Illinois Department of Insurance

BRUCE RAUNER
Governor

JENNIFER HAMMER
Director

VIA ELECTRONIC MAIL

July 30, 2018

Mr. John Snyder
President
Health Alliance Midwest, Inc.
3310 Fields South Drive
Champaign, IL 61822

Re: Health Alliance Midwest, Inc., NAIC 95513
Health Alliance Medical Plans, NAIC 77950
Market Conduct Examination Report Closing Letter

Dear Mr. Snyder:

The Department has reviewed your Company's proof of compliance for Health Alliance Medical Plans 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 Reports 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,

Erica Weyhenmeyer

Erica Weyhenmeyer
Temporary Assistant Deputy Director - Market Conduct
Illinois Department of Insurance
320 West Washington St., 5th Floor
Springfield, IL 62767
Phone: 217-782-1790
E-mail: Erica.Weyhenmeyer@Illinois.gov

ILLINOIS DEPARTMENT OF INSURANCE
MARKET CONDUCT EXAMINATION OF

HEALTH ALLIANCE MEDICAL PLANS, INC.

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	June 5, 2017 through December 30, 2017
EXAMINATION OF:	Health Alliance Medical Plans, Inc. NAIC Number: 77950
LOCATION:	301 South Vine Street Urbana, Illinois 61801
PERIOD COVERED:	July 1, 2015 through June 30, 2016 – Claims January 1, 2015 through June 30, 2016 – Complaints
EXAMINERS:	David Bradbury MCM, Examiner-in-Charge Patricia Hahn MCM

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I. FOREWORD

This is a comprehensive market conduct examination report of Health Alliance Medical Plans, Inc. ("Health Alliance" or the "Company"), NAIC Code 77950. This examination was conducted at the Company's office, located at 301 South Vine Street, Urbana, Illinois, 61801.

This examination report is generally a report by exception. However, failure to criticize specific practices, procedures or files does not constitute approval thereof by the Illinois Department of Insurance ("Department" or "DOI").

During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

II. SCOPE OF THE EXAMINATION

The Department has the authority to conduct this examination pursuant to, but not limited to, 215 ILCS 5/132.

The purpose of the examination was to determine if the Company complied with the Illinois Insurance Code (IIC), the Illinois Administrative Code (IAC), and to consider whether the Company's operations are consistent with the public interest. The primary period covered by this review is July 1, 2015 through June 30, 2016, for claims and January 1, 2015 through June 30, 2016, for complaints and appeals unless otherwise noted. Errors outside of this period discovered during the course of this examination may also be included in the report.

The examination was a comprehensive examination involving the following business functions and lines of business: claims handling practices, policy forms and advertising in use, producer licensing and the handling of consumer complaints, appeals and Department complaints for all lines of business.

In performing this examination, the examiners reviewed a sample of the Company's practices, procedures, products, forms, advertising, extra-contractual claim adjudication guidelines and files. Therefore, some noncompliant events may not have been discovered. As such, this report may not fully reflect all the practices and procedures of the Company. As indicated previously, failure to identify or criticize improper or noncompliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

III. SUMMARY

The following represent general findings, however specific details are found in each section of the report.

TABLE OF TOTAL VIOLATIONS

Criticism	Crit #	Statute/Rule	Description of Violation	Population	Sample	# of Violations	Error %
Denied Group Health	04	50 Ill. Adm. Code 919.50(a)(1)	Failed to provide the beneficiary with the Notice of Availability of the DOI on a denial letter.	58468	104	17	16%
Denied Group Health	05	50 Ill. Adm. Code 919.50(a)	Failed to affirm or deny claims within a reasonable time after receipt of due proof of loss.	58468	104	3	3%
Closed Without Payment Group Health	40	215 ILCS 5/368a(c)	Failed to provide notice of insufficient documentation for due proof of loss within 30 days of claim receipt.	213094	109	1	1%
Closed Without Payment Group Health	41	215 ILCS 5/154.6(n)	Failed to provide a reasonable and accurate explanation for claim denials.	213094	109	9	8%
Closed Without Payment Group Health	42 & 62	50 Ill. Adm. Code 919.50(a)(1)	Failed to provide the beneficiary with the Notice of Availability of the DOI on a denial letter.	213094	109	2	2%
Closed Without Payment Group Health	48	215 ILCS 5/368a(c)	Failed to pay interest when a claim is paid beyond 30 days in the amount of $73.19.	213094	109	1	1%
Paid Individual Health	56	50 Ill. Adm. Code 919.50(a)	Failed to affirm or deny claims within a reasonable time after receipt of due proof of loss.	161252	109	1	1%
Denied Individual Health	47	50 Ill. Adm. Code 919.50(a)(1)	Failed to provide the beneficiary with the Notice of Availability of the DOI on a denial letter.	12695	158	10	6%
Closed Without Payment Individual Health	53	215 ILCS 5/368a(c)	Failed to pay interest when a claim is paid beyond 30 days in the amount of $11.47.	48771	109	1	1%
Paid Individual Medicare Supplement	70	215 ILCS 5/368a(c)	Failed to pay claims within 30 days after receipt of due written proof of loss.	12102	109	49	45%
Denied Individual Medicare Supplement	80	215 ILCS 5/368a(c)	Failed to provide notice of insufficient documentation for due proof of loss within 30 days of claim receipt.	4748	107	61	57%
Denied Individual Medicare Supplement	81	50 Ill. Adm. Code 919.50(a)(1)	Failed to provide the beneficiary with the Notice of Availability of the DOI on a denial letter.	4748	107	32	30%

TABLE OF TOTAL VIOLATIONS							
Criticism	**Crit #**	**Statute/Rule**	**Description of Violation**	**Population**	**Sample**	**# of Violations**	**Error %**
Closed Without Payment Individual Medicare Supplement	44	50 Ill. Adm. Code 919.50(a)(1)	Failed to provide the beneficiary with the Notice of Availability of the DOI on a denial letter.	7849	109	6	6%
Paid Group Medicare Supplement	68	215 ILCS 5/368a(c)	Failed to provide notice of insufficient documentation for due proof of loss within 30 days of claim receipt.	1983	107	57	53%
Paid Group Medicare Supplement	69	50 Ill. Adm. Code 919.50(a)(1)	Failed to provide the insured with the Notice of Availability of the DOI on a partial denial letter.	1983	107	4	4%
Denied Group Medicare Supplement	89	50 Ill. Adm. Code 919.70(a)(2)	Failure to provide 45 day delay letter to insured.	1076	107	2	2%
Denied Group Medicare Supplement	90	50 Ill. Adm. Code 919.50(a)(1)	Failed to provide the beneficiary with the Notice of Availability of the DOI on a denial letter.	1076	107	39	36%
Closed Without Payment Group Medicare Supplement	65	215 ILCS 5/368a(c)	Failed to process claims timely.	1590	107	63	59%
Closed Without Payment Group Medicare Supplement	66	50 Ill. Adm. Code 919.50(a)(1)	Failed to provide the beneficiary with the Notice of Availability of the DOI on a denial letter.	1590	107	9	8%
Denied Short Term Health	83	215 ILCS 5/368a(c)	Failed to provide notice of insufficient documentation for due proof of loss within 30 days of claim receipt.	412	83	1	1%
Denied Short Term Health	84	50 Ill. Adm. Code 919.50(a)(1)	Failed to provide the beneficiary with the Notice of Availability of the DOI on a denial letter.	412	83	3	4%
Health Carrier External Reviews	95	215 ILCS 180/35(j)(4)	Failed to make payment on claim overturned on External Review totaling $4,796.24	91	91	1	1%
Health Carrier External Reviews	96,98,99, 101,104 & 106	215 ILCS 5/368a(c)	Failed to pay interest when a claim is paid beyond 30 days in the amount of $2,305.64.	91	91	6	7%
IDOI Complaints	120	50 Ill. Adm. Code 926.40(a)	Failed to respond to Department of Insurance complaints within the required time.	172	172	3	2%

IV. BACKGROUND

Health Alliance Medical Plans, Inc. is owned by Carle Holding Company, Inc., a for-profit subsidiary of the not-for-profit Carle Foundation in Urbana, Illinois. Health Alliance is a for-profit, domestic stock company licensed in Illinois and Iowa. The corporate headquarters is located at 301 S. Vine St., Urbana, Illinois. Health Alliance has been in business for more than 30 years, providing administrative and health insurance services to more than 2,000 fully insured and self-funded employer groups. These groups, along with individual and Medicare plans, cover more than 320,000 people.

Health Alliance Medical Plans, Inc. is the corporate successor to Carle Care, Inc., a not-for-profit health maintenance organization founded by Carle Clinic Association P.C. in Urbana, Illinois. Carle Care HMO enrolled its first member in March 1980, and became a federally qualified HMO five years later.

Ownership of Health Alliance changed in April 2010, when Carle Clinic Association, previous owner of Health Alliance, was acquired by The Carle Foundation. At that time, Health Alliance was also acquired and became a subsidiary of The Carle Foundation.

The primary location of the Company's books and records is 301 South Vine Street, Urbana, Illinois 61801.

V. METHODOLOGY

The market conduct examination covered the business for the period of July 1, 2015 through June 30, 2016 for claims, and January 1, 2015 through June 30, 2016 for the complaint/appeal file review. Specifically, the examination focused on a review of the following areas:

1. Producer Licensing
2. Claims
3. Department Complaints and Consumer Appeals

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

The report concerns itself with practices by the Company which resulted in 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 valid violations were cited in the report. The following methods were used to obtain the required samples and to assure a methodical selection:

Producer Licensing

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 Managed Care Reform and Patient Rights Act (215 ILCS 134/1 *et seq*.) and the Illinois Administrative Code (50 Ill. Adm. Code 101 *et seq.*).

The Department defines due proof of loss as medical records, investigation materials, written proofs, claim forms, authorizations, or other reasonable evidence of claim that is ordinarily required of insureds or beneficiaries. The Department's position is that the 30 days to pay (31 day delay for interest) starts when the last proof required from the claimant (beneficiary), medical record or investigation documentation is received by the Company. The paid and denied health and paid and denied Medicare supplement surveys resulted in criticisms.

Median payment periods were measured from the date all necessary proofs of loss were received to the date of payment or denial to the claimant. The period under review was July 1, 2015 through June 30, 2016.

Department Complaints, Consumer Appeals and External Independent Reviews

The Department requested the Company to provide all files relating to complaints received via the Department and those received directly from consumers. The Department also requested the Company provide files of all external independent reviews handled during the survey period.

Median periods were measured from the date of notification by the complainants to the date of response by the Company. The period under review was January 1, 2015 through June 30, 2016.

VI. SAMPLE SELECTION

Survey	Population	Reviewed	% Reviewed
CLAIMS ANALYSIS			
Paid Group Health	839049	109	.01%
Denied Group Health	58468	104	.01%
Closed Without Payment Group Health	213094	109	.05%
Paid Individual Health	161252	109	.06%
Denied Individual Health	12695	158	1%
Closed Without Payment Individual Health	48771	109	.02%
Paid Individual Medicare Supplement	12102	109	1%
Denied Individual Medicare Supplement	4748	107	2%
Closed Without Payment Individual Medicare Supplement	7849	109	1%
Paid Group Medicare Supplement	1983	107	5%
Denied Group Medicare Supplement	1076	107	10%
Closed Without Payment Group Medicare Supplement	1590	107	7%
Paid Short Term Health	321	83	26%
Denied Short Term Health	412	83	20%
Closed Without Payment Short Term Health	171	76	44%
PRODUCER LICENSING			
Agents	451	451	100%
Applications	6277	6277	100%
COMPLAINTS			
Consumer Complaints / Appeals	38	38	100%
Department Complaints	172	172	100%
Health Carrier External Reviews	91	91	100%
POLICY FORMS AND ADVERTISING			
Policy Forms	40	40	100%

VII. FINDINGS

A. Claims

1. Paid Group Health

109 files were reviewed. No exceptions were noted.

The median for payment was 16 days.

2. Denied Group Health

- In 17 instances out of the 104 files reviewed for an error percentage of 16%, the Company failed to provide "Notice of Availability of the Department of Insurance" on denied claims. This is a violation of 50 Ill. Adm. Code 919.50(a)(1).

- In three (3) instances out of the 104 files reviewed for an error percentage of 3%, the Company failed to affirm or deny the claim within a reasonable time. This is a violation of 50 Ill. Adm. Code 919.50(a).

The median for denial was 17 days.

3. Closed Without Payment Group Health

- In one (1) instance out of 109 files reviewed for an error percentage of 1%, the Company failed to provide notice of insufficient documentation for due proof of loss within 30 days of claim receipt. This is a violation of 215 ILCS 5/368a(c).

- In nine (9) instances out of 109 files reviewed for an error percentage of 8% the Company was criticized for failure to provide a reasonable and accurate explanation for claim denials. This is a violation of 215 ILCS 5/154.6(n).

- In two (2) instances out of 109 files reviewed for an error percentage of 2%, the Company failed to provide "Notice of Availability of the Department of Insurance" on denied claims. This is a violation of 50 Ill. Adm. Code 919.50(a)(1).

- In one (1) instance out of 109 files reviewed for an error percentage of 1%, the Company failed to pay interest when a claim remained unpaid beyond 30 days. Failure to pay the required interest is a violation of 215 ILCS 5/368a(c). The interest was paid during the examination.

Criticism	Crit #	Statute Rule	Description of Violation	Interest Paid
PH CWP GH	48	215 ILCS 5/368a(c)	Interest due to late payment	$73.19

The median for adjudication was 18 days.

4. Paid Individual Health

- In one (1) instance out of 109 files reviewed for an error percentage of 1%, the Company failed to affirm or deny the claim within a reasonable time. This is a violation of 50 Ill. Adm. Code 919.50(a).

The median for payment was 16 days.

5. Denied Individual Health

- In 10 instances out of 158 files reviewed for an error percentage of 6%, the Company failed to provide "Notice of Availability of the Department of Insurance" on denied claims. This is a violation of 50 Ill. Adm. Code 919.50(a)(1).

The median for denial was 22 days.

6. Closed Without Payment Individual Health

- In one (1) instance out of 109 files reviewed for an error percentage of 1%, the Company failed to pay interest when a claim remained unpaid beyond 30 days. Failure to pay the required interest is a violation of 215 ILCS 5/368a(c). The interest was paid during the examination.

Criticism	Crit #	Statute Rule	Description of Violation	Interest Paid
PH CWP GH	53	215 ILCS 5/368a(c)	Interest due to late payment	$11.47

The median for adjudication was 22 days.

7. Paid Individual Medicare Supplement

- In 49 instances out of 109 files reviewed for an error percentage of 45%, the Company failed to pay claims within 30 days after receipt of due written proof of loss. This is a violation of 215 ILCS 5/368a(c).

  The median for payment was 31 days.

8. Denied Individual Medicare Supplement

- In 61 instances out of 107 files reviewed for an error percentage of 57%, the Company failed to provide notice of insufficient documentation for due proof of loss within 30 days of claim receipt. This is a violation of 215 ILCS 5/368a(c).

- In 32 instances out of 107 files reviewed for an error percentage of 30%, the Company failed to provide the insured's beneficiary with the "Notice of Availability of the Department of Insurance" on denied claims. This is a violation of 50 Ill. Adm. Code 919.50(a)(1).

  The median for denial was 33 days.

9. Closed Without Payment Individual Medicare Supplement

- In six (6) instances out of 109 files reviewed for an error percentage of 6%, the Company failed to provide the insured's beneficiary with the "Notice of Availability of the Department of Insurance" on denied claims. This is a violation of 50 Ill. Adm. Code 919.50(a)(1).

  The median for adjudication was 30 days.

10. Paid Group Medicare Supplement

- In 57 instances out of 107 files reviewed for an error percentage of 53%, the Company failed to provide notice of insufficient documentation for due proof of loss within 30 days of claim receipt. This is a violation of 215 ILCS 5/368a(c).

- In four (4) instances out of 107 files reviewed for an error percentage of 4%, the Company failed to provide the insured with the "Notice of Availability of the Department of Insurance" on partially denied claims. This is a violation of 50 Ill. Adm. Code 919.50(a)(1).

  The median for payment was 34 days.

11. Denied Group Medicare Supplement

- In 2 instances out of 107 files reviewed for an error percentage of 2%, the Company failed to a 45 day delay letter to the insured. This is a violation of 50 Ill. Adm. Code 919.70(a)(2).

- In 39 instances out of 107 files reviewed for an error percentage of 36%, the Company failed to provide the insured's beneficiary with the "Notice of Availability of the Department of Insurance" on denied claims. This is a violation of 50 Ill. Adm. Code 919.50(a)(1).

  The median for denial was 35 days.

12. Closed Without Payment Group Medicare Supplement

- In 63 instances out of 107 files reviewed for an error percentage of 59%, the Company failed to process claims timely. This is a violation of 215 ILCS 5/368a(c).

- In nine (9) instances out of 107 files reviewed for an error percentage of 8%, the Company failed to provide the insured's beneficiary with the "Notice of Availability of the Department of Insurance" on denied claims. This is a violation of 50 Ill. Adm. Code 919.50(a)(1).

  The median for adjudication was 34 days.

13. Paid Short Term Health

  83 files were reviewed. No exceptions were noted.

  The median for payment was 17 days.

14. Denied Short Term Health

- In 1 instance out of 83 files reviewed for an error percentage of 1%, the Company failed to provide notice of insufficient documentation for due proof of loss within 30 days of claim receipt. This is a violation of 215 ILCS 5/368a(c).

- In three (3) instances out of 83 files reviewed for an error percentage of 4%, the Company failed to provide the insured's beneficiary with the "Notice of Availability of the Department of Insurance" on denied claims. This is a violation of 50 Ill. Adm. Code 919.50(a)(1).

  The median for denial was 24 days.

15. Closed Without Payment Short Term Health

  76 files were reviewed. No exceptions were noted.

  The median for adjudication was 14 days.

B. Complaints

1. Department Complaints

- In three (3) instances out of 172 files reviewed for an error percentage of 2% the Company failed to respond to the Department of Insurance complaints within the required time in violation of 50 Ill. Adm. Code 926.40(a). No request for an extension to the required 21 calendar days was contained in any file criticized.

2. Consumer Complaints / Appeals

A review of 38 Consumer Complaints / Appeals produced no criticisms.

3. External Independent Reviews

- In one (1) instance out of 91 files reviewed for an error percentage of 1%, the Company failed to pay the claim upon receipt of a notice of the decision reversing the adverse determination in violation of 215 ILCS 180/35(j)(4). The claim and all due interest for late payment were paid during the examination

Criticism	Crit #	Statute Rule	Description of Violation	Amount Underpaid
DB EXT RVW	95	215 ILCS 180/35(j)(4)	Overturned by External Review- Company did not make payment.	$4,796.24 plus $722.59 interest.

- In six (6) instances out of 91 files reviewed for an error percentage of 7%, the Company failed to pay interest when a claim remained unpaid beyond 30 days. Failure to pay the required interest is a violation of 215 ILCS 5/368a(c). The Company agreed and made payment when criticized.

Criticism	Crit #	Statute Rule	Description of Violation	Interest Paid
DB Ext Rvw	96	215 ILCS 5/368a(c)	Interest due to late payment	$48.00
DB Ext Rvw	98	215 ILCS 5/368a(c)	Interest due to late payment	$5.08
DB Ext Rvw	99	215 ILCS 5/368a(c)	Interest due to late payment	$1,911.13
DB Ext Rvw	101	215 ILCS 5/368a(c)	Interest due to late payment	$42.33
DB Ext Rvw	104	215 ILCS 5/368a(c)	Interest due to late payment	$287.76
DB Ext Rvw	106	215 ILCS 5/368a(c)	Interest due to late payment	$11.34
			Total Underpayments	$2,305.64

C. Producer Licensing

A review of 17,757 first year commissions paid to 784 producers was performed. No payment of commissions to unlicensed individuals was noted.

D. Policy Forms and Advertising

1. Policy Forms

Review of policy forms and addendums filed and in use for the period under review produced no criticisms.

2. Advertising

A review of nine (9) advertising pieces in use during the period under review produced no criticisms.

STATE OF ILLINOIS)
) ss
COUNTY OF COOK)

David Bradbury, 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 Alliance Medical Plans (collectively the "Company").

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 8th day of February, 2018

Notary Public

MARGARETA STEFIUC
Official Seal
Notary Public – State of Illinois
My Commission Expires Sep 15, 2021

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

HEALTH ALLIANCE MEDICAL PLANS, INC.
301 SOUTH VINE
URBANA, IL 61801-3347

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 Alliance Medical Plans, Inc. ("the Company"), NAIC 77950, 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.*) 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 their 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, they waive 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 provide a "Notice of Availability of the Department of Insurance" on denied claims as required by 50 Ill. Adm. Code 919.50(a)(1).

2. Institute and maintain policies and procedures whereby the Company shall ensure all parties are notified of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim, or shall otherwise ensure claims are paid within 30 days as required by 215 ILCS 5/368a(c).

3. Institute and maintain policies and procedures whereby the Company shall provide a reasonable and accurate explanation of the basis in the insurance policy or applicable law for denial of a claim as required by 215 ILCS 5/154.6(n).

4. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above three (3) orders within 30 days of execution of this Order.

5. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $36,800.00 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 ALLIANCE MEDICAL PLANS, INC.

Signature

John Snyder
Name

President + CEO
Title

Subscribed and sworn to before me this
1st day of June 2018.

Notary Public

OFFICIAL SEAL
AMANDA BRYAN
Notary Public - State of Illinois
My Commission Expires 9/08/2021

DEPARTMENT OF INSURANCE of the
State of Illinois:

DATE 6/18/18

Jennifer Hammer
Director