# Illinois Department of Insurance

BRUCE RAUNER
Governor

JENNIFER HAMMER
Director

VIA USPS MAIL

February 14, 2018

Ms. Paula A. Steiner
President & CEO
Health Care Service Corporation, A Mutual Legal Reserve Company
300 E. Randolph Street
Chicago, IL 60601-5099

**Re: Health Care Service Corporation, A Mutual Legal Reserve Company, NAIC # 70670**
***Market Conduct Examination Report Closing Letter***

Dear Ms. Steiner:

The Department has reviewed your Company's proof of compliance and deems it adequate and sufficient. Therefore, the Department is closing its file on this exam.

I intend to ask the Director to make the Examination Report and Stipulation and Consent Order available for public inspection as authorized by 215 ILCS 5/132. At the Department's discretion, specific content of the report may be subject to redaction for private, personal, or trade secret information prior to making the report public. However, any redacted information will be made available to other regulators upon request.

Please contact me if you have any questions.

Sincerely,

Jack Engle

Jack Engle, MCM
Assistant Deputy Director-Market Conduct and Analysis
Illinois Department of Insurance
320 West Washington- 5th Floor
Springfield, IL 62767
217-558-1058
E-mail: Jack.Engle@Illinois.gov

**HEALTH CARE SERVICE CORPORATION**

**A Mutual Legal Reserve Company**

# MARKET CONDUCT EXAMINATION REPORT

| | |
|---|---|
| DATE OF EXAMINATION: | July 8, 2013 through October 14, 2016 |
| EXAMINATION OF: | Health Care Service Corporation<br>A Mutual Legal Reserve Company<br>NAIC #70670 |
| LOCATION OF EXAMINATION: | 300 East Randolph Street<br>Chicago, Illinois 60601-5099 |
| PERIOD COVERED<br>BY EXAMINATION: | June 1, 2012 through June 1, 2013<br>Complaints / Appeals: January 1, 2010 through June 1, 2013 |
| EXAMINERS: | Derek Stepp<br>Heather Harley<br>James Hartsfield<br>Sean Connolly<br>Donna Lee Williams<br>Stanley Kupish<br>Chris Heisler<br>Lonnie L. Suggs<br>Max R. Weaver<br>Examiner-in-Charge |

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## I. SUMMARY

A comprehensive market conduct examination of Health Care Service Corporation, a Mutual Legal Reserve Company operating in Illinois through its Blue Cross and Blue Shield of Illinois division (Company or HCSC) was performed to determine compliance with Illinois statutes and the Illinois Administrative Code.

The following table represents general findings, with specific details found in each section of the report.

**Table of Total Violations**

| Crit # | Statute/Rule | Description of Violation | Population | Files Reviewed | # of Violations | Error % |
|---|---|---|---|---|---|---|
| 6 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Paid Group PPO Mental Health) | 1,273,195 | 109 | 1 | <1% |
| 10 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Paid Group PPO Terminal Illness) | 9,507 | 109 | 2 | 2% |
| 11 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Paid Individual PPO Health) | 5,938,862 | 109 | 18 | 17% |
| 11 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Paid Individual PPO Health) | 5,938,862 | 109 | 9 | 8% |
| 13 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Paid Individual PPO Behavioral Health) | 34,717 | 109 | 16 | 15% |
| 13 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Paid Individual PPO Behavioral Health) | 34,717 | 109 | 9 | 8% |
| 15 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Paid Individual PPO Mental Health) | 208,967 | 109 | 7 | 6% |
| 15 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Paid Individual PPO Mental Health) | 208,967 | 109 | 17 | 16% |
| 17 | 215 ILCS 5/368a(c) | Failure to pay claim timely and 9% interest is owed (Paid Individual PPO Durable Medical Equipment) | 15,656 | 109 | 1 | <1% |

| Table of Total Violations | | | | | | |
|---|---|---|---|---|---|---|
| **Crit #** | **Statute/Rule** | **Description of Violation** | **Population** | **Files Reviewed** | **# of Violations** | **Error %** |
| 17 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Paid Individual PPO Durable Medical Equipment) | 15,656 | 109 | 33 | 30% |
| 17 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Paid Individual PPO Durable Medical Equipment) | 15,656 | 109 | 25 | 23% |
| 19 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Paid Individual PPO Terminal Illness) | 2,832 | 109 | 20 | 18% |
| 19 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Paid Individual PPO Terminal Illness) | 2,832 | 109 | 8 | 7% |
| 23 | 215 ILCS 5/368a(c) | Failure to pay claim timely and 9% interest is owed (Paid Medicare Supplement Mental Health) | 413,988 | 109 | 1 | <1% |
| 23 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Paid Medicare Supplement Mental Health) | 413,988 | 109 | 1 | <1% |
| 26 | 215 ILCS 5/368a(c) | Failure to pay claim timely and 9% interest is owed (Paid Group Dental) | 521,292 | 109 | 1 | <1% |
| 26 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Paid Group Dental) | 521,292 | 109 | 1 | <1% |
| 27 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Group HMO Health) | 1,224,931 | 109 | 1 | <1% |
| 27 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Group HMO Health) | 1,224,931 | 109 | 1 | <1% |
| 29 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Group HMO Behavioral Health) | 26,204 | 109 | 1 | <1% |
| 29 | 50 Ill. Admin. Code 919.50(a)(1) | Failure to provide written Notice of Availability of the Department of Insurance (Denied Group HMO Health) | 26,204 | 109 | 8 | 7% |

| Table of Total Violations | | | | | | |
|---|---|---|---|---|---|---|
| **Crit #** | **Statute/Rule** | **Description of Violation** | **Population** | **Files Reviewed** | **# of Violations** | **Error %** |
| 30 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Group PPO Behavioral Health) | 32,950 | 109 | 4 | 4% |
| 31 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Group HMO Mental Health) | 94,878 | 109 | 2 | 2% |
| 31 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Group HMO Mental Health) | 94,878 | 109 | 1 | <1% |
| 31 | 50 Ill. Admin. Code 919.50(a)(1) | Failure to provide claimant written Notice of Availability of the Department of Insurance (Denied Group HMO Mental Health) | 94,878 | 109 | 1 | <1% |
| 32 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Group PPO Mental Health) | 161,199 | 109 | 13 | 12% |
| 32 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Group PPO Mental Health) | 161,199 | 109 | 7 | 6% |
| 33 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Group HMO Durable Medical Equipment) | 14,202 | 109 | 5 | 5% |
| 37 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Individual PPO Health) | 1,029,679 | 109 | 17 | 16% |
| 37 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Individual PPO Health) | 1,029,679 | 109 | 9 | 8% |
| 38 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Individual Indemnity Health) | 1,950 | 109 | 2 | 2% |
| 38 | 215 ILCS 5/368a(c) | Failure to pay claim timely and 9% interest on delayed claim (Denied Individual Indemnity Health) | 1,950 | 109 | 1 | <1% |

| Table of Total Violations | | | | | | |
|---|---|---|---|---|---|---|
| **Crit #** | **Statute/Rule** | **Description of Violation** | **Population** | **Files Reviewed** | **# of Violations** | **Error %** |
| 39 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Individual PPO Behavioral Health) | 8,768 | 109 | 20 | 18% |
| 39 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Individual PPO Behavioral Health) | 8,768 | 109 | 12 | 11% |
| 41 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Individual PPO Mental Health) | 44,534 | 109 | 20 | 18% |
| 41 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Individual PPO Mental Health) | 44,534 | 109 | 10 | 9% |
| 43 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Individual PPO Durable Medical Equipment) | 7,291 | 109 | 31 | 28% |
| 43 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Individual PPO Durable Medical Equipment) | 7,291 | 109 | 20 | 18% |
| 45 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Individual PPO Terminal Illness) | 1,063 | 109 | 17 | 16% |
| 45 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Individual PPO Terminal Illness) | 1,063 | 109 | 10 | 9% |
| 49 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Medicare Supplement Mental Health) | 114,745 | 109 | 9 | 8% |
| 49 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Medicare Supplement Mental Health) | 114,745 | 109 | 5 | 5% |
| 52 | 50 Ill. Admin Code 919.50(a) | Failure to affirm or deny claim within a reasonable time (Denied Group Dental Claims) | 95,544 | 109 | 7 | 6% |

| Table of Total Violations | | | | | | |
|---|---|---|---|---|---|---|
| **Crit #** | **Statute/Rule** | **Description of Violation** | **Population** | **Files Reviewed** | **# of Violations** | **Error %** |
| 52 | 50 Ill. Admin. Code 919.70(a)(2) | Failure to provide claimant written explanation for delay of claim (Denied Group Dental Claims) | 95,544 | 109 | 5 | 5% |
| 52 | 215 ILCS 5/368a(c) | Failure to pay claim timely and 9% interest on delayed claim (Denied Group Dental Claims) | 95,544 | 109 | 1 | <1% |
| 56 | 215 ILCS 5/368a(c) | Failure to pay claim timely and 9% interest on delayed claim (Pended Claims) | 123 | 73 | 1 | 1% |
| 57/ 58 | 50 Ill. Admin. Code 926.50 | Failure to maintain a Department and consumer complaint log containing required minimum information (Complaints) | 2,621 | 236 | Log | n/a |
| 57/ 58 | 50 Ill. Admin. Code 926.40(a) | Failure to respond timely to Department complaints (Complaints) | 2,004 | 116 | 23 | 20% |
| 57/ 58 | 50 Ill. Admin. Code 926.40(a) | Failure to respond timely to consumer complaints (Complaints) | 617 | 120 | 8 | 7% |
| 60 | 215 ILCS 180/35(j) | Failure to provide written notice of decision to DOI (External Independent Reviews) | 544 | 82 | 12 | 15% |
| 60 | 215 ILCS 180/35(b) | Failure to provide a timely eligibility response (External Independent Reviews) | 544 | 82 | 10 | 12% |
| 61 | 215 ILCS 5/500-85(a), (b) and (e) | Failure to notify Director of Insurance of producers terminated for cause (Licensing) | 2,606 | 2,606 | 4 | n/a |
| 61 | 215 ILCS 5/500-85(c) | Failure to notify the producer within 15 days of the termination (Licensing) | 2,606 | 2,606 | 4 | n/a |

## II. EXAMINATION COORDINATION

The examination involved a population of 87,200,000 claims, requiring a substantial dedication of resources by the Department and its vendor and HCSC. On average, up to five examiners were on HCSC's premises over an 18-month on-site review, in addition to off-site resources. HCSC responded to 330 initial information requests as part of the examination, which does not include subsequent follow-up requests. The broad scope of the examination resulted in an extended duration, during which there were examination team staffing changes which necessitated additional transition time. The Department acknowledges that extraordinary effort was required on the part of HCSC to customize and produce information in formats and categories not used in the ordinary course of business.

This examination was uniquely complex for both the examination team and HCSC due to the granular nature of the categories of the claims requested and reviewed. This impacted the efficiency of not only the responses to the requests but also the examination team's assessment of the responses. These factors ultimately resulted in the extended period to close the examination and issue this examination report.

## III. BACKGROUND

Health Care Service Corporation, (HCSC) a Mutual Legal Reserve Company, operates on a not-for-profit basis for the mutual benefit of its member contract holders. HCSC is located at 300 East Randolph Street, Chicago, Illinois. HCSC does business as Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, Blue Cross and Blue Shield of Texas and Blue Cross and Blue Shield of Montana. HCSC is an independent licensee of Blue Cross and Blue Shield Association and is licensed to use the Blue Cross and Blue Shield brands in these five states. HCSC was licensed in Illinois on October 1, 1936, as the Hospital Service Corporation. Illinois Medical Service was organized under the Medical Service Plan Act (Ill. Rev. Stat. Ch. 32, Sec. 563 *et seq.*) on October 21, 1947. The Company, which was created by the merger of Hospital Service Corporation and Illinois Medical Service, was organized and commenced operations as HCSC under the provisions of The Non-Profit Health Care Service Plan Act (Ill. Rev. Stat. Ch. 32, Sec. 551 *et seq.*) on October 1, 1975, the effective date of the Act.

Effective December 20, 1982, the Illinois Director of Insurance approved the Company's election to become subject to Article III of the Illinois Insurance Code, which governs mutual insurance companies. At that time, the Company adopted the name Health Care Service Corporation, a Mutual Legal Reserve Company.

The Company is licensed to do business in Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Idaho, Illinois, Indiana, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, Virginia, West Virginia and Wisconsin.

The Company's 2013 NAIC Annual Statement, Page 30 (Illinois), reflects the following information:

NAIC #70670

| | Line of Business | Direct Premiums Written | Direct Premiums Earned | Direct Losses Paid | Direct Losses Incurred |
|---|---|---|---|---|---|
| 11. | Health | $10,522,089,148 | $10,604,711,794 | $9,096,701,297 | $8,985,725,820 |

## IV. HMO STRUCTURE

On December 31, 1998, HCSC merged with Blue Cross Blue Shield of Texas, Inc. (BCBSTX). BCBSTX was organized as a non-profit hospital service plan on June 2, 1939. HCSC is the surviving company of the merger.

HCSC completed an assumption reinsurance agreement with Blue Cross and Blue Shield of New Mexico on July 1, 2001. This includes individual coverage, group coverage, administrative services contract and administrative services only business. In addition, HCSC purchased 100% of the stock of New Mexico HMO, Inc. (NMHMO).

In 2000, HCSC purchased NYLCare Health Plans of the Southwest, Inc. and NYLCare Health Plans of the Gulf Coast, Inc. The names of these HMOs were subsequently changed in 2000 to Southwest Texas HMO, Inc. and Texas Gulf Coast HMO, Inc., respectively. In 2001, Rio Grande HMO, Inc. and West Texas Health Plans, LC, (two other HMOs owned by HCSC) in addition with Texas Gulf Coast HMO, Inc., were merged into Southwest Texas HMO, Inc. with Southwest Texas HMO, Inc. being the surviving entity. Effective January 1, 2004, Southwest Texas HMO, Inc. merged into HCSC with HCSC assuming the assets, liabilities and contracts of Southwest Texas HMO, Inc.

On November 5, 2005, HCSC merged with Group Health Service of Oklahoma, Inc. (GHS), which does business as Blue Cross Blue Shield of Oklahoma. This transaction was accounted for as a statutory merger.

NMHMO transferred nearly all of its assets and all of its liabilities to its parent, HCSC, effective October 1, 2007, as part of a subscriber transfer agreement. NMHMO transferred its remaining assets to HCSC on December 18, 2007. NMHMO's Certificate of Authority was surrendered to the New Mexico Division of Insurance on December 18, 2007, and NMHMO was dissolved on that date.

## V. QUALITY ASSURANCE – COMPLAINTS AND APPEALS

If a member chooses to request a reconsideration of a claim, he/she may write the Company and an authorized representative will attempt to address the concerns through informal discussions. If the issue is not resolved through informal discussions, the member may file a complaint with the Company.

HCSC has established the following complaint review procedures.

Administrative Review – If the member or authorized representative chooses to appeal a non-clinical issue, an oral or written request or consideration expressing dissatisfaction or disagreement with an adverse benefit/coverage or administrative determination by HCSC, the request will be reviewed by persons not involved in the original decision.

Medical Review – If a member chooses to appeal a prior authorization medical decision, the appeal to change an adverse determination for care or services must be approved in whole or in part in advance of the member obtaining care or services.

If a member wants to change an adverse determination for care or services that has already been received, an appeal may be requested.

Expedited Review – If the member or health care provider believes that the standard time to review the denial of coverage could significantly increase the risk to the member's health, an expedited review may be requested orally or in writing.

The results for these reviews are presented in the Complaint Findings section of this report.

## VI. METHODOLOGY

The market conduct examination places emphasis on evaluating an insurer's systems and procedures used in dealings with insureds and claimants. The following categories are the general areas examined:

- Producer Licensing and Production
- Claim Procedures
- Policy Forms and Advertising
- Department of Insurance Complaints, Consumer Complaints and Appeals

Each of these categories is examined for compliance with Department of Insurance rules and regulations and applicable state laws.

The report concerns itself with improper practices performed by the Company which resulted in a failure to comply with Illinois statutes and/or administrative rules. Criticisms were prepared and communicated to the Company addressing violations discovered in the review process. All violations are cited in the report.

The following methods were used to obtain the required samples to ensure a methodical selection.

Producer Licensing and Production

Populations for the producer file reviews were determined by whether or not the producers were licensed by the State of Illinois. New business listings, for the period June 1, 2012 to June 1, 2013, were retrieved from Company records selecting newly solicited insurance applications which show an Illinois address for the applicant.

Claim Procedures

Claim surveys were selected using the following criteria:

- Paid Claims – payment for the coverage made during the examination period
- Denied Claims – denial of benefits for losses not covered by policy provisions
- Pended Claims – claims requiring additional information, prior to being paid or denied

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

All median payment periods were measured from the date the necessary proofs of loss were received to the date of payment or denial to the insured or the beneficiary.

Policy Forms and Advertising

The examination directive included claims, complaints, producer activity and an overview of underwriting related materials. A sample of policy forms were provided, however, a compliance review of forms was not performed. The only policy forms reviewed were those where claims needed clarification for coverage and/or exclusion(s). At that time, the Company only provided the section of the policy covering that specific situation and not the entire policy.

No advertising samples were reviewed. As part of the examination interrogatories, information related to the Company's advertising and marketing was requested and provided. Items included solicitation kits, telemarketing scripts and agent training materials. The review of these materials found no errors and the scope of the examination was not expanded to review advertising samples.

Department of Insurance Complaints, Consumer Complaints and Appeals

The Company was requested to provide all files relating to complaints which had been received via the Department of Insurance, received directly by the Company from the insured or his/her representative, as well as the appeals received from an insured or his/her representative. A copy of the Company's complaint register was also requested and reviewed.

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

The examination period for Department of Insurance complaints, consumer complaints and appeals was January 1, 2010 to June 1, 2013.

## VII. SAMPLE SELECTION

Based on information provided by the Company, the examiners determined the universes and sample sizes for each survey conducted. Using the guidelines in the NAIC Market Regulation Handbook and Department guidance, the examiners determined a credible sample, at a 95% confidence level, to be 109 samples. Note that in some instances the population was such that a census review was conducted rather than a sample review. Also, there were a few instances where the population was such that a larger sample was reviewed as indicated in Chapter 14 of the Market Regulation Handbook.

Using a combination of Audit Command Language (ACL) primarily for sample selection and Microsoft Excel for presentation, the examiners randomly selected records from various populations. In random sampling, a specific number of items to select, a random seed, and the population are needed to generate the samples. ACL uses the random seed to initialize a random number generator. As with all true random samples, each item has an equal chance of selection, but there is no guarantee that the results will be evenly distributed. Once the numbers were generated, they were provided to the Company for file retrieval.

| Survey | Population | # Reviewed | % Reviewed |
|---|---|---|---|
| **Producer Production Review** | | | |
| Terminated Producers | 2,606 | 2,606 | 100 |
| Producer Production | 5,864 | 5,864 | 100 |
| **Claims Review** | | | |
| Paid Individual PPO Health | 5,938,862 | 109 | <1 |
| Denied Individual PPO Health | 1,029,679 | 109 | <1 |
| Paid Individual Indemnity Health | 11,004 | 109 | <1 |
| Denied Individual Indemnity Health | 1,950 | 109 | 6 |
| Paid Individual Indemnity Mental Health | 566 | 109 | 19 |
| Denied Individual Indemnity Mental Health | 149 | 109 | 73 |
| Paid Individual PPO Mental Health | 208,967 | 109 | <1 |
| Denied Individual PPO Mental Health | 44,534 | 109 | <1 |
| Paid Individual Indemnity Behavioral Health | 29 | 29 | 100 |
| Denied Individual Indemnity Behavioral Health | 0 | N/A | N/A |
| Paid Individual PPO Behavioral Health | 34,717 | 109 | <1 |
| Denied Individual PPO Behavioral Health | 8,768 | 109 | 1 |
| Paid Individual PPO Durable Medical Equipment | 15,656 | 109 | <1 |
| Denied Individual PPO Durable Medical Equipment | 7,291 | 109 | 1 |
| Paid Individual Indemnity Durable Medical Equipment | 34 | 34 | 100 |
| Denied Individual Indemnity Durable Medical Equipment | 4 | 4 | 100 |
| Paid Individual PPO Terminal Illness | 2,832 | 109 | 4 |
| Denied Individual PPO Terminal Illness | 1,063 | 109 | 10 |
| Paid Individual Indemnity Terminal Illness | 0 | N/A | N/A |
| Denied Individual Indemnity Terminal Illness | 0 | N/A | N/A |
| Paid Group HMO Health | 3,122,671 | 109 | <1 |
| Denied Group HMO Health | 1,224,931 | 109 | <1 |

| | | | |
|---|---|---|---|
| Paid Group HMO Terminal Illness | 5,938 | 109 | 2 |
| Denied Group HMO Terminal Illness | 1,168 | 109 | 9 |
| Paid Group HMO Mental Health | 89,429 | 109 | <1 |
| Denied Group HMO Mental Health | 94,878 | 109 | <1 |
| Paid Group HMO Behavioral Health | 61,013 | 109 | <1 |
| Denied Group HMO Behavioral Health | 26,204 | 109 | <1 |
| Paid Group HMO Durable Medical Equipment | 83,942 | 109 | <1 |
| Denied Group HMO Durable Medical Equipment | 14,202 | 109 | <1 |
| Paid Group PPO Health | 27,512,500 | 109 | <1 |
| Denied Group PPO Health | 2,596,947 | 109 | <1 |
| Paid Group PPO Mental Health | 1,273,195 | 109 | <1 |
| Denied Group PPO Mental Health | 161,199 | 109 | <1 |
| Paid Group PPO Behavioral Health | 170,389 | 109 | <1 |
| Denied Group PPO Behavioral Health | 32,950 | 109 | <1 |
| Paid Group PPO Terminal Illness | 9,507 | 109 | <1 |
| Denied Group PPO Terminal Illness | 1,346 | 109 | 8 |
| Paid Group PPO Durable Medical Equipment | 111,800 | 109 | <1 |
| Denied Group PPO Durable Medical Equipment | 38,916 | 109 | <1 |
| Paid Group PPO Indemnity | 854,992 | 109 | <1 |
| Denied Group PPO Indemnity | 3,003 | 109 | <1 |
| Paid Group Dental | 521,292 | 109 | <1 |
| Denied Group Dental | 95,544 | 109 | <1 |
| Paid Medicare Supplement Health | 22,208,310 | 109 | <1 |
| Denied Medicare Supplement Health | 9,904,499 | 109 | <1 |
| Paid Medicare Supplement Behavioral Health | 12,004 | 109 | <1 |
| Denied Medicare Supplement Behavioral Health | 9,321 | 109 | <1 |
| Paid Medicare Supplement Mental Health | 413,988 | 109 | <1 |
| Denied Medicare Supplement Mental Health | 114,475 | 109 | <1 |
| Paid Medicare Supplement Terminal Illness | 3 | 3 | 100 |
| Denied Medicare Supplement Terminal Illness | 1,418 | 109 | 8 |
| Paid Medicare Supplement Durable Medical Equipment | 410,329 | 109 | <1 |
| Denied Medicare Supplement Durable Medical Equipment | 112,060 | 109 | <1 |
| Pended Claims | 123 | 73 | 59 |
| Paid Individual Prescription | 8,610,053 | 120 | <1 |
| | | | |
| **Department Complaints and Consumer Appeals** | | | |
| Department Complaints | 2,004 | 116 | 6 |
| Consumer Complaints | 617 | 120 | 19 |
| External Independent Reviews | 544 | 82 | 15 |
| Appeals | 17,858 | 120 | <1 |

## VIII. FINDINGS

### A. COMPANY OPERATIONS

A review of the committee agenda, minutes of recent meetings and the membership roster produced no criticisms.

### B. PRODUCER LICENSING AND PRODUCTION ANALYSIS

1. Licensing

a. The review of the producer termination files resulted in four (4) files cited for failure to report terminations for cause to the Illinois Director of Insurance within 30 days, as required by 215 ILCS 500-85(a), (b) and (e).

b. The Company failed to notify four (4) producers within 15 days following their termination, as required by 215 ILCS 500-85(c).

2. Production Analysis

A review of the production analysis produced no criticisms.

### C. CLAIMS

1. Paid Group HMO Health

A review of 109 Paid Group HMO Health Claim files produced no criticisms.

The median for payment was three (3) days.

2. Paid Group PPO Health

A review of 109 Paid Group PPO Health Claim files produced no criticisms.

The median for payment was two (2) days.

3. Paid Group HMO Behavioral Health

A review of 109 Paid Group HMO Behavioral Health Claim files produced no criticisms.

The median for payment was 12 days.

4. Paid Group PPO Behavioral Health

A review of 109 Paid Group PPO Behavioral Health Claim files produced no criticisms.

The median for payment was three (3) days.

5. Paid Group HMO Mental Health

A review of 109 Paid Group HMO Mental Health Claim files produced no criticisms.

The median for payment was eight (8) days.

6. Paid Group PPO Mental Health

In one (1) instance of the 109 Paid Group PPO Mental Health Claim files reviewed, for an error rate of less than 1%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for payment was one (1) day.

7. Paid Group HMO Durable Medical Equipment

A review of 109 Paid Group HMO Durable Medical Equipment Claim files produced no criticisms.

The median for payment was eight (8) days.

8. Paid Group PPO Durable Medical Equipment

A review of 109 Paid Group PPO Durable Medical Equipment Claim files produced no criticisms.

The median for payment was 13 days.

9. Paid Group HMO Terminal Illness

A review of 109 Paid Group HMO Terminal Illness Claim files produced no criticisms.

The median for payment was 24 days.

10. Paid Group PPO Terminal Illness

In two (2) instances of the 109 Paid Group PPO Terminal Illness Claim files reviewed, for an error rate of 2%, the Company failed to send a 45-day letter providing a reasonable

written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for payment was 16 days.

11. Paid Individual PPO Health

a. In 18 instances of the 109 Paid Individual PPO Health Claim files reviewed, for an error rate of 17%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In nine (9) instances of the 109 Paid Individual PPO Health Claim files reviewed, for an error rate of 8%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for payment was six (6) days.

12. Paid Individual Indemnity Health

A review of 109 Paid Individual Indemnity Health Claim files produced no criticisms.

The median for payment was one (1) day.

13. Paid Individual PPO Behavioral Health

a. In 16 instances of the 109 Paid Individual PPO Behavioral Health Claim files reviewed, for an error rate of 15%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In nine (9) instances of the 109 Paid Individual PPO Behavioral Health Claim files reviewed, for an error rate of 8%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for payment was six (6) days.

14. Paid Individual Indemnity Behavioral Health

A review of 29 Paid Individual Indemnity Behavioral Health Claim files produced no criticisms.

The median for payment was one (1) day.

15. Paid Individual PPO Mental Health

a. In seven (7) instances of the 109 Paid Individual PPO Mental Health Claim files reviewed, for an error rate of 6%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

b. In 17 instances of the 109 Paid Individual PPO Mental Health Claim files reviewed, for an error rate of 16%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

The median for payment was seven (7) days.

16. Paid Individual Indemnity Mental Health

A review of 109 Paid Individual Indemnity Mental Health Claim files produced no criticisms.

The median for payment was one (1) day.

17. Paid Individual PPO Durable Medical Equipment

a. In one (1) instance of the 109 Paid Individual PPO Durable Medical Equipment Claim files reviewed, for an error rate of less than 1%, the Company failed to pay 9% interest on a claim not paid within 30 days after receipt of the proof of loss. This is in violation of 215 ILCS 5/368a(c).

b. In 33 instances of the 109 Paid Individual PPO Durable Medical Equipment Claim files reviewed, for an error rate of 30%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

c. In 25 instances of the 109 Paid Individual PPO Durable Medical Equipment Claim files reviewed, for an error rate of 23%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for payment was 23 days.

18. Paid Individual Indemnity Durable Medical Equipment

A review of 34 Paid Individual Indemnity Durable Medical Equipment Claim files produced no criticisms.

The median for payment was three (3) days.

19. Paid Individual PPO Terminal Illness

a. In 20 instances of the 109 Paid Individual PPO Terminal Illness Claim files reviewed, for an error rate of 18%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In eight (8) instances of the 109 Paid Individual PPO Terminal Illness Claim files reviewed, for an error rate of 7%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for payment was 13 days.

20. Paid Individual Indemnity Terminal Illness

The Company reported no Paid Individual Indemnity Terminal Illness Claims.

21. Paid Medicare Supplement Health

A review of 109 Paid Medicare Supplement Health Claim files produced no criticisms.

The median for payment was one (1) day.

22. Paid Medicare Supplement Behavioral Health

A review of 109 Paid Medicare Supplement Behavioral Health Claim files produced no criticisms.

The median for payment was three (3) days.

23. Paid Medicare Supplement Mental Health

a. In one (1) instance of the 109 Paid Medicare Supplement Mental Health Claim files reviewed, for an error rate of less than 1%, the Company failed to pay 9% interest, in the amount of $6.51, on a claim not paid within 30 days after receipt of the proof of loss. This is in violation of 215 ILCS 5/368a(c).

b. In one (1) instance of the 109 Paid Medicare Supplement Mental Health Claim files reviewed, for an error rate of less than 1%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for payment was two (2) days.

24. Paid Medicare Supplement Durable Medical Equipment

A review of 109 Paid Medicare Supplement Durable Medical Equipment Claim files produced no criticisms.

The median for payment was one (1) day.

25. Paid Medicare Supplement Terminal Illness

A review of three (3) Paid Medicare Supplement Terminal Illness Claim files produced no criticisms.

The median for payment could not be established.

26. Paid Group Dental

a. In one (1) instance of the 109 Paid Group Dental Claim files reviewed, for an error rate of less than 1%, the Company failed to pay 9% interest, in the amount of $2.83, on a claim not paid within 30 days after receipt of the proof of loss. This is in violation of 215 ILCS 5/368a(c).

b. In one (1) instance of the 109 Paid Group Dental Claim files reviewed, for an error rate of less than 1%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for payment was one (1) day.

27. Denied Group HMO Health

a. In one (1) instance of the 109 Denied Group HMO Health Claim files reviewed, for an error rate of less than 1%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In one (1) instance of the 109 Denied Group HMO Health Claim files reviewed, for an error rate of less than 1%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for payment could not be established.

28. Denied Group PPO Health

A review of 109 Denied Group PPO Health Claims produced no criticisms.

The median for denial was eight (8) days.

29. Denied Group HMO Behavioral Health

a. In one (1) instance of the 109 Denied Group HMO Behavioral Health Claim files reviewed, for an error rate of less than 1%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In eight (8) instances of the 109 Denied Group HMO Behavioral Health Claim files reviewed, for an error rate of 7%, the Company failed to provide the Notice of Availability of the Department of Insurance in claim denial explanations. This is in violation of 50 Ill. Admin. Code 919.50(a)(1).

The median for denial was 12 days.

30. Denied Group PPO Behavioral Health

In four (4) instances of the 109 Denied Group PPO Behavioral Health Claim files reviewed, for an error rate of 4%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for denial was 14 days.

31. Denied Group HMO Mental Health

a. In two (2) instances of the 109 Denied Group HMO Mental Health Claim files reviewed, for an error rate of 2%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In one (1) instance of the 109 Denied Group HMO Mental Health Claim files reviewed, for an error rate of less than 1%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

c. In one (1) instance of the 109 Denied Group HMO Mental Health Claim files reviewed, for an error rate of less than 1%, the Company failed to provide the Notice of Availability of the Department of Insurance on denied claim forms, as required by 50 Ill. Admin. Code 919.50(a)(1).

The median for denial was seven (7) days.

32. Denied Group PPO Mental Health

a. In 13 instances of the 109 Denied Group PPO Mental Health Claim files reviewed, for an error rate of 12%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In seven (7) instances of the 109 Denied Group PPO Mental Health Claim files reviewed, for an error rate of 6%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for denial was 10 days.

33. Denied Group HMO Durable Medical Equipment

In five (5) instances of the 109 Denied Group HMO Durable Medical Equipment Claim files reviewed, for an error rate of 5%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for denial was three (3) days.

34. Denied Group PPO Durable Medical Equipment

A review of 109 Denied Group PPO Durable Medical Equipment Claim files produced no criticisms.

The median for denial was 15 days.

35. Denied Group HMO Terminal Illness

A review of 109 Denied Group HMO Terminal Illness Claim files produced no criticisms.

The median for denial was 16 days.

36. Denied Group PPO Terminal Illness

The Company reported no Denied Group PPO Terminal Illness Claims.

37. Denied Individual PPO Health

a. In 17 instances of the 109 Denied Individual PPO Health Claim files reviewed, for an error rate of 16%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In nine (9) instances of the 109 Denied Individual PPO Health Claim files reviewed, for an error rate of 8%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for denial was 28 days.

38. Denied Individual Indemnity Health

a. In two (2) instances of the 109 Denied Individual Indemnity Health Claim files reviewed, for an error rate of 2%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

b. In one (1) instance of the 109 Denied Individual Indemnity Health Claim files reviewed, for an error rate of less than 1%, the Company failed to pay 9% interest, in the amount of $32.91, on a claim not paid within 30 days after receipt of the proof of loss. This is in violation of 215 ILCS 5/368a(c).

The median for payment was three (3) days.

39. Denied Individual PPO Behavioral Health

a. In 20 instances of the 109 Denied Individual PPO Behavioral Health Claim files reviewed, for an error rate of 18%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In 12 instances of the 109 Denied Individual PPO Behavioral Health Claim files reviewed, for an error rate of 11%, the Company failed to send a 45-day letter providing a reasonable written explanation of the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for denial was 17 days.

40. Denied Individual Indemnity Behavioral Health

The Company did not report any Denied Individual Indemnity Behavioral Health Claims.

41. Denied Individual PPO Mental Health

a. In 20 instances of the 109 Denied Individual PPO Mental Health Claim files reviewed, for an error rate of 18%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In 10 instances of the 109 Denied Individual PPO Mental Health Claim files reviewed, for an error rate of 9%, the Company failed to send a 45-day letter providing a reasonable written explanation of the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for denial was 17 days.

42. Denied Individual Indemnity Mental Health

A review of 109 Denied Individual Indemnity Mental Health Claim files produced no criticisms.

The median for denial was 13 days.

43. Denied Individual PPO Durable Medical Equipment

a. In 31 instances of the 109 Denied Individual PPO Durable Medical Equipment Claim files reviewed, for an error rate of 28%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In 20 instances of the 109 Denied Individual PPO Durable Medical Equipment Claim files reviewed, for an error rate of 18%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for denial was 26 days.

44. Denied Individual Indemnity Durable Medical Equipment

A review of four (4) Denied Individual Indemnity Durable Medical Equipment Claim files produced no criticisms.

No median for denial was established.

45. Denied Individual PPO Terminal Illness

a. In 17 instances of the 109 Denied Individual PPO Terminal Illness Claim files reviewed, for an error rate of 16%, the Company failed to affirm or deny liability within

a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In 10 instances of the 109 Denied Individual PPO Terminal Illness Claim files reviewed, for an error rate of 9%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for denial was 28 days.

46. Denied Individual Indemnity Terminal Illness

The Company reported no Denied Individual Indemnity Terminal Illness Claims.

47. Denied Medicare Supplement Health

A review of 109 Denied Medicare Supplement Health Claim files produced no criticisms.

The median for denial was three (3) days.

48. Denied Medicare Supplement Behavioral Health

A review of 109 Denied Medicare Supplement Behavioral Health Claim files produced no criticisms.

The median for denial was 12 days.

49. Denied Medicare Supplement Mental Health

a. In nine (9) instances of the 109 Denied Medicare Supplement Mental Health Claim files reviewed, for an error rate of 8%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In five (5) instances of the 109 Denied Medicare Supplement Mental Health Claim files reviewed, for an error rate of 5%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

The median for denial was 12 days.

50. Denied Medicare Supplement Durable Medical Equipment

A review of 109 Denied Medicare Supplement Durable Medical Equipment Claim files produced no criticisms.

The median for denial was seven (7) days.

51. Denied Medicare Supplement Terminal Illness

A review of 109 Denied Medicare Supplement Terminal Illness Claim files produced no criticisms.

The median for denial was nine (9) days.

52. Denied Group Dental

a. In seven (7) instances of the 109 Denied Group Dental Claim files reviewed, for an error rate of 6%, the Company failed to affirm or deny liability within a reasonable time after receipt of the proof of loss. This is in violation of 50 Ill. Admin Code 919.50(a).

b. In five (5) instances of the 109 Denied Group Dental Claim files reviewed, for an error rate of 5%, the Company failed to send a 45-day letter providing a reasonable written explanation for the delay in handling the claim. This is in violation of 50 Ill. Admin. Code 919.70(a)(2).

c. In one (1) instance of the 109 Denied Group Dental Claim files reviewed, for an error rate of less than 1%, the Company failed to pay 9% interest, in the amount of $141.28, on a claim not paid within 30 days after receipt of the proof of loss. This claim was improperly denied and payment plus interest should have been made. When the examiners requested information regarding this claim, the Company discovered the error and issued a payment, however, they failed to include the interest payment. This is in violation of 215 ILCS 5/368a(c).

The median for denial was six (6) days.

53. Paid Group PPO Indemnity

A review of 109 Paid Group PPO Indemnity Claim files produced no criticisms.

The median for payment was 10 days.

54. Denied Group PPO Indemnity

A review of 109 Denied Group PPO Indemnity Claim files produced no criticisms.

The median for denial was 10 days.

55. Paid Individual Prescription

A review of 109 Paid Individual Prescription Claim files produced no criticisms.

The median for payment was 14 days.

56. Pended Claims

In one (1) instance of the 73 Pended Claim files reviewed, for an error rate of 1%, the Company failed to pay 9% interest, in the amount of $12.65, on a claim not paid within 30 days after receipt of the proof of loss. This is in violation of 215 ILCS 5/368a(c).

The median for payment was 19 days.

D. COMPLAINTS AND CONSUMER APPEALS

1. Department of Insurance and Consumer Complaints

The examiners reviewed 116 Department of Insurance Complaint files and 120 Consumer Complaint files. 68 of the 120 Consumer Complaint files provided to the examiners were not complaints.

a. The Company failed to maintain a complaint register for both DOI and Consumer Complaints containing the minimum required information, as defined in Exhibit B of 50 Ill. Admin. Code 926.50. Three required elements were missing from the register itself, though the information was readily accessible by the Company.

b. The Company failed to respond to 23 DOI complaint files within 21 days, as required by 50 Ill. Admin. Code 926.40(a).

c. The Company failed to respond to eight (8) consumer complaint files within 21 days, as required by 50 Ill. Admin. Code 926.40(a).

The median response time for complaints was 9 days.

2. Appeals

The examiners reviewed 120 Appeal files. No violations were noted.

3. External Independent Reviews

The examiners reviewed 82 External Independent Review files.

a. In 12 instances, the Company failed to provide a written notice of decision to the Department of Insurance, as required by 215 ILCS 180/35(j).

b. In 10 instances, the Company failed to provide a timely eligibility review response within 5 days, as required by 215 ILCS 180/35(b).

## IX. CYBERSECURITY RISK ASSESSMENT

In conjunction with this examination, the Department hired independent third party examiners to conduct a Cybersecurity Assessment of the Company to assist the Department and the Company in preventative assessment of cyber risks. In mid-2016, an assessment report containing four (4) non-critical recommendations was presented to the Company. Further, HCSC's cybersecurity program was generally assessed to be "Implemented and Managed," meaning the Company has identified cyber risk as a high priority and is actively managing the risk. The Department recognizes that no cybersecurity program is impenetrable but expects that companies will actively and reasonably seek to mitigate those risks and react swiftly and appropriately should an incident occur. All recommendations were addressed to the Department's satisfaction and no violations were found. A detailed assessment will be provided to necessary insurance regulators and other government officials who can maintain its confidentiality, but the assessment will not be made public in the interests of protecting the security of HCSC's and its members' data pursuant to the Director's authority under 215 ILCS 5/132.5 and 215 ILCS 5/404(1)(a).

STATE OF ILLINOIS )
) ss
COUNTY OF SANGAMON )

Max R. Weaver, being first duly sworn upon his/her 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 Health Care Services Corporation, A Mutual Legal Reserve Company NAIC#70670;

That the Examiner-In-Charge 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 Company 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 Company's business and affairs and the manner in which the Company conducts its business;

That neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is an officer of, connected with, or financially interested in the Company nor any of the Company's affiliates other than as a policyholder or claimant under a policy or as an owner of shares in a regulated diversified investment company, and that neither the Examiner-In-Charge nor any other persons so designated 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 Company pursuant to the authority vested in the Examiner-In-Charge by the Director of Insurance of the State of Illinois;

That she/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 Company 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 Company.

Examiner-In-Charge

Subscribed and sworn to before me

this 15 day of October, 2014.

Notary Public

OFFICIAL SEAL
PHILIP S. SANSON
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 3-12-2017

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

**HEALTH CARE SERVICE CORPORATION**
**A MUTUAL LEGAL RESERVE COMPANY**
**300 E. RANDOLPH STREET**
**CHICAGO IL 60601-5099**

STIPULATION AND CONSENT ORDER

WHEREAS, the Director of the Illinois Department of Insurance ("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, Health Care Service Corporation, A Mutual Legal Reserve Company ("the Company"), NAIC 70670, 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 of the Company was conducted by a duly qualified examiner of the Department pursuant to Sections 132, 401, 402, 403, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402, 5/403, and 5/425); and

WHEREAS, as a result of the Market Conduct Examination, the Department examiner filed a Market Conduct Examination Report which is an official document of the Department; and

WHEREAS, the Market Conduct Examination Report cited various areas in which the Company was not in compliance with the Illinois Insurance Code (215 ILCS 5/1 *et seq.*), the Health Carrier External Review Act (215 ILCS 180/1 *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. The Market Conduct Examination indicated various areas in which the Company was not in compliance with provisions of the Illinois Insurance Code and Department Regulations; and

2. 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 Department Regulations.

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

1. Institute and maintain policies and procedures whereby the Company shall affirm or deny liability on claims within a reasonable time as required by 50 Ill. Adm. Code 919.50(a).

2. Institute and maintain policies and procedures whereby the Company shall provide a "Notice of Availability of the Department of Insurance" on denied claims as required by 50 Ill. Adm. Code 919.50(a)(1).

3. Institute and maintain policies and procedures whereby the Company shall provide the insured or beneficiary, when applicable, a reasonable written explanation for delay when a claim remains unresolved for forty-five (45) days from the date it is reported as required by 50 Ill. Adm. Code 919.70(a)(2).

4. Institute and maintain policies and procedures whereby the Company shall respond to the Department of Insurance by the date specified when notified of a complaint received by the Department as required by 50 Ill. Adm. Code 926.40(a).

5. Institute and maintain policies and procedures whereby the Company shall maintain a complaint record with the required minimum information for complaints received from the Department, as well as those received directly from the consumer, as required by 50 Ill. Adm. Code 926.50.

6. Institute and maintain policies and procedures whereby the Company shall ensure, within 5 days after the date of receipt of all necessary information, but in no event more than 45 days after the date of receipt of the request for an external review, that the assigned independent review organization provide written notice of its decision to uphold or reverse the adverse determination to all parties involved including the Department as required by and outlined in 215 ILCS 180/35(j).

7. Institute and maintain policies and procedures whereby the Company shall, within 5 days following the date of receipt of an external review request, complete a preliminary review of the request as required by and outlined in 215 ILCS 180/35(b).

8. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above seven (7) orders within 30 days of execution of this Order.

9. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $320,000 to be paid within 30 days of 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 **Health Care Service Corporation, A Mutual Legal Reserve Company**

Maurice D. Smith

Signature

Maurice Smith

Name

President, Blue Cross and Blue Shield of Illinois

Title

Subscribed and sworn to before me this 5th day of JANUARY 2018.

LINDA WATSON-VASSAR
Official Seal
Notary Public - State of Illinois
My Commission Expires Nov 21, 2020

L. Vassar

Notary Public

DEPARTMENT OF INSURANCE of the State of Illinois:

DATE 1/5/2018

Jennifer Hammer/pgp

Jennifer Hammer
Director