REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

UNITED CONCORDIA INSURANCE COMPANY

AS OF DECEMBER 31, 2014

Conducted from March 11, 2015

Through

June 2, 2016

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 86-0307623
NAIC: 85766

COMMONWEALTH OF VIRGINIA

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BUREAU OF INSURANCE

I, Greg Lee, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of United Concordia Insurance Company as of December 31, 2014, completed at the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2016-00275 finalizing the Report.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Bureau at the City of Richmond, Virginia, this 4th day of January, 2017.

Greg Lee

Examiner in Charge

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of United Concordia Insurance Company (hereinafter referred to as "UCIC") was conducted under the authority of various sections of the Code of Virginia and regulations found in the Virginia Administrative Code including, but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1809 and 38.2-3407.15 C of the Code of Virginia (hereinafter referred to as "the Code").

The period of time covered for the current examination was January 1, 2014, through December 31, 2014. The desk examination was initiated on March 11, 2015, and completed on June 2, 2016, at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia. The violations cited and the comments included in this Report are the opinions of the examiners.

The examiners may not have discovered every non-compliant activity in which the company is engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

The purpose of the examination was to determine whether UCIC was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code. Compliance with the following regulation was considered in this examination process:

14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance;

14 VAC 5-100-10 et seq.	Rules Governing the Submission for Approval of Life, Accident and Sickness, Annuity, Credit Life and Credit Accident Sickness Policy Forms;
14 VAC 5-400-10 et seq.	Rules Governing Unfair Claim Settlement Practices; and

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIPs)
- Ethics & Fairness in Carrier Business Practices
- Advertising
- Policy and Other Forms
- Agents
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act
- Premium Notices/Collections/Reinstatements
- Cancellations/Nonrenewals
- Complaints
- Claim Practices

Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to UCIC during the course of the examination.

II. COMPANY HISTORY

United Concordia Insurance Company (UCIC) commenced operations on December 10, 1975, and is licensed as a Life, Accident and Health corporation, organized under the laws of Arizona. UCIC is a direct subsidiary of United Concordia Life and Health Insurance Company, a direct subsidiary of United Concord Companies, Inc., which in turn is a wholly owned subsidiary of Highmark Inc. (Highmark), a diversified healthcare focused organization and a licensed Blue Cross and Blue Shield Association member. UCIC was licensed in the Commonwealth of Virginia on July 25, 1990.

UCIC is one of several dental insurance companies within the United Concordia group of companies that provide nationwide coverage to the members of Highmark and its affiliates. The company is authorized to write life, and accident and health in 41 states. Additionally, UCIC offers dental indemnity through its accident and health insurance licenses. The Company has a reinsurance agreement with United Concordia Life & Health Insurance Company (UCLH). Under the agreement, UCIC cedes 50% of all underwritten premiums, claims expense and administrative expenses to UCLH. The company supports approximately 562,000 risk members.

As of December 31, 2014, total membership in the Commonwealth of Virginia was 79,215 and health premiums written totaled $25,741,359.

III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

Section 38.2-5801 of the Code prohibits the operation of an MCHIP unless the health carrier is licensed as provided in this title. Section 38.2-5802 sets forth the requirements for the establishment of an MCHIP, including the necessary filings with the Commission and the State Health Commissioner.

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES

Section 38.2-5803 A of the Code requires that the following be provided to covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers.
2. A description of the service area or areas within which the MCHIP shall provide health care services.
3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specific arbitration agreement.
4. Notice that the MCHIP is subject to regulation in Virginia by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.
5. A prominent notice stating, "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided, which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance."

As discussed in Review Sheet MC28, the review revealed that UCIC failed to provide its covered persons with Item #4, enumerated above. UCIC agreed with the examiners' observations and stated that it "…will file a revised Certificate of Coverage which will contain the information required…"

COMPLAINT SYSTEM

The examiners selected a sample of 53 from a total population of 269 written complaints/appeals received during the examination time frame.

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner.

The examiners reviewed the sample complaints/appeals for compliance with UCIC's established complaint system procedures and the requirements of the Code. The review revealed 27 instances where UCIC failed to establish and maintain its approved complaint system, in violation of § 38.2-5804 A of the Code. Examples are discussed in the following paragraphs.

TIMELINESS

UCIC's approved complaint system procedures state that "We will review the Adverse Determination and notify You of Our decision within ten (10) working days of the request for reconsideration." The review revealed 2 instances where UCIC failed to notify the covered person of its decision within 10 working days. An example is discussed in Review Sheet MC03. UCIC agreed with the examiners' observations.

HANDLING

UCIC's approved complaint system procedures state that an appeal of a Final Adverse Determination notification "…will include…reference to specific plan provisions on which the determination was based." As discussed in Review Sheet MC17, the Final Adverse Determination notification in the appeal file failed to include a reference to the

specific plan provisions on which the determination was based. UCIC disagreed with the examiners' observations and stated that:

> United Concordia Insurance Company (UCIC), provided the appropriate reference to the member and provider. The Company believes it has exceeded the Virginia requirement by providing the detailed basis and clinical rationale for the adverse determination that was specific to the procedures member received. Reference to the plan provision is inherently provided by stating the clinical basis for the denial. In doing so, UCIC provided sufficient detail to communicate that the decision was not medically necessary. Services may be denied under the Policy by the medically necessary exclusion.
>
> The denial letter dated September 30, 2014 contains the basis of the determination. Third paragraph informs the member/provider that our decision was based off review of the information submitted, our internal Company guidelines (which are developed by licensed healthcare providers) and guidelines established by American Dental Association. Fourth paragraph contains the clinical rationale of the decision. The Explanation of Benefits (EOB) also provides additional details of the clinical rationale, reason for the denial, coverage amounts under the plan, etc.

The examiners responded that UCIC has not "…exceeded the Virginia requirement by providing the detailed basis and clinical rationale for the adverse determination that was specific to the procedures member received." UCIC's filed complaint system procedures state that it will provide "…an explanation of clinical judgment on which the determination was based" and "…reference to the specific plan provisions." Additionally, UCIC's approved complaint system procedures do not state that the notification letter and EOB are considered part of the final adverse determination notice and should be read in conjunction with each other.

IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 of the Code requires that every provider contract entered into by a carrier shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services.

PROVIDER CONTRACTS

The examiners reviewed a sample of 15 from a total population of 4,348 provider contracts in-force during the examination time frame. The contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

The review revealed that in 81 instances, UCIC's provider contracts failed to contain 1 of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular Code Section, Number of Violations, and a Review Sheet Example are referred to in the table below.

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1	1	EF10
§ 38.2-3407.15 B 1 b	14	EF01
§ 38.2-3407.15 B 2	1	EF10
§ 38.2-3407.15 B 3	15	EF03
§ 38.2-3407.15 B 4	1	EF10
§ 38.2-3407.15 B 4 a	14	EF04
§ 38.2-3407.15 B 4 a (ii) (d)	14	EF05
§ 38.2-3407.15 B 5	1	EF10
§ 38.2-3407.15 B 6	1	EF10
§ 38.2-3407.15 B 7	1	EF10
§ 38.2-3407.15 B 8	1	EF10
§ 38.2-3407.15 B 9	15	EF06
§ 38.2-3407.15 B 10	1	EF10
§ 38.2-3407.15 B 11	1	EF10

An example of some of the violations cited were discussed in Review Sheet EF06, where the examiners' initial observations stated, in part, that:

> …UCIC deleted the words *"…and implement*" and replaced the phrase "*…the terms and conditions of the provider contract*" with "*…United Concordia's requirements*" which made the specific provision less stringent upon the carrier than what was required by §§ 38.2-3407.15 B 4 a and 38.2-3407.15 B 4 a (ii) (d) of the Code…
>
> …UCIC inserted the phrases "*…in writing within thirty (30) calendar days of receipt…*" and "*…such document shall become effective and binding without further action by Dentist or United Concordia,*" which made the specific provision more stringent upon the provider than what was required by § 38.2-3407.15 B 9 of the Code.

UCIC disagreed with the examiners' observations and stated, in part, that:

> The cited section of code does not require explicit inclusion of the words and phrases noted by the Examiner. The absence of words specifically identified by the reviewer as being omitted from the provider agreement, those words being "and implement" do not constitute a violation of the law. The requirement to 'implement' is inherent in the inclusion of the requirement in the provider contract as those items are inherently the Company's responsibility…Inclusion of the language "United Concordia's requirements" instead of "the terms and conditions of the provider contract" is another issue the Company asserts is relevant only when considering the semantic value of the language.

The examiners maintained their findings and responded that the introduction or deletion of any text that made the statutory language required less stringent upon the dental carrier and more burdensome upon the dental provider, would fail to comply with the requirements of § 38.2-3407.15 B of the Code.

UCIC failed to amend its provider contracts to comply with § 38.2-3407.15 B with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15, which prohibits as a general business practice, failing to comply with § 38.2-3407.15 of the Code.

Payment for Services by Dentists and Oral Surgeons

Section 38.2-3407.17 B of the Code states that no contract between a dental plan and a dentist or oral surgeon may establish the fee or rate that the dentist or oral surgeon is required to accept for the provision of health care services, or require that a dentist or oral surgeon accept the reimbursement paid as payment in full, unless the services are covered services under the applicable dental plan.

As discussed in Review Sheet EFD01, the review of the sample provider contracts revealed that in 10 instances, UCIC introduced language into its dental provider contracts that failed to comply with § 38.2-3407.17 B of the Code. UCIC disagreed with the examiners' observations and stated that:

> United Concordia Insurance Company (UCIC) respectfully disagrees with the State that it is not in compliance with § 38.2-3407.17 of the Virginia Code. Fundamentally, UCIC believes the statute cited by the State is not applicable to business UCIC conducts in the State of Virginia. This provision of law applies to contracts between a *dental plan* and a dental or oral surgeon. The statute defines "dental plan" as follows:
>
> > *(i) an insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical, and surgical or major medical coverage on an expense-incurred basis, (ii) an entity providing individual or group accident and sickness subscription contracts, (iii) a dental services plan offering or administering prepaid dental services, (iv) a health maintenance organization providing a health care plan, and (v) a dental plan organization.*
>
> UCIC does not issue individual or group accident and sickness insurance policies providing hospital, medical, and surgical or major medical coverage, nor does UCIC issue subscription contracts, offer or administer prepaid dental services or is a licensed dental plan organization in the State of Virginia. Therefore, UCIC requests the State to withdraw its observation of contracts 2-9, 14 and 15.
>
> In the alternative, should the State find this provision of the law applicable to UCIC business in the State of Virginia it still holds it is in compliance. Section C of § 38.2-3407.17 of the Virginia Code states this provision of

the law applies to contracts entered into, amended, extended or renewed on or after July 1, 2010. Contract numbers 2-9 were all executed in 2009, prior to the effective date of the law cited by the State. Once executed, United Concordia Companies Inc. provider contracts do not have an expiration/renewal date, in other words they are "evergreen". United Concordia Companies Inc. has not amended, extended or renewed contracts 2-9 since they were executed in 2009, therefore with an effective date of July 1, 2010 this provision of the law would not apply to these contracts. Again, UCIC respectfully requests the State withdraw its observation of contracts 2-9.

With respect to contracts 14 and 15, UCIC contests that, here too, it is in compliance with the law. United Concordia Companies Inc. does not *require* dental providers to accept a lesser reimbursement as payment in full for non-covered services, as prohibited by law. Rather, Section 5 of contracts 14 and 15 gives the provider the voluntary option to accept the Maximum Allowable Charge for non-covered services. A provider can easily opt out of this term of the agreement by not initialing the statement found at the end of the contract which states:

> *By separately initialing, Dentist signifies agreement to limit his/her charges for non-covered services to the Maximum Allowable Charge under provision number 5 of this Agreement.*

Section 5 within the Agreement clearly refers the provider where his/her initials are required and states that without their initials the provider is not agreeing to discount their payment for non-covered services. The voluntary option to accept a discounted fee for non-covered services is not in violation of the State's law which prohibits the contract from *requiring* such an arrangement. Therefore, UCIC kindly requests the withdrawal of the observations cited for contracts 14 and 15.

The examiners maintained our findings and responded that:

UCIC is an insurer issuing group accident and sickness insurance to insureds in the Commonwealth of Virginia and is a "Dental plan" as defined under § 38.2-3407.17 A of the Code of Virginia. UCIC has amended the fee schedules applicable to these 10 provider contracts multiple times since July 1, 2010. Therefore, all 10 of the provider contracts cited are subject to the statute's requirements. The dental providers in question cannot opt-in to a contract provision that is not permitted by the Code of Virginia.

PROVIDER CLAIMS

Section 38.2-510 A 15 of the Code prohibits as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain specific provisions, requiring the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that in the processing of any payment for claims for health care services, every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

The examiners reviewed a sample of 100 claims from a population of 458 claims processed under the sample provider contracts during the examination time frame.

The review revealed that UCIC was in substantial compliance.

V. ADVERTISING

A review was conducted of UCIC's advertising materials to determine compliance with the Unfair Trade Practices Act, to include §§ 38.2-502, 38.2-503 and 38.2-504 of the Code, as well as 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed (14 VAC 5-90-50).

A sample of 83 was selected from a total population of 1,084 advertisements distributed in Virginia during the examination time frame was reviewed. The review revealed that 2 of the advertisements contained violations. In the aggregate, there were 3 violations, which are discussed in the following paragraphs.

14 VAC 5-90-170 A requires an insurer to maintain at its home or principal office a complete file of all advertisements with a notation indicating the manner and extent of distribution and the form number of any policy referred to in the advertisement. The review revealed that UCIC was in substantial compliance.

14 VAC 5-90-55 A states that an invitation to inquire shall contain a provision in the following or substantially similar form: "This policy has [exclusions] [limitations]

[reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [write] your insurance agent or the company [whichever is applicable]." The review revealed 2 violations of this section. An example is discussed in Review Sheet AD31, where the invitation to inquire failed to contain the required disclosure. UCIC disagreed with the examiners' observations, and stated that:

> United Concordia Insurance Company (UCIC) maintains the advertisement cited is an institutional ad, the primary purpose of which is to educate the audience on the importance of oral wellness and its connection to overall health, and to increase recognition of the company is promoted as a proponent of dental wellness. The oral wellness research is the focus of the advertisement, and the reader is prompted a number of times to learn more about how a healthier mouth can lead to a healthier body by visiting the website, UCMissingPiece.com. Appropriate disclosures are provided on the website…but are not required in the advertisement because of its institutional nature. The company respectfully requests that this observation be withdrawn.

The examiners maintained their findings and responded that the advertisement referred to benefits and constituted an "invitation to inquire" as defined in 14 VAC 5-90-30, and was required to contain the disclosures required by 14 VAC 5-90-55 A. Listing the location of the marketing website of UCIC's wellness program on the "magazine cover wrap" is not an adequate means of providing the disclosures required. 14 VAC 5-90-40 states that all information required to be disclosed by this chapter be set out conspicuously and in close conjunction with the statements to which the information relates.

14 VAC 5-90-90 C states that the source of any statistics used in an advertisement shall be identified in the advertisement. The review revealed 1 violation of this section. As discussed in Review Sheet AD31, the source provided for a statistic

related to per person outpatient diabetic drug costs was not identified. UCIC agreed with the examiners' observations.

SUMMARY

UCIC violated 14 VAC 5-90-55 A and 14 VAC 5-90-90 C, which placed it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

VI. POLICY AND OTHER FORMS

A review was conducted to determine if UCIC complied with various statutory, regulatory, and administrative requirements governing the filing and approval of forms.

14 VAC 5-100-10 et seq. Rules Governing the Submission for Approval of Accident and Sickness Policy Forms and § 38.2-316 of the Code set forth the filing and approval requirements for forms that are to be issued or issued for delivery in Virginia.

Sections 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code set forth the filing and approval requirements for group and individual policies, certificates of insurance, amendments, riders and application/enrollment forms used in connection with any group accident and sickness insurance policy issued in Virginia.

Group Dental

The examiners reviewed a sample of 40 from the total population of 383 group dental accident and sickness policies issued during the examination time frame.

The review revealed that in 259 instances, UCIC issued the certificate of coverage form Certificate of Insurance (No Form #) prior to the form being filed with, and approved by, the Commission, in violation of §§ 38.2-316 A and 38.2-316 C 1 of the Code in each instance. An example is discussed in Review Sheet PF03, where UCIC deleted the form number and made a substantive textual revision to a previously filed Certificate of Insurance. Under the Late Enrollment section, the words "***…specified in any applicable Late Entrant Rider to the Certificate of Insurance***" were deleted and replaced with "…required by applicable state or federal law or permitted by Your Group under the rules of its benefit plans." This variation was not mentioned in the Statement

of Variability that accompanied the original form filing. UCIC disagreed with the examiners' observations in Review Sheet PF03, and stated that:

> The Certificate of Insurance identified in these observations was approved by the Department on February 21, 2003 (see Exhibit 3)…This form was submitted to the Department for review on December 4, 2002 under submission number 7-19688 (see Exhibit 3). When the form was submitted for review and approval it was assigned form number 9804-B (07/02), which could be found on the first page of the certificate. However, due to a system error the form number did not carry over in these particular instances. United Concordia Insurance Company respectfully requests the Department to withdraw the above referenced observations.

The examiners maintained their findings and responded that "14 VAC 5-100-50 3 requires that a form be submitted in the final form in which it is to be marketed or issued."

Individual Dental

The examiners reviewed a sample of 10 from the total population of 4,013 group dental accident and sickness policies issued during the examination time frame.

The review revealed that the individual policies and the schedules of benefits and endorsements issued with the individual policies were filed with and approved by the Commission.

ACCIDENT AND SICKNESS RATE FILING

Section 38.2-316 A of the Code sets forth the requirements for the filing of rates and rate changes. The review revealed that UCIC was in substantial compliance.

APPLICATION/ENROLLMENT FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application and enrollment forms prior to use.

The review revealed that in 28 instances, UCIC used an enrollment form that had not been filed with and approved by the Commission, in violation of §§ 38.2-316 B and 38.2-316 C 1 of the Code. The Form Number and a Review Sheet example documenting the violations are listed in the following table.

Form Name & Form Number	# of Violations	Review Sheet Example
Dental Enrollment Form 5000 (07/05)	**18**	**PF01**
United Concordia Enrollment/Change Form	**1**	**PF05**
United Concordia Dental Enrollment Form	**6**	**PF24**
United Concordia Dental Enrollment Form MDFFS5000 (09/06)	**1**	**PF19**
United Concordia Dental High Dental Low Option Enrollment Form	**2**	**PF08**

UCIC disagreed with the examiners' observations concerning the above forms. An example is discussed in UCIC'S response to Review Sheet PF01, where it stated:

> The enrollment form "Dental Enrollment Form 5000 (07/05)" was approved by the Department in November 18, 2005. This was a paper filing as the ability to file electronically was not available at this time. This enrollment form was submitted to the Department on October 18, 2005…under submission number 7-25110 (see Exhibit 1). [BOI Employee] subsequently approved the filing on November 18, 2005 (see Exhibit 2). United Concordia Insurance Company respectfully requests the Department to withdraw the above referenced observations.

The examiners responded that 14 VAC 5-100-50 2 requires that the full and proper corporate name of the insurer prominently appear on the cover sheet of all

applications and other forms. The use of a trade name on a policy form in such a way that implies that another company is responsible for the obligations undertaken in the policy is prohibited. Additionally, 14 VAC 5-100-50 3 states that a form must be submitted in the final form in which it is to be marketed or issued. When the enrollment form was originally filed by UCIC, it had the full and proper corporate name of the insurer on the enrollment form. In every instance where the form, Dental Enrollment Form 5000 (07/05), was cited by the examiners, UCIC had removed the insurer's proper corporate name and replaced it with "UNITED CONCORDIA, America's Premier Dental Insurer," a trade name. This level of variability is not permitted by 14 VAC 5-100-10 et seq.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer issuing an accident and sickness policy shall file its explanation of benefits forms for approval.

The review revealed 1 violation of this section. As discussed in Review Sheet PF26, during the course of the claims review it was determined that in certain instances, UCIC made substantive revisions to its filed EOB form by adding the trade name of another insurance company and deleting UCIC's full and proper corporate name. UCIC responded that it "…acknowledges that the explanation of benefits has been revised since the initial filing" and that it "…intends to take corrective action to bring the EOBs into compliance with 14 VAC 5-100-50 2 and to file the EOBs for approval as required…"

VII. AGENTS

The purpose of this review was to determine compliance with various sections of Title 38.2, Chapter 18 of the Code. The 44 agents and 23 agencies designated in the sample of 140 new business files were reviewed.

LICENSED AGENT REVIEW

Section 38.2 1822 A of the Code requires that a person be licensed prior to soliciting contracts or acting as an agent in the Commonwealth.

The review revealed that UCIC was in substantial compliance.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires that an insurer, within 30 calendar days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent.

The review revealed 92 violations of this section. An example is discussed in Review Sheet AG08, where UCIC failed to reject a group insurance application submitted by an agency that was not appointed. UCIC agreed with the examiners' observations.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commission or other valuable consideration to an agent or agency which was not appointed or which was not licensed at the time of the transaction.

The review revealed 91 violations of this section. An example is discussed in Review Sheet AG02, where UCIC paid commission or other valuable consideration to

an agency that was not appointed. UCIC disagreed with the examiners' observations and stated that:

> [Agent Name] is an employee of our vendor for processing individual dental coverage, [Agency Name]. [Agency Name] uses [Agent Name] to denote a "house account" when the sale was direct to consumer. These instances occur when the consumer goes directly to the [Agency Name] website to select and enroll in their own dental coverage without the assistance or involvement of a producer.

The examiners maintained their findings and responded that the documentation provided indicated that UCIC accepted applications from and paid commission to the agency and failed to file a notice of appointment with the Commission. The Administrative Services Agreement between UCIC and [Agency Name] stated that it "…shall pay [Agency Name] a fee of $.90 for each new Policy sold by/through any such sales consultant."

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an insurer notify the agent within 5 calendar days, and the Commission within 30 calendar days, upon termination of the agent's appointment. A sample of 40 was selected from the total population of 1,376 agents whose appointments terminated during the examination time frame.

As discussed in Review Sheet AG01, the review revealed that UCIC failed to notify 4 agents of termination of appointment within 5 calendar days, in violation of § 38.2-1834 D of the Code in 4 instances. UCIC agreed with the examiners' observations.

VIII. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of UCIC's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514 of the Code and the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620 of the Code.

UNDERWRITING/UNFAIR DISCRIMINATION

The review was conducted to determine whether UCIC's underwriting guidelines were unfairly discriminatory, whether applications were underwritten in accordance with UCIC's procedures and correct premiums were being charged.

UNDERWRITING REVIEW

The examiners reviewed a sample of 140 from the total population of 4,396 accident and sickness insurance policies issued during the examination time frame.

The review revealed no evidence of unfair discrimination.

On July 11, 2014, UCIC notified the Bureau that it was withdrawing from the individual dental insurance market. The Company entered the individual dental insurance market in Virginia in 2010. In 2014, in addition to traditional individual dental insurance policies, the Company offered certified individual policies both through the Federal Health Insurance Marketplace and in the off-exchange market. UCIC fully exited the individual dental market in Virginia on December 31, 2015.

MECHANICAL RATING REVIEW

The review revealed that UCIC calculated premium amounts in accordance with its established guidelines.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires a company to establish standards for collection, use and disclosure of personal/privileged information gathered in connection with insurance transactions.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of the disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The review revealed that the disclosure authorizations used by UCIC in the underwriting of its group and individual business were in substantial compliance.

ADMINISTRATIVE LETTERS 2010-12 & 2014-05

The purpose of these Administrative Letters is to inform life and accident and sickness insurers of the disclaimer required to be attached to policies in order to comply with § 38.2-1715 B of the Code, which states that an insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The summary document, *Notice of Protection Provided by the Virginia Life, Accident and Sickness Insurance Guaranty Association,* was approved effective November 1, 2010.

The review revealed that UCIC was in substantial compliance.

IX. PREMIUM NOTICES/COLLECTIONS/REINSTATEMENTS

UCIC's procedures for processing premium notices, collections and reinstatements were reviewed for compliance with its established procedures.

PREMIUM NOTICES

Group Policies

Invoices are generated between the 1st and 5th of the month for the current month's coverage. Groups can elect to receive a quarterly invoice. Groups have 2 arrangements by which they can be billed. "Pay as Billed" is an arrangement whereby the group pays the invoiced amount in full without making any manual adjustments or taking credit for enrollment changes. "Self-Billing" is an arrangement where the group calculates the invoice amount due based on its enrollment records and pays accordingly. This arrangement must be pre-approved UCIC's Finance Department and is only available for groups with more than 300 subscribers.

The review revealed that UCIC's premium notices were generated in accordance with its established procedures.

Individual Policies

Members are billed in advance and pay in advance. Bills are produced on the second Friday of the month and the premium due date is the 25th of each month. The "tolerance level" is 99%. If UCIC does not receive 99% of the total amount billed, the paid-to date will not advance and the case will be moved into the past due process.

The review revealed that UCIC's premium notices were generated in accordance with its established procedures.

COLLECTIONS

Group Policies

A past due letter is sent 25 days after the invoice due date. An "intent to term letter" is sent 50 days after the oldest invoice due date, if more than one invoice is past due. A delinquency indicator is placed on the group's account when this letter is sent. A termination letter is sent 65 days after the oldest invoice due date. Certain "A-list" groups are permanently excluded from the delinquency process. The sales department assumes the responsibility for collection of all outstanding balances for all A-list groups. Approval from Senior Sales Management is required to designate a group as A-list.

The review revealed that UCIC was in substantial compliance with its established procedures for collections.

Individual Policies

The termination date is at the end of the grace period for Virginia-issued policies. Once the termination is processed, the Non-Payment of Premium Termination Letter is generated and sent to the policyholder. It was UCIC's policy to send a case to a Collections Agency for amounts greater than $25.00.

The review revealed that UCIC was in substantial compliance with its established procedures for collections.

REINSTATEMENTS

Group Policies

Groups seeking reinstatement must have been cancelled within the previous twelve-month period and have no prior reinstatements. Upon receipt of a request for

reinstatement, the Account Manager will complete an underwriting request form. Underwriting will research and analyze the group's experience, payment history or participation level as appropriate. If denied, Underwriting will respond to the request noting the denial. If approved, the Account Manager will collect the premium and reinstatement fee and Dental Enrollment Forms (if applicable). If a group is reinstated and subsequently canceled for delinquency or not meeting minimum participation levels, there will be no consideration for a second reinstatement.

This policy applies to all UCIC commercial group business. This policy does not apply to groups that are referred to as special or A-List Accounts and groups deemed "Sensitive or High Profile" by senior management.

A sample of 10 was selected from the total population of 38 groups whose coverage was reinstated during the examination time frame. The review revealed that UCIC was in substantial compliance with its established procedures for reinstatement.

Individual Policies

UCIC's procedures state that a policy may be reinstated without requiring a written request for the following "valid" reasons:

- Premium billing issues which are no fault of the policyholder
- Address change not processed timely
- Electronic Funds Transfer (EFT) or Credit Card (CC) account number not processed timely
- Payment was received within 1-4 business days after termination

A written request is required to be reviewed and approved by UCIC for the following reasons:

- Natural Disaster Events
- Delayed Mail
- Family Emergency
- Premium Payment was short, but payment was made in good faith

- If the 1st falls on a weekend or during a Holiday, allow X amount of days for payment to post
- Policyholder forgot to submit address change
- Policyholder forgot to submit updated EFT/CC information to UCIC resulting in account not being drafted

For policyholders who qualify for immediate reinstatement there will be no lapse in coverage. Policyholders who do not qualify for immediate reinstatement may re-apply for coverage after 3 years.

A sample of 4 was selected from the total population of 8 individuals whose coverage was reinstated during the examination time frame. The review revealed that UCIC was in substantial compliance with its established procedures for reinstatement.

X. CANCELLATIONS/NONRENEWALS

The examination included a review of UCIC's cancellation/nonrenewal practices and procedures to determine compliance with the policy provisions, the requirements of § 38.2-508 of the Code covering unfair discrimination and the notification requirements of § 38.2-3542 C of the Code.

Group Policies

A sample of 24 was selected from a total population of 209 group accident and sickness policies that were cancelled, non-renewed, or terminated during the examination time frame.

The review revealed that UCIC was in substantial compliance with its established procedures, the policy provisions, and the notification requirements of § 38.2-3542 C of the Code. There was no evidence of unfair discrimination in the sample files reviewed.

Individual Policies

A sample of 35 was selected from a total population of 400 individual accident and sickness policies that were cancelled, non-renewed, or terminated during the examination time frame.

The review revealed that UCIC was in substantial compliance with its established procedures and the policy provisions. There was no evidence of unfair discrimination in the sample files reviewed.

XI. COMPLAINTS

UCIC's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

A sample of 53 was selected from a total population of 269 written complaints. The review revealed that UCIC was in substantial compliance.

XII. CLAIM PRACTICES

The examination included a review of UCIC's claim practices for compliance with §§ 38.2-510 and 38.2-3407.1 of the Code, and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of closed claims processed under group and individual dental policies.

PAID CLAIM REVIEW

A sample of 250 was selected from a population of 124,228 claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

INTEREST

Section 38.2-3407.1 B of the Code states that interest upon claim proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment.

All of the claims in the paid claims sample were reviewed for compliance with this section in addition to any claims in the denied claims sample that were adjusted to pay during, or subsequent to, the examination time frame.

The review revealed 2 violations of § 38.2-3407.1 B of the Code. In both instances, the amount of statutory interest due was not paid. An example is discussed in Review Sheet CL09, where UCIC took 107 days to pay the claim and failed to pay the statutory interest. UCIC responded that:

United Concordia Insurance Company (UCIC) partially disagrees with the observations. Services for this claim were provided by a California (CA) provider so the applicable CA regulations were applied when adjusting this claim. The first time the claim adjudicated the benefit information was not correctly loaded. This issue was subsequently corrected thereby resulting in the claim adjustment.

The examiners responded that, "…this claim was paid under a group dental policy issued in the Commonwealth of Virginia and is subject to the statutory interest requirements of § 38.2-3407.1 B of the Code..."

TIME PAYMENT STUDY

The time payment study was computed by measuring the time it took UCIC, after receiving the properly executed proof of loss, to issue a check for payment. The term "working days" does not include Saturdays, Sundays or holidays. The study was conducted on the sample of 250 paid accident and sickness claims.

PAID CLAIMS

Claim Type	Working Days to Settle	Number of Claims	Percentage
Accident & Sickness	0 – 15	235	94%
	16 – 20	5	2%
	Over 20	10	4%

Of the 250 claims reviewed for the time study, 6% of the claims were not settled within 15 working days.

DENIED CLAIM REVIEW

A sample of 100 was selected from a population of 13,741 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

The total sample of 250 paid claims and 100 denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time.

14 VAC 5-400-60 A requires that within 15 working days after receipt of properly executed proofs of loss, the insurer shall advise the claimant of acceptance or denial of the claim by the insurer.

14 VAC 5-400-70 B requires an insurer to include specific reference to a policy exclusion in the written denial, when a denial is based on such exclusion.

The review was conducted using the date the letter or check was mailed or the date the electronic transfer of funds was completed as the settlement date.

14 VAC 5-400-50 A – In 3 instances, a claim was not acknowledged within 10 working days upon receipt of notification. An example is discussed in Review Sheet CL03.

14 VAC 5-400-60 A – in 3 instances, a claimant was not advised of the acceptance or denial of a claim within 15 working days after proof of loss was received.

An example is discussed in Review Sheet CL03, where UCIC took 38 working days to affirm the claim after receipt of proof of loss.

14 VAC 5-400-70 B – As discussed in Review Sheet CL10, in 1 instance, an EOB sent to a claimant failed to specifically reference the policy exclusion that was the basis of the claim denial.

THREATENED LITIGATION

UCIC informed the examiners that there were no claim files that involved threatened litigation received during the examination time frame.

XIII. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, the examiners recommend that UCIC implement the following corrective actions. UCIC shall:

1. Establish and maintain procedures to ensure that notice that the MCHIP is subject to regulation by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1 is provided to covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued, as required by § 38.2-5803 A 4 of the Code;
2. Establish procedures to ensure that it maintains its established complaint system approved by the Commission, as required by § 38.2-5804 A of the Code;
3. Establish and maintain procedures to ensure that every "provider contract" as defined in § 38.2-3407.15 A of the Code does not contain provisions that are more burdensome upon the provider than the specific provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 4 a, 38.2-3407.15 B 4 a (ii) d, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10 and 38.2-3407.15 B 11 of the Code;
4. Immediately amend its provider contracts with dentists and oral surgeons in Virginia to comply with § 38.2-3407.17 B of the Code;
5. Establish and maintain procedures to ensure that invitations to inquire contain the disclosure required by 14 VAC 5-90-55 A;

6. Establish and maintain procedures to ensure that the source of any statistic used in an advertisement is identified, as required by 14 VAC 5-90-90 C;
7. Establish and maintain procedures to ensure that all Certificates of Insurance are filed for approval prior to use, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code;
8. Establish and maintain procedures to ensure that all enrollment forms are filed for approval prior to use, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code;
9. Establish and maintain procedures to ensure that its Explanation of Benefit (EOB) forms are filed for approval prior to use, as required by § 38.2-3407.4 A of the Code;
10. Establish and maintain procedures for compliance with §§ 38.2-1812 A and 38.2-1833 A 1 of the Code concerning the appointment and payment of commission to agents and agencies;
11. Strengthen its procedures for notifying agents and agencies of appointment termination within 5 calendar days, as required by § 38.2-1834 D of the Code;
12. Establish and maintain procedures for the payment of interest on accident and sickness claim proceeds, as required by § 38.2-3407.1 B of the Code;
13. Review and consider for re-adjudication all dental claims processed under Virginia issued policies where dental services were provided outside of Virginia that took greater than 15 working days to pay for the years of 2013, 2014, 2015 and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks for the

interest along with a letter of explanation or statement on the EOB that, “As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission’s Bureau of Insurance, it was determined that this interest had not been paid previously”;

14. Review its established procedures to ensure that it acknowledges the receipt of notification of all claims within 10 working days, as required by 14 VAC 5-400-50 A;
15. Establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A;
16. Establish and maintain procedures to ensure that specific reference to a policy exclusion is included in the written denial when a claim denial is based on such exclusion, as required by 14 VAC 5-400-70 B; and
17. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above corrective actions have been completed.

XIV. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by UCIC's officers and employees during the course of this examination is gratefully acknowledged.

Gregory Lee, FLMI, CIE, MCM and Freddie Oliver of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie R. Fairbanks

Julie Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division

XV. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Disclosures and Representations to Enrollees
§§ 38.2-5803 A 4, 1 violation, MC28
Complaint System
§ 38.2-5804 A, 27 violations, MC01, MC02, MC03, MC04, MC05, MC06, MC07, MC08, MC09, MC10, MC11, MC12, MC13, MC14, MC15, MC16, MC17, MC18, MC19, MC20, MC21, MC22, MC23, MC24, MC25, MC26, MC27
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
Provider Contracts
§ 38.2-510 A 15, 1 violation, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF10, EF11, EF12, EF13, EF14, EF15
§ 38.2-3407.15 B 1, 1 violation, EF10
§ 38.2-3407.15 B 1 b, **14 violations**, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF11, EF12, EF13, EF14, EF15
§ 38.2-3407.15 B 2, 1 violations, EF10
§ 38.2-3407.15 B 3, 15 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF10, EF11, EF12, EF13, EF14, EF15
§ 38.2-3407.15 B 4, 1 violation, EF10
§ 38.2-3407.15 B 4 a, 14 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF11, EF12, EF13, EF14, EF15
§ 38.2-3407.15 B 4 a (ii) (d), 14 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF11, EF12, EF13, EF14, EF15
§ 38.2-3407.15 B 5, 1 violation, EF10
§ 38.2-3407.15 B 6, 1 violation, EF10
§ 38.2-3407.15 B 7, 1 violation, EF10

§ 38.2-3407.15 B 8, 1 violation, EF10
§ 38.2-3407.15 B 9, 15 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF10, EF11, EF12, EF13, EF14, EF15
§ 38.2-3407.15 B 10, 1 violation, EF10
§ 38.2-3407.15 B 11, 1 violation, EF10
Payment for Services by Dentists and Oral Surgeons
§ 38.2-3407.17 B, 10 violations, EFD01 (10)
ADVERTISING
14 VAC 5-90-55 A, 2 violations, AD30, AD31
14 VAC 5-90-90 C, 1 violation, AD31
POLICY FORMS
§ 38.2-316 A, 259 violations, PF03 (107), PF15 (4), PF18 (97), PF22 (51)
§ 38.2-316 B, 28 violations, PF01, PF02, PF04, PF05, PF06, PF07, PF08 (2), PF09, PF10, PF11, PF12 (8), PF13, PF14, PF16, PF17, PF19, PF20, PF21, PF23, PF24
§ 38.2-316 C 1, 287 violations, PF01, PF02, PF03 (107), PF04, PF05, PF06, PF07, PF08 (2), PF09, PF10, PF11, PF12 (8), PF13, PF14, PF15 (4), PF16, PF17, PF18 (97), PF19, PF20, PF21, PF22 (51), PF23, PF24
§ 38.2-3407.4 A, 1 violation, PF26
AGENTS
§ 38.2-1812 A, 91 violations, AG02 (89) AG07, AG08
§ 38.2-1833 A 1, 92 violations, AG02 (89), AG03, AG07, AG08
§ 38.2-1834 D, 4 violations, AG01 (4)
CLAIM PRACTICES
§ 38.2-3407.1 B, 2 violations, CL01, CL09
14 VAC 5-400-50 A, 3 instances of non-compliance, CL01, CL02, CL03
14 VAC 5-400-60 A, 3 instances of non-compliance, CL01, CL02, CL03
14 VAC 5-400-70 B, 1 instance of non-compliance, CL10

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

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September 13, 2016

CERTIFIED MAIL 7015 1520 0003 0918 9670
RETURN RECEIPT REQUESTED

Ms. Cynthia J. Reinecker
Lead External Audit Support Analyst
United Concordia Insurance Company
4401 Deer Path Road, DRP 3A
Harrisonburg, PA 17110

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Reinecker:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of United Concordia Insurance Company (UCIC) for the period of January 1, 2014, through December 31, 2014. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of UCIC, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. UCIC's response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Julie R Fairbanks

Julie Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
(804) 371-9385

JRF:mhh
Enclosure
cc: Althelia Battle

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile™

October 21, 2016

VIA ELECTRONIC MAIL
Ms. Julie Fairbanks, AIE, FLMI, AIRC, MCM
Virginia BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
P.O. Box 1157
Richmond, VA 23218

Re: United Concordia Insurance Company ("United Concordia" or "Company")
Response to Market Conduct Examination Exposure Draft

Dear Ms. Fairbanks:

This letter is in response to your September 13, 2016 correspondence providing our Company the exposure draft examination report of United Concordia.

This response will address those areas within the body of the Report where the Company has comments and will respond to Section XIII Corrective Action Plan. Thank you for the opportunity to respond.

Section IV. Ethics & Fairness in Carrier Business Practices - Provider Contracts

The Company notes that 15 violations of §38.2-3407.15 B 2 of the Code of Virginia are cited in the draft report. This section requires that every provider contract contain a provision requiring the carrier to adhere to and comply with certain minimum fair business standards in the processing and payment of claims for health care services. Specifically, §38.2-3407.15 B 2 states (emphasis added):

*"A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails **timely** to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 6 of this subsection. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim."*

The Commission finds fault with the Company's substitution of "within 30 days" for the word "timely," claiming that this substitution makes the requirement less stringent upon the carrier. At its core, this provision requires the carrier to request any necessary information for a non-clean claim within 30 days and prohibits a carrier from refusing to pay the claim if it fails to notify the claimant within the permitted timeframe that additional information is missing. "Timely" as used in §38.2-3407.15 B 2 is in direct

reference to the 30 days given to a carrier to request missing information for a non-clean claim. Any request for information after the 30 days permitted would be untimely. The Company's substitution of "within 30 days" for "timely" is consistent with the notification requirements of §38.2-3407.15 B 2 and is more specific than the word "timely" used within §38.2-3407.15 B 2. As such, it does not lessen the requirements on the carrier, rather, it reinforces for the reader the timeframe within which the law requires the carrier to request missing information. The Company respectfully requests that this finding be removed from the final report.

Section VI. Policy and Other Forms - Group Dental

The Company notes that the Commission finds 259 instances of a Certificate of Insurance being issued prior to the form being filed with and approved by the Commission, which is in violation of §§ 38.2-316A and 38.2-316 C I of the Code of Virginia. Specifically, the Commission notes two violations: (1) the form number was not printed in the bottom left corner of the form and (2) a textual revision was made to the form in the Late Enrollment section, which the Commission states was not specified in the filed Statement of Variability.

With regard to the missing form number, the Company has clarified that a system anomaly resulted in the Certificate of Insurance printing without its designated form number, despite every other filed form in the sample policy packages properly including the required form number. The form at issue was filed and approved by the Bureau of Insurance. The Company provided specific evidence to the Commission of the filing in which the form was approved by the Commission, including the Commission's designated tracking number and images of the filing with stamped approval dates. The form was issued as approved in the filing, however, during the issue process, a system error occurred resulting in the omission of the form number on it. The Company respectfully disagrees that it used a form before it was filed and approved. The Company's contract generation system has been updated to ensure that the form number prints as required by 14 Virginia Administrative Code 5-100-50.1

With regard to the textual revision made in the Late Enrollment section of the Certificate of Insurance, the Commission acknowledges in its finding that the Statement of Variability was filed for this form. Variability statement number 12 in that filing, which was approved by the Commission on February 21, 2003 in filing number 7-19688, and which is associated with the Late Enrollment section of the Certificate of Insurance reads, "This bracketed language allows United Concordia to customize enrollment variations for specific group request or product variations." By approving this form, including its associated statement of variability, the Commission acknowledged that textual variations may occur and permitted the Company to make such variations.

The Company respectfully requests that both of the findings above be removed from the final report.

Section XIII. Corrective Action Plan

United Concordia has restated Section XIII. Corrective Action Plan and has responded to each finding accordingly.

1. **Establish and maintain procedures to ensure that notice that the MCHIP is subject to regulation by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1 is provided to covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued, as required by § 38.2-5803 A 4 of the Code;**

The Regulatory Compliance department for the Company maintains procedures according to which it posts to an internal site all of the approved policy forms that may be issued to a policyholder. The Certificate of Insurance that includes the required notice with regard to the MCHIP being regulated by the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1 was filed and approved by the Commission on April 13, 2015 and has been posted to the site maintained by Regulatory Compliance. This Certificate of Insurance containing the required notice will be issued according to the Account Installation department's procedures to all policyholders and made available to all covered persons at the time the contract is issued.

2. **Establish procedures to ensure that it maintains its established complaint system approved by the Commission, as required by § 38.2-5804 A of the Code;**

   The Company will review its approved complaint procedures and make revisions as needed to clarify what the Company considers a final adverse determination notice. Any revisions to the complaint system will be filed for approval by the Commission and reviewed with our Appeals staff.

3. **Establish and maintain procedures to ensure that every "provider contract" as defined in § 38.2-3407.15 A of the Code does not contain provisions that are more burdensome upon the provider than the specific provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 4 a, 38.2-3407.15 B 4 a (ii) d, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10 and 38.2-3407.15 B 11 of the Code;**

   The Regulatory Compliance department maintains a process by which provider contracts are reviewed and filed for approval with state regulators, if required, prior to use. Regulatory Compliance will enhance its existing procedures as to this process. The Company will amend its existing Virginia provider contracts to further clarify the requirements of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 1 b, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 4 a, 38.2-3407.15 B 4 a (ii) d, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10 and 38.2-3407.15 B 11 of the Code. The Company maintains that it is currently in full compliance with the provisions of §38.2-3407.15 B 2, as explained earlier in its response to the Commission's findings.

4. **Immediately amend its provider contracts with dentists and oral surgeons in Virginia to comply with § 38.2-3407.17 B of the Code;**

   The Company will amend its existing Virginia provider contracts to further clarify the requirements of § 38.2 3407.17 B of the Code.

5. **Establish and maintain procedures to ensure that invitations to inquire contain the disclosure required by 14 VAC 5-90-55 A;**

   The Regulatory Compliance department maintains an advertising manual used by the Marketing staff when advertisements are created and by the Regulatory Compliance department when advertisements are reviewed prior to release. This manual currently addresses the different types of advertising and the disclosure requirements related to each type of advertising. Regulatory Compliance will review these requirements with its staff and with Marketing to ensure that advertisements are properly categorized and the correct disclosures are included.

6. **Establish and maintain procedures to ensure that the source of any statistic used in an advertisement is identified, as required by 14 VAC 5-90-90 C;**

   The Regulatory Compliance department maintains an advertising manual used by the marketing staff when advertisements are created and by the Regulatory Compliance department when advertisements are reviewed prior to release. This manual currently includes the requirement that statistics be properly sourced, and the violation noted resulted from human error, as all of the other statistics in the advertisement reviewed were properly sourced. Regulatory Compliance will review these requirements with its staff and with Marketing to enhance their awareness of the requirement to source all statistics used in advertisements.

7. **Establish and maintain procedures to ensure that all Certificates of Insurance are filed for approval prior to use, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code;**

   The Regulatory Compliance department maintains a process by which all policy forms, including Certificates of Insurance, are filed for approval with state regulators, if required, prior to use. Further, the Company provided evidence to the Commission that the Certificates of Insurance in question were filed and approved prior to use. At issue in this finding was a system anomaly that omitted the form number for the Certificates of Insurance in the printed and issued policy forms package despite the form number from being included on all other forms in the policy package. The Company will enhance procedures related to quality review of the contract generation system output to ensure that all filed forms are printed with their filed form number as required by 14 Virginia Administrative Code 5-100-50.1.

8. **Establish and maintain procedures to ensure that all enrollment forms are filed for approval prior to use, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code;**

   The Regulatory Compliance department maintains a process by which all policy forms, including enrollment forms, are filed for approval with state regulators, if required, prior to use. In the cases cited, enrollment forms approved for use in another state were accidentally used by the Company. In order to ensure that the accurate enrollment form is chosen, Regulatory Compliance developed and released to the Company a tool that matches each enrollment/application form to the state(s) in which it is approved for use. A reminder will be sent quarterly to the sales team to direct them to this resource. Further, the Account Installation department maintains a procedure by which form use is quality checked upon group set up and corrected forms are requested, if necessary.

9. **Establish and maintain procedures to ensure that its Explanation of Benefit ("EOB") forms are filed for approval prior to use, as required by § 38.2-3407.4 A of the Code;**

   The Regulatory Compliance department maintains a process by which all policy forms, including EOB forms, are filed for approval with state regulators, if required, prior to use. Regulatory Compliance will enhance its existing procedures to draw additional attention to EOB forms specifically. It will also send to the analysts and compliance staff in the Operations department a semi-annual reminder that any changes to Virginia EOB forms must be filed for approval prior to their use.

10. **Establish and maintain procedures for compliance with §§ 38.2-1812 A and 38.2-1833 A 1 of the Code concerning the appointment and payment of commission to agents and agencies;**

    Eighty-nine of the 92 violations cited occurred with a vendor, which processed our individual dental cases. In all of these instances, their Senior Vice President of Account Management was assigned to

the case to denote a "house account" sale. The Company now understands that, given the structure of the vendor agreement, this would fall under the definition of an indirect commission. The Company's agreement with the vendor in question has terminated thus eliminating the risk of any such violations going forward. The Company will ensure all necessary appointments are in place prior to issuing direct or incorrect commissions if another similar relationship should develop in the future.

Of the remaining three violations, two were additional individual dental sales in conjunction with the vendor referenced above. As stated above, this agreement has terminated and the Company has exited the individual dental market. All group dental sales are handled internally, which provides for greater oversight by the Company.

The remaining violation cited was with a group sale accepted from an unappointed agent. This violation was the result of human error. The agency's appointment was terminated but the termination date was not entered into the Company's commission system. Had the termination date been entered as is required by the Company's established procedure, the sale would not have been accepted and commissions would not have been paid. The Producer Administration staff will be reminded of the existing procedure for terminating agents.

11. **Strengthen its procedures for notifying agents and agencies of appointment termination within 5 calendar days, as required by § 38.2-1834 D of the Code;**

    The Company acknowledges that in four instances a termination letter was either not able to be produced for review, or the letter notification exceeded the five calendar days required by § 38.2 1834 D of the Code. The Company has further enhanced its capabilities to notify producers in the required timeframe. Provided the producer has an email address on file with the Company, the producer will receive a systematic email notification of their appointment termination on the same day that it occurs. If a producer does not have an email address or if the email address is invalid, the producer will receive a mailed notification of their appointment termination as they had in the past.

12. **Establish and maintain procedures for the payment of interest on accident and sickness claim proceeds, as required by § 38.2-3407.1 B of the Code;**

    The Company will review its current procedures for issuing interest payments and make any necessary changes to the process to comply with § 38.2-3407.1 B.

13. **Review and consider for re-adjudication all dental claims processed under Virginia issued policies where dental services were provided outside of Virginia that took greater than 15 working days to pay for the years of 2013, 2014, 2015 and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously";**

    The Company will review claims processed under Virginia issued policies where dental services were provided outside of Virginia that took greater than 15 working days for the years 2013, 2014, 2015 and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B. Due to the excessive expense that is incurred to manually issue a check and the low average dollar amount of dental claims, which would result in inordinately small interest payments, the Company requests Virginia Bureau of Insurance to limit the issuance of payments under the corrective action plan to interest penalties greater than fifteen ($15.00) dollars.

14. **Review its established procedures to ensure that it acknowledges the receipt of notification of all claims within 10 working days, as required by 14 VAC 5-400-50 A;**

    The Company will review its current procedures on acknowledging receipt of claims to ensure the receipt notification is issued within 10 working days as required by 14 VAC 5-400-50 A.

15. **Establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A;**

    The Company will advise claimants of acceptance or denial of claim within 15 working days. If a claim cannot be accepted or denied within 15 working days, the Company will issue a delay notice to comply with 14 VAC-400-60A.

16. **Establish and maintain procedures to ensure that specific reference to a policy exclusion is included in the written denial when a claim denial is based on such exclusion, as required by 14 VAC 5-400-70 B; and**

    The Company maintains procedures to ensure the denial notice contains a detailed explanation of the determination which includes both the basis and clinical rationale specific to the procedure the member received or may receive. The claim for Review Sheet CL 10 did contain both the basis and clinical rationale of the determination. The Company will review its process to include a reference to the policy exclusion when services are not dentally necessary.

17. **Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above corrective actions have been completed**.

    Within 120 days of the finalization of the VA Bureau of Insurance Report, the Company will furnish the examiners with documentation that the corrective actions plans have been completed.

Thank you for your attention to this matter. Should you have questions, please contact me at (717) 260-6894 or via email at cynthia.reinecker@ucci.com.

Sincerely,

Cynthia J. Reinecker
Lead External Audit Support Analyst

cc: Ryan Caboot, Highmark
Bhaskar Machiraju, UCCI
Krista Maddigan, Highmark Inc.
Misha Patel, UCCI
Ben Schaefer, Highmark

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
www.scc.virginia.gov/boi

November 17, 2016

CERTIFIED MAIL 7015 1520 0003 0918 9724
RETURN RECEIPT REQUESTED

Ms. Cynthia J. Reinecker
Lead External Audit Support Analyst
United Concordia Insurance Company
4401 Deer Path Road, DRP 3A
Harrisonburg, PA 17110

RE: Target Market Conduct Examination Report

Dear Ms. Reinecker:

The examiners have received and reviewed UCIC's response to the Draft Report dated October 21, 2016. This letter will primarily address those areas of the response where UCIC disagreed with the findings and corrective actions of the Report or where upon further review, the examiners determined that modifications to the findings were necessary.

Section IV. Ethics & Fairness in Carrier Business Practices – Provider Contracts

Upon further review, the violations of § 38.2-3407.15 B 2 of the Code associated with Review Sheets EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF11, EF12, EF13, EF14 and EF15 have been removed from the Report. UCIC failed to provide an adequate response to Review Sheet EF10. The examiners informed UCIC in a July 8, 2015 email that, "EF10 concerned a contract negotiated on behalf of UCIC by an intermediary. The criticisms in EF10 are not the same as those specified in EF01-09 and EF11-15."

Section VI. Policy and Other Forms – Group Dental

The examiners do not agree that, "the form at issue was filed with and approved by the Bureau of Insurance." The Certificate of Coverage was issued in error by UCIC without a form number. Forms submitted to the Bureau without a form number in the lower left-hand corner of the first page would not be approved. Additionally, the form contained a substantive textual revision to previously approved form that was not adequately delineated in the statement of variability that accompanied the form filing.

The Bureau of Insurance has statutory authority to approve policy forms and a statement of variability is only reviewed to the extent that it modifies specific language in a filed policy form. As stated in the Report, 14 VAC 5-100-10 et seq. requires that a policy form be submitted in the final form in which it is to be issued. Additionally, the regulation requires that any revision or modification of a previously approved form be clearly indicated in the letter of transmittal, which shall set forth the exact changes that are intended. If UCIC intends to, "…customize for group specific enrollment variations" it is required to include the specific language of each variation as bracketed text in the policy form itself or describe the specific language of each textual variation in the statement of variability. UCIC also has the option of submitting a revised statement of variability to the Bureau by means of an informational filing via SERFF. The level of variability asserted by UCIC in regards to its policy form filings is not permitted by 14 VAC 5-100-10 et seq. and no changes to the Report are necessary.

Section XII. Corrective Action Plan

3. The examiners acknowledge UCIC's intent to amend its direct contracts with Virginia providers to comply with the requirements of Ethics and Fairness in Carrier Business Practices Act. However, UCIC's response failed to address providers in Virginia whose contracts were negotiated on UCIC's behalf by an intermediary. Please see our comments above regarding Review Sheet EF10.

13. The examiners are willing to permit the remittance of interest penalty amounts below a certain dollar threshold to the Virginia Department of the Treasury's Unclaimed Property Division. Once the examiners obtain the results of UCIC's review of the claims in question, we would be willing to enter into a discussion with UCIC as to what constitutes a reasonable threshold.

The examiners appreciate UCIC's stated intent to comply with the Report's Corrective Action Plan.

A copy of the entire Report with revised pages is attached and the revised pages contain the only substantive revisions we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that UCIC violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 of the Code, §§ 38.2-503 and 38.2-510 A 15 of the Code, in addition to 14 VAC 5-90-55 A and 14 VAC 5-90-90 C of Rules Governing the Advertisement of Accident and Sickness Insurance.

It also appears that UCIC violated §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-1812 A, 38.2-1833. A 1, 38.2-1834 D, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.15 B 1, 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 4 a, 38.2-3407.15 B 4 a (ii) (d), 038.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3407.17 B, 38.2-5803 A 4 and 38.2-5804 A of the Code.

Violations of the above sections of the Code can subject UCIC to monetary penalties of up to $5,000 for each violation and suspension or revocation of its license to transact business in the Commonwealth of Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter

Very truly yours,

Julie R. Fairbanks

Julie R. Fairbanks, AIE, AIRC, FLMI, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
Telephone (804) 371-9385

Ms. Cynthia J. Reinecker
Lead External Audit Support Analyst
United Concordia Insurance Company
4401 Deer Path Road, DRP 3A16
Harrisonburg, PA 17110

Althelia P. Battle, FLMI, HIA, AIE, MHP, AIRC, ACS
Deputy Commissioner
Bureau of Insurance
Post Office Box 1157
Richmond, VA 23218

RE: **Alleged violations of the** Unfair Trade Practices Act, specifically **subsection 1 of § 38.2-502 of the Code, §§ 38.2-503 and 38.2-510 A 15 of the Code, in addition to 14 VAC 5-90-55 A and 14 VAC 5-90-90 C of** Rules Governing the Advertisement of Accident and Sickness Insurance, **as well as, §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-1812 A, 38.2-1833. A 1, 38.2-1834 D, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.15 B 1, 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 4 a, 38.2-3407.15 B 4 a (ii) (d), 038.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3407.17 B, 38.2-5803 A 4 and 38.2-5804 A of the Code.**

Dear Ms. Battle:

This will acknowledge receipt of your letter dated November 29, 2016, concerning the above-captioned matter.

UCIC wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of $29,000, payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement; it is entitled to a hearing in this matter and waives its right to such a hearing and agrees to comply with the Corrective Action Plan contained in the Market Conduct Examination Report as of December 31, 2014.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Yours very truly,

Daniel J. Wright
SVP & CFO
Company Representative

12/5/2016
Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, DECEMBER 28, 2016

161240319

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2016-00275

UNITED CONCORDIA INSURANCE COMPANY,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that United Concordia Insurance Company ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia"), violated §§ 38.2-316 A, 38.2-316 B, and 38.2-316 C (1) of the Code of Virginia ("Code") by failing to comply with policy and form filing requirements; violated §§ 38.2-502 (1) and 38.2-503 of the Code, as well as 14 VAC 5-90-55 A and 14 VAC 5-90-90 C of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.*, by failing to comply with advertising requirements; violated § 38.2-510 A (15) of the Code by failing to comply with claim settlement practices; violated § 38.2-1812 A of the Code by paying commissions for services as an agent to persons who were not properly licensed and appointed; violated §§ 38.2-1833 A (1) and 38.2-1834 D of the Code by failing to comply with agent licensing requirements; violated §§ 38.2-3407.15 B (1), 38.2-3407.15 B (2), 38.2-3407.15 B (3), 38.2-3407.15 B (4), 38.2-3407.15 B (5), 38.2-3407.15 B (6), 38.2-3407.15 B (7), 38.2-3407.15 B (8), 38.2-3407.15 B (9), 38.2-3407.15 B (10), and 38.2-3407.15 B (11) of the Code by failing to comply with ethics and fairness requirements for business practices; violated § 38.2-3407.1 B of the Code by failing to

pay interest at the legal rate of interest from the date of 15 working days from the Defendant's receipt of proof of loss to the date that the claim was paid; violated § 38.2-3407.4 A of the Code by failing to comply with explanation of benefits requirements; violated § 38.2-3407.17 B of the Code by failing to comply with the payment for services by dentist and oral surgeons requirements; violated § 38.2-5803 A (4) of the Code by failing to comply with disclosures and representations to enrollees requirements; and violated § 38.2-5804 A of the Code by failing to comply with procedures to establish and maintain an approved complaint system for each of its Managed Care Health Insurance Plans.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of its right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has tendered to Virginia the sum of Twenty-nine Thousand Dollars ($29,000) waived its right to a hearing, and agreed to comply with the corrective action plan contained in the target market conduct examination report as of December 31, 2014.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau, is of the opinion that the Defendant's offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.

(2) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Cynthia J. Reinecker, Lead External Audit Support Analyst, United Concordia Insurance Company, 4401 Deer Path Road, DRP 3A, Harrisonburg, Pennsylvania 17110; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Althelia P. Battle.

A True Copy
Teste:

Joel H. Peck
Clerk of the
State Corporation Commission