

DELAWARE DEPARTMENT OF INSURANCE
MARKET CONDUCT EXAMINATION REPORT

Highmark BCBSD Inc.

NAIC # 53287

Examination Authority # 53287-14-PP-704
800 Delaware Avenue
Wilmington, DE 19801-1368

As of

September 30, 2014

Karen Weldin Stewart, CIR-ML
Commissioner



Delaware Department of Insurance

I, Karen Weldin Stewart, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON EXAMINATION, made as of September 30, 2014 on

Highmark BCBSD Inc.

is a true and correct copy of the document filed with this Department.

Attest By: W. Bradley



In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover.

Karen Weldin Stewart, CIR-ML
Insurance Commissioner

Karen Weldin Stewart, CIR-ML
Commissioner




Delaware Department of Insurance

REPORT ON EXAMINATION
OF THE
Highmark BCBSD Inc.
AS OF
September 30, 2014

The above-captioned Report was completed by examiners of the Delaware Department of Insurance.

Consideration has been duly given to the comments, conclusions and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted and filed as an official record of this Department.



Karen Weldin Stewart, CIR-ML
Insurance Commissioner

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Honorable Karen Weldin Stewart CIR-ML
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Stewart:

In compliance with the instructions contained in Certificate of Examination Authority Number 53287-14-PP-704 and pursuant to statutory provisions including 18 Del. CODE §318-322, a market conduct examination has been conducted of the affairs and practices of:

Highmark BCBSD Inc.

The examination was performed as of September 30, 2014. Highmark BCBSD Inc., hereinafter referred to as the "Company", was incorporated under the laws of Delaware. The examination consisted of two phases, an on-site phase and an off-site phase. The on-site phase of the examination was conducted at the following Company location:

800 Delaware Avenue
Wilmington, DE 19801-1368

The off-site examination phase was performed at the offices of the Delaware Department of Insurance, hereinafter referred to as the "Department" or "DDOI," or other suitable locations.

The report of examination herein is respectfully submitted.

EXECUTIVE SUMMARY

Highmark BCBSD Inc. is domiciled in Delaware and is licensed in Delaware. The Company's main administrative offices are located in Wilmington, DE.

The examination focused on the Company's health insurance business in the following areas of operation: Company Operations and Management; Complaint Handling and Claims.

The following exceptions were noted in the area of operation reviewed:

Complaints: 36 Exceptions - 18 Del. C. §2304 Unfair methods of competition and unfair or deceptive acts or practices defined.

– The Company's complaint log did not reflect a detailed description of the disposition.

Complaints: 2 Exceptions - 18 Del. C. §2304 Unfair methods of competition and unfair or deceptive acts or practices defined.

– The Company's failed to respond to two inquiries from the Department of Insurance within 21 days.

Complaints: 26 Exceptions - 18 Del. Admin. Code 902 §1.2.1.2 – Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.

- The Company failed to issue a response within 15 working days in regard to the insured's communication on a claim for 26 claims related communications.

Claims: 234 Exceptions - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

- The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim. Note: 26 claims were paid within 31 to 37 Days due to contracted payment dates with providers. The claims were processed under thirty days, however due to the provider contracts; the claims were not paid until the contracted payment day, which could have been up to one week from the date the claims were approved. Each provider's checks are cut on certain days of the week, thus a check that is approved on the thirtieth day may not be issued anywhere from one to six days later.

SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by 18 Del. CODE §318-322 and covered the experience period of September 1, 2013 through September 30, 2014.

The examination focused on the Company's activities related to health insurance, including the Company's compliance with Delaware statutes, rules and regulations focusing on compliance with Delaware prompt pay requirements. Functional areas reviewed include Company Operations and Management, Complaint Handling, Provider Relations, Policyholder Services and Claims.

METHODOLOGY

This examination was performed in accordance with Market Regulation standards established by the Department and examination procedures suggested by the NAIC. While the examiner's report on the errors found in individual files, the examination also focuses on general business practices of the Company.

The Company identified the universe of files for each segment of the review. Based on the universe sizes, random sampling was utilized to select the files reviewed during this examination.

Delaware Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. An exception is any instance of Company activity that does not comply with an insurance statute or regulation. Exceptions contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of exceptions identified during the examination and review written summaries provided on the exceptions found.

COMPANY HISTORY

Highmark BCBSD Inc. (the "Company"), formerly BCBSD, Inc., was originally incorporated by the filing of a Certificate of Incorporation with the Secretary of State on

August 16, 1935 as a non-profit, non-stock corporation. Since its founding, the Company has remained a not-for-profit Delaware corporation regulated as a health service corporation under the Delaware Insurance Code. The Company, as a licensee of the Blue Cross and Blue Shield Association (the “BCBSA”), underwrites various indemnity and managed care health insurance products, as well as Medicare supplemental, dental and vision products. The Company also provides Administrative Services Contracts (“ASCs”) to self-funded plans. The Company is licensed to solicit business as a health service corporation in the State of Delaware only.

On January 1, 2012, BCBSD Inc. became an affiliate of Highmark Inc. (a national diversified health and wellness company based in Pittsburgh, Pennsylvania) and the corporate name was changed to Highmark, BCBSD Inc. Highmark Inc. became the primary licensee of the BCBSA for the BlueCross® and BlueShield® service marks in Delaware. Highmark BCBSD Inc. operates as a controlled affiliate of Highmark Inc. within the meaning of the BCBSA rules. The Company is a separate legal entity and not liable for Highmark, Inc.’s obligations.

In accordance with its Certificate of Incorporation and Bylaws, all corporate powers and business property and affairs of the Company are managed by, or under the direction of, the Company’s Board of Directors (the “Board”). The management and control of the Company is vested in the Board (which consists of nine members – four Class A, four Class B, and one President Director). Highmark Inc., is entitled to elect the Directors of the Board in the manner and subject to the terms of the Bylaws of the Company.

The officers of the Company are elected by the Board. Those persons serving as officers of the Company are: Timothy J. Constantine, President; Todd P. Graham, Treasurer; and William E. Kirk, III, Corporate Secretary.

COMPANY OPERATIONS AND MANAGEMENT

Internal Audit

The Company provided information and documentation related to internal audits and internal market regulation/conduct audit reviews. Included with the requests were regulatory actions and court actions taken against the Company and Market Conduct Examination Reports. The requested information and supporting documentation was provided by the Company and reviewed during the course of the examination.

The examination included a review of internal audit reports and internal market regulation/conduct audits under the examination scope.

There were no exceptions noted.

CONSUMER COMPLAINTS

The Company provided a list of complaints filed with the Company during the examination period. The list included complaints received from the Delaware

Department of Insurance, as well as complaints made directly to the Company on behalf of Delaware consumers.

The Company's complaint log consisted of 1,349 non-DOI complaints and 178 DOI complaints for the experience period of September 1, 2013 through September 30, 2014. Sample selections of 113 non-DOI and 79 DOI complaints were chosen for review. The logs were reviewed for compliance with 18 Del. C. §2304 (17). Complaint files involving claims were also reviewed for compliance with 18 Del. C. §2304 (26) and 18 Del. Admin. Code 902 §1.2.1.2. The following violations were noted:

36 Exceptions – 18 Del. C. §2304 Unfair methods of competition and unfair or deceptive acts or practices defined.

(17) Failure to maintain complaint handling procedures.-Failure of any person to maintain a complete record of all the complaints which they have received since the date of its last examination as otherwise required in this title. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance.

The log did not reflect a detailed description of the disposition for 36 complaints.

Recommendation: It is recommended the Company provide a detailed description of the disposition on the complaint log.

2 Exceptions – 18 Del. C. §2304 Unfair methods of competition and unfair or deceptive acts or practices defined.

(26) Failure to respond to regulatory inquiries. – No person shall, with such frequency as to indicate a general business practice, fail to provide preliminary substantive responses to inquiries from the Department of Insurance regarding the denial of claims, cancellation, nonrenewal, or refusal of benefits, refusal to pre-authorize benefits, or violations of this title, within 21 days of such inquiry. A response in compliance with this paragraph shall not preclude the provision of additional information responsive to the inquiry.

The Company failed to respond to 2 inquiries from the Department of Insurance within 21 days.

Recommendation: It is recommended the Company provide a preliminary substantive response to inquiries from the Department of Insurance within 21 days.

26 Exceptions – 18 Del. Admin Code 902 §1.2.1.2

Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.

The Company failed to issue a response within 15 working days in regard to the insured's claim.

Recommendation: It is recommended the Company respond to communications from the insured with respect to claims within 15 working days.

CLAIMS

The examiners were provided data for all claims received during the examination period. The data contained 4,411,217 records. A listing of Pharmacy claims was also received which contained 960,883 pharmacy claims. ACL® software was utilized to analyze the data and to segment it into manageable categories. The examiners reviewed a total of 1192 claims in 15 categories to assess the Company's compliance in each category. The categories included claims paid by the number of days between claim receipt and payment or denial (1 to XX days, ...) and by claim status types (Original A, D Claims...). A sample of claims with a code of "J" was not reviewed. Claims with a code of "J" were reviewed in other samples. The total amount claims with a code of "J" is 226,200. A statistical sample was selected for each time and status category with the intention of identifying any patterns of activity within each category related to the prompt payment of claims.

It is important to recognize that the length of time between claim submission and claim payment is not prima facie evidence of the Company's failure to meet the prompt payment standards. The examiners reviewed each claim individually to determine if there were reasonable explanations for why a claim might be delayed for more than 30, 60, 90 or 365 days. In some instances, the time between original receipt and ultimate payment of the claim was delayed due to delays in provider information submission, provider audits that raised questions about the claims original processing that resulted in additional information submissions or other scenarios the examiners find were reasonable and beyond the Company's control. Those types of scenarios were not considered a violation.

Likewise, if the Company took action within a 30 day period but the action resulted in an incorrect claim processing, the Company was found to be in violation of prompt pay requirements. Merely taking action within the specified timeframe is inadequate; the prompt action must be accurate.

Also, delays in Blue Card payments due to delayed submission by the original processing entity were not held against the company for the purpose of determining prompt pay violations. A Blue Card claim is one that is incurred outside of the Highmark BCBSD Inc. network but covers a Highmark BCBSD insured. For the purpose of determining prompt payment, the measure of timeliness was based on the date the claim was received

at Highmark BCBSD Inc., not the date it was received by the separate Blue Cross Blue Shield legal entity in another jurisdiction.

A summary of findings for each category is below:

1 to 30 days

The examiners reviewed 115 of 3,013,203 claims that were either paid or denied between 1 and 30 days after receipt. The following are findings from the review:

No exceptions noted.

31 to 45 days

The examiners reviewed 115 of 96,555 claims that were either paid or denied between 31 and 45 days after receipt. The following are findings from the review:

39 Exceptions - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

§6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

- 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*
- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim.

Note: 26 claims were paid within 31 to 37 days due to contracted payment dates with providers. The claims were processed under thirty days, however due to the provider contracts; the claims were not paid until the contracted payment day, which could have been up to one week from the date the claims were approved. Each provider's checks are cut on certain days of the week, thus a check that is approved on the thirtieth day may not be issued anywhere from one to six days later.

46 to 60 days

The examiners reviewed 115 of 53,447 claims that were either paid or denied between 46

and 60 days after receipt. The following are findings from the review:

38 Exceptions - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

§6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

- 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*
- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim.

61 to 90 days

The examiners reviewed 115 of 80,341 claims that were either paid or denied between 61 and 90 days after receipt. The following are findings from the review:

38 Exceptions - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

§6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

- 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*
- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim.

91 to 365 days

The examiners reviewed 115 of 204,696 claims that were either paid or denied between 91 and 365 days after receipt. The following are findings from the review:

29 Exceptions - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

§6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

- 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*
- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim.

Over 365 days

The examiners reviewed 115 of 2,092 claims that were either paid or denied after 365 days after receipt. The following are findings from the review:

28 Exceptions - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

§6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

- 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*
- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim.

The examiners also selected a sample from each status code for review. The following claim reviews have been completed according to coding the Company uses for various claims. A brief definition has been added to explain the meaning of each status code from which the sample files were selected for review. It has been determined that these codes by themselves, do not have an effect on the timeliness of the claim payment.

Original A

The examiners reviewed 115 of 3,869,303 claims files with a status of Original A. Original A consists of the entire universe of claims from the exam period, excluding claims with status codes D, H, J, M S, U, V and pharmacy claims. The following findings were noted during the review:

7 Exceptions - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

§6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

- 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*
- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim.

Pharmacy Claims

The examiners reviewed 115 of 960,883 pharmacy claims. The following findings were noted during the review:

26 Exceptions - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

§6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

- 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*
- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim.

D Claims

The examiners reviewed 10 of 119 claims with a code of “D”. Claims with a status of “D” are claim lines that have been deleted from the system. The following findings were noted during the review:

1 Exception - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

§6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

- 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*
- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim.

H Claims

The examiners reviewed 10 of 5,867 claims with a status of H. Claims with a code of “H”, indicates that the claim line has been finalized and moved to a history state. The following findings were noted during the review:

There were no exceptions noted.

M Claims

The examiners reviewed 10 of 16,580 claims with a code of M. Claims with a status of “M” indicate that the system has merged multiple procedure codes into one line under a different code.

There were no exceptions noted.

S Claims

The examiners reviewed both files with a status of S. Claims with a code of “S” indicate that the claim has been sent to another system. The following findings were noted during the review:

1 Exception - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

§6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

- 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*
- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim.

U Claims

The examiners reviewed 10 of 1,375 claims with a code of U. Claims with a status of “U” are a result of the Discussion Logic Processing System (DLPS) combining lines when necessary on a claim, the “inactive” line then shows as a “U”.

There were no exceptions noted for this section.

Void Claims

The examiners reviewed 115 of 291,771 claims with a code of V. Claims with a code of “V” have been voided. The following findings were noted during the review:

27 Exceptions - 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services

§6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

- 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*
- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

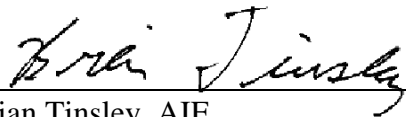
The Company failed to either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim.

CONCLUSION

The recommendations made below identify corrective measures the Department finds necessary as a result of the exceptions noted in the Report. Location in the Report is referenced in parenthesis.

- It is recommended that the Company include in its complaint log a disposition for each complaint in accordance with 18 Del. C. §2304. (page 5)
- It is recommended that the Company respond to all inquiries from the Department of Insurance within 21 days in accordance with 18 Del. C. §2304. (page 5)
- It is recommended that the Company either pay, deny, or to provide a reason for the inability to pay a claim in writing within 30 days after receipt of a clean claim in accordance with 18 Del. Admin. Code 1310. (pages 7-12)

The examination conducted by Shelly Schuman, Brian Tinsley, Linda Armstrong, and Jason Nemes is respectfully submitted.



Brian Tinsley, AIE
Examiner-in-Charge
Market Conduct
Delaware Department of Insurance