of the insurance company and a Field Service Representative of the Association.
- Membership dues derived from the sale of Association membership go the Association, and insurance premiums derived from the sale of insurance go to the insurance company.
- With respect to states where association group insurance is issued, an applicant may not acquire insurance coverage under an association group type master policy unless the applicant is also a member of the association.

The Association Disclosure is used nationally. The Companies' agents are carefully trained on the necessity to use the Association Disclosure form at the point of sale and to explain its purpose each and every time they are discussing the sale of an association group plan with a potential customer. The Association Disclosure form must be provided by the agent and left with the applicant, who also must sign a "Confirmation of Presentation, Disclosure and Receipt" form, acknowledging receipt of the Association Disclosure form. If this signed document is not included with the application, the Companies return the entire application to the agent. A copy of the Association Disclosure is attached as Exhibit 2 and a copy of the Confirmation Form is attached as Exhibit 4.

Even in states where membership is required to obtain insurance, association membership is not required to maintain the insurance. This fact is explained in a recent revision to the Association Disclosure. The Finding related to this required action indicates that consumers may be confused by the dual role served by the salesperson as an agent and a Field Service Representative and that this may not be in the best interest of the consumer. The Companies respectfully disagree with this assessment. The Associations and the Companies are separate entities, and this fact is clearly disclosed to consumers through the

sales presentation and the Association Disclosure which was implemented in September 2004.

It is standard practice in the association group insurance market, rather than an exception, for agents to also act as representatives of various associations. In addition, the Companies' agents have been extensively trained since TTACC was initiated in 2003 to always disclose that they are agents of the insurance company and Field Service Representatives of the Association. Please refer to the response to Required Action #6C below.

The Companies also respectfully state that they do not use the Associations for marketing products as indicated in Required Action 6B. Insurance products are marketed by agents who are appropriately licensed and appointed to represent the Companies. The Companies issue group insurance policies to the Associations (or their Trustee) under which members of the Association can apply for such insurance coverage. The Associations are not established for the purpose of marketing insurance products.

Finding #6C: *A* ***Policy Fee*** *was charged to consumers who reside in individual (non-association) states while no* ***Policy Fee*** *was charged if the consumer resides in an association group state. The Company did not clearly disclose to regulators how the* ***Policy Fees*** *and the association* ***New Member Admin Fees*** *are allocated between the insurance company and the associations. The Company represented that the* ***Policy Fee*** *reflects the cost of issuing a policy, establishing the required records, sending premium notices, and other related expenses. The Company also represented in writing that the* ***Policy Fee*** *is subject to premium tax. No* ***Policy Fee*** *is added to policies issued in states where the applicant must join the association to buy insurance (referred to as "association group" states).*

Required Action #6C: *The Company needs to clearly disclose to regulators how the* ***Policy Fees*** *and the association* ***New Member Admin Fees*** *are allocated between the insurance company and the associations. This will assist the Company in providing to the regulators an accurate accounting for premium tax purposes and for the proper accounting for premium refunds to insureds.*

Company Response: The Association Administration fee is remitted in its entirety to the Association and does not constitute consideration for an insurance product underwritten by the Insurance Companies. As such, the Association administration fee is not subject to premium tax.

The policy fees that are charged for individual policies underwritten by the Insurance Companies are included with rate filings when required by state insurance laws and regulations. As such, policy fees are disclosed to state regulators through the rate filing requirements of the state and the Companies accurately account for such policy fees for premium tax purposes and refund purposes where collected in the individual states.

Finding #6D: *The Examiners noted significant changes in the structure of the Company during the examination period. The Company divested itself of many of the peripheral affiliations with other non-insurance entities that may have impacted the cost of the insurance to consumers/policyholders.*

Required Action #6D: *The Company needs to remain vigilant that is relationships with all entities are cost effective and do not adversely impact the cost of insurance to consumers/policyholders.*

Company Response: The Companies are highly regulated entities in all jurisdictions in which they are licensed, including oversight by their state regulators through the following mechanisms:

- The Companies have obtained and continue to maintain the appropriate Certificates of Authority to conduct business in all states where they solicit insurance.
- Inter-company agreements are subject to approval through the Companies' domestic states in accordance with the applicable Insurance Holding Company Acts. The Companies made and continue to make all such required filings, including all affiliate agreements.
- The Companies prepare and submit Annual Statements each year to the NAIC and the state regulatory departments.

- Financial examinations are routinely conducted by the Companies' domestic states. No issues relating to the above Finding have ever been noted through the domestic states' financial examinations.
- The Companies have always been compliant in making annual Form B filings with their domestic regulators, and these filings disclose information regarding affiliated relationships and transactions, as well as other information regarding financial information and ownership.

The Companies have been and will remain vigilant that their relationships with all entities are cost effective and do not adversely impact the cost of insurance to consumers/policyholders.

Finding #7: *The handling of complaints and grievances included the following findings based upon our attribute testing:*

A. All complaints were not recorded in the required format on the Company's complaint register.

B. The Company did not take adequate steps to finalize and dispose of complaints in accordance with rules and regulations, applicable statutes and contract language.

C. The timeframe within which the Company responded to complaints was not in accordance with applicable statutes, rules and regulations.

D. The Company did not treat all written complaints submitted by or on behalf of a covered person as a grievance in states where separate grievance laws apply.

E. For Complaints involving agent's actions, the Company did not request an agent statement in all instances. In addition, there was inconsistent evidence that disciplinary actions were taken against agents involved in the complaints.

F. The Company's Complaint Action Team (CAT), chaired by SEA division head of consumer affairs, focuses solely on complaints in an effort to identify actions designed to reduce the number of complaints. This team operated independently with no executive management oversight. If compliance related issues arise from these meetings, it was the responsibility of various managers to see that each issue is addressed. Once this issue had been released to the manager, there was no follow-up to ensure that the issue was handled appropriately.

Required Action #7: *For complaints and grievances to be handled appropriately, the Company must take the following actions:*

A. *All complaints must be recorded and logged correctly in compliance with states' laws and the Company's stated procedure.*

Company Response: The Companies respectfully submit that the data in the Attribute Testing indicates the errors related to this Finding and reported for Standard 1 (pages 79 - 80 of the draft report) were all within the allowable 10% error tolerance level provided in the NAIC Market Regulation Handbook. Further, the Companies are concerned that this Required Action and the related Finding could be improperly construed to indicate that the Companies did not record any complaints in the required format in its complaint register the way it is written. The Companies have written procedures in place regarding complaint handling that require all complaints to be logged in the Companies' complaint register.

Because the Finding was based upon Attribute Testing and the Attribute Testing error results were within a 10% error tolerance, the Companies respectfully request that the Finding and related Required Action be removed from the report.

The Companies have completed the following activities to enhance the management of complaint logs:

- Complaint oversight and management was centralized in the Compliance Department's Complaint Oversight and Reporting Unit as of January 1, 2006. Complaint logs are maintained by this Unit.
- Since December 2005, periodic training sessions have been conducted for all employees to ensure complaints are appropriately identified and routed correctly for logging and tracking. Complaint handling training sessions are conducted every six (6) months with employees who have direct contact with customers. All other employees receive annual training. The most recent complaint training was conducted in August 2007.
- Agents receive complaint training through TTACC.

- A new Complaint Handling System ("CHS") has been developed and was implemented as of June 2007. With the establishment of this new system, workflows for complaints have also been reviewed and enhanced. All written complaints, including complaints from state regulatory departments, are still entered into the complaint logs through a centralized location in the Complaint Oversight and Reporting Unit. Verbal complaints are entered into the CHS by escalation teams in the Customer Care and Customer Advocacy Departments who are specially trained to handle verbal complaint calls. The CHS will allow more reporting capabilities that were not available under the prior complaint tracking system. The additional reporting capabilities will allow the Companies to better manage complaint handling and to monitor complaints for trends and patterns that require corrective action.

B. The Company must ensure that all issues raised in a complaint/grievance are acknowledged and investigated, finalized/disposed of in accordance with rules and regulations, applicable statutes and contract language.

Company Response: The Companies respectfully submit they passed the attribute testing related to this Standard. The data in the Attribute Testing in the Draft Report for Standard 3 (pages 80 - 81 of the Draft Report) indicates there was one (1) error for MEGA from a sample size of 50 (or 2%) and two (2) errors for Mid-West from a sample size of 50 (or 4%) with regard to insufficient information being provided to a complainant. These error levels are well within the 10% allowable error tolerance level under the NAIC Market Regulation Handbook. Further, the Companies are concerned that this Required Action and the related Finding could be improperly construed to indicate that the Companies did not take adequate steps to appropriately finalize and resolve any complaints in a compliant manner.

Because the Finding was based on Attribute Testing and the error results of Attribute Testing were very low, the Companies respectfully request that the Finding and related Required Action be removed from the report.

Notwithstanding the above, the Companies continually strive to improve the quality of complaint investigations and resolution processes. The Customer Advocacy Group ("CAG") maintains a Complaint Manual that provides guidance for response time and

response content, as well as investigator guidelines and complaint handling procedures. All of these procedures require that complaint responses must be answered timely and that all issues must be addressed.

An audit process was implemented by CAG in January 2006 to review complaints and ensure that standards related to complaint handling are met. CAG has responsibility for investigating and responding to consumer complaints on behalf of ASG. Audits are routinely conducted to ensure that complaints are being responded to timely and in compliance with company and regulatory standards, which includes providing complete responses with all appropriate supporting documentation in response to a consumer complaint.

The Companies are standardizing the grievance handling process. The date targeted for completion of this project is Q1 2008.

C. *The Company must comply with the timeliness of response and timeliness of resolution of each complaint/grievance as required by applicable statutes, rules and regulations.*

Company Response: The Companies respectfully submit that they passed the attribute testing related to this Standard. The data in the Attribute Testing in the Draft Report for Standard 4 (page 81 of the Draft Report) indicates that there were three (3) errors for MEGA from a sample size of 50 (or 6%) and two (2) errors for Mid-West from a sample size of 50 (or 4%) with regard to situations in which a complaint was not responded to in a timely manner. These error levels are well within the 10% allowable error tolerance level under the NAIC Market Regulation Handbook. Further, the Companies are concerned that this Required Action and the related Finding could be improperly construed to indicate that the Companies did not respond to any complaints on a timely basis.

Because the Finding was based on Attribute Testing and the error results of the Attribute Testing were low, the Companies respectfully request that the Finding and related Required Action be removed from the report.

State laws and regulations, as well as the Companies' internal procedures, pertaining to complaint handling were incorporated into the new Complaint Handling System (noted under Required Action #7A above) to ensure compliance with state requirements. The Complaint Handling System will also allow for changes related to the Companies' policies and procedures as well as state laws and regulations to ensure ongoing compliance with applicable internal and external requirements.

Complaint oversight and management was centralized in the Compliance Department's Complaint Oversight and Reporting Unit as of January 2006. The Complaint Oversight and Reporting Unit has responsibility for monitoring to ensure that complaints are being responded to and resolved in a timely manner. This Unit provides an "Open Item" report to each division of the Companies that includes a list of all open complaints that require a response.

As indicated under Required Action #7B, audit procedures are in place to review complaints and ensure that standards related to complaint handling are met.

D. *The Company must identify those jurisdictions that have statutes or regulations defining a grievance.*
   - *The Company must train appropriate personnel to identify grievances upon receipt.*
   - *The Company must develop procedures for staff to follow when handling grievances. The procedures must be state specific.*

Company Response: The Companies respectfully submit that they passed the attribute testing related to this Standard. The data in the Attribute Testing in the Draft Report for NAIC Market Regulation Handbook Grievance Standard #1 (pages 82 – 83 of the Draft Report) indicates that there were two (2) errors for each MEGA and Mid-West related to grievance handling. The error level for MEGA was 7.1% and therefore within the 10% allowable error tolerance level under the NAIC Market Regulation Handbook. With regard to Mid-West, two (2) errors were noted (from a small population of 12), however, one of those errors related to timely acknowledging and responding to a grievance rather than identification of a grievance. Further, the Companies are concerned that this Required Action and the related Finding could be improperly

construed to indicate that the Companies did not properly treat any complaint as a grievance in states where required.

Because the Finding was based on Attribute Testing and the error results of the Attribute Testing were low, the Companies respectfully request that the Finding and related Required Action be removed from the report.

Notwithstanding the above, as indicated under item 7.B., the Companies are working to standardize the grievance handling process. State specific procedures will be implemented as necessary to address any unique state requirements that fall outside of the standard procedures. The Companies will continue to conduct periodic training on complaint recognition and handling during new employee orientation and for existing staff (every six (6) months for staff who have direct contact with customers and annually for all other employees). In addition, staff training for new employees and existing staff will be expanded during Q1 2008 to include grievance recognition and handling.

E. *The Company must request an agent statement for all complaints involving an agent's actions.*

Company Response: The Companies respectfully submit that they passed the attribute testing related to this Standard. The data in the Attribute Testing in the Draft Report for Standard 3 (page 80 – 81 of the Draft Report) indicates that there was one (1) error from a sample size of 50 (or 2%) that related to the Companies' process of obtaining agent statements. Further, the Company is concerned that this Required Action and the related Finding are not accurate as they could be improperly construed to indicate that the Companies did not ever request an agent's statement when investigating a complaint. In accordance with the Companies' complaint handling procedures, the Companies' consistent practice is and always has been to request an agent's statement when investigating a consumer complaint that includes allegations relating to agent activity. The Customer Advocacy Group has added this requirement to its audit procedures.

Because the Finding was based on Attribute Testing and the error results of Attribute Testing were low, the Companies respectfully request that the Finding and related Required Action be removed from the report.

F. The Company must improve its complaint handling controls and establish strong oversight of the complaint handling process by:

- *Preparation of a report to regulators which outlines the complaint-related business practice reforms the Company has implemented to date which address the many concerns expressed in complaints. Included with the report should be documentation to evidence and support the adequacy of such reforms. This report can be used by regulators in developing a workplan for a follow-up examination.*
- *Creation of a tracking log for issues forwarded to the* ***Complaint Action Team*** *and establishing a procedure to ensure that there is ownership and accountability for the process.*

Company Response: The Companies have reported the key enhancements and activities that have been completed to date, as well as future planned enhancements and activities, that address concerns identified in complaints and expressed in this Draft Report. We respectfully refer to the responses provided to Findings #1, 2, 6, and 7 related to agent training and monitoring, consumer disclosure and complaint handling.

The Companies' Complaint Action Team ("CAT") was reestablished during 2007. The CAT meetings are now the responsibility of and chaired by the head of the Complaint Oversight and Reporting Unit. The Chief Compliance Officer and Deputy Compliance Officer are members of the CAT and provide oversight for this CAT meeting process. By year-end 2007, the CAT meeting process will be enhanced to include tools and processes to track issues identified and discussed during meetings to ensure ownership of those issues by year-end 2007.

Finding #8: *The examination of underwriting practices disclosed that Policyholders who paid their premiums via direct bill received advanced notice that their coverage was going to expire. The notice also explained that a grace period existed for 30 days after coverage ended. During this time, the premium could be paid and coverage could be maintained.*

Policyholders paying via an automatic bank draft did not receive a notice that explained the grace period. This practice is discriminatory.

Company Response: The Companies respectfully submit that they did not act in a discriminatory manner against customers who pay premiums by automatic bank draft and notices regarding grace period provisions. The grace period provision is stated in each insurance plan issued by the Companies. As a result, all insureds' insurance documents provide them with information regarding the grace period provision applicable to their plan. Further, the Companies submit that there was no finding during the examination process that the Companies did not comply with plan provisions or state laws with respect to administration of the grace period provision.

Additionally, the Companies note that the examiner's concern memo #29, dated April 17, 2006, contained findings and recommendations related to the adequacy of the grace period notice on coverage cancellation letters, and did not reference any element of "advance notice." The examiner's memo also stated "In our review of the sample, no coverage was lapsed until the end of the grace period." In addition, the examiner's Findings Log provided to the Companies in December 2006 contained the examiner's recommendation that "The Company reports that the automatic bank draft letter has been modified to include the grace period notification. This recommendation (related to a follow up review of lapsed policies be undertaken to assure the modified versions are used) was removed from the examiner's Findings Log because it did not meet the NAIC threshold for failure."

Finally, the examiner's concern memo and Findings Log both state "This discrepancy *could have* [*emphasis added*] resulted in unfair discrimination against direct automatic draft policyholders who were not informed of the grace period." However, the Draft Report states "This practice is discriminatory." This conclusion was not previously communicated by the examiner and does not appear to be supported by the examiner's findings.

Since the examiner's recommendation was removed from the December 2006 Findings Log, the Companies respectfully request that this Finding and the Required Action be removed from the Draft Report. Alternatively, the Companies respectfully request that verbiage indicating that the Companies' practices were discriminatory be removed from the Draft Report.

Required Action #8: *Cancellation, non-renewal and discontinuance notices must be handled consistently for all policies and must comply with policy provisions and state laws. This includes information about the availability of a grace period provided to the insured and other parties to the contract.*

Company Response: While the Companies believe that its practices were compliant with applicable plan provisions and state laws, the Companies agreed to revise notices that are provided to its customers who pay premiums by automatic bank draft to reference the grace period provision contained in each plan. This action was completed in December 2005 and documentation of this change was provided to the Examiners during the examination process.

Finding #9: *The Examiners completed a review of UICI's compliance program.*

A. UICI did not have a central compliance department to oversee compliance for all companies, divisions and affiliates. Each division or functional unit was responsible for managing its own compliance program.

B. SEA was the only functional unit with a substantial compliance program at the time of the field work. All divisions of the Company had some type of compliance structure in place to address issues but there was no consistency between divisions.

Required Action #9: *The Company must centralize the compliance program to promote consistency in all business units. The Company's adherence to its Compliance Plan and compliance program enhancements must be independently evaluated at periodic intervals and should be re-examined in the next 12 to 18 months. The Company must inform regulators on a timely and periodic basis concerning the program's enhancements and changes to its compliance procedures.*

Company Response: Since 2003, the Companies have made great strides toward establishing and maintaining a comprehensive, dynamic compliance program for the entire enterprise. As of February 2007, all of the Companies' compliance initiatives have been centralized under the Compliance Department to promote consistency and accuracy across all business units. This undertaking has been accomplished through the commitment and under the guidance of senior executives in the Companies, who have made it a priority for

the entire enterprise. The goal of this endeavor has been and will be to provide accurate information regarding laws and regulations to all business units and to work with the business units to implement an effective compliance program that is embedded into every business activity of the Companies and their agents. The following significant activities have been accomplished over the last two (2) years:

- The position of General Counsel for Insurance Operations and Chief Compliance Officer was established in July 2005.

- A Deputy Compliance Officer was hired in mid-2006 to assist the General Counsel in building a comprehensive compliance program for the enterprise. The Deputy Compliance Officer was promoted to Chief Compliance Officer in early 2007, and the compliance program was centralized into the Companies' Compliance Department under the direction of the Chief Compliance Officer.

- In August 2006, the Compliance and Governance Committee of the Board of Directors was established to provide additional high level oversight and guidance related to the Companies' compliance efforts. One of the four purposes of the Committee's charter is "to oversee and monitor the Companies' compliance and regulatory functions, which shall include the assessment on a periodic basis for the processes related to the Companies' risk and control environment, the oversight of the integrity of the Companies' compliance with legal and regulatory requirements and evaluation of the Companies' overall compliance program." The Committee meets quarterly in conjunction with the Board of Directors' meetings, and reports to the Board on issues of concern. It receives direct reports from the Chair of the Companies' Regulatory Advisory Panel, which is described below.

- The Regulatory Advisory Panel ("RAP") was established in August 2006. Members of the Panel include: (1) Susan Stead, who served at the Ohio Department of Insurance for 15 years, including six (6) years as assistant director within the Office of Investigative & Licensing Services, where she was responsible for the Market Conduct, Fraud & Enforcement, and Agent Licensing divisions; (2) Jose Montemayor, who served as Texas Insurance Commissioner from 1999 to 2005; (3) Audrey Samers, who served as Deputy Superintendent and General Counsel of the New York Insurance Department

from 2001 to 2006; and (4) Tommy Thompson, who served as the United States Health and Human Services Secretary from 2001 to 2005 and is a former Governor of Wisconsin.

The RAP meets quarterly and reports to the Compliance and Governance Committee of the Board of Directors. These experienced professionals provide insight and advice to the Companies on a wide variety of regulatory issues. In addition, the Chair of the Panel spends one day a month on site to assist the Chief Compliance Officer and General Counsel in developing new programs and overseeing existing programs. The Mission Statement of the Regulatory Advisory Panel is attached as Exhibit 5.

- The Companies have also engaged the services of Betty Patterson, who until recently was the Senior Associate Commissioner, Financial Program (including Market Conduct Examinations) with the Texas Department of Insurance, to assist in developing the day-to-day aspects of the Companies' compliance efforts. Ms. Patterson reports to the Companies' General Counsel and Chief Compliance Officer and has complete and open access to HealthMarkets' CEO and the RAP.

- The Executive Compliance Committee was established in October 2006. The purpose of this Committee is to bring compliance issues to the Companies' senior executives for consideration and to make decisions regarding compliance direction and focus. The Committee meets regularly and includes the Chief Executive Officer, Chief Financial Officer, General Counsel, Chief Compliance Officer, Chief Information Officer, representatives from AMG, ASG operations, and Compliance Audit, as well as other senior executives of the Companies.

- The Companies have also established a Compliance Audit group that reports directly to the Compliance & Governance Committee of the HealthMarkets, Inc. Board of Directors. Compliance Audit has responsibility for conducting follow-up audits on remediation efforts and actions taken in response to market conduct examination commitments. The Compliance Audit group recommends improvements to operations and processes when issues are identified.

- In August 2007, the Companies created a new Operational Compliance Department within ASG, the Companies' largest business unit. This new Department is responsible for compliance-related oversight of ASG. Operational Compliance also works with other ASG departments to design and implement compliance-related initiatives and enhancements in response to new laws and regulations as well as commitments made to regulators. In addition to compliance implementation oversight, Operational Compliance is charged with monitoring the ongoing compliance of the operation through audits of policies and procedures and the review and analysis of processing metrics. This effort takes place parallel to the monitoring and analysis occurring within the Compliance Audit group.

- A Corporate Compliance Manual is in the final stages of development and will be completed by year-end 2007.

. Please see Exhibit 6 for the current organizational chart for the Compliance Department.

Finding #10: Performance Drive Awards, Inc. (PDA) and Success Driven Awards, Inc. (SDA)

Required Action #10: *The Company should prepare separate financial information of PDA and SDA on an annual basis and have it available to domestic regulators upon request.*

Company Response: The Companies have in the past and continue to prepare separate stand-alone financial statements for PDA and SDA. These financial statements are available to the Companies' domestic regulators upon request.

Finding #11: *The Company had a matching stock benefit for its agents/FSRs who were members of the agent stock plans. … The Company had indicated that it had historically recorded the compensation expense related to the matching feature on PDA's and SDA's books, since PDA and SDA are the legal entities that, in accordance with the terms of the Agent Plan documents, have the legal obligation to pay such compensation.*

Required Action #11: *The Company should provide regulators authoritative accounting support for its treatment of the agent's stock benefit match.*

Company Response: The Companies have properly accounted for the agent's stock benefit match with respect to financial reporting purposes. The Statutory, GAAP and SEC accounting literature indicates the compensation expense should be recorded in the company that benefits from or for which the services were rendered (SSAP 13 par 13) (FASB #123(R) par 11) and (Codification of Staff Accounting Bulletins, Topic 14). The Companies have recorded the expense as applying to the legal entity that has the obligation under the applicable business agreements. The Companies respectfully submit that this Finding and Required Action should be removed from the Draft Report.

Finding #12: *While the examination was in process, the Company engaged an outside consulting firm to review areas under examination based on prior market conduct examination findings. The Examiners requested a copy of the report prior to the examination to help identify areas of concern. The Companies declined to share the report with the Examiners indicating the review was not complete. On November 15, 2005, the Company presented a progress report to the Examines and regulators in the form of a PowerPoint presentation. In subsequent discussions with the Company after their presentation, they asserted the report fell under attorney-client and work-product protections and declined to provide additional information regarding the review. By law in every state, companies are compelled to share information that is pertinent to the examination process.*

Required Action #12: *The Company must provide a copy of the consultant's report or an overview of the report for review by the regulators and Examiners.*

Company Response: The Companies wish to cooperate with this Required Action to the extent possible. The Companies will consult further with outside counsel regarding the privilege issue to determine if any kind of overview may be provided in response to this Required Action without waiving the attorney/client privilege status of the documents. In the event the Companies are able to provide an overview of the reports without waiving the attorney/client privilege status of the documents, then the Companies propose to work with the Lead States to determine how such an overview may be provided to the Lead States while maintaining the confidentiality of the document.

The Companies respectfully submit the following legal analysis regarding the attorney/client privilege status of the documents as a matter expressing and reserving these rights.

I. The Outside Consultant's Reports Are Privileged Documents

We first note that Washington law, similar to that in most states, mandates that examiners "shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the National Association of Insurance Commissioners." RCW § 48.03.025. We note that the NAIC Marked Regulation Handbook contains several references to the obligation to recognize attorney-client and work-product protections. For example, the Handbook states: "Recognition of attorney-client privileged documents or work products should occur during the file review." See p.285. Similarly, the Handbook notes:

> Work papers retained by the company or its independent reviewer may provide additional useful information for market analysis purposes. Regulators must be sensitive, however, to the confidentiality concerns raised by these materials, as discussed in the NAIC White Paper Regulatory Access to Insurer Information: The Issues of Confidentiality. . . . In some states, self-evaluative privilege statutes provide specific guidance on the regulators' access rights and confidentiality obligations, whereas regulators in other states must consider a variety of issues related to the protection of proprietary information, attorney work product, trade secrets, and other privileged information.

See p.31.

As mentioned above, in March 2000, the NAIC adopted a White Paper titled: "Regulatory Access to Insurer Information: The Issues of Confidentiality and Privilege" (the "White Paper"). The Introduction states on pp. 6-7:

> With respect to the attorney-client privilege and attorney work product doctrine, there is general agreement that, when the privilege claim is narrowly drawn to meet applicable legal standards, the regulator should make every effort to obtain the needed information in other ways. There are situations in which insurers and regulators differ over access to specific documents, but as a practical matter, regulators generally accept the validity of the attorney-client privilege and will try

> to accommodate reasonable claims of attorney-client privilege and attorney work product protection.

The section of the White Paper addressing the application of the attorney-client privilege states:

> States establish attorney-client and other applicable privileges by statutes, court rules, and judicial decisions. Departments of Insurance are not exempt from the reach of those privileges, nor is an insurer deprived of the protections afforded to it by law when it is a regulatory agency that is seeking privileged information.

White Paper, p.9. The summary of this section concludes: "When the privilege clearly exists, the majority of the courts have found its protection to be absolute, thereby precluding the regulator from compelling disclosure of the privileged communication." See p.19.
With respect to the work product doctrine, the White Paper concludes: "The attorney work product doctrine is a rule of fairness protecting the attorney's preparation for litigation. Such a rule is necessary in the administration of justice which relies upon an adversarial system in the search for truth. Nevertheless, upon a showing of substantial need, a court may rule that disclosure of the attorney's work product is appropriate." See p.21.

The above information demonstrates that the examiners should recognize the attorney-client privilege and work-product doctrine to the extent that they apply to the outside consultant's reports. Since laws governing the application of these privileges are similar in most jurisdictions, the Companies refer to the law of Washington to show that the outside consultant's reports should be protected from production pursuant to the attorney-client privilege and work-product doctrine.

A. Attorney-Client Privilege

RCW § 5.60.060(2) states the Washington rule regarding attorney-client privilege:

> An attorney or counselor shall not, without the consent of his or her client, be examined as to any communication made by the client to him or her, or his or her advice given thereon in the course of professional employment.

This same privilege afforded the attorney is also extended to the client under the common law rule. *State v. Emmanuel*, 259 P.2d 845, 854 (1953) (citing *State v. Ingels*, 104 P.2d 944, *cert. denied*, 311 U.S. 708 (1940)).

Washington courts have also examined whether the attorney-client privilege extends to communications involving third parties. In *State v. Aquino-Cervantes*, 945 P.2d 767, 771-72 (Wash. App. 1997), the court ruled that the privilege extended to an interpreter utilized by an attorney during communications with a client, stating: "We analogize to cases holding that the attorney-client privilege extends to third parties indispensable to an attorney's provision of legal services to the client, such as legal secretaries and accountants." (Emphasis added.) The *Aquino-Cervantes* court referred to the decision in *United States v. Kovel*, 296 F.2d 918 (2d Cir.1961), where the court determined that the attorney-client privilege applied to communications from an accountant employed by an attorney for the client's benefit.

Washington courts have also applied the attorney-client privilege to materials developed during the course of an attorney's investigation. In *Gray v. Morgan Stanley DW Inc.*, 2005 Wash. App. LEXIS 3182, 9-10 (Wash. Ct. App. 2005), the court noted that "'the privilege exists to protect not only the giving of professional advice to those who can act on it but also the giving of information to the lawyer to enable him to give sound and informed advice. The first step in the resolution of any legal problem is ascertaining the factual background and sifting through the facts with an eye to the legally relevant.'" (quoting *Upjohn Co. v. U. S.,* 449 U.S. 383, 390-91, 101 S. Ct. 677, 66 L. Ed. 2d 584 (1981)).

The outside consultant's reports qualify as privileged documents under the above analysis. In addition, the outside consultant's reports were utilized by HealthMarkets' counsel to assist the Companies in responding to the multi-state market conduct examination and in addressing any compliance issues raised by examiners during the examination.

B. Work-Product Doctrine

Washington Civil Rule 26(b)(4) codifies the work-product rule, which protects materials prepared by an attorney in anticipation of litigation and states that:

> a party may obtain discovery of documents and tangible things otherwise discoverable . . . and prepared in anticipation of litigation . . . only upon a showing that the party seeking discovery has substantial need of the materials in the preparation of his case and that he is unable without undue hardship to obtain the substantial equivalent of the materials by other means.

"An attorney's gathering of factual items and documents is protected from disclosure, under the work product rule set forth in CR 26(b)(4), unless the person requesting disclosure demonstrates substantial need and an inability, without undue hardship, to obtain the documents or items from another source." *Limstrom v. Ladenburg*, 963 P.2d 869, 877 (Wash. 1998).

The fact that a multi-state market conduct examination had been called on the Companies before they engaged the outside consultant establishes that the outside consultant's reports were prepared in anticipation of litigation. A market conduct examination is the initiation of an adversarial administrative action, which qualifies as "litigation" for purposes of the work-product doctrine. As a result, the outside consultant's reports qualify for protection under the work-product doctrine because they were commissioned to assist legal counsel in advising Companies' management with respect to responding to the market conduct examination. In addition, the Companies do not believe that the examiners can establish a substantial need for the outside consultant's report or undue hardship in obtaining the information from other sources because the examiners had access to the same information as the outside consultant in order to conduct its examination of the Companies.

II. Conclusion

The Companies believe that the outside consultant's reports are protected documents under the attorney-client privilege and work-product doctrine under Washington and similar state laws. The Companies believe that the examiners should recognize these privileges pursuant to the Handbook and the White Paper notwithstanding an insurers obligation to cooperate with examiners and produce information under state examination laws.

Finding #13: *As noted in the Subsequent Developments section of this report, the Company has represented that many improvements and changes in their practices and*

procedures were implemented subsequent to the examination time period and subsequent to the completion of the Examiners field work.

Required Action #13: *The Company must prepare a report to regulators outlining concisely by examination area all business reforms, improvements and changes to policies and procedures implemented through a current date.*

Company Response: The Companies have reported the key enhancements and activities that have been or will be completed that address issues expressed in the Draft Report in this response. In particular, Findings 1, 2, 3, 4, 6 and 7 include enhancements related to agent training and oversight, claims operations, disclosures to consumers, and complaint handling. The Companies continue to work to identify new opportunities for improvement and refine proposed actions described in this response.

In closing, the Companies again wish to express their appreciation to the Lead States for the opportunity to respond to the Draft Report and for the assistance provided by the examiners and the Lead States during the examination process. The Companies continue their commitment to full cooperation and open dialogue with the Lead States and Participating States as the examination report is finalized. The Companies also wish to restate their commitment to their continued efforts to improve and enhance operations, including but not limited to, agent training and oversight, compliance programs, complaint handling and claims operations.

Exhibit 1

The MEGA Life and Health
Insurance Company

A HealthMarkets Company
Keeping the Promise of Affordable Coverage

Benefit Confirmation Department
9151 Boulevard 26
P.O. Box 982010
North Richland Hills, TX 76182-8010

December 4, 2007

Congratulations on becoming a customer of The MEGA Life and Health Insurance Company.

We have been unsuccessful in our attempts to contact you by telephone to confirm your benefit selections. Here are a few important reminders regarding your Certificate/Policy.

The product you have purchased is a Catastrophic Expense PPO Certificate. It features a schedule of benefits with accompanying deductibles, co-pays, and benefit maximums you selected at the time of application. This defined schedule of benefits helps keep your plan affordable. Your insurance plan provides valuable health insurance coverage, but it is not a comprehensive major medical plan. You should have recently received a packet containing a complete copy of your plan. We encourage you to review your plan, its benefits and limitations thoroughly, and contact us if you have any questions regarding your coverage.

The plan you selected is one of our most popular product offerings and allows you to select any doctor or hospital. Please refer to the front of your i.d. card for the provider network associated with your plan. By utilizing network providers, you may be eligible for a discount on medical charges covered under the terms and conditions of your Certificate/Policy. In addition, you are able to enhance your plan by adding important riders which provide additional coverage and protection.

We also encourage you to review the answers to the questions on your application for completeness and accuracy. The MEGA Life and Health Insurance Company has relied on the completeness and accuracy of your answers to the health questions in issuing your coverage. Please contact us at the toll free number with any additions or corrections you might have to your application.

We are pleased to have this opportunity to be of service to you. Please feel free to contact us with any questions on our website at www.megainsurance.com or by calling 1-800-646-1696. Our business hours are 8:00 a.m. to 5:00 p.m., Monday through Friday.

Sincerely,

Benefit Confirmation Department
BENCONFIRM

Exhibit 2

CONFIDENTIAL SETTLEMENT COMMUNICATION

Disclosures Regarding

Certain Business Relationships

The MEGA Life and Health Insurance Company

and

The National Association for the Self-Employed, Inc.

Introduction

Set forth below is additional information concerning the National Association for the Self-Employed, Inc. ("NASE") and The MEGA Life and Health Insurance Company ("MEGA") and a description of the relationships between the two organizations.

More about the NASE

NASE is a membership organization that provides certain benefits to its Members. NASE is organized under the laws of the State of Texas and its principal place of business is Capital Center, 1235 Main Street, Suite 100, Grapevine, Texas 76051. NASE also has an office in Washington, D.C., from which it carries out many of its legislative and advocacy efforts. NASE is governed by a board of directors, the members of which are elected in staggered terms by Members of the NASE, with election occurring on one-third of the directors each year. Members of the NASE are entitled to vote on the selection of members of the board of directors at the annual meeting of the NASE. NASE maintains a website at www.nase.org. NASE Members are required to pay monetary dues. NASE has no direct or indirect ownership interest in HealthMarkets, Inc. f/k/a UICI, a Delaware corporation ("HealthMarkets"), Specialized Association Services, Ltd. ("SAS"), or any affiliate or subsidiary of HealthMarkets or SAS.

More about MEGA and HealthMarkets

MEGA is an Oklahoma domiciled life and health insurance company with an administrative office located in North Richland Hills, Texas. MEGA is licensed to issue health, life, and annuity insurance policies to consumers in all states except New York. MEGA is an indirect wholly-owned subsidiary of HealthMarkets.

Effective April 5, 2006, HealthMarkets is a privately held company, the principal shareholders of which include investment affiliates of The Blackstone Group, Goldman Sachs Capital Partners, and DLJ Merchant Banking Partners (each of which is a private equity firm), certain members of current management and independent insurance agents associated with UGA – Association Field Services (a division of MEGA) and Cornerstone America (a division of Mid-West National Life Insurance Company of Tennessee, an indirect wholly-owned subsidiary of HealthMarkets).

HealthMarkets remains subject to the reporting and certain other obligations under the Securities Exchange Act of 1934, as amended, and files annual, quarterly, and current reports, proxy statements, and other information with the Securities and Exchange Commission. You may inspect and copy such reports, proxy statements and other information at the public reference facilities maintained by the Securities and Exchange Commission at:

Room 1204
Judiciary Plaza
450 Fifth Street, N.W
Washington, D.C. 20549

Citicorp Center
500 West Madison Street
Chicago, Illinois 60661

You may call the Securities and Exchange Commission at 1-800-SEC-0330 for further information about the public reference facilities. This material may also be obtained from the Securities and Exchange Commission's worldwide web site at http://www.sec.gov. HealthMarkets maintains a website at www.healthmarkets.com.

Relationships between MEGA and Affiliates and the NASE

The salesperson that a prospective Member or prospective insured speaks with about NASE Membership and about MEGA insurance products serves both as a licensed insurance agent of MEGA and as a Field Service Representative for new Members for the NASE. The insurance premiums derived from the sale of insurance go to MEGA and the membership dues derived from the sale of the NASE Memberships go to the NASE. The salesperson acts on behalf of MEGA (and not the NASE) when discussing, explaining, and describing MEGA insurance products and premiums. The salesperson acts on behalf of the NASE (and not MEGA) when discussing, explaining, and describing NASE benefits. The NASE pays an affiliate of HealthMarkets for enrolling Members in the NASE and reimburses MEGA for the cost of certain electronic transactions. The NASE purchases a member benefit from Benefit Administration for the Self-Employed, LLC, which is owned in part by an affiliate of HealthMarkets. In your state, membership in the NASE is not required in order to apply for the individual policy of insurance with MEGA.

SAS (which is controlled by the adult children of the late Ronald L. Jensen, HealthMarkets' founder) is a party to an agreement with the NASE to provide certain member fulfillment services. NASE pays SAS for these services. A subsidiary of HealthMarkets also sells new membership sales leads to the Field Service Representatives. Neither HealthMarkets nor MEGA has any ownership interest in SAS or in the NASE. SAS has no ownership interest in the NASE.

CONFIDENTIAL SETTLEMENT COMMUNICATION

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HealthMarkets remains subject to the reporting and certain other obligations under the Securities Exchange Act of 1934, as amended, and files annual, quarterly, and current reports, proxy statements, and other information with the Securities and Exchange Commission. You may inspect and copy such reports, proxy statements, and other information at the public reference facilities maintained by the Securities and Exchange Commission at:

Room 1204
Judiciary Plaza
450 Fifth Street, N.W
Washington, D.C. 20549

Citicorp Center
500 West Madison Street
Chicago, Illinois 60661

You may call the Securities and Exchange Commission at 1-800-SEC-0330 for further information about the public reference facilities. This material may also be obtained from the Securities and Exchange Commission's worldwide web site at http://www.sec.gov. HealthMarkets maintains a website at www.healthmarkets.com.

Relationships between MEGA and Affiliates and the NASE

The NASE and MEGA entered into an agreement, pursuant to which the NASE has agreed to make available to its Members certain insurance products offered by MEGA. This agreement with MEGA may only be terminated by MEGA or by the NASE upon not less than one year's advance notice to the other party.

The salesperson that a prospective Member or prospective insured speaks with about NASE Membership and about MEGA insurance products serves both as a licensed insurance agent of MEGA and as a Field Service Representative for new Members for the NASE. The insurance premiums derived from the sale of insurance go to MEGA and the membership dues derived from the sale of the NASE Memberships go to the NASE. The salesperson acts on behalf of MEGA (and not the NASE) when discussing, explaining, and describing MEGA insurance products and premiums. The salesperson acts on behalf of the NASE (and not MEGA) when discussing, explaining, and describing other NASE benefits. The NASE pays an affiliate of HealthMarkets for enrolling Members in the NASE and reimburses MEGA for the cost of certain electronic transactions. The NASE purchases a member benefit from Benefit Administration for the Self-Employed, LLC, which is owned in part by an affiliate of HealthMarkets.

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Disclosures Regarding Association Group Insurance

About Association Group Insurance

The NASE makes available to its members insurance coverage provided through MEGA. The NASE serves as the Association Group Master Policyholder of an association group insurance policy issued by MEGA. In the event MEGA approves your application, MEGA will issue to you an individual insurance certificate evidencing your insurance coverage under the Association Group Master Policy. Under the law of most states, you may not acquire insurance coverage under an association group - type master policy unless you are also a member of an association. However, association membership is not required to maintain the insurance.

Underwriting

While the master policy issued by MEGA to the NASE is referred to as an association group policy, the law of most states permits MEGA to review and underwrite your individual application, both at the time of your initial application and thereafter if you apply for coverage under a different master policy form issued by MEGA or if you apply to add coverage under the policy form on which your initial coverage was issued. As a result, based on MEGA's assessment of your health, MEGA may elect to accept coverage or decline to issue to you a certificate evidencing coverage under the Association Group Master Policy.

Exhibit 3

Claims Process Flow Example

Copyright © 2006-2007 The MEGA Life and Health Insurance Company, Mid-West National Life Insurance Company of Tennessee and The Chesapeake Life Insurance Company (the “Companies”)

Sample Case

In this example, we will follow a bill submitted for charges from assignment of a claim number(s) until final adjudication, showing the resulting EOB. This example is an actual case (data fields have been obscured for HIPPA privacy).

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Administrative Services Group

Sample Case

Copy of Bill

This is a copy of the bill for the claim in this example. This bill has six lines of service, which in the adjudication system, will split over two claims. The explanation of benefits (EOB) generated at the end of the adjudication process reflects all lines of the bill and the total benefit allowance from both claims on one EOB.

PLEASE DO NOT STAPLE IN THIS AREA

MEGA LIFE/PHCS
PO BOX 982009
NORTH RICHLAND HILLS TX 76182

APPROVED OMB-0938-0008

PICA CHS06 TX503

HEALTH INSURANCE CLAIM FORM

1a. INSURED'S I.D. NUMBER: 9053957448/INSCTR

11. INSURED'S POLICY GROUP OR FECA NUMBER: 9053957448 INSCTR

11c. INSURANCE PLAN NAME OR PROGRAM NAME: MEGA LIFE/PHCS

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE — SIGNED: SIGNATURE ON FILE DATE: 02 24 2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE — SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS: 02 24 2005

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: PAUL I COOK

17a. I.D. NUMBER OF REFERRING PHYSICIAN: F27870

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 02 24 2005 TO 03 03 2005

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: 1. 218 1 2. 218 2 3. 401 9 4. 285 8

24A Date(s) of Service From	B Place of Service	C Type of Service	D CPT/HCPCS	Modifier	E Diagnosis Code	F $ Charges	G Days or Units	K Reserved for Local Use
02242005	21	I	85730	26	1	10 00	1	MDH5242
02242005	21	I	85610	26	1	9 00	1	MDH5242
02242005	21	I	85025	26	1	10 00	1	MDH5242
02242005	21	I	80053	26	1	23 00	1	MDH5242
02242005	21	I	80061	26	1	23 00	1	MDH5242
02242005	21	I	81001	26	1	12 00	1	MDH5242

25. FEDERAL TAX I.D. NUMBER: 74-1720245

26. PATIENT'S ACCOUNT NO.: 176.186951.1

27. ACCEPT ASSIGNMENT? YES

28. TOTAL CHARGE: $ 87 00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER: ELIZABETH A HARTWELL, SIGNED DATE 03 15 2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED: MEMORIAL HERMANN HOSP -IN, 6411 FANNIN, HOUSTON TX 77030

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: 800/213-7788, MEMORIAL PATHOLOGY CONSULTANT, PO BOX 741169, HOUSTON TX 772741169, PIN# MDH5242

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90)

*** CONTINUED ***

MED50M.A1106T000298.HCFA.0085D9.5727

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Sample Case

Eligibility Screen

The policy number is entered.

```
  POL ID/MEMBER 09053957448     PLAN NO KH25     CLASS             **ELIGIBILITY
     FIRST             MI  LAST     HEALTH CHOICE-BASIC:25875-C (01/01)  IN HOUSE
NAME                                                                   STATUS
ST                         /                        CLAIM NO   -        -
CITY                   ST     ZIP 77469               ALT ID 373957448 XREF
PHONE                            ACTIVATION         ISSUE ST TX  SITUS ST AL SUSP
DIV                                                 APP DATE  020604        COM
LOC                                                   ASSOC POL ID/RIDER INFO
DED   $3000 R&B    $300                             KH25    A3 KA57        K044
                                                    KZ01       K318        LPX8R
C A    # REL   FIRST  MI      LAST          EFF1   TERM1     EFF2    TERM2    BIRTH  S
```

```
  POL ID/MEMBER 09053957448     PLAN NO KH25     CLASS             **ELIGIBILITY
     FIRST             MI  LAST     HEALTH CHOICE-BASIC:25875-C (01/01)  IN HOUSE
NAME                                                                   STATUS
ST                         /                        CLAIM NO E-V63599-01
CITY                   ST     ZIP 77469               ALT ID 373957448 XREF
PHONE                            ACTIVATION         ISSUE ST TX  SITUS ST AL SUSP
DIV                                                 APP DATE  020604        COM
LOC                                                   ASSOC POL ID/RIDER INFO
DED   $3000 R&B    $300                             KH25    A3 KA57        K044
                                                    KZ01       K318        LPX8R
C A    # REL   FIRST  MI      LAST          EFF1   TERM1     EFF2    TERM2    BIRTH  S
      *01 M                               0221042 1121072                           F
      *02 S                               0221042 1121072                           M
       03
       04
       05
       06
       07

COMMENT   NO WVRS
PATIENT
                                                      ID KLN    DATE 102207     NEXT
  DIRECTED PPO -     PRIVATE HEALTHCARE SYSTEMS, INC           EFF.    04-03-07
  PRESS PA2 FOR MESSAGES.   PRESS ENTER TO SAVE CHANGES.
```

This represents the eligibility / policy data that is assigned to the claim.

The claim number is then assigned.

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Administrative Services Group

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Understanding Film Numbers

When a bill arrives at the Company, it is tied to the appropriate policy number and eligibility is verified.

An individual bill is linked to one or more claim numbers on the adjudication system. These claim numbers are linked by a unique film number which is representative of the first claim number assigned to the bill.

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Sample Case

First Claim: Cause Codes

A cause code is a code used to link claims together by an episode of illness or accident. A major function of cause codes is to track accumulations of dollar(s) amounts (lifetime, max limits etc.) It is extremely important to link claims with their appropriate cause code. Examiners select cause codes using the criteria outlined in the Cause Code Selection Policies and Procedures, available on the eManual.

```
GCRPC042                              UICI                              10-22-07
 LTRV KLN                         CAUSE SCREEN                           16:02.36

                               DEPENDENT #       01
                               CERT #   09053957448

    CAUSE  INCURRED DATE   DST/   DX     DESCRIPTION
                           DIA
     DUPS    08/26/2004           38872  REFERRED OTOGENIC PAIN
     MAMS    02/15/2005    MAM    V7612  OTHER SCREENING MAMMOGRAM
     PAPS    12/30/2004    PAP    V723   GYNECOLOGICAL EXAMINATION
     PVCS    12/30/2004    PAP    V723   GYNECOLOGICAL EXAMINATION
     001S    05/27/2004           4010   ESSENTIAL HYPERTENSION, MALIGNANT
     002S    06/09/2004           7061   OTHER ACNE
     003S    08/26/2004           38872  REFERRED OTOGENIC PAIN
     004S    12/06/2004           2189   LEIOMYOMA OF UTERUS, UNSPECIFIED
     005S    02/28/2005           7823   EDEMA
     006S    04/12/2005           13101  TRICHOMONAL VULVOVAGINITIS
     007S    06/02/2005    PHA    463    ACUTE TONSILLITIS

   NEXT

   MORE NEXT CAUSE CODES AVAILABLE
```

Cause codes can be selected from a list of previous codes used by an individual, or a new cause can be created if needed. This particular example uses the previously established cause code of 004s.

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Administrative Services Group

Sample Case

First Claim: Establishing a Cause

HEALTH INSURANCE CLAIM FORM

1a. INSURED'S I.D. NUMBER: 053957448

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: COHEN MD UT, ALAN M M

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: 1. 2189 2. 6262

24. 12 06 2004 12 06 2004 22 99243 1 240 00 1 179

25. FEDERAL TAX I.D. NUMBER: 760459500 26. PATIENT'S ACCOUNT NO.: G46491792 28. TOTAL CHARGE: 240 00

31. COHEN MD ALAN 32. COHEN MD, 6411 FANNIN, HOUSTON, TX 77030 33. UTP, P O BOX 201088, HOUSTON TX 77216

```
 CLM E-L35212-02 PAT FELECIA    M ** HISTORY ** 12/28/04 REA    ID JJS **HISTORY
R 122204 I 120604  C 2189  D 6262             PO PPO PC   PL    Z01
  DATES     PRO AI BC  PROC  #SV  TOTCHG   DENY     DED    CONSIDER  %    PAY AMT
1206 120604 UT A ODV 99243   01 00179.00 00179.00 0000.00 00000.00 000 00000.00
1206 120604 UT A ODV 99243   01 00061.00 00000.00 0000.00 00000.00 000 00000.00

CAUSE 004S BY 837 ST TX TOTALS:000240.00 000179.00 0000.00 000000.00  000000.00
RMRKS 1   RMRKS 2   RMRKS 3   RMRKS 4   RMRKS 5   RMRKS 6   RMRKS 7   RMRKS 8
AG        PS D1
PAYEE    ID 04359098001551  SAVINGS    DISC/INT     CHK AMT   REG CHECK NO CLR DT
UTP                        0000000.00  0000000.00  0000000.00

NOTE
HST NOTE

N  NEXT  RIDER      IN OV N CLM CD    F# EL3521201  DRG     FE    AAT   SUB
THIS IS THE LAST CLAIM FOR FILM # EL3521201
```

Diagnosis Codes
218.9: Leiomyoma of uterus

This is a historical claim and bill processed with cause code 004s.

This claim has a primary diagnosis code of 218.9. All subsequent claims with a related diagnosis code are linked to this primary diagnosis code of 218.9.

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Administrative Services Group

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Example Bill

First Claim: Diagnosis Codes and Film Number

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. 218 1 — 3. 401 9

2. 218 2 — 4. 285 8

24. A B C D E

Diagnosis codes, as shown on bill and Processor 1:
218.9: Leiomyoma of uterus
218.2: Subserous leiomyoma of uterus
401.9: Essential hypertension, unspecified
285.8: Other specified anemias

Claim Number

```
CLM E-V63599-01 PAT              M ** HISTORY ** 03/28/05 REA PB ID JJS **HISTORY
R 032105 I 120604  C 2189   D 2182  4019  2858  PO PPO PC    PL 21 KH25
  DATES     PRO AI BC  PROC  #SV  TOTCHG    DENY     DED    CONSIDER  %   PAY AMT
0224 022405 ME A IXL 8573026 01 00002.75 00000.00 0000.00 00002.75 080 00002.20
0224 022405 ME A IXL 8573026 01 00007.25 00000.00 0000.00 00000.00 000 00000.00
0224 022405 ME A IXL 8561026 01 00001.75 00000.00 0000.00 00001.75 080 00001.40
0224 022405 ME A IXL 8561026 01 00007.25 00000.00 0000.00 00000.00 000 00000.00
0224 022405 ME A IXL 8502526 01 00003.75 00000.00 0000.00 00003.75 080 00003.00
0224 022405 ME A IXL 8502526 01 00006.25 00000.00 0000.00 00000.00 000 00000.00
0224 022405 ME A IXL 8005326 01 00005.25 00000.00 0000.00 00005.25 080 00004.20
0224 022405 ME A IXL 8005326 01 00017.75 00000.00 0000.00 00000.00 000 00000.00
CAUSE 004S BY EDI ST TX TOTALS:000052.00 000000.00 0000.00 000013.50   000010.80
RMRKS 1   RMRKS 2   RMRKS 3   RMRKS 4   RMRKS 5   RMRKS 6   RMRKS 7   RMRKS 8
Q3        PS D1     Q3        PS D3     Q3        PS D5     Q3        PS D7
PAYEE                      SAVINGS     DISC/INT     CHK AMT  REG CHECK NO CLR DT
MEMORIAL PATHOLOGY CONSU  0000000.00  0000000.00  0000010.

NOTE
HST NOTE

.  NEXT  BASE       IN OV N CLM CD    F# EV6359901  DRG      FE    AAT    SUB
THIS IS THE FIRST CLAIM FOR FILM # EV6359901
```

Film Number

This is the diagnosis used to determine the cause code. This diagnosis was established from a prior claim.

As shown, the film number represents the claim number assigned to the bill. The claim was processed based on a prior claim with the primary diagnosis of 218.9, as shown on the previous slide. The diagnosis of 218.1 from this bill relates to cause code 004s; therefore, 218.9 was utilized.

Note: *The diagnosis code fields (programming was completed as of 11/17/06) represent the first three diagnosis codes on the bill. This example shows a claim processed prior to locking the diagnosis code fields.*

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Sample Case

First Claim: Billed Charges

The lines of service on the bill are shown on the adjudication system.

Note: *Due to system limitations, discounted (repriced) charges are shown on separate lines in the adjudication system.*

```
CLM E-V63599-01 PAT              M ** HISTORY ** 03/
R 032105 I 120604  C 2189  D 2182  4019  2858  PO
  DATES     PRO AI  BC  PROC    #SV  TOTCHG    DENY
0224 022405 ME A IXL 8573026 01 00002.75 00000.00
0224 022405 ME A IXL 8573026 01 00007.25 00000.00
0224 022405 ME A IXL 8561026 01 00001.75 00000.00
0224 022405 ME A IXL 8561026 01 00007.25 00000.00
0224 022405 ME A IXL 8502526 01 00003.75 00000.00 0000.00 00003.75 080 00003.00
0224 022405 ME A IXL 8502526 01 00006.25 00000.00 0000.00 00000.00 000 00000.00
0224 022405 ME A IXL 8005326 01 00005.25 00000.00
0224 022405 ME A IXL 8005326 01 00017.75 00000.00
CAUSE 004S BY EDI ST TX TOTALS:000052.00 000000.00
RMRKS 1    RMRKS 2    RMRKS 3    RMRKS 4    RMRKS 5
Q3         PS D1      Q3         PS D3      Q3
PAYEE                       SAVINGS     DISC/INT
MEMORIAL PATHOLOGY CONSU  0000000.00  0000000.00

NOTE
HST NOTE
F# EV6359901
```

First charge on the bill = $10.00
$2.75 in charges eligible for consideration
$7.25 discount

Second charge on the bill = $9.00
$1.75 in charges eligible for consideration
$7.25 discount

Third charge on the bill = $10.00
$3.75 in charges eligible for consideration
$6.25 discount

Fourth charge on the bill = $23.00
$5.25 in charges eligible for consideration
$17.75 discount

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. 218 1 3. 401 9
2. 218 2 4. 285 8

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From	To	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
02242005		21	I	85730	26	1	10 00	1				MDH5242
02242005		21	I	85610	26	1	9 00	1				MDH5242
02242005		21	I	85025	26	1	10 00	1				MDH5242
02242005		21	I	80053	26	1	23 00	1				MDH5242
02242005		21	I	80061	26	1	23 00	1				MDH5242
02242005		21	I	81001	26	1	12 00	1				MDH5242

25. FEDERAL TAX I.D. NUMBER: 74-1720245 (SSN / EIN)
26. PATIENT'S ACCOUNT NO.: 176,186951.1
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES / NO
28. TOTAL CHARGE: $ 87 00
29. AMOUNT PAID: $ 0.00
30. BALANCE DUE: $

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Sample Case

First Claim: Benefit Codes

The benefit codes are determined based on the procedure code and place of service submitted on the bill. In this example, the procedure codes are lab charges rendered while the Insured was hospital confined.

```
CLM E-V63599-01 PAT            M ** HISTORY ** 03/28/05 REA PB ID JJS **HISTORY
R 032105 I 120604  C 2189  D 2182  4019  2858  PO PPO PC  PL 21 KH25
  DATES     PRO AI BC  PROC   #SV  TOTCHG    DENY     DED    CONSIDER  %   PAY AMT
0224 022405 ME A IXL 8573026 01 00002.75 00000.00 0000.00 00002.75 080 00002.20
0224 022405 ME A IXL 8573026 01 00007.25 00000.00 0000.00 00000.00 000 00000.00
0224 022405 ME A IXL 8561026 01 00001.75 00000.00 0000.00 00001.75 080 00001.40
0224 022405 ME A IXL 8561026 01 00007.25 00000.00 0000.00 00000.00 000 00000.00
0224 022405 ME A IXL 8502526 01 00003.75 00000.00 0000.00 00003.75 080 00003.00
0224 022405 ME A IXL 8502526 01 00006.25 00000.00 0000.00 00000.00 000 00000.00
0224 022405 ME A IXL 8005326 01 00005.25 00000.00 0000.00 00005.25 080 00004.20
0224 022405 ME A IXL 8005326 01 00017.75 00000.00 0000.00 00000.00 000 00000.00
CAUSE 004S BY EDI  ST TX TOTALS:000052.00 000000.00 0000.00 000013.50  000010.80
              KS 2   RMRKS 3   RMRKS 4   RMRKS 5   RMRKS 6   RMRKS 7   RMRKS 8
              D1     Q3        PS D3     Q3        PS D5     Q3        PS D7
                              SAVINGS    DISC/INT    CHK AMT   REG CHECK NO CLR DT
              OLOGY CONSU   0000000.00  0000000.00  0000010.80   15575674  040405
HST NOTE
.  NEXT  BASE        IN OV N CLM CD   F#
                                      359
```

The place of service is 21, "inpatient hospital," which matches the bill.

Procedure Codes:
85730 26 Thromboplastin time (substitution)
85610 26 Prothrombin time
85025 26 Complete CBC
80053 26 Comprehensive metabolic panel
Benefit Code:
IXL: Inpatient x-ray or lab
Note: *Modifier 26 means these services are professional components*

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. 218 1
2. 218 2
3. 401 9
4. 285 8

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
02242005	21	I	85730 26	1	10 00	1				MDH5242
02242005	21	I	85610 26	1	9 00	1				MDH5242
02242005	21	I	85025 26	1	10 00	1				MDH5242
02242005	21	I	80053 26	1	23 00	1				MDH5242
02242005	21	I	80061 26	1	23 00	1				MDH5242
02242005	21	I	81001 26	1	12 00	1				MDH5242

25. FEDERAL TAX I.D. NUMBER SSN EIN: 74-1720245 | 26. PATIENT'S ACCOUNT NO.: 176.186951.1 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO | 28. TOTAL CHARGE $ 87 00 | 29. AMOUNT PAID $ 0.00 | 30. BALANCE DUE $

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Sample Case

Second Claim: Billed Charges

First and second line in the adjudication system is the 5th charge on the bill = $23.00
$6.75 in charges eligible for consideration
$16.25 discount

The third and fourth line in the adjudication system is the 6th charge on the bill = $12.00
$1.50 in charges eligible for consideration
$10.50 discount

The lines of service on the bill are shown on the adjudication system.

This additional claim holds the remaining lines 5 and 6 from the bill.

All the lines of service are tied to the film number.

```
CLM E-V63600-01 PAT          M ** HISTORY ** 03/28/0
R 032105 I 120604  C 2189  D 2182  4019  2858  PO PPO
DATES     PRO AI BC  PROC   #SV  TOTCHG    DENY     DE
0224 022405 ME A IXL 8006126 01 00006.75 00000.00 000
0224 022405 ME A IXL 8006126 01 00016.25 00000.00 000
0224 022405 ME A IXL 8100126 01 00001.50 00000.00 000
0224 022405 ME A IXL 8100126 01 00010.50 00000.00 000

CAUSE 004S BY EDI  ST TX TOTALS:000035.00 000000.00 0000.00 000008.25  000006.60
RMRKS 1   RMRKS 2   RMRKS 3   RMRKS 4   RMRKS 5   RMRKS 6   RMRKS 7   RMRKS 8
Q3        PS D1     Q3        PS D3
PAYEE                       SAVINGS    DISC/INT     CHK AMT   REG CHECK NO CLR DT
MEMORIAL PATHOLOGY CONSU  0000000.00 0000000.00 0000006.60   15575674  040405

NOTE
HST NOTE

F# EV6359901  DRG    FE    AAT    SUB
/6359901
```

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. 218 1
2. 218 2
3. 401 9
4. 285 8

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
02242005		21	1	85730 26	1	10 00	1				MDH5242
			1	85610 26	1	9 00	1				MDH5242
02242005		21	1	85025 26	1	10 00	1				MDH5242
02242005		21	1	80053 26	1	23 00	1				MDH5242
02242005		21	1	80061 26	1	23 00	1				MDH5242
02242005		21	1	81001 26	1	12 00	1				MDH5242

25. FEDERAL TAX I.D. NUMBER 74-1720245 SSN EIN | 26. PATIENT'S ACCOUNT NO. 176,186951.1 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO | 28. TOTAL CHARGE $ 87 00 | 29. AMOUNT PAID $ 0.00 | 30. BALANCE DUE $

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Sample Case

First Claim: Total Benefit Allowance

The first claim was processed for a benefit allowance of $10.80.

```
EOB ADDRESSEE                                          CLAIM E-V63599-01       **HISTORY
     STR 1                              BASE
     STR 2
 CITY                                  PLN KH25     CLASS     DIV     LOC     SH
   PAYEE NAME MEMORIAL PATHOLOGY CONSUL                      PAT NO 1761869511
     STR 1 PO BOX 741169                        CHECK AMT   0000010.80   REG IND
     STR 2                                      CHECK NO 15575674             EI
     CITY  HOUSTON        TX 77274 1169         TAX NO 741720245 E RM
   PAYEE NAME                                        PAT NO
     STR 1                                      CHECK AMT                REG IND
     STR 2                                      CHECK NO                      EI
     CITY                                       TAX NO             RM
   PAYEE NAME                                        PAT NO
     STR 1                                      CHECK AMT                REG IND
     STR 2                                      CHECK NO                      EI
     CITY                                       TAX NO             RM
   PAYEE NAME                                        PAT NO
     STR 1                                      CHECK AMT                REG IND
     STR 2                                      CHECK NO                      EI
     CITY                                       TAX NO             RM
     REMARKS

   DAYS TO COMPLETE CLAIM 007 ** HISTORY ** SET UP EDI PAY JJS APP       NEXT
```


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Sample Case

Second Claim: Total Benefit Allowance

The second claim was processed for a benefit allowance of $6.60.

```
EOB ADDRESSEE                                             CLAIM E-V63600-01        **HISTORY
    STR 1                                BASE
    STR 2
CITY                                   PLN KH25     CLASS      DIV      LOC      SH
  PAYEE NAME MEMORIAL PATHOLOGY CONSUL                     PAT NO 1761869511
    STR 1 PO BOX 741169                             CHECK AMT  0000006.60  REG IND
    STR 2                                           CHECK NO 15575674           EI
    CITY  HOUSTON         TX 77274 1169             TAX NO 741720245 E RM
  PAYEE NAME                                               PAT NO
    STR 1                                           CHECK AMT              REG IND
    STR 2                                           CHECK NO                    EI
    CITY                                            TAX NO             RM
  PAYEE NAME                                               PAT NO
    STR 1                                           CHECK AMT              REG IND
    STR 2                                           CHECK NO                    EI
    CITY                                            TAX NO             RM
  PAYEE NAME                                               PAT NO
    STR 1                                           CHECK AMT              REG IND
    STR 2                                           CHECK NO                    EI
    CITY                                            TAX NO             RM
    REMARKS

  DAYS TO COMPLETE CLAIM 007 ** HISTORY ** SET UP EDI PAY JJS APP       NEXT
```

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Sample Case

EOB Copy for Provider

PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
85730	26
85610	26
85025	26
80053	26
80061	26
81001	26

The procedure codes from both claims are shown on the EOB. These correspond to the codes used on the bill.

The total billed on the EOB reflects the total from the bill: **$87.00**

28. TOTAL CHARGE

$ 87 00

THE MEGA LIFE AND HEALTH INSURANCE COMPANY
P.O. BOX 982009
N. RICHLAND HILLS, TX 76182-8009

No. 15575674

THE BANK OF NEW YORK (DELAWARE) 62-35/311
NEWARK, DE 19711

PAY EXACTLY SEVENTEEN AND 40/100 DOLLARS***
****

CHECK DATE	AMOUNT OF CHECK
03/28/2005	*******$17.40

Void After 90 Days

To The Order Of
MEMORIAL PATHOLOGY CONSUL
PO BOX 741169
HOUSTON TX 77274-1169

NON-NEGOTIABLE

Security features included. Details on back.

BCN: 9543957448

VOID VOID VOID

the MEGA Life and Health Insurance Company | UICI The Insurance Center

Claim Department
9151 Grapevine Highway
P.O. Box 982009
North Richland Hills, TX 76182-8009

March 28, 2005

MEMORIAL PATHOLOGY CONSUL
PO BOX 741169
HOUSTON TX 77274-1169

Date Processed: 03/28/2005
Health ID Number: 0905395744[illegible]
Insured Name:
Film / Claim Number: EV6359901 E-V63599-01
Patient:

If you have any questions please contact our Customer Service Associates at 1-800-527-2845 Monday through Friday from 8:00am to 5:00pm.
www.megainsurance.com

The claim number reflects the film number, which is common to both claims.

Provider: MEMORIAL PATHOLOGY CONSUL — THIS IS NOT A BILL — Patient Account Number: 1761869511

Type of Service	Service Date	Procedure Code	Total Charges	PPO Discount	Not Covered	Covered Amount	Copay	Balance	Total Payment	See Remarks
IP RADIO & LAB	02/24/2005	8573026	10.00	7.25		2.75		2.75	2.20	Q3 PS
IP RADIO & LAB	02/24/2005	8561026	9.00	7.25		1.75		1.75	1.40	Q3 PS
IP RADIO & LAB	02/24/2005	8502526	10.00	6.25		3.75		3.75	3.00	Q3 PS
IP RADIO & LAB	02/24/2005	8005326	23.00	17.75		5.25		5.25	4.20	Q3 PS
IP RADIO & LAB	02/24/2005	8006126	23.00	16.25		6.75		6.75	5.40	Q3 PS
IP RADIO & LAB	02/24/2005	8100126	12.00	10.50		1.50		1.50	1.20	Q3 PS

Total Billed Charges: $87.00

IRS Withholding:
Adjustment Due to Other Insurance:
Total Paid: $17.40
Patient Liability: $4.35

PAYMENT SUMMARY SECTION
Payment made to: MEMORIAL PATHOLOGY CONSUL
Amount Paid: $17.40
Check Number: 0015575674

PPO Discount Total: $65.25
Base Deductible:
Optional Benefit Deductible:

REMARKS SECTION
Please note: The provider of service may not accept a PPO Discount on Non-Covered Charges.
All amounts shown on this Explanation of Benefits only apply to this Claim.
These charges have been considered under the base plan and all applicable optional benefits.

Q3 BENEFITS HAVE BEEN REDUCED BY YOUR 20% COINSURANCE.

PS A DISCOUNT WAS PROCESSED ON THIS PROVIDER'S BILL IN ACCORDANCE TO OUR CONTRACT WITH PHCS.

The total on the EOB reflects the totals from the two claims:
Claim E-V63599-01 = $10.80
Claim E-V63600-01 = $6.60
Total Paid= $17.40

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Sample Case

EOB to Insured

PROCEDURES, SERVICES, OR SUPPLIES
(Explain Unusual Circumstances)

CPT/HCPCS	MODIFIER
85730	26
85610	26
85025	26
80053	26
80061	26
81001	26

The procedure codes from both claims are shown on the EOB. These correspond to the codes used on the bill.

Claim Department
9151 Grapevine Highway
P.O. Box 982009
North Richland Hills, TX 76182-8009

March 28, 2005

Date Processed: 03/28/2005
Health ID Number: 09053957448
Insured Name:
Film / Claim Number: EV6359901 E-V63599-01
Patient:

If yo... our ... 1-80... from 8:00am to 5:00pm.
www.megainsurance.com

The claim number reflects the film number, which is common to both claims.

Provider: MEMORIAL PATHOLOGY CONSUL — THIS IS NOT A BILL — Patient Account Number: 1761869511

Type of Service	Service Date	Procedure Code	Total Charges	PPO Discount	Not Covered	Covered Amount	Copay	Balance	Total Payment	See Remarks
IP RADIO & LAB	02/24/2005	8573026	10.00	7.25		2.75		2.75	2.20	Q3 PS
IP RADIO & LAB	02/24/2005	8561026	9.00	7.25		1.75		1.75	1.40	Q3 PS
IP RADIO & LAB	02/24/2005	8502526	10.00	6.25		3.75		3.75	3.00	Q3 PS
IP RADIO & LAB	02/24/2005	8005326	23.00	17.75		5.25		5.25	4.20	Q3 PS
IP RADIO & LAB	02/24/2005	8006126	23.00	16.25		6.75		6.75	5.40	Q3 PS
IP RADIO & LAB	02/24/2005	8100126	12.00	10.50		1.50		1.50	1.20	Q3 PS

Total Billed Charges: $87.00

IRS Withholding:
Adjustment Due to Other Insurance:
Total Paid: $17.40
Patient Liability: $4.35

The total billed on the EOB reflects the total from the bill:
$87.00

...MENT SUMMARY SECTION
Payment made to: MEMORIAL PATHOLOGY CONSUL
Amount Paid: $17.40
Check Number: 0015575674

PPO Discount Total: $65.25
Base Deductible:
Optional Benefit Deductible:

...ARKS SECTION
Please note: **The provider of service may not accept a PPO Discount on Non-Covered Charges.**
All amounts shown on this Explanation of Benefits only apply to this Claim.
These charges have been considered under the base plan and all applicable optional benefits.

Q3 BENEFITS HAVE BEEN REDUCED BY YOUR 20% COINSURANCE.

PS A DISCOUNT WAS PROCESSED ON THIS PROVIDER'S BILL IN ACCORDANCE TO OUR CONTRACT WITH PHCS.

28. TOTAL CHARGE
$ 87 00

The total benefit allowance on the EOB reflects the totals from the two claims:
Claim E-V63599-01 = $10.80
Claim E-V63600-01 = $6.60
Total Paid= $17.40

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Exhibit 4

CONFIDENTIAL SETTLEMENT COMMUNICATION

CONFIRMATION OF PRESENTATION, DISCLOSURES AND RECEIPT

1. The Insurance Agent (the "Agent") whose signature appears below personally visited me to determine my interest in applying for insurance with Mid-West National Life Insurance Company of Tennessee. I understand that the individual presenting the individual policies of insurance offered by Mid-West National Life Insurance Company of Tennessee in this state is a licensed and appointed insurance agent for Midwest. The Agent provided me an insurance brochure and I had the opportunity to read the insurance brochure, before I signed the application. The Agent clearly explained to me the provisions, limitations and exclusions of the insurance plan(s) which I am applying for, and answered all of my questions to my satisfaction before I signed the application. **I understand the type of coverage that I am applying for and, after careful review, I chose the insurance plan that best suits my needs and the needs of any dependents listed on the application form.**

   ⇨**Primary Initial Here**: ________ ⇦

   In addition, the Agent explained to me that the insurance that I have applied for, including insurance applied on any dependents listed on the application will not become effective until the Certificate / Policy is issued by the Company.

   I acknowledge that the Agent asked each and every question on the application and that answers on the application are truthful and complete answers. **I have signed the application only after a full review of the questions and answers.**

   I understand and agree that if any material information is incorrect or omitted from the application it could provide the basis for the Company to deny future claims, refuse coverage and to refund my premiums as though the Certificate/Policy had never been issued.

2. In signing this form, I agree that neither the Agent nor the Company is bound by any knowledge or statements made by the Agent or me, unless set forth in writing in the application. I authorize the check tendered with the application to be deposited immediately upon receipt by the home office. I agree that the Company's depositing of my check does not create coverage with the Company and should the Company fail to approve my application for coverage, I will receive a full refund of all insurance premiums given to the Agent at the time of my application. **I understand that coverage is not effective unless and until the Certificate/Policy is issued by the Company.**

   By signing this receipt, I acknowledge that I have had adequate time to read the contents of this form and that I received a copy of the brochure and/or a copy of the outline of coverage, if applicable in my state.

3. I understand that membership in the Association is NOT required in order to apply for he individual policies of insurance. I want to join the Association in order to take advantage of the numerous benefits available to its members. I understand that Mid-West National Life Insurance Company of Tennessee and the Association are separate and distinct entities. I further understand that if I cancel my individual policies of insurance at any time, I will continue to be a member of the Association unless I contact them directly to cancel my membership.

4. If I enrolled in an optional Association Membership, I agree that the Insurance Agent/Field Service Representative identified below has delivered to me a copy of the Disclosures regarding Mid-West National Life Insurance Company of Tennessee and the Association Relationship document (the "Disclosures") and answered any questions I had to assure that I completely understand the information. In signing this form, I agree that I have carefully read and understand the information contained in the Disclosures.

   In signing this form, I agree that I have carefully read and I understand all the statements as listed above.

____

Applicant's Printed Name (Last, First, MI)

____________________ Date (mm/dd/yy) ______________

Signature

____ ____________

Insurance Agent/Field Service Representative Printed Name (Last, First, MI) Agent Number

____________________ Date (mm/dd/yy) ______________

Signature

CONFIDENTIAL SETTLEMENT COMMUNICATION

CONFIRMATION OF PRESENTATION, DISCLOSURES AND RECEIPT

1. The Insurance Agent (the "Agent") whose signature appears below personally visited me to determine my interest in applying for insurance with Mid-West National Life Insurance Company of Tennessee. The Agent provided me an insurance brochure and I had the opportunity to read the insurance brochure, before I signed the application. The Agent clearly explained to me the provisions, limitations and exclusions of the insurance plan(s) which I am applying for, and answered all of my questions to my satisfaction before I signed the application. **I understand the type of coverage that I am applying for and, after careful review, I chose the insurance plan that best suits my needs and the needs of any dependents listed on the application form.**

   ⇨**Primary Initial Here**: __________⇦

   In addition, the Agent explained to me that the insurance that I have applied for, including insurance applied on any dependents listed on the application will not become effective until the Certificate / Policy is issued by the Company.

   I acknowledge that the Agent asked each and every question on the application and that answers on the application are truthful and complete answers. **I have signed the application only after a full review of the questions and answers.**

   I understand and agree that if any material information is incorrect or omitted from the application it could provide the basis for the Company to deny future claims, refuse coverage and to refund my premiums as though the Certificate/Policy had never been issued.

2. In signing this form, I agree that neither the Agent nor the Company is bound by any knowledge or statements made by the Agent or me, unless set forth in writing in the application. I authorize the check tendered with the application to be deposited immediately upon receipt by the home office. I agree that the Company's depositing of my check does not create coverage with the Company and should the Company fail to approve my application for coverage, I will receive a full refund of all insurance premiums given to the Agent at the time of my application. **I understand that coverage is not effective unless and until the Certificate/Policy is issued by the Company.**

   By signing this receipt, I acknowledge that I have had adequate time to read the contents of this form and that I received a copy of the brochure and/or a copy of the outline of coverage, if applicable in my state.

3. The Insurance Agent/Field Service Representative identified below has delivered to me a copy of the Disclosures regarding Mid-West National Life Insurance Company of Tennessee and the Association Relationship document (the "Disclosures") and answered any questions I had to assure that I completely understand the information. In signing this form, I agree that I have carefully read and understand the information contained in the Disclosures.

   In signing this form, I agree that I have carefully read and I understand all the statements as listed above.

____

Applicant's Printed Name (Last, First, MI)

______________________________ Date (mm/dd/yy) ______________

Signature

______________________________ ______________

Insurance Agent/Field Service Representative Printed Name (Last, First, MI) Agent Number

______________________________ Date (mm/dd/yy) ______________

Signature

CONFIDENTIAL SETTLEMENT COMMUNICATION

CONFIRMATION OF PRESENTATION, DISCLOSURES AND RECEIPT

1. The Insurance Agent (the "Agent") whose signature appears below personally visited me to determine my interest in applying for insurance with The MEGA Life and Health Insurance Company. I understand that the individual presenting the individual policies of insurance offered by The MEGA Life and Health Insurance Company in this state is a licensed and appointed insurance agent for MEGA. The Agent provided me an insurance brochure and I had the opportunity to read the insurance brochure, before I signed the application. The Agent clearly explained to me the provisions, limitations and exclusions of the insurance plan(s) which I am applying for, and answered all of my questions to my satisfaction before I signed the application. **I understand the type of coverage that I am applying for and, after careful review, I chose the insurance plan that best suits my needs and the needs of any dependents listed on the application form.**

   ⇨Initial Here: __________ ⇦

   In addition, the Agent explained to me that the insurance that I have applied for, including insurance applied on any dependents listed on the application, will not become effective until the Policy is issued by the Company.

   I acknowledge that the Agent asked each and every question on the application and that answers on the application are truthful and complete answers. **I have signed the application only after a full review of the questions and answers.**

   I understand and agree that if any material information is incorrect or omitted from the application it could provide the basis for the Company to deny future claims, refuse coverage and to refund my premiums as though the Policy had never been issued.

2. In signing this form, I agree that neither the Agent nor the Company is bound by any knowledge or statements made by the Agent or me, unless set forth in writing in the application. I authorize the check tendered with the application to be deposited immediately upon receipt by the home office. I agree that the Company's depositing of my check does not create coverage with the Company and should the Company fail to approve my application for coverage, I will receive a full refund of all insurance premiums given to the Agent at the time of my application. **I understand that coverage is not effective unless and until the Policy is issued by the Company.**

   By signing this receipt, I acknowledge that I have had adequate time to read the contents of this form and that I received a copy of the brochure and/or a copy of the outline of coverage, if applicable in my state.

3. I understand that membership in the Association is NOT required in order to apply for the individual polices of insurance. I want to join the Association in order to take advantage of the numerous benefits available to its members. I understand that The MEGA Life and Health Insurance Company and the Association are separate and distinct entities. I further understand that if I cancel my individual policies of insurance at any time, I will continue to be a member of the Association unless I contact them directly to cancel my membership.

4. If I am enrolled in an optional Association Membership, I agree that the Insurance Agent/Field Service Representative identified below has delivered to me a copy of the Disclosures regarding The MEGA Life and Health Insurance Company and the Association Relationship document (the "Disclosures") and answered any questions I had to assure that I completely understand the information. In signing this form, I agree that I have carefully read and understand the information contained in the Disclosures.

In signing this form, I agree that I have carefully read and I understand all the statements as listed above.

____

Applicant's Printed Name (Last, First, MI)

______________________ **Date (mm/dd/yyyy)** ____________

Signature

______________________________________ ____________

Insurance Agent/Field Service Representative Printed Name (Last, First, MI) **Agent Number**

______________________ **Date (mm/dd/yyyy)** ____________

Signature

M/CDR IND 8/06 RETURN TO HOME OFFICE

CONFIDENTIAL SETTLEMENT COMMUNICATION

CONFIRMATION OF PRESENTATION, DISCLOSURES AND RECEIPT

1. The Insurance Agent (the "Agent") whose signature appears below personally visited me to determine my interest in applying for insurance with The MEGA Life and Health Insurance Company. The Agent provided me an insurance brochure and I had the opportunity to read the insurance brochure, before I signed the application. The Agent clearly explained to me the provisions, limitations and exclusions of the insurance plan(s) which I am applying for, and answered all of my questions to my satisfaction before I signed the application. **I understand the type of coverage that I am applying for and, after careful review, I chose the insurance plan that best suits my needs and the needs of any dependents listed on the application form.**

   ⇨Initial Here: ___________ ⇦

   In addition, the Agent explained to me that the insurance that I have applied for, including insurance applied on any dependents listed on the application, will not become effective until the Certificate/Policy is issued by the Company.

   I acknowledge that the Agent asked each and every question on the application and that answers on the application are truthful and complete answers. **I have signed the application only after a full review of the questions and answers.**

   I understand and agree that if any material information is incorrect or omitted from the application it could provide the basis for the Company to deny future claims, refuse coverage and to refund my premiums as though the Certificate/Policy had never been issued.

2. In signing this form, I agree that neither the Agent nor the Company is bound by any knowledge or statements made by the Agent or me, unless set forth in writing in the application. I authorize the check tendered with the application to be deposited immediately upon receipt by the home office. I agree that the Company's depositing of my check does not create coverage with the Company and should the Company fail to approve my application for coverage, I will receive a full refund of all insurance premiums given to the Agent at the time of my application. **Iu nderstand that coverage is not effective unless and until the Certificate/Policy is issued by the Company.**

   By signing this receipt, I acknowledge that I have had adequate time to read the contents of this form and that I received a copy of the brochure and/or a copy of the outline of coverage, if applicable in my state.

3. The Insurance Agent/Field Service Representative identified below has delivered to me a copy of the Disclosures regarding The MEGA Life and Health Insurance Company and the Association Relationship document (the "Disclosures") and answered any questions I had to assure that I completely understand the information. In signing this form, I agree that I have carefully read and understand the information contained in the Disclosures.

In signing this form, I agree that I have carefully read and I understand all the statements as listed above.

____
Applicant's Printed Name (Last, First, MI)

____________________ **Date (mm/dd/yyyy)** ____________
Signature

______________________________________ ____________
Insurance Agent/Field Service Representative Printed Name (Last, First, MI) **Agent Number**

____________________ **Date (mm/dd/yyyy)** ____________
Signature

M/CDR 12/05 **RETURN TO HOME OFFICE**

Exhibit 5

CONFIDENTIAL SETTLEMENT COMMUNICATION

HEALTHMARKETS, INC.

REGULATORY ADVISORY PANEL

OBJECTIVES AND MISSION STATEMENT

HealthMarkets, Inc. ("the Company") has established a Regulatory Advisory Panel (the "RAP") in order to ensure that the Company receives the benefit of and is provided objective, rigorous compliance advice and counsel from experienced leaders in the financial services industry.

Members of the RAP shall have the following mission:

- To provide the Company's Board of Directors (the "Board") and the Company with objective advice and guidance regarding regulatory compliance issues.
- To provide the Board and the Company information regarding regulatory trends, issues and initiatives.
- To provide the Board and the Company feedback on the Company's compliance initiatives.
- To report on a regular periodic basis to the Board regarding these issues and topics.

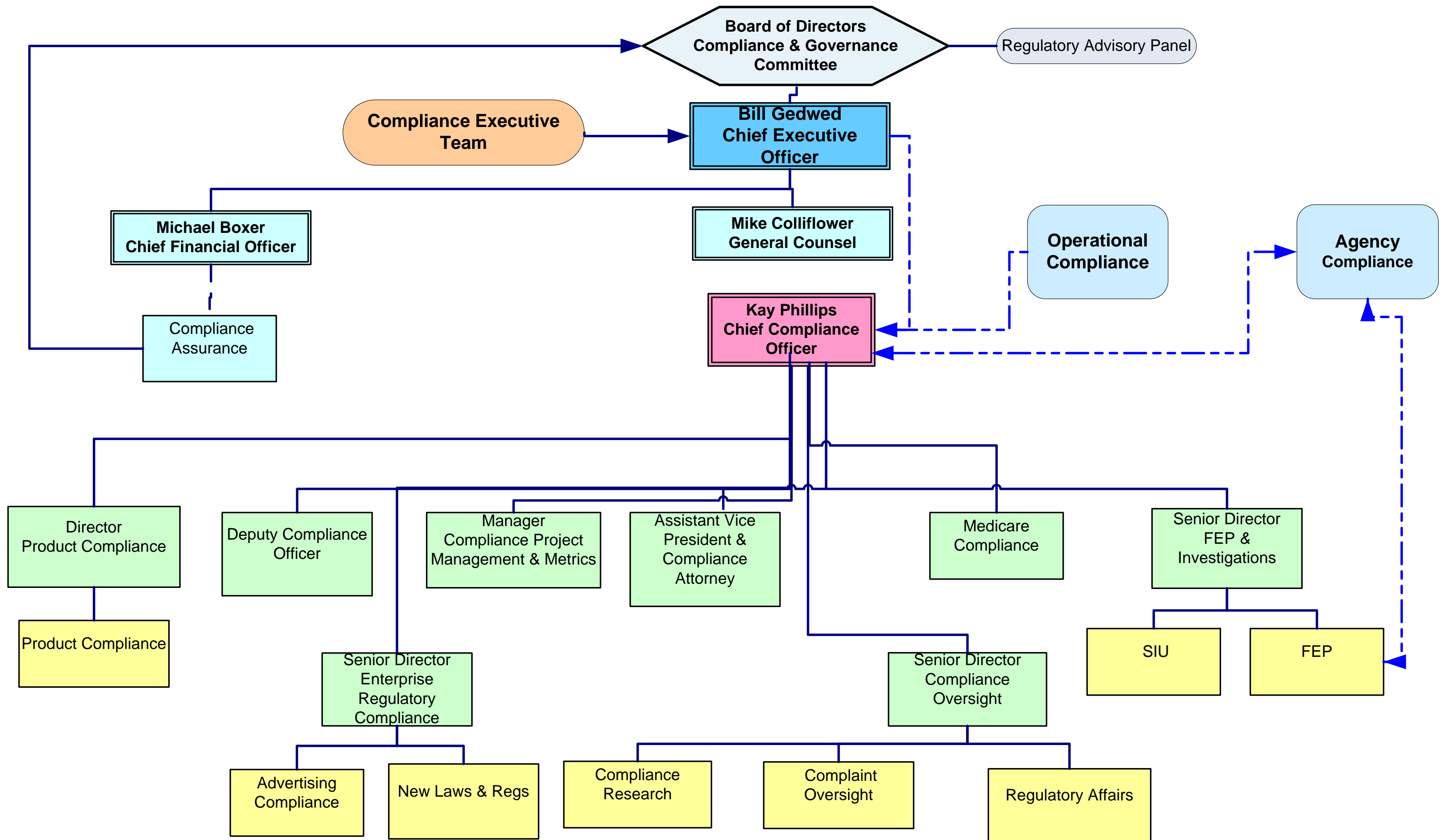
Members of the RAP shall be former insurance or other financial service industry regulators, compliance experts, and others who have significant and meaningful experience in legal, compliance or regulatory matters as specifically applied in the insurance and financial services industry. The RAP shall consist of no fewer than three members as determined by the Board, each of whom shall have no relationship to the Company that may interfere with the exercise of his or her independence from management and the Company.

The RAP shall meet no less frequently than quarterly and at other times as necessary or requested by the Board or the Chief Compliance Officer, during which meetings the members will hear presentations about current Company compliance and regulatory issues and initiatives, and will provide their advice and feedback. The RAP shall have the authority, to the extent it deems it necessary or appropriate, to retain special legal counsel or other consultants to advise the RAP and carry out its mission as prescribed hereby.

A member of the RAP shall report to the Board after each RAP meeting regarding the matters discussed at the RAP meeting, and the results of the discussion.

Members of the RAP shall be retained solely in an advisory capacity to the Company and the Board and shall not have statutory responsibilities or be subject to liabilities as directors under the laws of Delaware or the laws of any other jurisdiction.

Exhibit 6


Board of Directors
Compliance & Governance
Committee
Regulatory Advisory Panel
Compliance Executive
Team
Bill Gedwed
Chief Executive
Officer
Michael Boxer
Chief Financial Officer
Mike Colliflower
General Counsel
Operational
Compliance
Agency
Compliance
Compliance
Assurance
Kay Phillips
Chief Compliance
Officer
Director
Product Compliance
Deputy Compliance
Officer
Manager
Compliance Project
Management & Metrics
Assistant Vice
President &
Compliance
Attorney
Medicare
Compliance
Senior Director
FEP &
Investigations
Product Compliance
SIU
FEP
Senior Director
Enterprise
Regulatory
Compliance
Senior Director
Compliance
Oversight
Advertising
Compliance
New Laws & Regs
Compliance
Research
Complaint
Oversight
Regulatory Affairs