Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

May 20, 2013

Sent via USPS certified mail
return receipt requested

Dan Haney
Humana Health Plan, Inc. and
Humana Benefit Plan of Illinois, Inc.
1100 Employers Boulevard
Green Bay, Wisconsin 54334

Dear Mr. Haney:

A Market Conduct Examination of your companies was conducted by authorized examiners designated by the Director of Insurance pursuant to Illinois Insurance Code Sections 132, 401, 402, 403 and 425 of the Illinois Insurance Code. The period covered by the examination was January 1, 2011 through December 31, 2011. The examination also covered complaints from January 1, 2009 through February 3, 2012.

As required by Illinois Insurance Code Section 132, the Director must notify the company made the subject of any market conduct examination of the contents of the verified examination report before filing it and making the report public of any matters relating thereto, and must afford the company an opportunity to demand a hearing with reference to the facts and other evidence therein contained. A copy of the examination report is accordingly enclosed with this letter as well as a Stipulation and Consent Agreement. The company may request a hearing within 10 days after receipt of the examination report by giving the Director written notice of the request, together with a statement of its objections. The examination report will generally not be filed until hearing is completed.

Companies that do not demand a formal hearing may submit their rebuttal with respect to any matters in the examination report. The rebuttal will be considered by the Director before the examination report is filed. Please provide any rebuttals, or the signed Stipulation and Consent Order, to the undersigned by close of business, Wednesday, June 5, 2013. In the event that the Company elects to sign the Stipulation and Consent Order, please sign and return both copies. The Director will sign both copies and a fully executed copy will be returned to you for your records. Note that the Stipulation and Consent requires proof of compliance with Orders 1 through 12 and payment of a civil forfeiture in the amount of $50,000 within 30 days of the receipt of the fully executed Stipulation and Consent Order.

122 S. Michigan Avenue, 19th Floor
Chicago, Illinois 60603
(312) 814-2420
http://insurance.illinois.gov

Once the report of examination has been filed, the exam report, the company's rebuttal, if any, and corresponding Orders (if applicable) are public documents under the Freedom of Information Act (5 ILCS 140/1 *et el.*) and may be-posted on the Department's website. In the event of a formal hearing, the record of the hearing, the Hearing Officer Recommendations and the Director's final Order are also public documents and may be posted on the Department's website. Please contact me if you have any questions. I may be reached at 312-814-2420.

Sincerely,

Amanda J. Kimble
Assistant General Counsel
Illinois Department of Insurance
Amanda.Kimble@illinois.gov

This Market Conduct Examination was conducted pursuant to Sections 5/132, 5/401, 5/402, 5/403 and 5/425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402, 5/403 and 5/425). It was conducted in accordance with standard procedures of the Market Conduct Examination Section by duly qualified examiners of the Illinois Department of Insurance.

This report is divided into five parts. They are as follows: Summary, Background, Methodology, Findings and Technical Appendices. All files reviewed were reviewed on the basis of the files' contents at the time of the examination. Unless otherwise noted, all overcharges (underwriting) and/or underpayments (claims) were reimbursed during the course of the examination.

No company, corporation, or individual shall use this report or any statement, excerpt, portion, or section thereof for any advertising, marketing or solicitation purpose. Any company, corporation or individual action contrary to the above shall be deemed a violation of Section 149 of the Illinois Insurance Code (215 ILCS 5/149).

The Examiner-in-Charge was responsible for the conduct of this examination. The Examiner-in-Charge did approve of each criticism contained herein and has sworn to the accuracy of this report.

Amanda J. Kimble
Assistant General Counsel
Illinois Department of Insurance
Amanda.Kimble@illinois.gov

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF THE EXAMINATION OF:

HUMANA BENEFIT PLAN OF ILLINOIS, INC.
7915 N HALE AVENUE SUITE D
PEORIA, IL 61615

MARKET CONDUCT EXAMINATION WARRANT

I, the undersigned, Director of Insurance of the State of Illinois, pursuant to Sections 132, 401, 402, 403 and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402 and 5/425) do hereby appoint Examiner-In-Charge, Mike Hager and associates as the proper persons to examine the insurance business and affairs of Humana Benefit Plan of Illinois, Inc., NAIC # 60052, and to make a full and true report to me of the examination made by them of Humana Benefit Plan of Illinois, Inc., with a full statement of the condition and operation of the business and affairs of Humana Benefit Plan of Illinois Inc., with any other information as shall in their opinion be requisite to furnish me a statement of the condition and operation of its business and affairs and the manner in which it conducts its business. The costs of this examination shall be borne by the company.

The persons so appointed shall also have the power to administer oaths and to examine any person concerning the business, conduct, or affairs of Humana Benefit Plan of Illinois, Inc.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

IN TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed this Seal.

Done at the City of Springfield, this 27th day of January 2012.

Robert E. Wagner — *Acting Director*

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

I personally served a copy of the within Warrant by leaving said copy with Robin Verbruggen, at the hour of 2:45 PM on February 6, A.D., 2012.

Mike Hagen
Examiner

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF THE EXAMINATION OF:

HUMANA HEALTH PLAN , INC.
101 E MAIN ST.
LOUISVILLE, KY 40202

MARKET CONDUCT EXAMINATION WARRANT

I, the undersigned, Director of Insurance of the State of Illinois, pursuant to Sections 132, 401, 402, 403 and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402 and 5/425) do hereby appoint Examiner-In-Charge, Mike Hager and associates as the proper persons to examine the insurance business and affairs of Humana Health Plan, Inc., NAIC # 95885, and to make a full and true report to me of the examination made by them of Humana Health Plan, Inc., with a full statement of the condition and operation of the business and affairs of Humana Health Plan, Inc., with any other information as shall in their opinion be requisite to furnish me a statement of the condition and operation of its business and affairs and the manner in which it conducts its business. The costs of this examination shall be borne by the company.

The persons so appointed shall also have the power to administer oaths and to examine any person concerning the business, conduct, or affairs of Humana Health Plan, Inc.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

IN TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed this Seal.

Done at the City of Springfield, this 27th day of January, 2012.

Robert E. Wagner

Acting Director

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

I personally served a copy of the within Warrant by leaving said copy with Robin VerBrugge, at the hour of 2:45 PM on February 6, A.D., 2012.

Mike Hagen
Examiner

Humana Health Plan, Inc. and
Humana Benefit Plan of Illinois, Inc.

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	February 06, 2012 through January 15, 2013
EXAMINATION OF:	Humana Health Plan, Inc. NAIC Number: 119-95885 and Humana Benefit Plan of Illinois, Inc. NAIC Number: 119-60052
LOCATION:	1100 Employers Boulevard Green Bay, Wisconsin 54334
PERIOD COVERED BY EXAMINATION:	January 1, 2011 through December 31, 2011: Claims January 1, 2009 through February 03, 2012: Complaints
EXAMINERS:	C. Michael Hager - Examiner in Charge Patricia S. Hahn

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I. SUMMARY

1. The Company was criticized under 215 ILCS 5/154.6(d) for failure to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear.

2. The Company was criticized under 215 ILCS 5/154.6(i) for failure to affirm or deny claims within the required 30 days.

3. The Company was criticized under 215 ILCS 5/154.6(f) for a disproportionate number of meritorious complaints.

4. The Company was criticized under 215 ILCS 5/368a(c) for failure to process and pay interest on claims not paid within 30 days.

5. The Company was criticized under 215 ILCS 134/45(c) for failure to orally notify the party filing the appeal within 15 business days.

6. The Company was criticized under 215 ILCS 134/45(c) for failure to notify the party filing the appeal of all the information required to process an appeal within the required three (3) business days.

7. The Company was criticized under 215 ILCS 134/45(c) for failure to render a decision on appeals within the required 15 business days.

8. The Company was criticized under 215 ILCS 5/356z.3a for the underpayment of claims when the member has made a good faith effort to use the services of a contracted provider but one was unavailable.

9. The Company was criticized under 50 Ill. Adm. Code 2051.310(a)(6)(H) for the underpayment of claims when the insured has made a good faith effort to use the services of a contracted provider but one was unavailable.

10. The Company was criticized under 50 Ill. Adm. Code 919.50(a)(1) for failure to include the notice of availability of the Department of Insurance on the letters of denial of claims.

11. The Company was criticized under 50 Ill. Adm. Code 926.50 for failure to maintain the complaint records.

II. BACKGROUND

Humana Health Plan

Humana Health Plan, Inc. (HHP), a Kentucky corporation, was incorporated on August 23, 1982 and was licensed as a health maintenance organization in the Commonwealth of Kentucky on September 1, 1983. HHP is a wholly owned subsidiary of Humana Inc. ("Humana"), a Delaware corporation and the ultimate controlling person of an insurance and health maintenance organization holding company. HHP became an affiliate in the insurance holding company system on August 24, 1982 when Humana subscribed to 100% of the issued and outstanding shares of common stock of HHP. On August 3, 1984, Humana contributed 100% of the issued and outstanding shares of common stock of HHP to Group Health Insurance, Inc. (GHI), which, at the time, was an insurance and health maintenance organization holding company and a wholly owned subsidiary of Humana. GHI merged with Humana on December 1, 1992. Humana was the survivor of the merger.

Humana Benefit Plan of Illinois

Humana Benefit Plan of Illinois, Inc. (HBP) was incorporated on June 27, 1994 under its former name OSF Health Plans, Inc. (OSF). OSF was formerly owned by OSF Saint Francis, Inc., an Illinois corporation. Humana Inc., the ultimate parent in the holding company system, acquired OSF on May 22, 2008. On July 24, 2008, OSF changed its name to HBP. HBP was licensed as an accident and health insurance company on July 18, 1994 and licensed as a health maintenance organization on January 30, 1995.

The Company

The targets of this exam HHP, HBP and their subsidiaries, are collectively referred to as the Company in this report.

III. HMO STRUCTURE

HHP is a capitated independent practice association (IPA) and group network model health maintenance organization incorporated to do business in eight counties: Cook, DuPage, Lake, McHenry, Kane, Kendall, Will and Kankakee County, which are all in Northern Illinois. The HMO has its own on-staff service representatives and a network of independent insurance producers who market the group plans.

For the period under examination, the HMO contracted with 2861 primary care physicians, 5424 specialist physicians and 99 hospitals in Illinois.

IV. METHODOLOGY

The Market Conduct Examination covered the business for the period of January 1, 2011 through December 31, 2011 for claims and January 1, 2009 through February 3, 2012 for complaints. The following categories were the focus of this examination:

1. Sales, advertising and procedure files.
2. Enrollment procedures.
3. Claim procedures.
4. Department Complaints, Appeals and External Independent Reviews

The review of these categories is accomplished through examination of appointed and terminated producer files, claim files and complaint files. Each of these categories is examined for compliance with Department regulations and applicable State laws.

The report concerns itself with improper practices performed with such frequency as to indicate general business practices. Individual criticisms are identified and communicated to the HMO, but not cited in the report if not indicative of a general trend, except to the extent that there were underpayments in claim surveys or undercharges and/or overcharges in underwriting surveys. The following methods were used to obtain the required samples and to assure a methodical selection:

Producer Production

New business was reviewed to determine if solicitations had been made by duly licensed persons.

Claims

1. Paid Claims - Payment for claims made during the examination period.
2. Denied Claims - Denial of benefits during the examination period for losses not covered by certificate of coverage provisions.

All claims were reviewed for compliance with policy contracts and applicable Sections of

the Illinois Insurance Code (215 ILCS 5/1 *et seq.*), the Health Maintenance Organization Act (215 ILCS 125/6 *et seq.*), the Managed Care Reform and Patient Rights Act (215 ILCS 134/1 *et seq.*) and Illinois Administrative Code (50 Ill. Adm. Code 101 *et seq.*).

Median payment periods were measured from the date all necessary proofs of loss were received to the date of payment or denial to the member.

The period under review was January 1, 2011 through December 31, 2011.

Consumer and Insurance Department Complaints

The Company was requested to provide all files relating to complaints that were received via the Department of Insurance as well as those received directly by the Company from the insured or his/her representative. A copy of the Company's complaint register was also reviewed.

Median periods were measured from the date of notification of the complaint to the date of response to the Department.

The period under review was January 1, 2009 through February 3, 2012.

SELECTION OF SAMPLE

SURVEY	POPULATION	# REVIEWED	%REVIEWED
CLAIMS			
Paid Group HMO	311,075	120	0.04
Denied Group HMO	139,059	87	0.06
Paid Group DME	6,040	114	2.00
Denied Group DME	2,511	109	4.00
Paid Group IPA HMO	414,551	120	0.03
Denied Group IPA HMO	38,108	120	0.30
COMPLAINTS			
Department Complaints HHP	102	102	100
Department Complaints HBP	12	12	100
Consumer Complaints and Appeals	1,318	500	38
External Independent Review	3	3	100
CONSUMER ADVISORY COMMITTEE			
Consumer Advisory Committee	16	16	100
POLICY FORM REVIEW			
Policy Forms, Endorsements	12	12	100
Provider Contracts	6	6	100
PRODUCTION			
Producers/Applications	1,103/9,992	1,103/9,992	100
Terminated Producer Review	897	897	100

V. FINDINGS

A. Claims

1. Paid Group HMO

A review of 120 Paid Group HMO Claim files produced one (1) criticism. A general criticism was made under 215 ILCS 5/368a(c) for failing to affirm or deny claims within 30 days. 12 of 120 Paid Group HMO claim files, or 10% of Paid Group HMO Claim files, were found to be in violation.

The median for payment was five (5) days.

2. Denied Group HMO

A review of the Denied Group HMO Claim files produced four (4) criticisms. One (1) general criticism was made under 215 ILCS 5/154.6(i) for failure to affirm or deny claims within the required 30 days. 11 of 87 Denied Group HMO Claim files, or 13% of Denied Group HMO Claim files reviewed, were found to be in violation.

A second general criticism was made under 50 Ill. Adm. Code 919.50(a)(1) for failure to include the notice of availability of the Department of Insurance on the letters of denial. Twenty-three (23) of 87 Denied Group HMO Claim files, or 26% of Denied Group HMO Claim files reviewed, were found to be in violation.

One (1) individual criticism was made under 215 ILCS 5/154.6(d) for a claim underpayment in the amount of $308.80.

One (1) individual criticism was made under 215 ILCS 5/368a(c) for failure to pay interest on a claim not paid within 30 day for $6.64.

The median for denial was four (4) days.

3. Paid Group DME

A review of 114 durable medical equipment claim files produced no criticisms.

The median for payment was seven (7) days.

4. Denied Group DME

A review of 109 Denied Durable Medical Equipment Claim files produced one (1) criticism. A general criticism was made under 50 Ill. Adm. Code

919.50(a)(1) for failure to include notice of the Department of Insurance on the denial letters.

The median for denial was eight (8) days.

5. Paid Group IPA HMO

A review of 120 Paid Group IPA HMO claim files produced no criticisms.

The median for payment was seven (7) days.

6. Denied Group IPA HMO

A review of 120 Denied Group IPA HMO claim files produced two (2) criticisms. One (1) individual criticism was made under 215 ILCS 5/154.6(d) for an underpayment in the amount of $203.80. One (1) Individual criticism was made under 50 Ill. Adm. Code 2051.310(A)(6)(H) for failure to have adequate and accessible network providers, causing an underpayment in the amount of $23.75. The total underpayment amount is $227.55. The company made the underpayments prior to the completion of the examination.

The median for denial was 13 days.

B. Complaints

1. Department Complaints HHP

A review of 102 Department of Insurance Complaints for HHP produced eight (7) criticisms. One (1) general criticism was made under 215 ILCS 5/154.6(f) of the Illinois Insurance Code for a disproportionate number of meritorious complaints, 28 of 102, or 27% of Department of Insurance Complaints for HHP, were found in violation. Five (5) individual criticisms were made under 215 ILCS 5/368a(c) for interest underpayments in the amount of $122.52. One (1) individual criticism was made under 215 ILCS 5/154.6(d) for an underpayment in the amount of $347.78.

2. Department Complaints HBP

A review of the 12 Department of Insurance Complaints for HBP produced two (2) criticisms. One (1) individual criticism was made under 215 ILCS 5/368a(c) for an interest underpayment in the amount of $71.92. One (1) general criticism was made under 50 Ill. Adm. Code 926.50 for failure to maintain Department of Insurance Complaint records. 2 of 12, or

17% of Department of Insurance Complaints for HBP, were not included on the Log/Register.

The median for response for complaints was 20 days for HHP and 9 days for HBP.

3. Consumer Complaints and Appeals

A review of 500 Appeals files produced 144 criticisms. Three (3) general criticisms were made. The first general criticism was made under 215 ILCS 134/45(c), for failure to notify the party filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal orally of its decision within 15 days. 182 of 500, or 36% of the Appeals files reviewed, were found in violation. The second general criticism was made under 215 ILCS 134/45(c), for failure to render a decision on appeals within the required 15 business days. 241 of 500, or 48% of Appeals files reviewed, were found in violation. A third general criticism was made under 215 ILCS 134/45(c), for failing to notify the party filing an appeal, within the required three (3) working days, of all information that the plan requires to evaluate the appeal. 122 of 500, or 24% of Appeals files reviewed, were found to be in violation. Ninety-nine (99) individual criticisms were made under 215 ILCS 5/368a(c), for failure to pay interest on claims not paid within 30 days. The total amount of the interest underpayments was $2,080.56. One (1) individual criticism was made under 215 ILCS 5/356z.3a for failure to pay claims when the member has made a good faith effort to use participating providers at the same rate as he would have paid if the participating provider was used, causing an underpayment in the amount of $121.55. The Company made this payment prior to the completion of the examination. Thirty-three (33) individual criticisms were made under 50 Ill. Adm. Code 2051.310(a)(6)(H) for failure to pay claims when the member has made a good faith effort to use participating providers at the same rate as he would have if the participating provider was used. The total amounts of underpayments were $18,270.76. Eight (8) individual criticisms were made under 215 ILCS 5/154.6(d) for underpayment of claims. The total amounts of underpayments were $4,859.51.

The median for response was 16 days.

4. External Independent Review

The review of 3 external independent review files produced no criticisms.

No median for response could be established.

C. Consumer Advisory Committee

1. A review of 16 Consumer Advisory Committee meeting minutes produced no criticisms.

D. Policy Form Review

1. A review of the Policy Forms, Applications and Membership materials produced no criticisms.

E. Production

1. Producers/Applications

A review of 11,095 producer licensing files and first year commissions produced no criticisms.

2. Terminated Producer Review

A review of 897 terminated producers produced no criticisms.

VI. INTERRELATED FINDINGS

A. Provider Terminations

The Company did not have any provider terminations during the survey period.

B. Provider Contracts

A review of a small sample of the provider contracts revealed that the required "hold harmless" and the "referral" and "preauthorization" clauses were part of the contract language. HHP seemed unwilling or unable to enforce the provider agreements since many of the member claims were referred out of network. The Company feels that they are unable to enforce the hold harmless clause and the members are being balance billed. Also, there were many claims for "Professional Interpretation" of lab findings. The Company excludes these payments from the HMO agreement, even if it is a participating provider or a non-participating provider. Members are then balance billed for these charges, some of which are costly. The Company should enforce participating provider contracts and assure that members are not billed for these charges. Additionally, the hold harmless clause should follow a member when a participating provider refers that member out of network.

In no instance should a member be balance billed. Members are not a party to the contract between the Company and the provider. The Company should negotiate a write off of claims resulting in balance billing or pay the full amount of the claim. If a member has been billed in error, the Company should determine what the member has already contributed toward the billing and reimburse that amount. When a member makes a good faith effort to use a participating provider and the provider then refers the member to a non-participating provider the members should experience no greater cost for these claims than if the referred non-provider were a participating provider.

During the course of the market conduct examination the Company was asked to provide a listing of all of the denied Professional Interpretation claims adjudicated during our survey period. HMO claims are processed through two systems: Metavance and CAS. The Metavance system is primarily used for PPO claims, but there is a limited number of HMO plans that are processed through the Metavance system. A majority of the HMO claims are processed through the CAS system. The Company reviewed the Professional Interpretation fees and found identified 77 claims and determined that 11 members had been balanced billed through the Metavance system. The Company identified 857 claims processed through the CAS system where non-participating providers were contacted in order to determine if a member was balanced billed. The Company has been working on these claims for a month (making calls) and has completed 210 claims. Of these claims, 70 claims involved balance billing and 140 claims did not. The Company should re-open the 11 claims from the Metavance system and the 70 claims from the CAS system and pay those claims. Additionally, the Company should assure that the members are reimbursed for any payments made toward these claims. For the remaining 857 claims, the Company should continue to make efforts to contact all of the non-participating providers, determine whether a member was balance billed and pay those claims.

While attempting to determine whether members were balanced billed, the Company encountered numerous problems due to provider deficiencies. Examples of these problems are:

- Provider could not locate the member
- Not responding to calls
- Would only review a limited number of claims per day

Humana should continue to make attempts to work with providers in order to determine which claims should be paid.

STATE OF WISCONSIN)
) ss
COUNTY OF BROWN)

C. Michael Hager, being first duly sworn upon his oath, deposes and says:

That he was appointed by the Director of Insurance of the State of Illinois (the "Director") as Examiner-In-Charge to examine the insurance business and affairs of Humana Health Plan, Inc., NAIC #95885, and Humana Benefit Plan of Illinois, Inc., NAIC #60052;

That, as Examiner-In-Charge, he was directed to make a full and true report to the Director of the examination with a full statement of the condition and operation of the business and affairs of the Companies with any other information as shall in the opinion of the Examiner-In-Charge be requisite to furnish the Director with a statement of the condition and operation of the Companies' business and affairs and the manner in which the Companies conducts their business;

That neither he nor any other persons designated as examiners nor any members of their immediate families is an officer of, connected with, or financially interested in the Companies nor any of the Companies' affiliates other than as policyholders, and that neither he nor any other persons designated as examiners nor any members of their immediate families is financially interested in any other corporation or person affected by the examination;

That an examination was made of the affairs of the Companies pursuant to the authority vested in the Examiner-In-Charge by the Director of Insurance of the State of Illinois;

That he was the Examiner-in-Charge of said examination and the attached report of examination is a full and true statement of the condition and operation of the insurance business and affairs of the Companies for the period covered by the Report as determined by the examiners;

That the Report contains only facts ascertained from the books, papers, records, or documents, and other evidence obtained by investigation and examined or ascertained from the testimony of officers or agents or other persons examined under oath concerning the business, affairs, conduct, and performance of the Companies.

C Michael Hager
C. Michael Hager
Examiner-In-Charge

Subscribed and sworn to before me
this 5th day of April , 2013.

Robin M. Verbrugge
Notary Public
Commission Expires 12-15-2013

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

Humana Health Plan, Inc. and
Humana Benefit Plan of Illinois, Inc.
1100 Employers Boulevard
Green Bay, Wisconsin 54334

STIPULATION AND CONSENT ORDER

WHEREAS, the Director (the "Director") of the Illinois Department of Insurance (the "Department") is a duly authorized and appointed official of the State of Illinois, having authority and responsibility for the enforcement of the insurance laws of this State; and

WHEREAS, Humana Health Plan, Inc. and Humana Benefit Plan of Illinois, Inc. (the "Company") is authorized under the insurance laws of this State and by the Director to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS, a Market Conduct Examination ("Examination") of the Company was conducted by duly qualified examiners of the Department pursuant to Sections 131.21, 132, 401, 402 and 425 of the Illinois Insurance Code (215 ILCS 5/131.21, 5/132, 5/401, 5/402 and 5/425); and

WHEREAS, the Department examiners have filed an examination report as an official document of the Department as a result of the Examination (the "Report"); and

WHEREAS, the Report cited 11 areas where the Company was not in compliance with the Illinois Insurance Code (215 ILCS 5/1 *et seq.*) and Department Regulations (50 Ill. Adm. Code 101 *et seq.*); and

WHEREAS, nothing herein contained, nor any action taken by the Company in connection with this Stipulation and Consent Order, shall constitute, or be construed as, an admission of fault, liability or wrongdoing of any kind whatsoever by the Company; and

WHEREAS, the Company is aware of and understands its various rights in connection with the Examination and Report, including the right to counsel, notice, hearing and appeal under Sections 132, 401, 402, 407 and 407.2 of the Illinois Insurance Code and 50 Ill. Adm. Code 2402; and

WHEREAS, the Company understands and agrees that by entering into this Stipulation and Consent Order, it waives any and all rights to notice and hearing; and

WHEREAS, the Company and the Director, for the purpose of resolving all matters raised by the Report and in order to avoid any further administrative action, hereby enter into this Stipulation and Consent Order;

NOW, THEREFORE, IT IS agreed by and between the Company and the Director as follows:

1. That the Market Conduct Examination indicated 11 areas where the Company was not in compliance with provisions of the Illinois Insurance Code and/or Department Regulations; and

2. That the Director and the Company consent to this Order requiring the Company to take certain actions to come into compliance with provisions of the Illinois Insurance Code and/or Department Regulations.

THEREFORE, IT IS HEREBY ORDERED by the undersigned Director that the Company shall:

1. Institute and maintain procedures to comply with 215 ILCS 5/154.6(d) of the Illinois Insurance Code whereby the Company effectuates prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear.

2. Institute and maintain procedures to comply with 215 ILCS 5/154.6(i) of the Illinois Insurance Code whereby the Company affirms or denies claims within the required 30 days.

3. Institute and maintain procedures to comply with 215 ILCS 5/154.6(f) of the Illinois Insurance Code whereby the Company reduces the number of meritorious complaints.

4. Institute and maintain procedures to comply with 215 ILCS 5/368a(c) of the Illinois Insurance Code whereby the Company processes and pays interest on claims which are not paid within 30 days.

5. Institute and maintain procedures to comply with 215 ILCS 134/45(c) of the Illinois Insurance Code whereby the Company orally notifies the party filing the appeal within 15 business days.

6. Institute and maintain procedures to comply with 215 ILCS 134/45(c) of the Illinois Insurance Code whereby the Company notifies the party filing the appeal of all the information required to process an appeal within the required three (3) business days.

7. Institute and maintain procedures to comply with 215 ILCS 134/45(c) of the Illinois Insurance Code whereby the Company renders decisions on appeals within the required 15 business days.

8. Institute and maintain procedures to comply with 50 Ill. Adm. Code 2051.310(a)(6)(H) of the Illinois Insurance Code whereby the Company ensures full payments of claims when members have made a good faith effort to use the services of a contracted provider but one was unavailable.

9. Re-open the 11 claims that were balance billed from the Metavance system and the 70 claims from the CAS system and pay those claims and reimburse members for any payments they made toward these claims.

10. The Company should contact providers on the remaining 857 claims to determine whether members were balance billed, pay those claims where members were balanced billed and reimburse members for any payments they made toward these claims.

11. Institute and maintain procedures to comply with 50 Ill. Adm. Code 919.50(a)(1) of the Illinois Administrative Code whereby the Company provides the insured "Notice of availability of the Department of Insurance" on denied claims.

12. Institute and maintain procedures to comply with 50 Ill. Adm. Code 926.50 of the Illinois Administrative Code whereby the Company properly maintains complaint records.

13. Submit to the Director proof of compliance with the Order within 30 days of the execution of this Order.

14. Pay to the Director a civil forfeiture in the amount of $50,000.00 to be paid within 30 days of the execution of this Order.

NOTHING contained herein shall prohibit the Director from taking any and all appropriate regulatory action as set forth in the Illinois Insurance Code, including but not limited to levying additional forfeitures, should the Company violate any of the provisions of this Stipulation and Consent Order or any provisions of the Illinois Insurance Code or Department Regulations.

On behalf of Humana Health Plan, Inc. and Humana Benefit Plan of Illinois, Inc.:

Joan O. Lenahan
Signature

Joan O. Lenahan
Name

Vice President & Corporate Secretary
Title

Subscribed and sworn to before me this
2nd day of October A.D. 2013.

Notary Public

Michele H. Sizemore
Notary Public
State at Large
Kentucky
My Commission Expires: 1-3-2015

DEPARTMENT OF INSURANCE of the
State of Illinois;

DATE October 7, 2013

Andrew Boron
Andrew Boron
Director

Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

January 3, 2014

Bruce Broussard
President
PO Box 74036
Humana Health Plan
Louisville, KY 40201

Re: ***Humana Health Plan, Inc., & Humana Benefit Plan of Illinois, Inc.***
Market Conduct Examination Report

Dear Mr. Broussard:

The company has submitted to the Department proofs of compliance with Order # 1 through Order #12 and has submitted the $50,000 civil forfeiture as outlined in the Stipulation and Consent Order issued by the Department. These proofs of compliance have been reviewed and are satisfactory.

The Department is closing its file on this exam. I intend to ask the Director to make the Examination Report available for public inspection as authorized by 215 ILCS 5/132.

Sincerely,

Caryn C. Carmean, A.C.A.S., M.A.A.A..
Acting Deputy Director Consumer Outreach and Protection
Illinois Department of Insurance
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