Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

October 22, 2013

Via Certified Mail
*Return receipt requested

Mr. Michael Benedict McAllister
President
Humana Insurance Company
1100 Employers Boulevard
DePere, Wisconsin 54115

RE: Market Conduct Examination of Humana Insurance Company

Dear Mr. McAllister,

A Market Conduct Examination of your company was conducted by authorized examiners designated by the Director of Insurance pursuant to Illinois Insurance Code Sections 132, 401, 402, 403 and 425. The period covered by the examination was January 1, 2011 through December 31, 2011. The examination also covered complaints from July 1, 2009 through January 1, 2011. Please find enclosed a report of the Market Conduct Examination of Humana Insurance Company, January 1, 2011 through December 31, 2011 being the period examined, and a Stipulation and Consent Order.

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, Friday, November 22, 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 15 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.

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 312-814-5411.

Sincerely,

Mary Jane Adkins
Assistant General Counsel
Illinois Department of Insurance
MaryJane.Adkins@illinois.gov

This Market Conduct Examination was conducted pursuant to Sections 5/132, 5/401, 5/401.5, 5/402, 5/403 and 5/425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/401.5, 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.

Mary Jane Adkins
Assistant General Counsel
Illinois Department of Insurance

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF THE EXAMINATION OF:

HUMANA INSURANCE COMPANY
1100 EMPLOYERS BOULEVARD
DE PERE, WI 54115

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 Insurance Company, NAIC # 73288, and to make a full and true report to me of the examination made by them of Humana Insurance company, with a full statement of the condition and operation of the business and affairs of Humana Insurance Company, 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 Insurance Company.

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

Done at the City of Springfield, this 6th day of April, 2017

Andrew Boron

Andrew Boron ***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 11:52 AM on April 19, 2012, A.D., 2012.

Mike Hagen
Examiner

HUMANA INSURANCE COMPANY

REPORT

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	January 16, 2013 through June 28, 2013
EXAMINATION OF:	Humana Insurance Company NAIC Number: 20-73288
LOCATION:	1100 Employers Boulevard DePere, Wisconsin 54115
PERIOD COVERED BY EXAMINATION:	January 1, 2011 through December 31, 2011 – Claims July 1, 2009 through the Start of The Examination – Appeals, External Independent Reviews and Complaints
EXAMINERS:	Patricia S. Hahn C Michael Hager - Examiner in Charge

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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, resulting in underpayments.

2. The company was criticized under 215 ILCS 5/154.6(i) for improper claims practices, for failure to affirm or deny claims within the required 30 days as required in 50 Ill. Adm. Code 919.50(a).

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 attempt to notify or orally notify the party filing the appeal of a decision on 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 preferred provider and one was unavailable.

10. The Company was criticized under 50 Ill. Adm. Code 919.70(a)(2) for improper claims practice for failure to provide the insured or beneficiary, when applicable, a reasonable written explanation of delay when the claim remains open for 45 days.

11. The Company was criticized under 215 ILCS 5/356(g) for an underpayment of a mammogram screening.

12. The Company was criticized under 215 ILCS 5/370(o) for an underpayment of emergency room claim.

13. The Company was criticized under 215 ILCS 5/356q for failing to include temporomandibular joint disorder and craniomandibular disorder as optional coverage or to provide a written accept or reject of this coverage by the policy holder.

II. BACKGROUND

Humana Insurance Company (HIC), a Wisconsin corporation, was incorporated on December 18, 1968. HIC was licensed as a life and health insurance company on December 30, 1968 in the State of Wisconsin and licensed to do business in Illinois on February 8, 1984. HIC is licensed as a life and health insurance company in all states and the District of Columbia except New York and New Hampshire. HIC is owned 100% by CareNetwork, Inc., a Wisconsin general business corporation and wholly owned subsidiary of Humana Inc. (HUMANA), a Delaware corporation and an insurance and health maintenance organization holding company and the ultimate controlling entity. HIC became an affiliate in the insurance holding company system on October 13, 1995, when EMPHESYS Financial Group, Inc., a Delaware corporation merged into HEW, Inc., a wholly owned subsidiary of HUMANA. EMPHESYS Financial Group, Inc., (EFG) was the survivor of the merger.

Effective December 31, 2001, as approved by the Wisconsin Office of the Commissioner of Insurance (OCI), Humana Insurance Company, a Missouri company, merged into Employers Health Insurance Company, and Employers Health Insurance Company subsequently changed its name to Humana Insurance Company. Until June 30, 2002, HIC was owned 88.7% by EFG, as listed above, and owned 11.3% by Wisconsin Employers Group, Inc., a Wisconsin corporation. Wisconsin Employers Group, Inc. was a wholly owned subsidiary of EFG. EFG was a wholly owned subsidiary of Humana Inc.

On May 1, 2002, a Form A was submitted to the OCI that requested permission for several mergers, including the merger of Wisconsin Employers Group, Inc., into EFG and the subsequent merger of EFG into CareNetwork, Inc. The mergers were approved by OCI for an effective date of June 30, 2002. As a result of the above referenced mergers, which included the stockholders of HIC, HIC became a wholly owned subsidiary of CareNetwork, Inc.

III. METHODOLOGY

The Market Conduct Examination covered the business for the period of January 1, 2011 through December 31, 2011 and for claims and July 1, 2009 through the start date of the examination for appeals, complaints and external independent reviews. Specifically, the examination focused on a review of the following areas.

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

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 improper practices performed with such frequency as to indicate general practices. Individual criticisms were identified and communicated to the company, but not cited in the report if not indicative of a general trend, except to the extent that underpayments and/or overpayments in claim surveys or undercharges and/or overcharges in underwriting surveys were cited in the report.

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 (Section 5/1 et seq.), the Managed Care Reform and Patient Rights Act (Section 134 et seq.) and the Illinois Administrative Code.

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.

Department Complaints and Consumer Appeals

The Company was requested to provide all files relating to complaints received via the Department of Insurance and those received directly from members. The Company was also requested to provide files of all member complaints and 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, 2009 through the start date of the examination.

SELECTION OF SAMPLE

SURVEY	POPULATION	# REVIEWED	% REVIEWED
PRODUCER ANALYSIS			
Producer/Applications	3,106/21630	3,106/ 21630	100
Terminated Agent Review	897	897	100
CLAIMS ANALYSIS			
Paid Individual Life	1	1	100
Paid Group Life	58	58	100
Denied Group Life	4	4	100
Paid Individual Hospital Indemnity	319	85	27
Denied Individual Hospital Indemnity	46	46	100
Paid Group PPO	454,035	120	0 .03
Denied Group PPO	215,459	120	0.06
Paid Humana One Individual PPO	154,195	120	0.08
Denied Humana One Individual PPO	46,768	120	0.26
Paid Individual Medicare Supplements	897	100	11.15
Denied Individual Medicare Supplements	669	100	14.95
Paid Short Term Disability	21	21	100
Denied Pre-Certification Claims	428	95	22.21
POLICY FORMS AND ADVERTISING REVIEW			
Policy Forms and Advertising Review	40	40	100
DEPT COMPLAINTS, CONSUMER COMPLAINTS AND EXTERNAL INDEPENDENT REVIEWS			
Department Complaints	561	100	17.83
Consumer Complaints (Appeals)	4,875	420	8.62

IV. FINDINGS

A. Producer Analysis

1. Agent Production

A review of 3,106 producers produced no criticisms.

2. Terminated Agent Review

A review of 897 terminated producers produced no criticisms. None were terminated for cause.

B. Claims Analysis

1. Paid Individual Life

A review of the paid individual life claim files produced no criticisms.

The median for payment could not be established because there was only one file.

2. Paid Group Life

A review of 58 paid group life claim files produced no criticisms.

The median for payment was 15 days.

3. Denied Group Life

A review of the 4 denied group life claim files produced no criticisms.

The median for denial could not be established.

4. Paid Individual Hospital Indemnity

A review of 85 paid individual hospital indemnity claim files produced no criticisms.

The median for payment was 10 days.

5. Denied Individual Indemnity

A review of 46 denied individual hospital indemnity files produced no criticisms.

The median for denial was nine (9) days.

6. Paid Group PPO

A review of 120 paid group preferred provider organization claim files produced no criticisms. The median for payment was four (4) days.

7. Denied Group PPO

A review of 120 denied group claim files produced two (2) criticisms. A general criticism was made under 50 Ill. Adm. Code 919.70(a)(2) for failure to provide the insured a reasonable written explanation of delay when the claim remains unresolved for 45 days. Fifteen (15) of 120, or 12.50%, were found to be in violation. A second general criticism was made under 215 ILCS 5/154.6(i) for failure to affirm or deny claims in the required 30 days. Twenty-six (26) of 120, or 22%, were found to be in violation.

The median for denial was five (5) days.

8. Paid Humana One Individual PPO

A review of 120 paid individual preferred provider organization claim files produced no criticisms.

The median for payment was four (4) days.

9. Denied Humana One Individual PPO

A review of 120 denied individual preferred provider organization claim files produced no criticisms.

The median for denial was four (4) days.

10. Paid Individual Medicare Supplements

A review of 100 paid Medicare supplement claim files produced one (1) criticism. An individual criticism was made under 215 ILCS 5/154.6(d) for not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear. This resulted in an underpayment of $38.21. The Company made this payment prior to the completion of the examination.

The median for payment was three (3) days.

11. Denied Individual Medicare Supplements

A review of 100 denied Medicare supplement files produced no criticisms.

The median for denial was four (4) days.

12. Paid Short Term Disability

A review of 21 paid short term disability files produced no criticisms.

The median for payment was 10 days. The mean for payment was 13 days.

13. Denied Pre-Certification Claims

A review of 95 of the pre-certification claim files produced two (2) Criticisms. One (1) general criticism was made under 215 ILCS 5/154.6i for failure to affirm or deny claims in the required 30 days. Seventeen (17) of the 95 or 18% of the files were found to be in violation. One (1) individual criticism was made under 215 ILCS 5/154.6(d) for not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear. This resulted in an underpayment of $727.46. The Company made payment prior to the completion of the examination.

The median for denial was twenty-one (21) days.

C. Policy Form and Advertising Review

A review of 40 policy forms and advertising produced one (1) criticisms A general criticism was made under 215 ILCS 5/356q for failure to include temporomandibular joint disorder and craniomandibular disorder or provide a written accept or reject of this coverage by the plan holder. Twenty (20) of 24, or 83.33%, of the certificates reviewed were found to be in violation.

D. Complaints, Appeals and External Independent Reviews

1. Department of Insurance Complaints

A review of 100 Department of Insurance complaints produced 17 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, 13 of 100 or 13% were found to be in violation. Fifteen (15) Individual criticisms were made under 215 ILCS 5/368a(c) of the Illinois Insurance Code for interest underpayments in the amount of $215.18. One (1) Individual Criticism was made under 215 ILCS 5/154.6(d) resulting in an underpayment in the amount of $176.80.

The median for response was 20 days.

2. Consumer Complaints/Appeals

A review of 420 Appeals files produced 127 criticisms. Three (3) general criticisms were made. The first general criticism was made under 215 ILCS 134/45(c) for failure to give the party filing the appeal an oral notice of the decision within the required three (3) business days. One hundred percent (100%) of the 420 files reviewed were found to be in violation.

The second general criticism was made under 215 ILCS 134/45(c) for failure to notify the party filing the appeal, the decision within the required 15 business days. 268 of 420 or 63.81% of the files reviewed were found to be in violation.

A third general criticism was made under 215 ILCS 134/45(c) for failing to acknowledge the appeal with all information the company needs to process the appeal within the required three (3) business days. 108 of 420 or 26% of the files reviewed were found to be in violation.

Seventy seven (77) 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 $3,696.72. The company made payment on all but nine (9) of these claims and they are listed in the orders to be reopened and paid.

Forty (40) criticisms were made under 50 Ill. Adm. Code 2051.310A(6)(H) for failure to pay claims in accordance with the Illinois Administrative Code when the member has made good faith effort to use participating providers at the same rate as he would have if the participating provider was used. This resulted in underpayments in the total amount of $59,579.75. The company made payment of all but seven (7) of these underpayments. Those underpayment amounts are to be determined and are listed in the orders.

Three (3) individual criticisms were 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 if the participating provider was used. The total amount of the underpayment was $2,613.25. The Company made payment on two (2) of the three (3) claims and the third one is listed in the orders to be reopened and paid.

Two (2) individual criticisms were made under 215 ILCS 5/154.6d for not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear. This

resulted in underpayments totaling $7,850.99. The Company made these payments prior to the completion of the examination.

One (1) individual criticism was made under 215 ILCS 5/370o for underpayment of an emergency room claim. The amount of the underpayment was $1,145.00. The Company made payment prior to the completion of the examination.

One (1) individual criticism was made under 215 ILCS 5/356g for failing to pay for a mammogram screening. The underpayment amount was $246.19. The Company made payment before the completion of the examination. The total underpayments were $75,131.89

The median for response was twenty-four (24) days.

V. INTERRELATED FINDINGS

The Company was asked to provide a listing of all of the Preferred Provider Organization (PPO) claims denied for professional interpretation. The listing identified 9,000 claims. The Company should contact the providers of the claims on the listing and determine if the members have been balance billed and do one of the following: Negotiate a write off of the charges, negotiate a discount and pay the claim, or pay the total amount of the claim. The insured should never be held accountable for these charges. Where the insured has made the payments toward these charges, the Company should reimburse or have the provider reimburse the insureds for the amounts paid.

The insureds are not a party to the contract between the Company and the providers and they should not be held accountable for the disputed claims. These claims are sometimes charged by participating providers and sometimes non-participating providers where the participating provider has referred the service to a non-participating facility or provider. The insureds have no control over these charges. The insureds are not allowed to be balance billed by in-network providers due to a clause in the provider contract which provides that if the contract is terminated the providers are not allowed to balance bill the members for charges beyond their control or disputed by the Company. Some in-network providers refer members claims out of network. It appears this is done because these in-network providers have a relationship with the out of network providers such as laboratories and refer the work which they cannot do themselves to those providers. The in-network providers should only refer the work to other in-network providers unless there are none available. In no case should the members be held accountable for charges beyond their co-pays and deductables.

When the insureds make a good faith effort to use participating providers and the service is referred to non-participating providers the insureds should experience no greater cost than if a participating provider was used.

It was determined that the listing provided included Non-Participating providers and ASO (Self Funded) claims. All of the ASO claims should be removed and the Non-Participating providers who were referred by participating providers should be left in and contacted. The claims where the insureds willfully utilized Non-Participating providers should be removed and not contacted.

STATE OF MINNESOTA)
) ss
COUNTY OF HENNEPIN)

Mike 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 Insurance Company, NAIC #73288

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 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 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 Company nor any of the Company's 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 Company 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 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.

Mike Hager
Mike Hager
Examiner-In-Charge

Subscribed and sworn to before me
this 16 day of October 2013.

Notary Public

MICHAEL PATRICK MOORE
Notary Public
Minnesota
My Commission Expires Jan. 31, 2017

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

HUMANA INSURANCE COMPANY
1100 EMPLOYERS BOULEVARD
DE PERE, WISCONSIN 54115

STIPULATION AND CONSENT ORDER

WHEREAS, the Director (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, Humana Insurance Company (Company) is authorized under the insurance laws of this State and by the Director as a foreign stock company, to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS, a Market Conduct 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 Market Conduct Examination; and

WHEREAS, said 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 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 various areas in which 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 whereby the Company pays claims accurately and completely as required by 215 ILCS 5/154.6(d).

2. Institute and maintain procedures whereby the company will affirm or deny claims within the required 30 days as required by 215 ILCS 5/154.6(i) and 50 Ill. Adm. Code 919.50(a).

3. Institute and maintain procedures whereby the company will not have a disproportionate number of meritorious complaints as required by 215 ILCS 5/154.6(f).

4. Institute and maintain procedures whereby the Company pay interest on claims not paid within 30 days as required by 215 ILCS 5/368a(c).

5. Institute and maintain procedures whereby the Company makes an oral notification of appeal decision within 15 days on an appeal decision as required by 215 ILCS 134/45(c).

6. Institute and maintain procedures whereby the Company notifies the member of all the information required to process an appeal within the required three (3) business days as required by 215 ILCS 134/45(c).

7. Institute and maintain procedures whereby the Company renders a decision on appeals within 15 business days as required by 215 ILCS 134/45(c).

8. Institute and maintain procedures whereby the Company pays claims when the insured has made a good faith effort to use the services of a contracted provider and ensure that the insured's out-of-pocket expense is no greater than if the care was from a contracted provider as required by 215 ILCS 5/356z.3a.

9. Institute and maintain procedures whereby the Company pays claims when the insured has made a good faith effort to use the services of a contracted provider and ensure that the insured's out-of-pocket expense is no greater as required by 50 Ill. Adm. Code 2051.310(A)(6)(H).

10. Institute and maintain procedures whereby the Company provides the insured or beneficiary when applicable a reasonable written explanation of delay when claims remains open for 45 days as required by 50 Ill. Adm. Code 919.70(a)(2).

11. Institute and maintain procedures whereby the Company pays mammogram screening claims properly as required by 215 ILCS 5/356(g).

12. Institute and maintain procedures whereby the Company pays emergency room claims properly as required by 215 ILCS 5/370(o).

13. Institute and maintain procedures whereby the Company includes coverage for temporomandibular joint disorder and craniomandibular disorder or provide a written accept or reject form for this coverage by the policy holder as required by 215 ILCS 5/356(q).

14. Reopen and pay the following claims with interest calculated to the date of payment:

Claim(s) #	Claim Amount
[redacted]	To be determined
	To be determined
	To be determined
	To be determined
	To be determined
	To be determined
	To be determined
	To be determined
	$14.87 Due
	$8.17 Due
	$350.31 Plus Interest
	$53.33 Due
	$5.48 Due
	To be determined.
	$49.97 Due
	$7.77 Due
5	$28.04 Due

15. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above 14 orders within 30 days of the execution of these orders.

16. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $50,000.00 to be paid within 30 days of the execution of these orders.

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 Insurance Company:

Joan O. Lenahan
Signature

Joan O. Lenahan
Name

Vice President & Corporate Secretary
Title

Subscribed and sworn to before me this 29 day of January 2014.

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

Notary Public

DEPARTMENT OF INSURANCE of the State of Illinois;

DATE February 10, 2014

Andrew Boron
Director

Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

February 27, 2014

Bruce Broussard
President
Humana Insurance Company
PO Box 740036
Louisville, KY 40201

Re: ***Humana Insurance Company***

Dear Mr. Broussard:

The company has submitted to the Department proofs of compliance with Order # 1 through Order #14 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,

Lysa Saran
Senior Policy Advisor
Illinois Department of Insurance
122 S. Michigan Avenue, 19th Floor
Chicago, IL 60603
Phone: 312-814-1767
Cell: 312-833-4396
E-mail: Lysa.Saran@Illinois.gov