

December 10, 2007

Mr. James T. Odiorne, CPA, JD  
Office of the Insurance Commissioner  
5000 Capitol Boulevard  
Tumwater, WA 98501

***Sent Via E-Mail and Overnight Delivery***

Re: The MEGA Life and Health Insurance Company, NAIC #97055,  
Midwest National Life Insurance Company of Tennessee, NAIC #66087,  
The Chesapeake Life Insurance Company, NMC #61832

Dear Mr. Odiorne:

I am pleased to enclose the response of The MEGA Life and Health Insurance Company, Mid-West National Life Insurance Company of Tennessee and The Chesapeake Life Insurance Company (collectively, the Companies) to the multi-state market conduct examination Draft Report.

We are submitting our Executive Summary and our Responses to Draft Report Findings and Required Actions, along with our Responses to the Results of Attribute Testing. Our response detail identifies areas where we disagree with the findings and the reasons for our disagreement. Where corrective actions for problem identified in the draft report are already in place those actions are fully described.

Thank you for your consideration and I look forward to hearing from you at your convenience.

Sincerely,



Kay D. Phillips  
Chief Compliance Officer

cc: Leslie Krier  
Ted Lehrbach  
Kara Baysinger  
Mike Colliflower

**RESPONSE TO THE  
MULTI-STATE MARKET CONDUCT EXAMINATION DRAFT REPORT  
OF  
THE HEALTHMARKETS, INC. INSURANCE COMPANIES**

**(Formerly Known As UICI)**

**The MEGA Life and Health Insurance Company  
Mid-West National Life Insurance Company of Tennessee  
and  
The Chesapeake Life Insurance Company**

**9151 Boulevard 26**

**North Richland Hills, Texas 76180-5605**

**EXAMINATION PERIOD**

**January 1, 2000 through December 31, 2004\***

**\*Examination period extended to December 31, 2005 to include attribute testing and agent interviews.**

**December 10, 2007**

CONFIDENTIAL SETTLEMENT COMMUNICATION

TABLE OF CONTENTS

<b>I. SECTION I: EXECUTIVE SUMMARY</b>	<b>3</b>
Introduction	3
Comments and Concerns	5
Section II of Response	7
Overview of Compliance Initiatives	9
<b>II. SECTION II: RESPONSES TO DRAFT REPORT FINDINGS AND     REQUIRED ACTIONS</b>	<b>11</b>
<b>III. EXHIBITS</b>	<b>59</b>

**SECTION 1 – EXECUTIVE SUMMARY**

**Introduction**

The MEGA Life and Health Insurance Company, Mid-West National Life Insurance Company of Tennessee and The Chesapeake Life Insurance Company (collectively, the Companies) wish to express their appreciation to the Washington Office of the Insurance Commissioner and the Alaska Division of Insurance (the Lead States) for the opportunity to respond to the Draft Report sent to the Companies on November 20, 2007. We are appreciative of the inclusion in the body of the Draft Report of many of the initiatives and enhancements the Companies have undertaken both during and after the examination period. We believe that, with only certain noted exceptions, the Draft Report presents an accurate picture of the Companies' efforts to improve their operations, compliance programs, agent training and oversight in the home office and the field, both during and after the examination period.

The Companies also believe they have effectively addressed or are addressing the findings identified in the Draft Report. Many of those enhancements have been in place for some time, while others are underway. Many of these enhancements are discussed more fully in Section II, the main body of this Response.

Our compliance program enhancements and improvements are a daily part of our Companies' commitments and operations, and are therefore, an ongoing and expanding part of what we do and who we are today as HealthMarkets companies. We appreciate the opportunity to discuss these compliance program enhancements and improvements in this Response, so that the Lead States, Participating States and the rest of the regulatory community have the most current information related to these ongoing efforts.

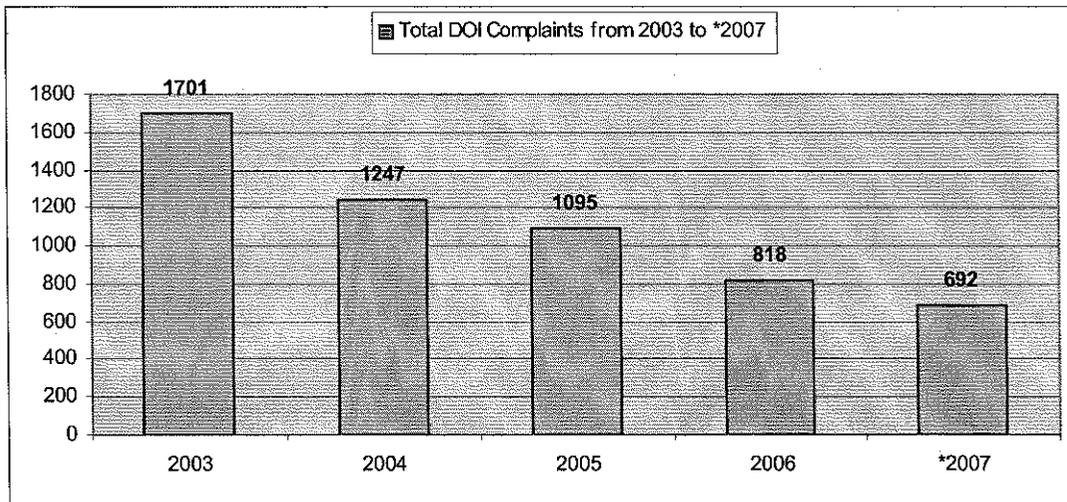
The Companies are committed to (1) offering health insurance at an affordable price to consumers who must pay the total costs of coverage on their own; (2) holding compliance as an enterprise-wide top priority; and (3) building open and trusting relationships with regulators through regular meetings and proactive interaction. The following improvements evidence our dedication to these goals:

## CONFIDENTIAL SETTLEMENT COMMUNICATION

1. Enhanced, comprehensive agent training and oversight implemented beginning in 2003, with efforts to enhance and improve agent training that continue today. The core of this expanded effort is our agent training program that is called "Training, Testing, Auditing, Complaints and Compliance" or TTACC.
2. Expand our existing program of agent oversight, through a newly-developed process called the Field Evaluation Program ("FEP"), to be kicked off during the first quarter of 2008. The FEP will include regular comprehensive field audits of the sales offices of each marketing division, and targeted audits when issues requiring prompt attention are identified. These audits will be done by Field Auditors within the Compliance Department, under the guidance of the Chief Compliance Officer.
3. Since September 2004, disclosure forms fully describing the relationship between the Companies and the associations have been used nationwide. The language in these disclosure forms have been approved by a Federal Court.
4. A post-sale Benefit Confirmation Call Program was implemented in April 2005 to confirm that purchasers of the Companies' base health insurance plans understand the benefits and limitations of their coverage.
5. More comprehensive insurance products were introduced in 2006 as an alternative to the Companies' scheduled benefit plans. We continue to focus on product needs of consumers in product development.

These changes and others currently underway have increased customer understanding and satisfaction with our products and services, as shown by a significant reduction in complaints and litigation against the Companies. Specifically, over the last three years, Department of Insurance complaints declined 52% and this downward trend has continued in 2007. Our records show that through November 30, 2007, DOI complaints are down nearly 9% from the prior year period. In addition, litigation against the Companies is down approximately one-half nationally since 2005.

## CONFIDENTIAL SETTLEMENT COMMUNICATION



\* 2007 MEGA, Mid-West and CLICO DOI count as of 11/30/07

### **Comments and Concerns**

The Companies are concerned about several issues and findings in the Draft Report.

1. Consumer Understanding: In the normal course of our business today, we make concerted efforts to assure that our customers understand the products they have purchased from our Companies. At the point of sale, our agents use detailed product brochures approved by our Compliance Department that thoroughly describe the product(s) we sell. At the end of the sales presentation, our agents are required to leave behind a product brochure that lists the benefits and limitations of the product the customer has purchased. After the sale is completed and the policy is issued, we make several telephone calls under our Benefit Confirmation Program (BCP) to our new customer to go over their plan with them. During those calls, we review the benefits and limitations of the policy they have purchased, and also confirm with them that our plans are not major medical or comprehensive health insurance policies.

If we do not connect via the telephone on the BCP call, we send a letter to the new insured. This letter contains a statement that this coverage is "not a comprehensive major medical plan." A copy of the form of letter is attached as Exhibit 1.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

We understand the concerns expressed in the Draft Report and we commit to the Lead States that we will work collaboratively with them to develop additional methods to help consumers have a better understanding of the Companies' products.

2. Association Disclosure: The Companies are concerned about Finding #3, which states: *"The Company discloses their relationship with the associations to consumers and policyholders, both orally and in writing. The Examiners found these disclosure methods insufficient."* In 2004, the Companies began to provide written disclosures at the point of sale that clearly delineate the relationship between the Companies and the associations. The Association Disclosure form was developed during the settlement of national litigation involving the Companies and was approved by a Federal Court. The Disclosure form cannot be changed without the approval by the Federal Court.

The Companies believe that their disclosure methods are sufficient based on the information provided above. In addition, the Companies are unaware of any statute or regulation that requires the use of such a disclosure form in the sale of association group insurance. We request that the language of this finding be deleted or modified, or that we be given the opportunity to discuss what other measures would satisfy the concerns expressed in the Draft Report. The Association Disclosure form is attached as Exhibit 2.

3. Dual Role of Agents: A third concern relates to the finding that our agents are sales agents for the Companies' health insurance plans, as well as enrollers for the associations. It is standard practice in the association group insurance market, rather than the exception, for agents to act in this dual capacity. Our agents are trained regarding their dual capacity and the need for them to clearly disclose their capacity when talking to prospects. In addition, we have undertaken to completely separate collection of the association dues and insurance premium payments at the point of sale and throughout the life of the policy. We obtain two checks during the sales process, and thereafter, either bill or draft separately for the association membership dues amount and the insurance premium. We submit that this separation should be sufficient when coupled with the agent training and the Association Disclosure form referenced in Item 2 above.

4. Attribute Testing: While the Draft Report noted deficiencies in the handling of complaints and grievances, we respectfully point out that the Companies complaint handling practices were within the NAIC Market Regulation Handbook's (the NAIC Handbook) stated error

CONFIDENTIAL SETTLEMENT COMMUNICATION

tolerance levels for every aspect of the attribute test standards listed in the Draft Report. The single exception was Grievance Standard 1, where two violations were noted for Mid-West among a sample size of twelve, which is a very small sample size.

The following table summarizes<sup>1</sup> the results of the Companies' attribute testing in the Draft Report. Please note that the overall results of these tests clearly indicate that the Companies successfully met the stated error tolerance level for all but four<sup>2</sup> of fifty tested attribute standards.

Standards	% in Compliance with Standard									
	MEGA				Mid-West				CLICO	
	Complaint	Grievance	Claims (Paid)	Claims (Denied)	Complaint	Grievance	Claims (Paid)	Claims (Denied)	Claims (Paid)	Claims (Denied)
1	90%	93%	100%	99%	96%	83%	97%	100%	96%	98%
2	N/A	N/A	100%	99%	N/A	N/A	96%	96%	96%	100%
3	94%	N/A	100%	98%	94%	N/A	96%	96%	96%	92%
4	92%	N/A	100%	100%	96%	N/A	100%	100%	100%	100%
5	N/A	N/A	100%	97%	N/A	N/A	98%	93%	98%	58%
6	N/A	N/A	97%	N/A	N/A	N/A	93%	N/A	92%	N/A
9	N/A	N/A	N/A	97%	N/A	N/A	N/A	94%	N/A	96%
11	N/A	N/A	100%	100%	N/A	N/A	100%	100%	100%	100%

**Section II of Response**

Section II of this response is devoted to a detailed response to the findings and required actions in the Draft Report. In summary, Section II includes requests for clarification or deletion of findings and/or required actions, additional information concerning the Companies' operations and examples of how identified issues have already been addressed, as the following highlights:

- Description of key enhancements accomplished with respect to organizational structure, field training and field monitoring activities since 2003 (Finding #1 and Finding #2);
- Explanations and requests related to Claims Handling (Finding #3), regarding:

<sup>1</sup> Excludes attribute testing results for Underwriting because the Draft Report does not identify any violations of the tested Underwriting standards.

<sup>2</sup> Three of the four tested standards that exceed the stated error tolerance levels relate to claim settlement practices for The Chesapeake Life Insurance Company, and make up .0096% of the total claims processed during the tested timeframe of 1/1/2005 through 6/30/2005.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

- The Companies' use of diagnosis and CPT codes (Finding #3A);
- Consecutive claim number issue and its resolution in December 2004 (Finding #3B);
- Revisions to Explanation of Benefit ("EOB") forms to include deductible information (Finding #3D);
- Quality assurance and independent internal audit processes to assure claims adjudication is compliant (Finding #3E);
  
- Companies' development and completion of a Claims Procedure Manual (Finding #4);
  
- Explanations and requests related to the Companies' and the Associations' operations (Finding #6) as follows:
  - Remittance of the initial and renewal payments for the Companies and the Associations (Finding #6A);
  - Use of a detailed disclosure form regarding the business relationships between the Companies and the Associations beginning in September 2004 (Finding #6B);
  - Handling of the Association administration fees (Finding #6C);
  
- Explanation that the results of the Attribute Testing on complaints and grievances indicate the errors were virtually all within the allowable 10% error tolerance level pursuant to NAIC standards and requests that these results be applied to findings and required actions (Findings #7.A.-7.F.);
  
- Explanation of the strides made by the Companies in creating a comprehensive, centralized compliance program to promote consistency throughout the entire enterprise (Finding #9); and
  
- The Companies' request for reconsideration of an alternative means of satisfying the examiners concerns related to the outside consultant's report (Finding #12).

**Overview of Compliance Initiatives**

The Companies have taken significant action in the last four years to develop a strong, sustainable compliance program that will enable them to enhance improvements achieved to date and to demonstrate effective compliance controls to the regulatory community.

- Beginning in late 2004, the Companies restructured the historically decentralized compliance efforts to create a comprehensive, centralized compliance structure with reporting directly to the Chief Executive Officer (CEO), the General Counsel and, ultimately, the Board of Directors of HealthMarkets, Inc.
- In early 2007, the Compliance Program was centralized into the Compliance Department under the direction of the Chief Compliance Officer (CCO). The CCO has unfettered access to the Chief Executive Officer (CEO), the Chief Operating Officer (COO), and other senior management personnel throughout the organization. In addition, the CCO interacts with and provides regular reports to the Compliance and Governance Committee of the HealthMarkets, Inc. Board of Directors. This centralization of compliance functions that had been spread throughout various departments and business units of the Companies has improved communication and coordination of the Companies' compliance goals, and has helped ensure a consistent interpretation of new laws and regulations across the enterprise.
- In early 2006, the Companies developed an internal Compliance Audit group that is charged with conducting follow up audits on remediation efforts and actions taken in response to market conduct examination commitments and with auditing the implementation of new laws and regulations by our business units. This group reports directly to the Compliance and Governance Committee of the Board of Directors.
- A Regulatory Advisory Panel (RAP) composed of respected former insurance regulators and other respected government officials was formed in August 2006. The RAP is independent and provides objective advice and guidance to the Companies regarding regulatory and compliance issues, trends and initiatives.
- In October 2006, the Executive Compliance Committee (ECC) was created, to bring compliance issues to the Companies' senior executives for their consideration. The

## CONFIDENTIAL SETTLEMENT COMMUNICATION

ECC meets regularly, and includes the CEO, Chief Operating Officer (COO), CFO, General Counsel, Chief Information Officer (CIO), the CCO, and senior management from the marketing division, AMG, the business processing center, Administrative Services Group (ASG), and Compliance Audit.

- The Companies recently created a department within ASG that is charged with compliance-related oversight. In coordination with the Companies' CCO, this new department, Operational Compliance, works with the operational departments within ASG to implement compliance-related enhancements in response to enacted new laws and regulations, and commitments made to regulators. In addition, Operational Compliance is also charged with monitoring the ongoing compliance of the operations within ASG.

The Companies are committed to working with the Lead States, our Domestic Regulators, and the Participating States on completion of the report. The Companies respectfully submit that we have addressed those concerns and criticisms in a wide variety of effective enhancements and improvements to our policies and procedures and our organization.

The Companies believe that they have made and are continuing to make extraordinary strides in improving our compliance with all laws and regulations that relate to our business. Fuller explanations of the many enhancements made in recent years, as well as responses to each of the Findings in the Draft Report are included in Section II of our Response.

## SECTION II – RESPONSES TO DRAFT REPORT FINDINGS AND REQUIRED ACTIONS

This Section of the response supplements the information set forth in the Executive Summary. The Companies have carefully reviewed the Findings and Required Actions described in the Draft Report together with the other sections of the Draft Report and respectfully submit the following comments and information for consideration. This Section of the Companies' response includes summary information regarding key initiatives completed by the Companies that are responsive to the Findings and Required Actions expressed in the Draft Report. The Companies continue to develop and implement additional planned actions to supplement the key enhancements that have already been implemented by the Companies. This response information also includes requests to change some of the report findings and required actions.

The Companies' Responses to the Findings and Required Actions are provided below in sequential order with the Draft Report:

***Finding #1:** Regulators noted that a majority of complaints stemmed from missing or inaccurate information during the initial contact between the agent and the customer. While the Company has devoted resources to refine internal operations, the agency program had not changed significantly. These issues will continue to persist until the Company becomes more involved in oversight of agents.*

The Companies have changed the agency program significantly and considerable enhancements have occurred with respect to agency operations, with much effort devoted to enhancing agent training and oversight. The Companies continue their long-time commitment to ensure that their customers receive complete and accurate information during the sales process. Key enhancements accomplished with respect to organizational structure, field training and field monitoring activities since 2003 include:

- **Agency Marketing Group.** The Agency Marketing Group ("AMG") was established in 2004 to provide centralized oversight of UGA (the marketing division of MEGA) and Cornerstone America ("Cornerstone," the marketing division of Mid-West) in a consistent manner. Compliance staff was dedicated to oversee agent training and monitoring programs in March 2005.

CONFIDENTIAL SETTLEMENT COMMUNICATION

- **TTACC Training Program, 2003.** A comprehensive, company-wide agent training platform entitled the "Training, Testing, Auditing, Compliance and Complaints" or "TTACC" program was introduced beginning in 2003. TTACC is a mandatory agent training program that covers a variety of insurance, sales and compliance related topics including, but not limited to, marketing guidelines, advertising guidelines, unfair trade practices, general sales presentation guidelines, proper disclosures, disciplinary policy and detailed product training. Training regarding ethics and sales practice standards are embedded throughout the TTACC training materials. State-specific training modules are designed to address the unique requirements that exist in each state, including products and mandated benefits.

At the initial implementation of TTACC in 2003, all appointed agents in each state were required to complete the TTACC training program for their state and pass a test covering the training materials with at least an 80% grade, or 90% in the case of Field Leaders. Since its inception, all new agents have been required to complete TTACC training and testing before they can write business for the Companies. All existing agents must also complete TTACC testing annually. As of November 2004, the Companies would not accept any business from an agent who has not completed the required training and testing. There are no exceptions to this rule.

While the basic objectives have not changed, TTACC has undergone numerous revisions since its initial rollout to improve the quality and effectiveness of the training provided to all of the Companies' agents. These revisions have moved UGA and Cornerstone (our two dedicated sales divisions) to a single training platform, which ensures consistency of training across the two sales organizations. Over the years, the Companies have added sections to the training modules to address issues identified in internal audits or through a pattern of complaints, as well as the addition of new questions to the TTACC tests to ensure that agents understand the new training materials. We continue to review and improve TTACC, both in scope and specificity, as new products are introduced or new regulatory or statutory requirements are implemented. Several states, including Arizona, Delaware, Iowa, Massachusetts, Oregon, Washington, and Wisconsin, have sent representatives to attend agent training sessions, and the Companies have received favorable feedback from these states. The

## CONFIDENTIAL SETTLEMENT COMMUNICATION

Companies have made modifications to the training based on feedback from those states as part of our commitment to improve our agent training.

- **National Product Training Team, beginning December 2006.** A National Product Training Team ("the Training Team") was established in late 2006 to conduct comprehensive product training sessions at field offices. While Field Leaders have responsibility for TTACC new agent training in accordance with the Companies' approved TTACC materials, the Training Team conducts continuing education for existing products and delivers all training for new products and initiatives. In addition, the Training Team provides targeted training courses for products and compliance issues.

This team of professional trainers is overseen by the Vice President in charge of product training and development. This Vice President has a direct reporting relationship to the head of the Companies' operations. The Training Team is currently staffed with 12 members, including ten (10) traveling trainers and two (2) compliance support members. The Training Team has conducted 70 training sessions this year, including 47 refresher courses, at field offices.

- **Other Training Opportunities (ongoing):** Other training opportunities are continually provided to the agents, including but not limited to:
  - Field leaders hold weekly meetings with their field force, and a portion of these meetings is usually dedicated to compliance training. Field leaders may use training materials or other compliance information developed and provided by the Companies, or they may address issues of concern that have been identified within their field office. The field leaders continue to reinforce product knowledge and important compliance information during these weekly sessions.
  - The Companies conduct regular field leader meetings to provide essential training and to communicate important company strategies, including compliance-related information. The field hierarchy includes Regional, Divisional and District sales leaders who oversee the activities of the agents in their

## CONFIDENTIAL SETTLEMENT COMMUNICATION

respective regions. During these sessions, the Companies provide presentations on leadership skills to help field leaders develop their own skills and those of their agents as part of Field Leadership Training sessions, held since 2004. Compliance, financial responsibility, and peer-to-peer training on job-specific responsibilities are topics that are typically covered at each of these training schools for the field leaders. In addition, the Companies receive feedback from the field leaders regarding ways the Companies can help their field force to better serve their customers as part of regular meetings with an advisory board called the Leaders' Congress. This group provides feedback and insight regarding future company initiatives, including compliance-related projects, as well as agent training and oversight programs.

- **Field Leader and Agent Handbooks, beginning June 2006.** Agents at every level of the hierarchy are provided with a Handbook, through which the Companies' standards related to ethical behavior are reinforced. Separate Handbooks were developed for the various levels of the field hierarchy, including writing Agents, District Leaders and Division Leaders, in order to ensure that all levels of the hierarchy are informed on guidelines pertinent to their responsibilities. The Handbooks cover a variety of topics related to compliance, including but not limited to, disclosures required regarding the relationship between the insurance company and the Association, complaint handling, sales presentation standards, basic insurance industry terms, advertising guidelines, and federal guidelines related to privacy, telephone do-not-call lists and anti-money laundering. Agents are required to sign an acknowledgement as certification that they have received and read the Handbook, and they are accountable for compliance with the guidelines in the Handbook. (Agents' accountability is discussed in further detail in the response to Finding 2h.) The Handbooks are available to examiners upon request.
- **AMG Advisor, beginning April 2005:** In addition to TTACC training, the Companies also send monthly "AMG Advisor" publications to the field force which provide refresher training information regarding various topics, such as advertising guidelines, HIPAA Guidelines, HIPAA Eligible Individual qualification, Telephone Do-Not-Call List requirements, and the Agency Management System ("AMS"). Field leaders are encouraged to use these publications as training materials at their regular weekly meetings. The AMG Advisors are also maintained on the marketing division websites as

## CONFIDENTIAL SETTLEMENT COMMUNICATION

resource information available to all agents. Examples of prior AMG Advisor publications are available to examiners upon request.

- **Point-of-Sale Scripts, December 2005:** In December 2005, the Companies worked with the field leaders of UGA and Cornerstone to develop and approve point-of-sale scripts that outline the information and topics to be covered during an agent's sales presentation. The scripts are approved by the Compliance Department and are maintained on the marketing divisions' websites so that they are readily available and easily accessible by the Companies' agents.
- **Agency Management System ("AMS"), July 2006.** The AMS captures information regarding agent activity, including but not limited to complaints, mix of business, Benefit Confirmation Program ("BCP") call and general performance metrics. This tool is available on-line to all field leaders and agents to view their respective hierarchy and personal information. The AMS is also used by the Companies' management as a source of information to monitor agents' activities.
- **Benefit Confirmation Program, beginning April 2005.** The Companies implemented a post-sale BCP in April 2005. Initially, the objective of this program was for the Companies to contact all consumers who had purchased a scheduled benefit health plan and ensure that the consumer understood the coverage they purchased. Such calls are made post-issue (within three (3) to four (4) weeks after the health insurance plan has been delivered), and customers who cannot be reached by telephone after three (3) attempts are contacted by letter. Phone messages and letters provided to insureds who cannot be reached include specific invitation to the insured to contact the Customer Care Department with any questions. In January 2007, the BCP was expanded so that all customers who purchase a health benefit plan from the Companies are contacted.

During the BCP call, the Customer Service Representative reviews features of the insured's plan with him/her to ensure the insured understands the coverage purchased, including but not limited to the following features:

- Type of coverage selected (for example, Basic Hospital/Medical Surgical Expense Plan) and, for scheduled plans, that the coverage differs from a comprehensive major medical and catastrophic plan;

## CONFIDENTIAL SETTLEMENT COMMUNICATION

- The deductibles of the plan and how the deductibles are applied;
- The aggregate and lifetime maximum amounts of the plan;
- The benefits provided by the base plan and any optional benefit riders. The Customer Service Representative also confirms any optional benefit riders that were not selected; and
- Any adverse underwriting action that may have been taken.

The benefits and limitations of the insurance plan are also presented by the agent at the time of sale and this presentation is acknowledged in writing by the customer at that time.

Any issues brought to the Companies' attention by an insured during the BCP call regarding allegations of agent misconduct are logged and investigated as verbal complaints through the Companies' complaint handling processes. Agents with high complaints (more than five (5) in a rolling 12-month period) are reviewed by the Sales Practice Review Team (described below).

Summary reports are reviewed and analyzed by the Companies' senior management for trends to assist in further editing BCP scripts to achieve the highest level of customer understanding of their health coverage.

In October 2006, a number of questions were added to the BCP script to assist the Companies' management in monitoring agent actions. Those questions address "point-of-sale" issues, such as whether the agent properly explained the benefits and limitations of the proposed policy, whether he/she left a brochure with the customer, whether he/she answered questions the prospect had, and whether the customer found the sales materials helpful.

- **Sales Practice Review Team, beginning in 2005.** Agents' complaint-related activity is reviewed through the Sales Practice Review Team ("SPRT") that meets on a monthly basis. Agents who receive five (5) or more complaints during a rolling 12-month period are reviewed during SPRT meetings. Senior level management from the Companies, including the Chief Compliance Officer and General Counsel or Deputy General Counsel, the UGA Executive Vice President of Sales, the Cornerstone Executive Vice

## CONFIDENTIAL SETTLEMENT COMMUNICATION

President of Sales, the AMG Vice President of Sales Compliance and management staff from the Customer Advocacy Group, are regular participants in these monthly meetings.

While the Companies have an established process to address complaints involving agents through SPRT, the Companies do not wait for an agent to appear on the SPRT high complaint report before taking action regarding allegations of agent misconduct. Allegations of misconduct by an agent are investigated through an established protocol by the Customer Advocacy Group. Following such an investigation, an agent may be subject to immediate disciplinary action including termination.

- **Agent Due Process, November 2005:** The Companies adopted an "Agent Due Process" procedure for the purpose of monitoring, reviewing and correcting agent activity with respect to sales and marketing issues. The process ensures that disciplinary actions against agents, up to and including termination, are processed in a consistent and orderly manner.
- **TTACC Audits, beginning in 2005:** The audit portion of TTACC became operational for UGA during 2003. Upon the establishment of the Agency Marketing Group ("AMG", described above), an enhanced and consistent audit program was implemented for both UGA and Cornerstone. This audit program is still in use today. A dedicated team of compliance staff audits field offices at least once every 12 months to ensure a consistent training message is delivered throughout all the Companies' field offices. The auditor observes a TTACC training session to ensure that all required components of training are covered. The auditor also reviews other facets of the field office, such as agent files, to determine if appropriate file documentation is being maintained, and whether communications regarding regulatory changes and compliance information are being made regularly to agents by the field leaders. In addition, point-of-sale materials (e.g., product brochures) are reviewed to ensure that only current materials that have been approved by the Compliance Department are being used. The audit reports are provided to the Regional and Divisional Sales Leaders, the Executive Vice President of Sales and to the Chief Compliance Officer. If a division office fails an audit, the Regional Sales Leader takes steps to ensure that any corrective measures are completed, and the Companies typically re-audit the field office within the following 90 days to confirm that corrective actions were completed.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

- **Audits by Independent Law Firm:** In certain cases, the Companies have engaged the services of an independent law firm to conduct targeted, in-depth field audits of field offices. Some of these field audits were scheduled due to the requirements of market conduct examination settlements, while others resulted from the identification of potential compliance issues by the Companies. Reports of these field audits are submitted to the Companies' management. These audit reports require development and implementation of action plans to address issues identified during the audit, to correct any deficiencies identified and to evaluate the appropriateness of disciplinary actions. Follow-up is conducted by field leaders and the Companies' management until the action plans are completed.
- **Field Evaluation Program ("FEP"):** The Companies are developing and implementing a Field Evaluation Program which will provide oversight and monitoring of field agents through a comprehensive field audit program. This program will include interviews with Agents and Field Leaders and review of files and sales materials in each field office on topics such as general field office activities and documentation; recruiting; new and ongoing agent training and education; sales presentations, and complaint identification and reporting. The Company anticipates that implementation of the FEP will begin during the first quarter of 2008.
- **Complaint Monitoring:** The Companies regularly monitor complaint ratios and patterns of complaints through SPRT and within the Companies' operational units and the Compliance Department. Complaint statistics with an analysis of the reasons for complaints are reported quarterly to the HealthMarkets Board of Directors.

In addition to the enhancement of agent training and oversight described above, the Companies also introduced a new product portfolio, the CareOne product suite, beginning in February / March 2006. The Companies redesigned their products to provide more comprehensive insurance products as an alternative to the Companies' scheduled benefit plans. Many of the expanded benefits in our CareOne products were previously available only through optional benefit riders. Our customers can also elect additional benefits, depending on their needs and their cost concerns. The CareOne product suite has been

CONFIDENTIAL SETTLEMENT COMMUNICATION

released in 36 jurisdictions to date, and will continue to be released in other jurisdictions as regulatory approvals are received.

The Companies believe that the changes to organizational structure, improved and enhanced agent training program, implementation of the BCP, and increased monitoring of agent activities as described above, as well as the introduction of the CareOne product portfolio, have significantly enhanced our customers' understanding of the health insurance plans offered by the Companies. The impact of these changes is reflected through the reduction in the number of complaints submitted to regulators since 2003. Department of Insurance complaints have declined 52% from 2003 to 2006 (from 1701 complaints in 2003 to 818 complaints in 2006). The Companies' records also show that complaints are down another 9% through November 30, 2007 (692 complaints), compared to the same period in 2006 (759 complaints).

***Required Action #1:*** *The Company must modify its agency program to expand and improve its agent training particularly for new agents, by expanding its training program to include industry knowledge, ethics, product presentation, proper disclosures, consistent delivery across agencies, and a robust structure, among other enhancements, as follows:*

*To ensure agents and consumers thoroughly understand the product they are selling/buying and appropriate disclosures are made at the point of sale and in follow-up contacts, the Company must:*

- a. Strengthen the training program for new agents by including health insurance industry information.*
- b. Provide scheduled agent training more frequently based upon average agent retention statistics, such as every three to six months rather than annually.*
- c. Develop a standard but progressive curriculum for agents based upon experience level with the Company.*
- d. Strengthen the training program for existing agents, particularly product information, ethics and point-of-sale presentations.*
- e. Develop centralized standards and controls to manage agents and train agency management in appropriate controls and monitoring of agent and agency activities. Develop tools and metrics for measuring the effectiveness of training (e.g., reduction of complaints, reductions in cancellations, etc.).*

CONFIDENTIAL SETTLEMENT COMMUNICATION

- f. *Develop additional methods to help consumers have a better understanding of the Companies' products during the sales process.*
- g. *Train Benefit Confirmation Program (BCP) staff to be assertive in reviewing coverages with clients to ensure more calls are successfully completed.*

**Company Response:** The Companies agree to continue the expansion and improvement of the TTACC training program for all agents as well as oversight activities. In addition to the extensive array of agent training and oversight initiatives already implemented (and addressed in the response to Finding #1), the Companies are evaluating methods to implement this Required Action with an emphasis on continued improvements to the TTACC program and monitoring activities, including the development and implementation of additional tools and metrics to assist in this process. The following initiatives are planned and in progress toward completion:

- The Companies are expanding and enhancing the training programs for new and existing agents to include modules covering basic health insurance industry information and ethics. Agents will be required to complete an on-line "e-learning" module covering these topics prior to their participation in the TTACC classroom training. TTACC tests will be revised to include tests items for basic health insurance industry and ethics information. The targeted completion date for these new TTACC modules and updated tests is December 31, 2007.
- The Handbooks for Agents, District Leaders and Division Leaders are being revised to include a section dedicated to ethics-related topics. Agents and Field Leaders will be required to annually acknowledge their receipt and understanding of the new ethics section and their agreement abide by its guidelines. The targeted completion date for the Handbook updates is December 31, 2007.
- The Companies will continue to deliver training to all field offices and expand the plan for training delivery to provide for a minimum of three (3) product training courses for field agents each year beginning in 2008. The Companies will also develop a plan and associated training strategies to address supplemental training for divisions where remedial and/or additional training may be needed on an "as needed" basis by Q2 2008.

CONFIDENTIAL SETTLEMENT COMMUNICATION

- The Companies are working to develop a plan for a progressive curriculum for agents that will take a tiered approach to agent development, based on their tenure. Modules will be implemented as they are developed over the 12 months following completion of the plan. The targeted completion date for development of the plan is Q2 2008.
- The Companies have taken a number of steps to help consumers better understand the products they have purchased. At the point of sale, our agents use detailed product brochures approved by our Compliance Department that thoroughly describe the product(s) sold by the Companies. At the end of the sales presentation, our agents are required to leave behind a product brochure that lists the benefits and limitations of the product the customer has purchased. After the sale is completed and the policy is issued, the Companies make several telephone calls under our BCP program to our new customer to go over their plan with them.

The Companies understand the concerns expressed in the Draft Report. The Companies commit to the Lead States that they will work collaboratively with the Lead States to develop additional methods to help consumers have a better understanding of the Companies' products.

- The Companies agree to develop a strategy with a goal toward increasing the successful completion of BCP calls.

***Finding #2:*** *There was a lack of sufficient quality assurance procedures over agent activities such as monitoring and auditing the activities of agents and agency management. A review of the TTACC training and new product training confirmed the need to audit agents' actions in the field.*

- A. An internal audit plan is being implemented, but agent activities and transactions are not included in the initial audit program. The Company has indicated that agent activities will be subject to audits "at a later date."*
- B. Any internal audit program must include information used at point-of-sale to ensure that agents are correctly representing the products.*
- C. There is minimal, if any, accountability on the part of the regional directors, division managers and district managers for the actions of agents under their supervision.*

CONFIDENTIAL SETTLEMENT COMMUNICATION

**Company Response:** The Companies have agreed to, and have implemented, a multi-faceted audit process for agent training that is designed to ensure that agents are being properly trained in accordance with the Companies' standards. This audit process, as well as additional agent oversight activities, is described in the response to Finding #1.

The Companies respectfully submit that the Field Leaders, including Regional Directors, Division Managers and District Managers, were held accountable during the examination period and continue to be held accountable for the actions of the agents working within their hierarchy. Issues within a Field Leader's hierarchy have typically been identified through complaints, BCP results, reports of other agents and audits of field offices. The Companies take any allegations of agent misconduct seriously and investigate such issues. Field Leaders have been held accountable for activities within their teams through disciplinary actions (such as counseling, demotion, or termination of the contractual relationship with the Field Leader).

**Required Action #2:** *To provide adequate monitoring of agents and agent activities, the Company must:*

- a. *Implement quality assurance procedures over agent activities including monitoring procedures and periodic audits.*

**Company Response:** The Companies agree and remain committed to continuing enhancements with respect to monitoring and oversight of agent activity. Key enhancements accomplished to date that relate to agent monitoring and oversight activities are described under Finding #1 above.

- b. *Enhance the effectiveness of agent training by requiring monitored testing and monitoring the delivery of the training presentations by the field managers.*

**Company Response:** The Companies agree that monitored testing and delivery of the training presentations is appropriate. As an interim step, the Companies began administering all TTACC testing in a monitored environment, either at a division or satellite district field office on November 26, 2007. The Companies are evaluating options for a long-term solution, including the effectiveness of the interim solution, and

CONFIDENTIAL SETTLEMENT COMMUNICATION

will determine the approach for establishing on-going monitored agent testing by Q1 2008.

In addition, as of September 2007, the Companies imposed an eight (8) hour waiting period before an agent could re-take a failed TTACC test, during time additional training can be provided to ensure that the agent understands the material before again attempting to pass the test.

- c. *Implement a plan to monitor agents' actions using tools such as comprehensive field audits, phone interviews with recent customers, secret shoppers and trending of agent and agency related information, such as complaint statistics, cancellations, product upgrades and the like.*

**Company Response:** The Companies have implemented processes and programs to monitor the activities of agents. The key enhancements are described under Finding #1 above. The Companies continue to evaluate other methods to enhance agent oversight activities, including the following:

- The Companies are implementing additional monitoring using enhancements to the Agency Management System ("AMS") software tool. AMS is being enhanced to include additional indicators for reporting that will identify patterns in agent activity that may require review and corrective action. The system will prompt review of an agent or field leader who exceeds thresholds for key indicators. The targeted date for completion of the enhancements is Q3 2008.
  - The Companies are also expanding the Sales Practice Review Team ("SPRT") meeting to include the review of metrics for Field Leaders with regard to complaints attributed to the agents within their hierarchy by year-end 2007.
  - The Companies agree to consider additional monitoring actions.
- d. *Provide additional point-of-sale materials such as scripts and checklists for agent's use and ensure that all materials include appropriate disclosures.*

CONFIDENTIAL SETTLEMENT COMMUNICATION

**Company Response:** The Companies have provided agents with approved point-of-sale materials, including product brochures and point-of-sale scripts, for use during a sales presentation. The Companies are developing enhanced and/or new point-of-sale scripts and presentation materials to further promote consistent communication during sales presentations and providing additional training to agents regarding the use of such materials. The Companies expect to have new and enhanced materials available to agents during Q2 2008.

- e. *Investigate all agents with unusual trend statistics and all complaints regarding claims that allege that agents misrepresented the product at the point of sale. Any agent found to be misrepresenting the products at the time of sale should be retrained, disciplined or dismissed as appropriate for the circumstances.*

**Company Response:** The Companies have established processes to monitor complaint activity regarding agents. Those processes are described under Finding #1.

- f. *Hold field management, such as regional managers and above, accountable for the actions of each agent under their supervision. Field management performance assessment and overall compensation should contain a component that is tied to such performance measures as the number of complaints received about sales practices in the manager's territory, the number of cancellations and persistency of business written by the manager and his agents, and other actions that may be indicators of the overall performance of that manager's territory. Incentives should also be developed which reward regional managers who demonstrate effective accountability and management of their agents with respect to compliance requirements and performance.*

**Company Response:** The Companies respectfully submit that the Field Leaders, including Regional Directors, Division Managers and District Managers, have been and continue to be held accountable for the actions of the agents working within their hierarchy.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

With respect to current compensation models and accountability of Field Leaders, a "Taken Rate"<sup>3</sup> calculation is built into the calculations for compensation and qualifiers which measure the quality of business submitted by an agent. The Taken Rate is a key indicator of customer satisfaction and a key factor in our recognition and pay programs. The Taken Rate has significant financial implications related to the compensation that a Field Leader or agent might earn. The agent's Taken Rate is affected when an applicant cancels his/her insurance application and can indicate possible issues with an agent's submitted business. The Taken Rate will be used with other metrics that are captured in the Agency Management System (described on page 7) as a trigger to review an agent's performance when enhancements to the AMS are completed. An agent or Field Leader with a low Taken Rate will receive less remuneration than an agent with a higher Taken Rate.

The Companies are also evaluating additional methods of adjusting Field Leaders' compensation tied to specific compliance performance measures. The Companies' target date for determination of such program(s) is Q1 2008 with implementation of the program(s) to follow.

### ***Finding #3 – Claims Handling***

The Draft Report (under Finding #2, page 9) states that many deficiencies were noted in the Companies' claims handling practices and cites several different exceptions related to particular claims standards that were tested. The Companies recognize that their claims administration system has certain limitations that are reflected in some of the findings in the Draft Report. As a result, the Companies are formulating plans to address system-related claims issues on a long-term basis to further enhance their claims processing. These plans will be outlined by year-end 2007, with implementation to follow in 18-24 months. Despite the limitations of our current system, the Companies respectfully point out that their claims handling practices were within the 7% error tolerance level under the NAIC Market Regulation Handbook guidelines for each aspect of the Attribute Testing listed in the Draft Report with the exception of three (3) standards involving the extremely small number of accident claims processed by The Chesapeake Life Insurance Company (approximately

---

<sup>3</sup> The "Taken Rate" is a ratio of taken policies (*i.e.* those that are in force for at least one (1) month) compared to submitted policies and expressed as a percentage.

CONFIDENTIAL SETTLEMENT COMMUNICATION

.0096% of the claims processed during the examination period). Further, the Companies believe that some of the deficiencies cited in the Draft Report were inadvertent errors, and did not violate any legal standards, and most importantly, did not result in harm to consumers. The Companies are, therefore, offering the below response separating those items the Companies feel were not in violation of any NAIC specific standards and those the Companies have addressed, with details of their resolution.

**Finding #3A. Diagnosis and CPT Codes**

*When processing a claim, the Company enters diagnosis codes into its claims system that are different from what was submitted by the provider on the claim. This is performed with respect to the primary diagnosis code. The Company indicated it has been the practice of its claims department to change the diagnosis on one claim to match the diagnosis of an already existing claim (i.e., allergic reaction with an accident "E" code may have been re-coded as an allergy to match an existing allergy claim vs. a new accident). According to the Company, the practice was to give the insured the best benefit by tying that claim to an existing claim for the same diagnosis. By doing this, the insured purportedly would not incur a new deductible for a new claim. The Examiners also noted that the Company altered CPT codes submitted by the provider on the claim.*

...

*The Company indicated that diagnosis codes entered into its claims system are not the decisive factor behind benefit payment calculations and that ultimately, it does not impact the benefit payments made to claimants. According to the Company, a benefit payment is determined by the "Cause Code" and "Benefit Code" selected by its claims examiner. The Company explained that claims are adjudicated using the "Cause Code" and "Benefit Code" assigned to the claim during the adjudication process, rather than the diagnosis code and CPT code billed by a provider and captured in its claims system. The Company maintains that its claims adjudication system utilizes a programming mechanism, the "Cause Code," to tie all relative deductibles, co-pays, and co-insurance to a single cause in order to adjudicate claims consistent with the benefit schedules for its health plans. A "Benefit Code" for a claim is determined by the claims examiner and entered into the claims system to identify the type of service provided to the claimant (i.e. inpatient hospital charges, office visit, surgical, laboratory services, etc.). Therefore, the Company asserts that benefit payments are not impacted by the Company's practice of changing diagnosis codes submitted by a provider since the "Cause Code" and "Benefit Code" is the driver for its claims adjudication.*

CONFIDENTIAL SETTLEMENT COMMUNICATION

*The Examiners note that such a practice allows for claims examiners to make judgmental determinations of the "Cause Codes" or "Benefit Codes" assigned to a submitted claim rather than the provider's determination. This presents the potential risk that benefit payments by the Company on a claim may be incorrect or inconsistent with what the provider indicated.*

**Required Action #3A:** *The Company must identify and re-adjudicate any claims for which diagnosis and CPT codes were altered because of the risk that the claim may not have been paid correctly as a result of the code change. The Company must cease to alter diagnosis and CPT codes submitted by providers on claims.*

**Company Response:** The Companies do not alter diagnosis codes and CPT codes on claim forms submitted by providers. The Companies appreciate the acknowledgement in the Draft Report that the diagnosis codes and CPT Codes are not the decisive factor for benefit determination, but rather benefit determination is made based on the Cause Code and Benefit Code assigned in the claims system to the claims. A further explanation of how the diagnosis and CPT code information is captured and stored is represented in the attached claim process flow example. The example outlines the Companies' position that this finding does not lead to an indication of misuse of diagnosis or CPT codes resulting in improper claims adjudication outcomes to the detriment of any customer. Please refer to Exhibit 3.

Although there is some judgment on the part of the claim examiner to select the initial cause, there is consistency when claims are tied together using the same cause indicator. There are two key driver options for Cause Code, one for "sickness" and one for "accident" and there is a low likelihood that the claim examiner discretion will result in an incorrect choice. The other key piece of data known as the "Benefit Code" (which identifies the type of service such as office visit, surgical, laboratory service, etc.) is also selected and used to further determine the appropriate benefit package aligned with the "unaltered" primary diagnosis on the claim. In most mainstream claim adjudication systems, these factors are part of the benefit selection criteria and are used to drive benefit payments. The Companies administration system (Processor 1) has been in use for a long period of time and because of this has certain system limitations which are clearly reflected as part of this finding.

CONFIDENTIAL SETTLEMENT COMMUNICATION

The Companies have analyzed all claims from the claims sample used for the Attribute Testing and have determined that no claims were paid incorrectly as a result of this structure. Detailed policies and procedures exist and are updated as needed. These procedures were recently revised when the new programming to lock down diagnosis fields was completed in early 2007. The Companies strongly believe that claims have been processed correctly under the current system and have no indication that this process has contributed to any deficient claim adjudication practices that would require a re-adjudication of any claims.

The Companies respectfully request that the Required Action to re-adjudicate claims be removed from the Draft Report.

In the alternative, the Companies respectfully request that the Required Action be revised. The only method the Companies have to identify claims where a diagnosis or CPT Code on a provider bill may have been recorded differently in the claims system is to complete a manual comparison of each provider bill to the entries in the computer system for the millions of claims received during the examination period. As a result, the Companies respectfully request that this Required Action be revised in a manner that satisfies the objectives of the Required Action while providing the Companies with an action that is attainable. To this end, the Companies request that Required Action 3A be reworded as follows:

*The Company must identify the extent to which any claims were not adjudicated correctly as a result of a diagnosis or CPT code being altered. The Company will complete this identification of claims errors within the set of sample claims reviewed by the examiners during Attribute Testing. In the event that claims errors identified from the review of sample claims can be attributed to the alteration of a diagnosis or CPT code, and exceeds a 7% error level, then the Company will be required to conduct additional testing or corrective action as agreed by the Lead States.*

**Finding #3B. Claim Numbers**

*The Examiners noted that the Company had a claims handling practice whereby it assigned an additional consecutive claim number to a submitted claim if there were more than four*

## CONFIDENTIAL SETTLEMENT COMMUNICATION

*procedures codes (CPT) billed on it...This practice results in multiple claim numbers for a single occurrence or service. This distorts the Company's claim count and results in reporting incorrect data in relation to the number of claims it received and processed.*

**Required Action #3B:** *The Company must make changes to the claims adjudication system that will allow them to enter an entire claim into their system as a single claim.*

**Company Response:** The Companies respectfully submit that this issue was resolved in December 2004 through the use of a "Film Number" that ties all sub-claims together. This issue relates to the claims handling practice whereby the claims may be assigned multiple claim numbers for a single bill due to a system limitation in capturing the number of procedure codes that can be entered/processed at one time. The Companies' claim count and results are not compromised by this practice since a unique "film number" links all claims together for a single occurrence or service (single bill). The claim is counted as one claim yielding one Explanation of Benefits ("EOB") to the insured reflecting all billed charges. This is also demonstrated in the claims process flow example provided in Exhibit 3.

No consumer harm or violation of NAIC standards has resulted from this practice. However, the Companies are committed to enhancing our claims handling functions by implementing a claims administration system that addresses this limitation within the 18-24 month timeframe discussed above.

### **Finding #3C. Claim Delays**

*During the Examiners' review of a sample of paid and denied claims processed within the examination period, it was noted that investigations were not conducted in a timely manner. Additionally, when claims were delayed, claim delay letters used by the Company were not consistently sent, did not specify the reason for the claim delay and did not meet many state's claims handling requirements for claim adjudication delays due to investigations. It was also noted that the Company used acknowledgement letters as delay letters; however, the reason for the delay was not included.*

**Company Response:** This statement appears to relate to "NAIC Claims Standard #2: Investigations are conducted in a timely manner," and to "NAIC Claims Standard #3: Claims are settled in a timely manner as required by statutes, rules and regulations." Attribute

CONFIDENTIAL SETTLEMENT COMMUNICATION

testing results for NAIC Claims Standards #2 and #3 appear on pages 98 through 101 of the Draft Report. The Companies respectfully submit that they passed the attribute testing related to these NAIC standards and that Finding #3C should be revised to accurately reflect the results of the attribute testing. The first sentence of Finding #3C does not state the extent to which claims were found to be non-compliant with NAIC Claims Standard #2 and #3. This sentence could be improperly construed to indicate that no claims processed by the Companies were compliant with these NAIC Claims Standards for timely investigation of claims. The percentage of violations noted in the Attribute Testing for NAIC Claims Standards #2 and #3 were 4% or less which is well within the 7% error tolerance level set forth in the NAIC Market Regulation Handbook, with one exception. The exception related to CLICO denied claims for which the error level noted for attribute testing was 8%. Please note that the number of paid and denied claims processed by CLICO was an extremely small number within the total population of claims subject to the examination for the period of 1/1/05 to 6/30/05 (the CLICO claims count amounted to .00581% of the total claims population for paid claims (50 out of 860,065) and .01642% of the total claims population for denied claims (80 out of 487,207).

To add perspective to this issue, please note and consider that a total of 11 violations were found with respect to NAIC Claims Standard #2 out of a total of 500 sample files reviewed. With respect to NAIC Claims Standard #3, a total of 16 violations were noted out of a total of 500 sample files reviewed. Further, a total of seven (7) instances of failures to send delay letters are reported under NAIC Claims Standard #2 and a total of nine (9) instances of failure to send delay letters and two (2) instances of sending late claims delay letters late are reported under NAIC Claims Standard #3 out of a total of 500 sample files reviewed for each of these Standards.

The Companies respectfully request that this portion of the Finding and the related Required Action be reworded to indicate the results of the Attribute Testing.

***Required Action #3C:*** *All claims must be adjudicated in a timely manner as required by statute or rule in the appropriate jurisdiction based on claim submission location.*

**Company Response:** The Companies agree with this Required Action and maintain that claims are currently processed according to each state's claims prompt payment

CONFIDENTIAL SETTLEMENT COMMUNICATION

requirements. The Companies strive to ensure that each claim is processed timely, and have processes set up to include payment of interest on claims that are not processed timely in accordance with applicable state laws. The percentage of violations noted in the Attribute Testing for NAIC Claims Standards #2 and #3 were 4% or less which is well within the 7% error tolerance level set forth in the NAIC Market Regulation Handbook (with one exception of unique circumstance for which the error level noted for Attribute Testing was 8%).

*All delayed claims letters must include a reason for the delay.*

**Company Response:** The Companies send out letters to insureds when a claim is pending to advise that additional information being requested. To further improve this process and address the Required Action, the Companies have undertaken a project to evaluate solutions. First, the Companies are completing an analysis to determine the detailed requirements for claims-related correspondence to ensure that, in the event of a delay in claim processing, the associated letters contain the reason(s) for the delay. The letters will then be revised as appropriate, based on the results of the analysis. Development and implementation will begin once the requirements have been documented and approved. The date targeted for completion of the analysis is Q1 2008.

*The Company's practice of pending claims while waiting for information on other claims must cease.*

**Company Response:** During the examination period, the Companies' claims examiners discontinued the practice of pending claims that are unrelated to other claims being investigated. Claims are pending to request medical records or other information as necessary to ensure proper claims adjudication and as allowed by state law.

**Finding #3D: Explanation of Benefits**

*The Company's **Explanation of Benefits (EOB)** forms do not include information regarding the deductible applied to the claim. The lack of complete information on EOB forms makes it impossible for consumers and providers to determine if claims are properly paid.*

CONFIDENTIAL SETTLEMENT COMMUNICATION

**Required Action #3D:** *All Explanation of Benefit forms must include the deductible information pertinent to the claim.*

**Company Response:** The Companies agree to revise their Explanation of Benefit (“EOB”) forms. The Companies are in the process of updating the EOB to include more deductible information pertinent to the claim so it is easier for customers to understand. The Companies have revised their EOB form to reflect this enhancement in one Participating State and are continuing to make this revision effective in all states, with completion targeted for Q2 2008.

**Finding #3E: Independent Claims Audits**

**Required Acton #3E:** *The Company must perform independent routine and ongoing audits of claims to determine adherence with the Claims Procedures Manual and applicable laws and regulations. The results of such audits must be analyzed by compliance personnel to identify trends and root causes of claim mishandling, areas for training emphasis, and problem claim adjusters. Audits must result in action by the Company to correct those areas found to be problematic or deficient.*

**Company Response:** The Companies agree and have established quality assurance and independent internal audit processes to ensure that claims adjudication is compliant with the Companies’ internal procedures as well as applicable laws and regulations, as follows:

Quality assurance audits are conducted by a dedicated staff of 13 as part of the Claims Department daily operations.

The Compliance Audit department conducts independent periodic (weekly, monthly, quarterly and annual) audits of compliance related activities within business units and functional areas.

Audit results and recommendations are discussed with and reported to business unit management. The head of the operating division also reviews the draft audit report and provides comments. A final report is produced that includes any corrective action that the business unit management will perform to correct any issues. Final reports are distributed to

## CONFIDENTIAL SETTLEMENT COMMUNICATION

the Compliance Department and senior leadership. Issues are communicated to the Compliance & Governance Committee during their quarterly meetings. Compliance Audit, and the newly formed Operational Compliance Department (discussed below), follow-up to ensure that corrective action plans have been implemented.

The Companies recently created a department within the Administrative Services Group ("ASG") that is charged with compliance-related oversight. ASG administers the association group and individual health insurance and ancillary coverages written by the Companies. In coordination with the Companies' Chief Compliance Officer and compatible with the Companies' central Compliance Department, this new department, Operational Compliance, works with the operational departments within ASG to design and implement compliance-related initiatives and enhancements in response to new laws and regulations as well as commitments made to regulators. In addition to compliance implementation oversight, Operational Compliance is also charged with monitoring the ongoing compliance of the operation. This monitoring effort 1) utilizes the results of the Quality Assurance function within the operational units to assess issues and trends in processing performance and 2) utilizes the audit findings generated by Compliance Audit to determine whether corrective actions are operating appropriately. Based on conclusions reached through monitoring efforts, Operational Compliance will recommend additional remedial action where necessary. As such, this effort dovetails with the monitoring and analysis taking place within the Claims Department, and the periodic audits performed by Compliance Audit.

***Finding #4:*** *At the commencement of this multi-state market conduct examination, the Company did not have a Claims Procedures Manual.*

***Required Action #4:*** *The Company will develop and maintain a Claims Procedure Manual.*

**Company Response:** The Companies have already remedied this deficiency by developing and implementing a comprehensive claims manual in 2006 that includes written policies and procedures for the claims handling process. As with all of our policies and procedures, the claim manual will be reviewed and revised regularly as the Companies' needs dictate or as changes to laws or regulations may require.

CONFIDENTIAL SETTLEMENT COMMUNICATION

**Finding #5:** ...In reviewing a **CLICO** claim, the Examiners would often see a claim that had been initiated under **CLICO**, and an acknowledgement and delay letter would be sent to the provider or insured under this company name. However, if benefits were not available under the **CLICO** accident policy, the Company would utilize a "no claim" remark code to close the claim internally and then process the actual payment or denial for the claim under the insured's **MEGA** or **Mid-West** policy (whichever one was available or in-force). They used the **Explanation of Benefits (EOB)** statement to advise the insured of this action. This would be the only notification to the insured or the provider concerning the change of Company. The insured was never given the opportunity to question the denial of the **CLICO** claim.

**Required Action #5A:** All claims should be adjudicated under the Company in which the claim is being made.

**Required Action #5B:** Anytime a claim is denied, appropriate notification must be sent.

**Required Action #5C:** All claims must be documented correctly by being filed with the Company in which the [claim] is being made.

**Company Response:** The Companies wish to note that this Finding stems from an isolated incident and is no longer an issue. The CLICO accident policy was issued to fulfill a specific purpose, namely, as part of the settlement of national litigation. The CLICO accident plans were issued beginning in January 2005. As of July 1, 2007, less than 100 accident plans remained in force. No consumers were harmed as a result of this issue as the actual benefit payments due were not affected. Please note that the number of paid and denied claims processed by CLICO was an extremely small number within the total population of claims subject to the examination for the period of 1/1/05 to 6/30/05 (the CLICO claims count amounted to .00581% of the total claims population for paid claims (50 out of 860,065) and .01642% of the total claims population for denied claims (80 out of 487,207).

The Companies further note that Finding #5 and the related Required Actions relate to "NAIC Claims Standard #5: Claim files are adequately documented." Attribute testing results for NAIC Claims Standard #5 appear on pages 103 through 104 of the Draft Report.

CONFIDENTIAL SETTLEMENT COMMUNICATION

The Companies respectfully submit that Finding #5 of the Draft Report should be revised to accurately reflect the results of the attribute testing.

**Finding #6:** *The manner in which the Company and the association operate is not fully disclosed to those purchasing UICI insurance products.*

A. *During the examination period, the Company allowed agents to collect, at point of sale, a single check payable to a third party to pay the association dues and initial insurance premium. The amount collected could also include **Policy Fees, New Member Admin Fees** and other fees, some of which are remitted to the association and some of which are retained by the insurer. Little to no disclosure was made to the client concerning how the funds would be split. In some states, any amounts collected by the insurer in a single check or remittance may constitute "premium" and be subject to premium tax. The Company did not account for such statutory differences in their accounting for premium taxes.*

**Required Action #6A:** *The Company must change its procedures so that the insurance payments and the association payments are received as two separate payments. The Company must identify states in which the definition of premium includes all amounts collected by the insurer, and must advise those states of the possibility that the Company may need to amend premium tax filings. The Company must work with the affected regulatory jurisdictions to correct prior year filing errors.*

**Company Response:** The Companies and the Associations agreed to make revisions to the manner in which initial payments and renewal payments are remitted for Association fees/dues and insurance premiums. As of January 1, 2007, the Field Service Representative / Agent collects two separate payments at the time of application – one payment for the Association dues/fees which is made payable to the Association and separate payment for insurance premiums which is made payable to the Companies. The Companies are in the process of completing a project to split renewal billings and bank drafts so that separate billings and bank drafts are generated for association dues payments and insurance premiums. This project is in progress with an expected completion date during Q1 2008.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

In response to the Finding and Required Action related to the definition of premium and tax filings, the Companies respectfully submit the following. The Companies executed service agreements with the Associations that provide the Companies with the power and authority to collect Association fees and remit those fees to the Association. Based upon the agreements in place and as a convenience to consumers, the Companies and the Associations allowed Agents / Field Service Representatives to collect one initial payment from a consumer who applied for both an Association membership and an insurance plan at the same time. The initial payment included the Association administration fee (*i.e.*, noted by the examiner as the "New Member Admin Fee"), the Association dues, any amounts for other Association benefits, and the insurance premium including any policy fees, as applicable.

The initial payment made by the consumer was submitted to the Companies for processing. The total amount of funds submitted by the consumer for Association fees and dues was remitted to the Association (or Specialized Association Services on behalf of the Association) pursuant to service agreements between the entities. The Companies did not/do not retain any portion of the Association fees or dues that was/is collected. The Companies retain only the premium amount submitted by the consumer for an insurance product underwritten by the Companies (including any policy fees). As further support of this statement, please note the following statement in the Draft Report: "The Examiners found that the information contained in the Company-prepared flow charts depicting the flow of funds between UICI companies and the associations was accurate." (reference page 60 under "Overall Assessment of Flow of Funds Between Company and Associations)

The Companies respectfully submit that the remittance of Association fees / dues and insurance premiums in a single check does not determine that the Association fees / dues constitute "premium." The Association fees and dues were not submitted as consideration for an insurance product underwritten by the Companies. Such Association fees and dues were submitted as consideration for Association Membership and were remitted in their entirety to the respective Association (or Specialized Association Services on behalf of the Association) according to the service agreements in effect. Accordingly, the Association fees and dues do not constitute "premium" under the insurance laws of any state.

CONFIDENTIAL SETTLEMENT COMMUNICATION

The Companies respectfully submit that premium taxes have been appropriately accounted for and correctly paid to all state insurance departments with respect to this issue. Accordingly, the Companies request that the Finding and Required Action related to the question of whether Association fees / dues constitute premium for tax purposes be removed from the Draft Report.

**Finding #6B:** *Agents are both sales representatives for the insurance company and enrollers for the association. This causes confusion for new members and may be in conflict with the best interests of the consumer.*

*In addition, Finding #3 (from the Executive Summary of the Draft Report) states: The Company discloses their relationship with the associations to consumers and policy holders both orally and in writing. The Examiners found these disclosure methods insufficient. Additionally, transparency of activities, relationships and financial arrangements between various UICI affiliates and their interaction with the associations and other UICI affiliates is insufficient.*

**Required Action #6B:** *The Company must disclose, with emphasis and clarity, to consumers and policyholders the relationship between the Company and any associations it uses for marketing products.*

**Required Action #3 (from the Executive Summary of the Draft Report):** *The Company must provide sufficient information, oral and written, to consumers and policyholders regarding the Company's relationship with the associations and other UICI affiliates as applicable.*

**Company Response:** In September 2004, the Companies implemented the use of a detailed disclosure at the point of sale regarding business relationships between the respective insurance company and association in September 2004 (referred to as "Association Disclosure") during the examination period. The Association Disclosure was developed during the settlement of national litigation involving the Companies and approved by a Federal Court. Any changes to the Association Disclosure require approval by the Federal Court.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

The Association Disclosure clearly explains the relationship between the Companies and the Associations, including the following key information:

- Organizational information about the Association and the insurance company, including the fact that the Association is a separate entity from HealthMarkets and its affiliates and subsidiaries, with the entities having no direct or indirect ownership in each other.
- The fact that Association members are required to pay monetary dues for membership.
- Salespersons serve a dual role as both a licensed insurance agent of the insurance company and a Field Service Representative of the Association.
- Membership dues derived from the sale of Association membership go to the Association, and insurance premiums derived from the sale of insurance go to the insurance company.
- With respect to states where association group insurance is issued, an applicant may not acquire insurance coverage under an association group type master policy unless the applicant is also a member of the association.

The Association Disclosure is used nationally. The Companies' agents are carefully trained on the necessity to use the Association Disclosure form at the point of sale and to explain its purpose each and every time they are discussing the sale of an association group plan with a potential customer. The Association Disclosure form must be provided by the agent and left with the applicant, who also must sign a "Confirmation of Presentation, Disclosure and Receipt" form, acknowledging receipt of the Association Disclosure form. If this signed document is not included with the application, the Companies return the entire application to the agent. A copy of the Association Disclosure is attached as Exhibit 2 and a copy of the Confirmation Form is attached as Exhibit 4.

Even in states where membership is required to obtain insurance, association membership is not required to maintain the insurance. This fact is explained in a recent revision to the Association Disclosure. The Finding related to this required action indicates that consumers may be confused by the dual role served by the salesperson as an agent and a Field Service Representative and that this may not be in the best interest of the consumer. The Companies respectfully disagree with this assessment. The Associations and the Companies are separate entities, and this fact is clearly disclosed to consumers through the

CONFIDENTIAL SETTLEMENT COMMUNICATION

sales presentation and the Association Disclosure which was implemented in September 2004.

It is standard practice in the association group insurance market, rather than an exception, for agents to also act as representatives of various associations. In addition, the Companies' agents have been extensively trained since TTACC was initiated in 2003 to always disclose that they are agents of the insurance company and Field Service Representatives of the Association. Please refer to the response to Required Action #6C below.

The Companies also respectfully state that they do not use the Associations for marketing products as indicated in Required Action 6B. Insurance products are marketed by agents who are appropriately licensed and appointed to represent the Companies. The Companies issue group insurance policies to the Associations (or their Trustee) under which members of the Association can apply for such insurance coverage. The Associations are not established for the purpose of marketing insurance products.

***Finding #6C:*** *A Policy Fee was charged to consumers who reside in individual (non-association) states while no Policy Fee was charged if the consumer resides in an association group state. The Company did not clearly disclose to regulators how the Policy Fees and the association New Member Admin Fees are allocated between the insurance company and the associations. The Company represented that the Policy Fee reflects the cost of issuing a policy, establishing the required records, sending premium notices, and other related expenses. The Company also represented in writing that the Policy Fee is subject to premium tax. No Policy Fee is added to policies issued in states where the applicant must join the association to buy insurance (referred to as "association group" states).*

***Required Action #6C:*** *The Company needs to clearly disclose to regulators how the Policy Fees and the association New Member Admin Fees are allocated between the insurance company and the associations. This will assist the Company in providing to the regulators an accurate accounting for premium tax purposes and for the proper accounting for premium refunds to insureds.*

CONFIDENTIAL SETTLEMENT COMMUNICATION

**Company Response:** The Association Administration fee is remitted in its entirety to the Association and does not constitute consideration for an insurance product underwritten by the Insurance Companies. As such, the Association administration fee is not subject to premium tax.

The policy fees that are charged for individual policies underwritten by the Insurance Companies are included with rate filings when required by state insurance laws and regulations. As such, policy fees are disclosed to state regulators through the rate filing requirements of the state and the Companies accurately account for such policy fees for premium tax purposes and refund purposes where collected in the individual states.

***Finding #6D:** The Examiners noted significant changes in the structure of the Company during the examination period. The Company divested itself of many of the peripheral affiliations with other non-insurance entities that may have impacted the cost of the insurance to consumers/policyholders.*

***Required Action #6D:** The Company needs to remain vigilant that its relationships with all entities are cost effective and do not adversely impact the cost of insurance to consumers/policyholders.*

**Company Response:** The Companies are highly regulated entities in all jurisdictions in which they are licensed, including oversight by their state regulators through the following mechanisms:

- The Companies have obtained and continue to maintain the appropriate Certificates of Authority to conduct business in all states where they solicit insurance.
- Inter-company agreements are subject to approval through the Companies' domestic states in accordance with the applicable Insurance Holding Company Acts. The Companies made and continue to make all such required filings, including all affiliate agreements.
- The Companies prepare and submit Annual Statements each year to the NAIC and the state regulatory departments.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

- Financial examinations are routinely conducted by the Companies' domestic states. No issues relating to the above Finding have ever been noted through the domestic states' financial examinations.
- The Companies have always been compliant in making annual Form B filings with their domestic regulators, and these filings disclose information regarding affiliated relationships and transactions, as well as other information regarding financial information and ownership.

The Companies have been and will remain vigilant that their relationships with all entities are cost effective and do not adversely impact the cost of insurance to consumers/policyholders.

***Finding #7:*** *The handling of complaints and grievances included the following findings based upon our attribute testing:*

- A. All complaints were not recorded in the required format on the Company's complaint register.*
- B. The Company did not take adequate steps to finalize and dispose of complaints in accordance with rules and regulations, applicable statutes and contract language.*
- C. The timeframe within which the Company responded to complaints was not in accordance with applicable statutes, rules and regulations.*
- D. The Company did not treat all written complaints submitted by or on behalf of a covered person as a grievance in states where separate grievance laws apply.*
- E. For Complaints involving agent's actions, the Company did not request an agent statement in all instances. In addition, there was inconsistent evidence that disciplinary actions were taken against agents involved in the complaints.*
- F. The Company's Complaint Action Team (CAT), chaired by SEA division head of consumer affairs, focuses solely on complaints in an effort to identify actions designed to reduce the number of complaints. This team operated independently with no executive management oversight. If compliance related issues arise from these meetings, it was the responsibility of various managers to see that each issue is addressed. Once this issue had been released to the manager, there was no follow-up to ensure that the issue was handled appropriately.*

CONFIDENTIAL SETTLEMENT COMMUNICATION

**Required Action #7:** *For complaints and grievances to be handled appropriately, the Company must take the following actions:*

- A. *All complaints must be recorded and logged correctly in compliance with states' laws and the Company's stated procedure.*

**Company Response:** The Companies respectfully submit that the data in the Attribute Testing indicates the errors related to this Finding and reported for Standard 1 (pages 79 - 80 of the draft report) were all within the allowable 10% error tolerance level provided in the NAIC Market Regulation Handbook. Further, the Companies are concerned that this Required Action and the related Finding could be improperly construed to indicate that the Companies did not record any complaints in the required format in its complaint register the way it is written. The Companies have written procedures in place regarding complaint handling that require all complaints to be logged in the Companies' complaint register.

Because the Finding was based upon Attribute Testing and the Attribute Testing error results were within a 10% error tolerance, the Companies respectfully request that the Finding and related Required Action be removed from the report.

The Companies have completed the following activities to enhance the management of complaint logs:

- Complaint oversight and management was centralized in the Compliance Department's Complaint Oversight and Reporting Unit as of January 1, 2006. Complaint logs are maintained by this Unit.
- Since December 2005, periodic training sessions have been conducted for all employees to ensure complaints are appropriately identified and routed correctly for logging and tracking. Complaint handling training sessions are conducted every six (6) months with employees who have direct contact with customers. All other employees receive annual training. The most recent complaint training was conducted in August 2007.
- Agents receive complaint training through TTACC.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

- A new Complaint Handling System ("CHS") has been developed and was implemented as of June 2007. With the establishment of this new system, workflows for complaints have also been reviewed and enhanced. All written complaints, including complaints from state regulatory departments, are still entered into the complaint logs through a centralized location in the Complaint Oversight and Reporting Unit. Verbal complaints are entered into the CHS by escalation teams in the Customer Care and Customer Advocacy Departments who are specially trained to handle verbal complaint calls. The CHS will allow more reporting capabilities that were not available under the prior complaint tracking system. The additional reporting capabilities will allow the Companies to better manage complaint handling and to monitor complaints for trends and patterns that require corrective action.

*B. The Company must ensure that all issues raised in a complaint/grievance are acknowledged and investigated, finalized/disposed of in accordance with rules and regulations, applicable statutes and contract language.*

**Company Response:** The Companies respectfully submit they passed the attribute testing related to this Standard. The data in the Attribute Testing in the Draft Report for Standard 3 (pages 80 - 81 of the Draft Report) indicates there was one (1) error for MEGA from a sample size of 50 (or 2%) and two (2) errors for Mid-West from a sample size of 50 (or 4%) with regard to insufficient information being provided to a complainant. These error levels are well within the 10% allowable error tolerance level under the NAIC Market Regulation Handbook. Further, the Companies are concerned that this Required Action and the related Finding could be improperly construed to indicate that the Companies did not take adequate steps to appropriately finalize and resolve any complaints in a compliant manner.

Because the Finding was based on Attribute Testing and the error results of Attribute Testing were very low, the Companies respectfully request that the Finding and related Required Action be removed from the report.

Notwithstanding the above, the Companies continually strive to improve the quality of complaint investigations and resolution processes. The Customer Advocacy Group ("CAG") maintains a Complaint Manual that provides guidance for response time and

CONFIDENTIAL SETTLEMENT COMMUNICATION

response content, as well as investigator guidelines and complaint handling procedures. All of these procedures require that complaint responses must be answered timely and that all issues must be addressed.

An audit process was implemented by CAG in January 2006 to review complaints and ensure that standards related to complaint handling are met. CAG has responsibility for investigating and responding to consumer complaints on behalf of ASG. Audits are routinely conducted to ensure that complaints are being responded to timely and in compliance with company and regulatory standards, which includes providing complete responses with all appropriate supporting documentation in response to a consumer complaint.

The Companies are standardizing the grievance handling process. The date targeted for completion of this project is Q1 2008.

- C. *The Company must comply with the timeliness of response and timeliness of resolution of each complaint/grievance as required by applicable statutes, rules and regulations.*

**Company Response:** The Companies respectfully submit that they passed the attribute testing related to this Standard. The data in the Attribute Testing in the Draft Report for Standard 4 (page 81 of the Draft Report) indicates that there were three (3) errors for MEGA from a sample size of 50 (or 6%) and two (2) errors for Mid-West from a sample size of 50 (or 4%) with regard to situations in which a complaint was not responded to in a timely manner. These error levels are well within the 10% allowable error tolerance level under the NAIC Market Regulation Handbook. Further, the Companies are concerned that this Required Action and the related Finding could be improperly construed to indicate that the Companies did not respond to any complaints on a timely basis.

Because the Finding was based on Attribute Testing and the error results of the Attribute Testing were low, the Companies respectfully request that the Finding and related Required Action be removed from the report.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

State laws and regulations, as well as the Companies' internal procedures, pertaining to complaint handling were incorporated into the new Complaint Handling System (noted under Required Action #7A above) to ensure compliance with state requirements. The Complaint Handling System will also allow for changes related to the Companies' policies and procedures as well as state laws and regulations to ensure ongoing compliance with applicable internal and external requirements.

Complaint oversight and management was centralized in the Compliance Department's Complaint Oversight and Reporting Unit as of January 2006. The Complaint Oversight and Reporting Unit has responsibility for monitoring to ensure that complaints are being responded to and resolved in a timely manner. This Unit provides an "Open Item" report to each division of the Companies that includes a list of all open complaints that require a response.

As indicated under Required Action #7B, audit procedures are in place to review complaints and ensure that standards related to complaint handling are met.

- D. *The Company must identify those jurisdictions that have statutes or regulations defining a grievance.*
- *The Company must train appropriate personnel to identify grievances upon receipt.*
  - *The Company must develop procedures for staff to follow when handling grievances. The procedures must be state specific.*

**Company Response:** The Companies respectfully submit that they passed the attribute testing related to this Standard. The data in the Attribute Testing in the Draft Report for NAIC Market Regulation Handbook Grievance Standard #1 (pages 82 – 83 of the Draft Report) indicates that there were two (2) errors for each MEGA and Mid-West related to grievance handling. The error level for MEGA was 7.1% and therefore within the 10% allowable error tolerance level under the NAIC Market Regulation Handbook. With regard to Mid-West, two (2) errors were noted (from a small population of 12), however, one of those errors related to timely acknowledging and responding to a grievance rather than identification of a grievance. Further, the Companies are concerned that this Required Action and the related Finding could be improperly

## CONFIDENTIAL SETTLEMENT COMMUNICATION

construed to indicate that the Companies did not properly treat any complaint as a grievance in states where required.

Because the Finding was based on Attribute Testing and the error results of the Attribute Testing were low, the Companies respectfully request that the Finding and related Required Action be removed from the report.

Notwithstanding the above, as indicated under item 7.B., the Companies are working to standardize the grievance handling process. State specific procedures will be implemented as necessary to address any unique state requirements that fall outside of the standard procedures. The Companies will continue to conduct periodic training on complaint recognition and handling during new employee orientation and for existing staff (every six (6) months for staff who have direct contact with customers and annually for all other employees). In addition, staff training for new employees and existing staff will be expanded during Q1 2008 to include grievance recognition and handling.

*E. The Company must request an agent statement for all complaints involving an agent's actions.*

**Company Response:** The Companies respectfully submit that they passed the attribute testing related to this Standard. The data in the Attribute Testing in the Draft Report for Standard 3 (page 80 – 81 of the Draft Report) indicates that there was one (1) error from a sample size of 50 (or 2%) that related to the Companies' process of obtaining agent statements. Further, the Company is concerned that this Required Action and the related Finding are not accurate as they could be improperly construed to indicate that the Companies did not ever request an agent's statement when investigating a complaint. In accordance with the Companies' complaint handling procedures, the Companies' consistent practice is and always has been to request an agent's statement when investigating a consumer complaint that includes allegations relating to agent activity. The Customer Advocacy Group has added this requirement to its audit procedures.

CONFIDENTIAL SETTLEMENT COMMUNICATION

Because the Finding was based on Attribute Testing and the error results of Attribute Testing were low, the Companies respectfully request that the Finding and related Required Action be removed from the report.

- F. *The Company must improve its complaint handling controls and establish strong oversight of the complaint handling process by:*
- *Preparation of a report to regulators which outlines the complaint-related business practice reforms the Company has implemented to date which address the many concerns expressed in complaints. Included with the report should be documentation to evidence and support the adequacy of such reforms. This report can be used by regulators in developing a workplan for a follow-up examination.*
  - *Creation of a tracking log for issues forwarded to the **Complaint Action Team** and establishing a procedure to ensure that there is ownership and accountability for the process.*

**Company Response:** The Companies have reported the key enhancements and activities that have been completed to date, as well as future planned enhancements and activities, that address concerns identified in complaints and expressed in this Draft Report. We respectfully refer to the responses provided to Findings #1, 2, 6, and 7 related to agent training and monitoring, consumer disclosure and complaint handling.

The Companies' Complaint Action Team ("CAT") was reestablished during 2007. The CAT meetings are now the responsibility of and chaired by the head of the Complaint Oversight and Reporting Unit. The Chief Compliance Officer and Deputy Compliance Officer are members of the CAT and provide oversight for this CAT meeting process. By year-end 2007, the CAT meeting process will be enhanced to include tools and processes to track issues identified and discussed during meetings to ensure ownership of those issues by year-end 2007.

**Finding #8:** *The examination of underwriting practices disclosed that Policyholders who paid their premiums via direct bill received advanced notice that their coverage was going to expire. The notice also explained that a grace period existed for 30 days after coverage ended. During this time, the premium could be paid and coverage could be maintained.*

CONFIDENTIAL SETTLEMENT COMMUNICATION

*Policyholders paying via an automatic bank draft did not receive a notice that explained the grace period. This practice is discriminatory.*

**Company Response:** The Companies respectfully submit that they did not act in a discriminatory manner against customers who pay premiums by automatic bank draft and notices regarding grace period provisions. The grace period provision is stated in each insurance plan issued by the Companies. As a result, all insureds' insurance documents provide them with information regarding the grace period provision applicable to their plan. Further, the Companies submit that there was no finding during the examination process that the Companies did not comply with plan provisions or state laws with respect to administration of the grace period provision.

Additionally, the Companies note that the examiner's concern memo #29, dated April 17, 2006, contained findings and recommendations related to the adequacy of the grace period notice on coverage cancellation letters, and did not reference any element of "advance notice." The examiner's memo also stated "In our review of the sample, no coverage was lapsed until the end of the grace period." In addition, the examiner's Findings Log provided to the Companies in December 2006 contained the examiner's recommendation that "The Company reports that the automatic bank draft letter has been modified to include the grace period notification. This recommendation (related to a follow up review of lapsed policies be undertaken to assure the modified versions are used) was removed from the examiner's Findings Log because it did not meet the NAIC threshold for failure."

Finally, the examiner's concern memo and Findings Log both state "This discrepancy *could have [emphasis added]* resulted in unfair discrimination against direct automatic draft policyholders who were not informed of the grace period." However, the Draft Report states "This practice is discriminatory." This conclusion was not previously communicated by the examiner and does not appear to be supported by the examiner's findings.

Since the examiner's recommendation was removed from the December 2006 Findings Log, the Companies respectfully request that this Finding and the Required Action be removed from the Draft Report. Alternatively, the Companies respectfully request that verbiage indicating that the Companies' practices were discriminatory be removed from the Draft Report.

CONFIDENTIAL SETTLEMENT COMMUNICATION

**Required Action #8:** *Cancellation, non-renewal and discontinuance notices must be handled consistently for all policies and must comply with policy provisions and state laws. This includes information about the availability of a grace period provided to the insured and other parties to the contract.*

**Company Response:** While the Companies believe that its practices were compliant with applicable plan provisions and state laws, the Companies agreed to revise notices that are provided to its customers who pay premiums by automatic bank draft to reference the grace period provision contained in each plan. This action was completed in December 2005 and documentation of this change was provided to the Examiners during the examination process.

**Finding #9:** *The Examiners completed a review of UICI's compliance program.*

- A. *UICI did not have a central compliance department to oversee compliance for all companies, divisions and affiliates. Each division or functional unit was responsible for managing its own compliance program.*
- B. *SEA was the only functional unit with a substantial compliance program at the time of the field work. All divisions of the Company had some type of compliance structure in place to address issues but there was no consistency between divisions.*

**Required Action #9:** *The Company must centralize the compliance program to promote consistency in all business units. The Company's adherence to its Compliance Plan and compliance program enhancements must be independently evaluated at periodic intervals and should be re-examined in the next 12 to 18 months. The Company must inform regulators on a timely and periodic basis concerning the program's enhancements and changes to its compliance procedures.*

**Company Response:** Since 2003, the Companies have made great strides toward establishing and maintaining a comprehensive, dynamic compliance program for the entire enterprise. As of February 2007, all of the Companies' compliance initiatives have been centralized under the Compliance Department to promote consistency and accuracy across all business units. This undertaking has been accomplished through the commitment and under the guidance of senior executives in the Companies, who have made it a priority for

## CONFIDENTIAL SETTLEMENT COMMUNICATION

the entire enterprise. The goal of this endeavor has been and will be to provide accurate information regarding laws and regulations to all business units and to work with the business units to implement an effective compliance program that is embedded into every business activity of the Companies and their agents. The following significant activities have been accomplished over the last two (2) years:

- The position of General Counsel for Insurance Operations and Chief Compliance Officer was established in July 2005.
- A Deputy Compliance Officer was hired in mid-2006 to assist the General Counsel in building a comprehensive compliance program for the enterprise. The Deputy Compliance Officer was promoted to Chief Compliance Officer in early 2007, and the compliance program was centralized into the Companies' Compliance Department under the direction of the Chief Compliance Officer.
- In August 2006, the Compliance and Governance Committee of the Board of Directors was established to provide additional high level oversight and guidance related to the Companies' compliance efforts. One of the four purposes of the Committee's charter is "to oversee and monitor the Companies' compliance and regulatory functions, which shall include the assessment on a periodic basis for the processes related to the Companies' risk and control environment, the oversight of the integrity of the Companies' compliance with legal and regulatory requirements and evaluation of the Companies' overall compliance program." The Committee meets quarterly in conjunction with the Board of Directors' meetings, and reports to the Board on issues of concern. It receives direct reports from the Chair of the Companies' Regulatory Advisory Panel, which is described below.
- The Regulatory Advisory Panel ("RAP") was established in August 2006. Members of the Panel include: (1) Susan Stead, who served at the Ohio Department of Insurance for 15 years, including six (6) years as assistant director within the Office of Investigative & Licensing Services, where she was responsible for the Market Conduct, Fraud & Enforcement, and Agent Licensing divisions; (2) Jose Montemayor, who served as Texas Insurance Commissioner from 1999 to 2005; (3) Audrey Samers, who served as Deputy Superintendent and General Counsel of the New York Insurance Department

## CONFIDENTIAL SETTLEMENT COMMUNICATION

from 2001 to 2006; and (4) Tommy Thompson, who served as the United States Health and Human Services Secretary from 2001 to 2005 and is a former Governor of Wisconsin.

The RAP meets quarterly and reports to the Compliance and Governance Committee of the Board of Directors. These experienced professionals provide insight and advice to the Companies on a wide variety of regulatory issues. In addition, the Chair of the Panel spends one day a month on site to assist the Chief Compliance Officer and General Counsel in developing new programs and overseeing existing programs. The Mission Statement of the Regulatory Advisory Panel is attached as Exhibit 5.

- The Companies have also engaged the services of Betty Patterson, who until recently was the Senior Associate Commissioner, Financial Program (including Market Conduct Examinations) with the Texas Department of Insurance, to assist in developing the day-to-day aspects of the Companies' compliance efforts. Ms. Patterson reports to the Companies' General Counsel and Chief Compliance Officer and has complete and open access to HealthMarkets' CEO and the RAP.
- The Executive Compliance Committee was established in October 2006. The purpose of this Committee is to bring compliance issues to the Companies' senior executives for consideration and to make decisions regarding compliance direction and focus. The Committee meets regularly and includes the Chief Executive Officer, Chief Financial Officer, General Counsel, Chief Compliance Officer, Chief Information Officer, representatives from AMG, ASG operations, and Compliance Audit, as well as other senior executives of the Companies.
- The Companies have also established a Compliance Audit group that reports directly to the Compliance & Governance Committee of the HealthMarkets, Inc. Board of Directors. Compliance Audit has responsibility for conducting follow-up audits on remediation efforts and actions taken in response to market conduct examination commitments. The Compliance Audit group recommends improvements to operations and processes when issues are identified.

CONFIDENTIAL SETTLEMENT COMMUNICATION

- In August 2007, the Companies created a new Operational Compliance Department within ASG, the Companies' largest business unit. This new Department is responsible for compliance-related oversight of ASG. Operational Compliance also works with other ASG departments to design and implement compliance-related initiatives and enhancements in response to new laws and regulations as well as commitments made to regulators. In addition to compliance implementation oversight, Operational Compliance is charged with monitoring the ongoing compliance of the operation through audits of policies and procedures and the review and analysis of processing metrics. This effort takes place parallel to the monitoring and analysis occurring within the Compliance Audit group.
- A Corporate Compliance Manual is in the final stages of development and will be completed by year-end 2007.

Please see Exhibit 6 for the current organizational chart for the Compliance Department.

***Finding #10: Performance Drive Awards, Inc. (PDA) and Success Driven Awards, Inc. (SDA)***

***Required Action #10:*** *The Company should prepare separate financial information of PDA and SDA on an annual basis and have it available to domestic regulators upon request.*

**Company Response:** The Companies have in the past and continue to prepare separate stand-alone financial statements for PDA and SDA. These financial statements are available to the Companies' domestic regulators upon request.

***Finding #11:*** *The Company had a matching stock benefit for its agents/FSRs who were members of the agent stock plans. ... The Company had indicated that it had historically recorded the compensation expense related to the matching feature on PDA's and SDA's books, since PDA and SDA are the legal entities that, in accordance with the terms of the Agent Plan documents, have the legal obligation to pay such compensation.*

***Required Action #11:*** *The Company should provide regulators authoritative accounting support for its treatment of the agent's stock benefit match.*

CONFIDENTIAL SETTLEMENT COMMUNICATION

**Company Response:** The Companies have properly accounted for the agent's stock benefit match with respect to financial reporting purposes. The Statutory, GAAP and SEC accounting literature indicates the compensation expense should be recorded in the company that benefits from or for which the services were rendered (SSAP 13 par 13) (FASB #123(R) par 11) and (Codification of Staff Accounting Bulletins, Topic 14). The Companies have recorded the expense as applying to the legal entity that has the obligation under the applicable business agreements. The Companies respectfully submit that this Finding and Required Action should be removed from the Draft Report.

***Finding #12:** While the examination was in process, the Company engaged an outside consulting firm to review areas under examination based on prior market conduct examination findings. The Examiners requested a copy of the report prior to the examination to help identify areas of concern. The Companies declined to share the report with the Examiners indicating the review was not complete. On November 15, 2005, the Company presented a progress report to the Examiners and regulators in the form of a PowerPoint presentation. In subsequent discussions with the Company after their presentation, they asserted the report fell under attorney-client and work-product protections and declined to provide additional information regarding the review. By law in every state, companies are compelled to share information that is pertinent to the examination process.*

***Required Action #12:** The Company must provide a copy of the consultant's report or an overview of the report for review by the regulators and Examiners.*

**Company Response:** The Companies wish to cooperate with this Required Action to the extent possible. The Companies will consult further with outside counsel regarding the privilege issue to determine if any kind of overview may be provided in response to this Required Action without waiving the attorney/client privilege status of the documents. In the event the Companies are able to provide an overview of the reports without waiving the attorney/client privilege status of the documents, then the Companies propose to work with the Lead States to determine how such an overview may be provided to the Lead States while maintaining the confidentiality of the document.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

The Companies respectfully submit the following legal analysis regarding the attorney/client privilege status of the documents as a matter expressing and reserving these rights.

### I. The Outside Consultant's Reports Are Privileged Documents

We first note that Washington law, similar to that in most states, mandates that examiners "shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the National Association of Insurance Commissioners." RCW § 48.03.025. We note that the NAIC Marked Regulation Handbook contains several references to the obligation to recognize attorney-client and work-product protections. For example, the Handbook states: "Recognition of attorney-client privileged documents or work products should occur during the file review." See p.285. Similarly, the Handbook notes:

Work papers retained by the company or its independent reviewer may provide additional useful information for market analysis purposes. Regulators must be sensitive, however, to the confidentiality concerns raised by these materials, as discussed in the NAIC White Paper Regulatory Access to Insurer Information: The Issues of Confidentiality. . . . In some states, self-evaluative privilege statutes provide specific guidance on the regulators' access rights and confidentiality obligations, whereas regulators in other states must consider a variety of issues related to the protection of proprietary information, attorney work product, trade secrets, and other privileged information.

See p.31.

As mentioned above, in March 2000, the NAIC adopted a White Paper titled: "Regulatory Access to Insurer Information: The Issues of Confidentiality and Privilege" (the "White Paper"). The Introduction states on pp. 6-7:

With respect to the attorney-client privilege and attorney work product doctrine, there is general agreement that, when the privilege claim is narrowly drawn to meet applicable legal standards, the regulator should make every effort to obtain the needed information in other ways. There are situations in which insurers and regulators differ over access to specific documents, but as a practical matter, regulators generally accept the validity of the attorney-client privilege and will try

## CONFIDENTIAL SETTLEMENT COMMUNICATION

to accommodate reasonable claims of attorney-client privilege and attorney work product protection.

The section of the White Paper addressing the application of the attorney-client privilege states:

States establish attorney-client and other applicable privileges by statutes, court rules, and judicial decisions. Departments of Insurance are not exempt from the reach of those privileges, nor is an insurer deprived of the protections afforded to it by law when it is a regulatory agency that is seeking privileged information.

White Paper, p.9. The summary of this section concludes: "When the privilege clearly exists, the majority of the courts have found its protection to be absolute, thereby precluding the regulator from compelling disclosure of the privileged communication." See p.19.

With respect to the work product doctrine, the White Paper concludes: "The attorney work product doctrine is a rule of fairness protecting the attorney's preparation for litigation. Such a rule is necessary in the administration of justice which relies upon an adversarial system in the search for truth. Nevertheless, upon a showing of substantial need, a court may rule that disclosure of the attorney's work product is appropriate." See p.21.

The above information demonstrates that the examiners should recognize the attorney-client privilege and work-product doctrine to the extent that they apply to the outside consultant's reports. Since laws governing the application of these privileges are similar in most jurisdictions, the Companies refer to the law of Washington to show that the outside consultant's reports should be protected from production pursuant to the attorney-client privilege and work-product doctrine.

### A. Attorney-Client Privilege

RCW § 5.60.060(2) states the Washington rule regarding attorney-client privilege:

An attorney or counselor shall not, without the consent of his or her client, be examined as to any communication made by the client to him or her, or his or her advice given thereon in the course of professional employment.

## CONFIDENTIAL SETTLEMENT COMMUNICATION

This same privilege afforded the attorney is also extended to the client under the common law rule. *State v. Emmanuel*, 259 P.2d 845, 854 (1953) (citing *State v. Ingels*, 104 P.2d 944, cert. denied, 311 U.S. 708 (1940)).

Washington courts have also examined whether the attorney-client privilege extends to communications involving third parties. In *State v. Aquino-Cervantes*, 945 P.2d 767, 771-72 (Wash. App. 1997), the court ruled that the privilege extended to an interpreter utilized by an attorney during communications with a client, stating: "We analogize to cases holding that the attorney-client privilege extends to third parties indispensable to an attorney's provision of legal services to the client, such as legal secretaries and accountants." (Emphasis added.) The *Aquino-Cervantes* court referred to the decision in *United States v. Kovel*, 296 F.2d 918 (2d Cir.1961), where the court determined that the attorney-client privilege applied to communications from an accountant employed by an attorney for the client's benefit.

Washington courts have also applied the attorney-client privilege to materials developed during the course of an attorney's investigation. In *Gray v. Morgan Stanley DW Inc.*, 2005 Wash. App. LEXIS 3182, 9-10 (Wash. Ct. App. 2005), the court noted that "the privilege exists to protect not only the giving of professional advice to those who can act on it but also the giving of information to the lawyer to enable him to give sound and informed advice. The first step in the resolution of any legal problem is ascertaining the factual background and sifting through the facts with an eye to the legally relevant." (quoting *Upjohn Co. v. U. S.*, 449 U.S. 383, 390-91, 101 S. Ct. 677, 66 L. Ed. 2d 584 (1981)).

The outside consultant's reports qualify as privileged documents under the above analysis. In addition, the outside consultant's reports were utilized by HealthMarkets' counsel to assist the Companies in responding to the multi-state market conduct examination and in addressing any compliance issues raised by examiners during the examination.

### B. Work-Product Doctrine

Washington Civil Rule 26(b)(4) codifies the work-product rule, which protects materials prepared by an attorney in anticipation of litigation and states that:

## CONFIDENTIAL SETTLEMENT COMMUNICATION

a party may obtain discovery of documents and tangible things otherwise discoverable . . . and prepared in anticipation of litigation . . . only upon a showing that the party seeking discovery has substantial need of the materials in the preparation of his case and that he is unable without undue hardship to obtain the substantial equivalent of the materials by other means.

“An attorney’s gathering of factual items and documents is protected from disclosure, under the work product rule set forth in CR 26(b)(4), unless the person requesting disclosure demonstrates substantial need and an inability, without undue hardship, to obtain the documents or items from another source.” *Limstrom v. Ladenburg*, 963 P.2d 869, 877 (Wash. 1998).

The fact that a multi-state market conduct examination had been called on the Companies before they engaged the outside consultant establishes that the outside consultant’s reports were prepared in anticipation of litigation. A market conduct examination is the initiation of an adversarial administrative action, which qualifies as “litigation” for purposes of the work-product doctrine. As a result, the outside consultant’s reports qualify for protection under the work-product doctrine because they were commissioned to assist legal counsel in advising Companies’ management with respect to responding to the market conduct examination. In addition, the Companies do not believe that the examiners can establish a substantial need for the outside consultant’s report or undue hardship in obtaining the information from other sources because the examiners had access to the same information as the outside consultant in order to conduct its examination of the Companies.

### II. Conclusion

The Companies believe that the outside consultant’s reports are protected documents under the attorney-client privilege and work-product doctrine under Washington and similar state laws. The Companies believe that the examiners should recognize these privileges pursuant to the Handbook and the White Paper notwithstanding an insurers obligation to cooperate with examiners and produce information under state examination laws.

***Finding #13:*** *As noted in the Subsequent Developments section of this report, the Company has represented that many improvements and changes in their practices and*

CONFIDENTIAL SETTLEMENT COMMUNICATION

*procedures were implemented subsequent to the examination time period and subsequent to the completion of the Examiners field work.*

**Required Action #13:** *The Company must prepare a report to regulators outlining concisely by examination area all business reforms, improvements and changes to policies and procedures implemented through a current date.*

**Company Response:** The Companies have reported the key enhancements and activities that have been or will be completed that address issues expressed in the Draft Report in this response. In particular, Findings 1, 2, 3, 4, 6 and 7 include enhancements related to agent training and oversight, claims operations, disclosures to consumers, and complaint handling. The Companies continue to work to identify new opportunities for improvement and refine proposed actions described in this response.

In closing, the Companies again wish to express their appreciation to the Lead States for the opportunity to respond to the Draft Report and for the assistance provided by the examiners and the Lead States during the examination process. The Companies continue their commitment to full cooperation and open dialogue with the Lead States and Participating States as the examination report is finalized. The Companies also wish to restate their commitment to their continued efforts to improve and enhance operations, including but not limited to, agent training and oversight, compliance programs, complaint handling and claims operations.

# Exhibit 1

Benefit Confirmation Department  
9151 Boulevard 26  
P.O. Box 982010  
North Richland Hills, TX 76182-8010

December 4, 2007

Ref: [REDACTED] PPO

Dear Mr. Merrill:

Congratulations on becoming a customer of The MEGA Life and Health Insurance Company.

We have been unsuccessful in our attempts to contact you by telephone to confirm your benefit selections. Here are a few important reminders regarding your Certificate/Policy.

The product you have purchased is a Catastrophic Expense PPO Certificate. It features a schedule of benefits with accompanying deductibles, co-pays, and benefit maximums you selected at the time of application. This defined schedule of benefits helps keep your plan affordable. Your insurance plan provides valuable health insurance coverage, but it is not a comprehensive major medical plan. You should have recently received a packet containing a complete copy of your plan. We encourage you to review your plan, its benefits and limitations thoroughly, and contact us if you have any questions regarding your coverage.

The plan you selected is one of our most popular product offerings and allows you to select any doctor or hospital. Please refer to the front of your i.d. card for the provider network associated with your plan. By utilizing network providers, you may be eligible for a discount on medical charges covered under the terms and conditions of your Certificate/Policy. In addition, you are able to enhance your plan by adding important riders which provide additional coverage and protection.

We also encourage you to review the answers to the questions on your application for completeness and accuracy. The MEGA Life and Health Insurance Company has relied on the completeness and accuracy of your answers to the health questions in issuing your coverage. Please contact us at the toll free number with any additions or corrections you might have to your application.

We are pleased to have this opportunity to be of service to you. Please feel free to contact us with any questions on our website at [www.megainsurance.com](http://www.megainsurance.com) or by calling 1-800-646-1696. Our business hours are 8:00 a.m. to 5:00 p.m., Monday through Friday.

Sincerely,

Benefit Confirmation Department  
BENCONFIRM

# Exhibit 2

# CONFIDENTIAL SETTLEMENT COMMUNICATION

## Disclosures Regarding

### Certain Business Relationships

The MEGA Life and Health Insurance Company

and

The National Association for the Self-Employed, Inc.

#### Introduction

Set forth below is additional information concerning the National Association for the Self-Employed, Inc. ("NASE") and The MEGA Life and Health Insurance Company ("MEGA") and a description of the relationships between the two organizations.

#### More about the NASE

NASE is a membership organization that provides certain benefits to its Members. NASE is organized under the laws of the State of Texas and its principal place of business is Capital Center, 1235 Main Street, Suite 100, Grapevine, Texas 76051. NASE also has an office in Washington, D.C., from which it carries out many of its legislative and advocacy efforts. NASE is governed by a board of directors, the members of which are elected in staggered terms by Members of the NASE, with election occurring on one-third of the directors each year. Members of the NASE are entitled to vote on the selection of members of the board of directors at the annual meeting of the NASE. NASE maintains a website at [www.nase.org](http://www.nase.org). NASE Members are required to pay monetary dues. NASE has no direct or indirect ownership interest in HealthMarkets, Inc. f/k/a UICI, a Delaware corporation ("HealthMarkets"), Specialized Association Services, Ltd. ("SAS"), or any affiliate or subsidiary of HealthMarkets or SAS.

#### More about MEGA and HealthMarkets

MEGA is an Oklahoma domiciled life and health insurance company with an administrative office located in North Richland Hills, Texas. MEGA is licensed to issue health, life, and annuity insurance policies to consumers in all states except New York. MEGA is an indirect wholly-owned subsidiary of HealthMarkets.

Effective April 5, 2006, HealthMarkets is a privately held company, the principal shareholders of which include investment affiliates of The Blackstone Group, Goldman Sachs Capital Partners, and DLJ Merchant Banking Partners (each of which is a private equity firm), certain members of current management and independent insurance agents associated with UGA – Association Field Services (a division of MEGA) and Cornerstone America (a division of Mid-West National Life Insurance Company of Tennessee, an indirect wholly-owned subsidiary of HealthMarkets).

HealthMarkets remains subject to the reporting and certain other obligations under the Securities Exchange Act of 1934, as amended, and files annual, quarterly, and current reports, proxy statements, and other information with the Securities and Exchange Commission. You may inspect and copy such reports, proxy statements and other information at the public reference facilities maintained by the Securities and Exchange Commission at:

Room 1204  
Judiciary Plaza  
450 Fifth Street, N.W  
Washington, D.C. 20549

Citicorp Center  
500 West Madison Street  
Chicago, Illinois 60661

You may call the Securities and Exchange Commission at 1-800-SEC-0330 for further information about the public reference facilities. This material may also be obtained from the Securities and Exchange Commission's worldwide web site at <http://www.sec.gov>. HealthMarkets maintains a website at [www.healthmarkets.com](http://www.healthmarkets.com).

# CONFIDENTIAL SETTLEMENT COMMUNICATION

## Relationships between MEGA and Affiliates and the NASE

The salesperson that a prospective Member or prospective insured speaks with about NASE Membership and about MEGA insurance products serves both as a licensed insurance agent of MEGA and as a Field Service Representative for new Members for the NASE. The insurance premiums derived from the sale of insurance go to MEGA and the membership dues derived from the sale of the NASE Memberships go to the NASE. The salesperson acts on behalf of MEGA (and not the NASE) when discussing, explaining, and describing MEGA insurance products and premiums. The salesperson acts on behalf of the NASE (and not MEGA) when discussing, explaining, and describing NASE benefits. The NASE pays an affiliate of HealthMarkets for enrolling Members in the NASE and reimburses MEGA for the cost of certain electronic transactions. The NASE purchases a member benefit from Benefit Administration for the Self-Employed, LLC, which is owned in part by an affiliate of HealthMarkets. In your state, membership in the NASE is not required in order to apply for the individual policy of insurance with MEGA.

SAS (which is controlled by the adult children of the late Ronald L. Jensen, HealthMarkets' founder) is a party to an agreement with the NASE to provide certain member fulfillment services. NASE pays SAS for these services. A subsidiary of HealthMarkets also sells new membership sales leads to the Field Service Representatives. Neither HealthMarkets nor MEGA has any ownership interest in SAS or in the NASE. SAS has no ownership interest in the NASE.

**CONFIDENTIAL SETTLEMENT COMMUNICATION**  
**Disclosures Regarding**

**Certain Business Relationships**

**The MEGA Life and Health Insurance Company**

**and**

**The National Association for the Self-Employed, Inc.**

**Introduction**

Set forth below is additional information concerning the National Association for the Self-Employed, Inc. ("NASE") and The MEGA Life and Health Insurance Company ("MEGA") and a description of the relationships between the two organizations.

**More about the NASE**

NASE is a membership organization that provides certain benefits to its Members. NASE is organized under the laws of the State of Texas and its principal place of business is Capital Center, 1235 Main Street, Suite 100, Grapevine, Texas 76051. NASE also has an office in Washington, D.C., from which it carries out many of its legislative and advocacy efforts. NASE is governed by a board of directors, the members of which are elected in staggered terms by Members of the NASE, with election occurring on one-third of the directors each year. Members of the NASE are entitled to vote on the selection of members of the board of directors at the annual meeting of the NASE. NASE maintains a website at [www.nase.org](http://www.nase.org). NASE Members are required to pay monetary dues. NASE has no direct or indirect ownership interest in HealthMarkets, Inc. f/k/a UICI, a Delaware corporation ("HealthMarkets"), Specialized Association Services, Ltd. ("SAS"), or any affiliate or subsidiary of HealthMarkets or SAS.

**More about MEGA and HealthMarkets**

MEGA is an Oklahoma domiciled life and health insurance company with an administrative office located in North Richland Hills, Texas. MEGA is licensed to issue health, life, and annuity insurance policies to consumers in all states except New York. MEGA is an indirect wholly-owned subsidiary of HealthMarkets.

Effective April 5, 2006, HealthMarkets is a privately held company, the principal shareholders of which include investment affiliates of The Blackstone Group, Goldman Sachs Capital Partners, and DLJ Merchant Banking Partners (each of which is a private equity firm), certain members of current management and independent insurance agents associated with UGA – Association Field Services (a division of MEGA) and Cornerstone America (a division of Mid-West National Life Insurance Company of Tennessee, an indirect wholly-owned subsidiary of HealthMarkets).

HealthMarkets remains subject to the reporting and certain other obligations under the Securities Exchange Act of 1934, as amended, and files annual, quarterly, and current reports, proxy statements, and other information with the Securities and Exchange Commission. You may inspect and copy such reports, proxy statements, and other information at the public reference facilities maintained by the Securities and Exchange Commission at:

Room 1204  
Judiciary Plaza  
450 Fifth Street, N.W.  
Washington, D.C. 20549

Citicorp Center  
500 West Madison Street  
Chicago, Illinois 60661

You may call the Securities and Exchange Commission at 1-800-SEC-0330 for further information about the public reference facilities. This material may also be obtained from the Securities and Exchange Commission's worldwide web site at <http://www.sec.gov>. HealthMarkets maintains a website at [www.healthmarkets.com](http://www.healthmarkets.com).

# CONFIDENTIAL SETTLEMENT COMMUNICATION

## Relationships between MEGA and Affiliates and the NASE

The NASE and MEGA entered into an agreement, pursuant to which the NASE has agreed to make available to its Members certain insurance products offered by MEGA. This agreement with MEGA may only be terminated by MEGA or by the NASE upon not less than one year's advance notice to the other party.

The salesperson that a prospective Member or prospective insured speaks with about NASE Membership and about MEGA insurance products serves both as a licensed insurance agent of MEGA and as a Field Service Representative for new Members for the NASE. The insurance premiums derived from the sale of insurance go to MEGA and the membership dues derived from the sale of the NASE Memberships go to the NASE. The salesperson acts on behalf of MEGA (and not the NASE) when discussing, explaining, and describing MEGA insurance products and premiums. The salesperson acts on behalf of the NASE (and not MEGA) when discussing, explaining, and describing other NASE benefits. The NASE pays an affiliate of HealthMarkets for enrolling Members in the NASE and reimburses MEGA for the cost of certain electronic transactions. The NASE purchases a member benefit from Benefit Administration for the Self-Employed, LLC, which is owned in part by an affiliate of HealthMarkets.

SAS (which is controlled by the adult children of the late Ronald L. Jensen, HealthMarkets' founder) is a party to an agreement with the NASE to provide certain member fulfillment services. NASE pays SAS for these services. A subsidiary of HealthMarkets also sells new membership sales leads to the Field Service Representatives. Neither HealthMarkets nor MEGA has any ownership interest in SAS or in the NASE. SAS has no ownership interest in the NASE.

## Disclosures Regarding Association Group Insurance

### About Association Group Insurance

The NASE makes available to its members insurance coverage provided through MEGA. The NASE serves as the Association Group Master Policyholder of an association group insurance policy issued by MEGA. In the event MEGA approves your application, MEGA will issue to you an individual insurance certificate evidencing your insurance coverage under the Association Group Master Policy. Under the law of most states, you may not acquire insurance coverage under an association group - type master policy unless you are also a member of an association. However, association membership is not required to maintain the insurance.

### Underwriting

While the master policy issued by MEGA to the NASE is referred to as an association group policy, the law of most states permits MEGA to review and underwrite your individual application, both at the time of your initial application and thereafter if you apply for coverage under a different master policy form issued by MEGA or if you apply to add coverage under the policy form on which your initial coverage was issued. As a result, based on MEGA's assessment of your health, MEGA may elect to accept coverage or decline to issue to you a certificate evidencing coverage under the Association Group Master Policy.

# Exhibit 3

# Claims Process Flow Example

Effective Date: 10/23/2007

Revised:

Copyright © 2006-2007 The MEGA Life and Health Insurance Company, Mid-West National Life Insurance Company of Tennessee and The Chesapeake Life Insurance Company (the "Companies")

## Sample Case

In this example, we will follow a bill submitted for charges from assignment of a claim number(s) until final adjudication, showing the resulting EOB. This example is an actual case (data fields have been obscured for HIPPA privacy).





## Understanding Film Numbers

When a bill arrives at the Company, it is tied to the appropriate policy number and eligibility is verified.

An individual bill is linked to one or more claim numbers on the adjudication system. These claim numbers are linked by a unique film number which is representative of the first claim number assigned to the bill.

# Sample Case

## First Claim: Cause Codes

A cause code is a code used to link claims together by an episode of illness or accident. A major function of cause codes is to track accumulations of dollar(s) amounts (lifetime, max limits etc.) It is extremely important to link claims with their appropriate cause code. Examiners select cause codes using the criteria outlined in the Cause Code Selection Policies and Procedures, available on the eManual.

CAUSE	INCURRED DATE	DST/DIA	DX	DESCRIPTION
001S	08/26/2004		38872	REFERRED OTOGENIC PAIN
002S	02/15/2005	MAM	V7612	OTHER SCREENING MAMMOGRAM
003S	12/30/2004	PAP	V723	GYNCOLOGICAL EXAMINATION
004S	12/30/2004	PAP	V723	GYNCOLOGICAL EXAMINATION
005S	05/27/2004		4010	ESSENTIAL HYPERTENSION, MALIGNANT
006S	06/09/2004		7061	OTHER ACNE
007S	08/26/2004		38872	REFERRED OTOGENIC PAIN
	12/06/2004		2189	LEIOMYOMA OF UTERUS, UNSPECIFIED
	02/28/2005		7823	EDEMA
	04/12/2005		13101	TRICHOMONAL VULVOVAGINITIS
	06/02/2005	PHA	463	ACUTE TONSILLITIS

10-22-07  
16:02.36

UICI  
CAUSE SCREEN  
DEPENDENT # 01  
CERT # 09053957448

GCRPC042  
LTRV KLN

Cause codes can be selected from a list of previous codes used by an individual, or a new cause can be created if needed. This particular example uses the previously established cause code of 004S.





# Example Bill

## First Claim: Diagnosis Codes and Film Number

Diagnosis codes, as shown on bill and Processor 1:  
 218.9: Leiomyoma of uterus  
 218.2: Subserous leiomyoma of uterus  
 401.9: Essential hypertension, unspecified  
 285.8: Other specified anemias

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)	A	B	C	D	E
1. 218.1				401.9	
2. 218.2				285.8	
24.					

Claim Number

CLM E-V63599-01 PAT	M	** HISTORY	** 03/28/05 REA	PB	ID	JJS	** HISTORY					
R 032105 I 120604 C 2189 D 2182 4019 2858 PO PPO PC PL 21 KH25												
DATES	PRO	AI	BC	PROC	#SV	TOTCHG	DENY	DED	CONSIDER	%	PAY	AMT
0224 022405 ME A IXL 8573026 01 00007.25 00000.00 00000.00 00002.75 080 00002.20												
0224 022405 ME A IXL 8573026 01 00007.25 00000.00 00000.00 00000.00 000 00000.00												
0224 022405 ME A IXL 8561026 01 00001.75 00000.00 00000.00 00001.75 080 00001.40												
0224 022405 ME A IXL 8561026 01 00007.25 00000.00 00000.00 00000.00 000 00000.00												
0224 022405 ME A IXL 8502526 01 00003.75 00000.00 00000.00 00003.75 080 00003.00												
0224 022405 ME A IXL 8502526 01 00006.25 00000.00 00000.00 00000.00 000 00000.00												
0224 022405 ME A IXL 8005326 01 00005.25 00000.00 00000.00 00005.25 080 00004.20												
0224 022405 ME A IXL 8005326 01 00017.75 00000.00 00000.00 00000.00 000 00000.00												
CAUSE 004S-BX-EDI ST TX TOTALS:000052.00 008000.00 00000.00 000013.50 000010.80												
RMRKS 1 RMRKS 2 RMRKS 3 RMRKS 4 RMRKS 5 RMRKS 6 RMRKS 7 RMRKS 8												
PS D1 Q3 PS D2 Q3 PS D3 Q3 PS D4 Q3 PS D5 Q3 PS D6 Q3 PS D7												
PAYEE SAVINGS DISC/INT CHK AMT												
MEMORIAL PATHOLOGY CONSU 0000000.00 0000000.00 0000010.												
REG CHECK NO CLR DT												

This is the diagnosis used to determine the cause code.  
 This diagnosis was established from a prior claim.

Film Number

FE AAT SUB  
 NEXT BASE IN OV N CLM CD F# EV6359901 DRG  
 THIS IS THE FIRST CLAIM FOR FILM # EV6359901

As shown, the film number represents the claim number assigned to the bill. The claim was processed based on a prior claim with the primary diagnosis of 218.9, as shown on the previous slide. The diagnosis of 218.1 from this bill relates to cause code 004s; therefore, 218.9 was utilized.

**Note:** The diagnosis code fields (programming was completed as of 11/17/06) represent the first three diagnosis codes on the bill. This example shows a claim processed prior to locking the diagnosis code fields.





# Sample Case

## First Claim: Benefit Codes

The benefit codes are determined based on the procedure code and place of service submitted on the bill. In this example, the procedure codes are lab charges rendered while the insured was hospital confined.

The place of service is 21, "inpatient hospital," which matches the bill.

CLM E-V63599-01 PAT M \*\* HISTORY \*\* 03/28/05 REA B \*\* JJS \*\* HISTORY  
 R 032105 I 120604 C 2189 D 2182 4019 2838 PO PPO PC PL 21 M25  
 DATES PRO AI BC PROC #SV TOTCHG DENY DED CONSIDER % PAY AMT  
 0224 022405 ME A IXL 8573026 01 00002.75 00000.00 00002.75 080 00002.20  
 0224 022405 ME A IXL 8573026 01 00007.25 00000.00 00007.25 080 00000.00  
 0224 022405 ME A IXL 8561026 01 00001.75 00000.00 00001.75 080 00001.40  
 0224 022405 ME A IXL 8561026 01 00007.25 00000.00 00007.25 080 00000.00  
 0224 022405 ME A IXL 8502526 01 00003.75 00000.00 00003.75 080 00003.00  
 0224 022405 ME A IXL 8502526 01 00006.25 00000.00 00006.25 080 00000.00  
 0224 022405 ME A IXL 8005326 01 00005.25 00000.00 00005.25 080 00004.20  
 0224 022405 ME A IXL 8005326 01 00017.75 00000.00 00017.75 080 00000.00  
 CAUSE 0045 BY EDI ST TX TOTALS: 000052.00 000000.00 00000.00 000013.50 000010.80  
 KS 2 RMRKS 3 RMRKS 4 RMRKS 5 RMRKS 6 RMRKS 7 RMRKS 8  
 D1 Q3 PS D3 Q3 PS D5 Q3 PS D7  
 SAVINGS DTSC/INT CHK AMT REG CHECK NO CLR DT  
 00000000.00 00000000.00 00000000.00 00000010.80 15575674 040405

**Procedure Codes:**  
 85730 26 Thromboplastin time (substitution)  
 85610 26 Prothrombin time  
 85025 26 Complete CBC  
 80053 26 Comprehensive metabolic panel

**Benefit Code:**  
 IXL: Inpatient x-ray or lab  
**Note: Modifier 26 means these services are professional components**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE LINES 1, 2, 3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAL RE submission CODE	23. PRIOR AUTHORIZATION NUMBER	24. ORIGINAL REF. NO.
1. L218.1			
2. L218.2			
3. 02242005	8573026	MDH5242	
4. 02242005	8561026	MDH5242	
5. 02242005	8502526	MDH5242	
6. 02242005	8005326	MDH5242	
7. 02242005	8005326	MDH5242	
8. 02242005	8100126	MDH5242	
25. PATIENTS ACCOUNT NO. 74-1720245	176.186951.1	87.00	0.00



# Sample Case

## Second Claim: Billed Charges

First and second line in the adjudication system is the 5th charge on the bill = \$23.00  
 \$6.75 in charges eligible for consideration  
 \$16.25 discount

The third and fourth line in the adjudication system is the 6th charge on the bill = \$12.00  
 \$1.50 in charges eligible for consideration  
 \$10.50 discount

The lines of service on the bill are shown on the adjudication system.  
 This additional claim holds the remaining lines 5 and 6 from the bill.

CLM E-V63600-01 PAT M \*\* HISTORY \*\* 03/28/0  
 R 032105 I 120604 C 2189 D 2182 4019 2858 PO PPC  
 DATES PRO AI BC PROC #SV TOTCHG DENY DB  
 0224 022405 ME A IXL 8006126 01 00006.75 00000.00 000  
 0224 022405 ME A IXL 8006126 01 00016.25 00000.00 000  
 0224 022405 ME A IXL 8100126 01 00001.50 00000.00 000  
 0224 022405 ME A IXL 8100126 01 00010.50 00000.00 000

CAUSE 0045 BY EDI ST TX TOTALS:000035.00 000000.00 0000.00 000008.25 000006.60  
 RMRKS 1 RMRKS 2 RMRKS 3 RMRKS 4 RMRKS 5 RMRKS 6 RMRKS 7 RMRKS 8  
 Q3 PS D1 Q3 PS D3  
 PAYEE SAVINGS DISC/INT CHK AMT REG CHECK NO CLR DT  
 MEMORIAL PATHOLOGY CONSU 0000000.00 0000000.00 0000000.60 15575674 040405

F# EV6359901 DRG FE AAT SUB /6359901

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)	22. MEDICARE RESUBMISSION CODE	23. PRIOR AUTHORIZATION NUMBER	24. ORIGINAL REF. NO.
MM DD YY MM DD YY	DIAGNOSIS CODE	CHARGES	UNITS
02242005 02242005	85730 26	10 00 1	MDH5242
02242005 02242005	85610 26	9 00 1	MDH5242
02242005 02242005	85025 26	10 00 1	MDH5242
02242005 02242005	80053 26	23 00 1	MDH5242
02242005 02242005	80061 26	23 00 1	MDH5242
02242005 02242005	81001 26	12 00 1	MDH5242
25. FEDERAL TAX ID NUMBER			26. AMOUNT PAID
74-1720245			87.00
27. TOTAL CHARGE			0.00
28. BALANCE DUE			\$



Proprietary and Confidential

**Sample Case**  
*First Claim: Total Benefit Allowance*

The first claim was processed for a benefit allowance of \$10.80.

EOB ADDRESSEE	CLAIM E-V63599-01	**HISTORY
STR 1	BASE	
STR 2	PLN KH25	
CITY	PAYEE NAME MEMORIAL PATHOLOGY CONSUL	
	STR 1 PO BOX 741169	
	STR 2 TX 77274 1169	
	CITY HOUSTON	
PAYEE NAME		
STR 1		
STR 2		
CITY		
PAYEE NAME		
STR 1		
STR 2		
CITY		
PAYEE NAME		
STR 1		
STR 2		
CITY		
REMARKS		
	DAYS TO COMPLETE CLAIM 007 ** HISTORY ** SET UP EDI PAY JJS APP	NEXT

# Sample Case

Second Claim: Total Benefit Allowance

The second claim was processed for a benefit allowance of \$6.60.

EOB ADDRESSEE	CLAIM E-V63600-01	**HISTORY
STR 1	BASE	
STR 2	PLN KH25	
CITY	PAYEE NAME MEMORIAL PATHOLOGY CONSUL	
	STR 1 PO BOX 741169	
	STR 2	
	CITY HOUSTON TX 77274 1169	
	PAYEE NAME	
	STR 1	
	STR 2	
	CITY	
	PAYEE NAME	
	STR 1	
	STR 2	
	CITY	
	REMARKS	
	DAYS TO COMPLETE CLAIM 007 ** HISTORY ** SET UP EDI PAY JJS APP	NEXT
	CLASS	LOC SH
	PAT NO 1761869511	
	CHECK AMT 000006.60	REG IND
	CHECK NO 15575874	EI
	TAX NO 741720245 E RM	
	PAT NO	REG IND
	CHECK AMT	EI
	CHECK NO	
	TAX NO	RM
	PAT NO	REG IND
	CHECK AMT	EI
	CHECK NO	
	TAX NO	RM
	PAT NO	REG IND
	CHECK AMT	EI
	CHECK NO	
	TAX NO	RM



# Sample Case EOB to Insured

**the MEGA**  
Life and Health Insurance Company

**UICI**  
The Insurance Center

Claim Department  
9151 Grapevine Highway  
P.O. Box 982008  
North Richland Hills, TX 76182-8009

March 28, 2005

The procedure codes from both claims are shown on the EOB. These correspond to the codes used on the bill.

The claim number reflects the film number, which is common to both claims.

PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS   MODIFIER
85730 26
85610 26
85025 26
80053 26
80061 26
81001 26

Date Processed: 03/28/2005  
Health ID Number: 0505353444  
Film / Claim Number: E-V63599-01  
Patient: E-V636901

If you call from 8:00am to 5:00pm  
7-81  
www.megainsurance.com  
Patent Account Number: 176189511

THIS IS NOT A BILL

Type of Service	Date	Procedure Code	Total Charges	PPO Discount	Not Covered	Covered Amount	Balance	Co-pay	Total Payment	See Remarks
IP RADIO & LAB	02/24/2005	8573026	10.00	7.25		2.75	2.75		2.75	
IP RADIO & LAB	02/24/2005	8561026	5.00	3.75		1.25	1.25		1.25	
IP RADIO & LAB	02/24/2005	8502526	10.00	6.25		3.75	3.75		3.75	
IP RADIO & LAB	02/24/2005	8005326	23.00	17.75		5.25	5.25		5.25	
IP RADIO & LAB	02/24/2005	8006126	23.00	16.25		6.75	6.75		6.75	
IP RADIO & LAB	02/24/2005	8100126	12.00	10.50		1.50	1.50		1.50	

The total billed on the EOB reflects the total from the bill: **\$87.00**

Total Billed Charges: **\$87.00**

Adjustment Due to Offset Insurance: **\$17.40**

Total Patient Liability: **\$43.38**

MEMORIAL PATHOLOGY CONSULT

Amount Paid: \$17.40  
Check Number: 0015575874

PPO Discount Total: \$89.25  
Base Deductible: \$17.40  
Optional Benefit Deductible: \$0.00

MEMORIAL PATHOLOGY CONSULT  
Please note: The provider of service may not accept a PPO Discount on Non-Covered Charges. All amounts shown on this Explanation of Benefits only apply to this claim. These charges have been considered under the base plan and all applicable optional benefits.

Q3 BENEFITS HAVE BEEN REDUCED BY YOUR 20% COINSURANCE.  
PC A DISCOUNT WAS PROCESSED ON THIS PROVIDER'S BILL IN ACCORDANCE TO OUR CONTRACT WITH PHCS.

**28. TOTAL CHARGE**  
**\$ 87.00**

The total benefit allowance on the EOB reflects the totals from the two claims:  
Claim E-V63599-01 = \$10.80  
Claim E-V63600-01 = \$6.60  
Total Paid = \$17.40

**MEMORIAL PATHOLOGY CONSULT**  
Keeping the Promise of Affordable Coverage  
Administrative Services Group

Proprietary and Confidential

# Exhibit 4

# CONFIDENTIAL SETTLEMENT COMMUNICATION

## CONFIRMATION OF PRESENTATION, DISCLOSURES AND RECEIPT

1. The Insurance Agent (the "Agent") whose signature appears below personally visited me to determine my interest in applying for insurance with Mid-West National Life Insurance Company of Tennessee. I understand that the individual presenting the individual policies of insurance offered by Mid-West National Life Insurance Company of Tennessee in this state is a licensed and appointed insurance agent for Midwest. The Agent provided me an insurance brochure and I had the opportunity to read the insurance brochure, before I signed the application. The Agent clearly explained to me the provisions, limitations and exclusions of the insurance plan(s) which I am applying for, and answered all of my questions to my satisfaction before I signed the application. I understand the type of coverage that I am applying for and, after careful review, I chose the insurance plan that best suits my needs and the needs of any dependents listed on the application form.

⇒ Primary Initial Here: \_\_\_\_\_ ⇐

In addition, the Agent explained to me that the insurance that I have applied for, including insurance applied on any dependents listed on the application will not become effective until the Certificate / Policy is issued by the Company.

I acknowledge that the Agent asked each and every question on the application and that answers on the application are truthful and complete answers. I have signed the application only after a full review of the questions and answers.

I understand and agree that if any material information is incorrect or omitted from the application it could provide the basis for the Company to deny future claims, refuse coverage and to refund my premiums as though the Certificate/Policy had never been issued.

2. In signing this form, I agree that neither the Agent nor the Company is bound by any knowledge or statements made by the Agent or me, unless set forth in writing in the application. I authorize the check tendered with the application to be deposited immediately upon receipt by the home office. I agree that the Company's depositing of my check does not create coverage with the Company and should the Company fail to approve my application for coverage, I will receive a full refund of all insurance premiums given to the Agent at the time of my application. I understand that coverage is not effective unless and until the Certificate/Policy is issued by the Company.

By signing this receipt, I acknowledge that I have had adequate time to read the contents of this form and that I received a copy of the brochure and/or a copy of the outline of coverage, if applicable in my state.

3. I understand that membership in the Association is NOT required in order to apply for the individual policies of insurance. I want to join the Association in order to take advantage of the numerous benefits available to its members. I understand that Mid-West National Life Insurance Company of Tennessee and the Association are separate and distinct entities. I further understand that if I cancel my individual policies of insurance at any time, I will continue to be a member of the Association unless I contact them directly to cancel my membership.
4. If I enrolled in an optional Association Membership, I agree that the Insurance Agent/Field Service Representative identified below has delivered to me a copy of the Disclosures regarding Mid-West National Life Insurance Company of Tennessee and the Association Relationship document (the "Disclosures") and answered any questions I had to assure that I completely understand the information. In signing this form, I agree that I have carefully read and understand the information contained in the Disclosures.

In signing this form, I agree that I have carefully read and I understand all the statements as listed above.

\_\_\_\_\_  
Applicant's Printed Name (Last, First, MI)

\_\_\_\_\_  
Date (mm/dd/yy)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Insurance Agent/Field Service Representative Printed Name (Last, First, MI)

\_\_\_\_\_  
Agent Number

\_\_\_\_\_  
Date (mm/dd/yy)

\_\_\_\_\_  
Signature

# CONFIDENTIAL SETTLEMENT COMMUNICATION

## CONFIRMATION OF PRESENTATION, DISCLOSURES AND RECEIPT

1. The Insurance Agent (the "Agent") whose signature appears below personally visited me to determine my interest in applying for insurance with Mid-West National Life Insurance Company of Tennessee. The Agent provided me an insurance brochure and I had the opportunity to read the insurance brochure, before I signed the application. The Agent clearly explained to me the provisions, limitations and exclusions of the insurance plan(s) which I am applying for, and answered all of my questions to my satisfaction before I signed the application. I understand the type of coverage that I am applying for and, after careful review, I chose the insurance plan that best suits my needs and the needs of any dependents listed on the application form.

⇒ Primary Initial Here: \_\_\_\_\_ ⇐

In addition, the Agent explained to me that the insurance that I have applied for, including insurance applied on any dependents listed on the application will not become effective until the Certificate / Policy is issued by the Company.

I acknowledge that the Agent asked each and every question on the application and that answers on the application are truthful and complete answers. I have signed the application only after a full review of the questions and answers.

I understand and agree that if any material information is incorrect or omitted from the application it could provide the basis for the Company to deny future claims, refuse coverage and to refund my premiums as though the Certificate/Policy had never been issued.

2. In signing this form, I agree that neither the Agent nor the Company is bound by any knowledge or statements made by the Agent or me, unless set forth in writing in the application. I authorize the check tendered with the application to be deposited immediately upon receipt by the home office. I agree that the Company's depositing of my check does not create coverage with the Company and should the Company fail to approve my application for coverage, I will receive a full refund of all insurance premiums given to the Agent at the time of my application. I understand that coverage is not effective unless and until the Certificate/Policy is issued by the Company.

By signing this receipt, I acknowledge that I have had adequate time to read the contents of this form and that I received a copy of the brochure and/or a copy of the outline of coverage, if applicable in my state.

3. The Insurance Agent/Field Service Representative identified below has delivered to me a copy of the Disclosures regarding Mid-West National Life Insurance Company of Tennessee and the Association Relationship document (the "Disclosures") and answered any questions I had to assure that I completely understand the information. In signing this form, I agree that I have carefully read and understand the information contained in the Disclosures.

In signing this form, I agree that I have carefully read and I understand all the statements as listed above.

\_\_\_\_\_  
Applicant's Printed Name (Last, First, MI)

\_\_\_\_\_  
Date (mm/dd/yy)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Insurance Agent/Field Service Representative Printed Name (Last, First, MI)

\_\_\_\_\_  
Agent Number

\_\_\_\_\_  
Date (mm/dd/yy)

\_\_\_\_\_  
Signature

# CONFIDENTIAL SETTLEMENT COMMUNICATION

## CONFIRMATION OF PRESENTATION, DISCLOSURES AND RECEIPT

1. The Insurance Agent (the "Agent") whose signature appears below personally visited me to determine my interest in applying for insurance with The MEGA Life and Health Insurance Company. I understand that the individual presenting the individual policies of insurance offered by The MEGA Life and Health Insurance Company in this state is a licensed and appointed insurance agent for MEGA. The Agent provided me an insurance brochure and I had the opportunity to read the insurance brochure, before I signed the application. The Agent clearly explained to me the provisions, limitations and exclusions of the insurance plan(s) which I am applying for, and answered all of my questions to my satisfaction before I signed the application. I understand the type of coverage that I am applying for and, after careful review, I chose the insurance plan that best suits my needs and the needs of any dependents listed on the application form.

⇒ Initial Here: \_\_\_\_\_ ⇐

In addition, the Agent explained to me that the insurance that I have applied for, including insurance applied on any dependents listed on the application, will not become effective until the Policy is issued by the Company.

I acknowledge that the Agent asked each and every question on the application and that answers on the application are truthful and complete answers. I have signed the application only after a full review of the questions and answers.

I understand and agree that if any material information is incorrect or omitted from the application it could provide the basis for the Company to deny future claims, refuse coverage and to refund my premiums as though the Policy had never been issued.

2. In signing this form, I agree that neither the Agent nor the Company is bound by any knowledge or statements made by the Agent or me, unless set forth in writing in the application. I authorize the check tendered with the application to be deposited immediately upon receipt by the home office. I agree that the Company's depositing of my check does not create coverage with the Company and should the Company fail to approve my application for coverage, I will receive a full refund of all insurance premiums given to the Agent at the time of my application. I understand that coverage is not effective unless and until the Policy is issued by the Company.

By signing this receipt, I acknowledge that I have had adequate time to read the contents of this form and that I received a copy of the brochure and/or a copy of the outline of coverage, if applicable in my state.

3. I understand that membership in the Association is NOT required in order to apply for the individual policies of insurance. I want to join the Association in order to take advantage of the numerous benefits available to its members. I understand that The MEGA Life and Health Insurance Company and the Association are separate and distinct entities. I further understand that if I cancel my individual policies of insurance at any time, I will continue to be a member of the Association unless I contact them directly to cancel my membership.
4. If I am enrolled in an optional Association Membership, I agree that the Insurance Agent/Field Service Representative identified below has delivered to me a copy of the Disclosures regarding The MEGA Life and Health Insurance Company and the Association Relationship document (the "Disclosures") and answered any questions I had to assure that I completely understand the information. In signing this form, I agree that I have carefully read and understand the information contained in the Disclosures.

In signing this form, I agree that I have carefully read and I understand all the statements as listed above.

\_\_\_\_\_  
Applicant's Printed Name (Last, First, MI)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

\_\_\_\_\_  
Insurance Agent/Field Service Representative Printed Name (Last, First, MI)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

\_\_\_\_\_  
Agent Number

M/CDR IND 8/06

RETURN TO HOME OFFICE

# CONFIDENTIAL SETTLEMENT COMMUNICATION

## CONFIRMATION OF PRESENTATION, DISCLOSURES AND RECEIPT

1. The Insurance Agent (the "Agent") whose signature appears below personally visited me to determine my interest in applying for insurance with The MEGA Life and Health Insurance Company. The Agent provided me an insurance brochure and I had the opportunity to read the insurance brochure, before I signed the application. The Agent clearly explained to me the provisions, limitations and exclusions of the insurance plan(s) which I am applying for, and answered all of my questions to my satisfaction before I signed the application. I understand the type of coverage that I am applying for and, after careful review, I chose the insurance plan that best suits my needs and the needs of any dependents listed on the application form.

Initial Here: \_\_\_\_\_

In addition, the Agent explained to me that the insurance that I have applied for, including insurance applied on any dependents listed on the application, will not become effective until the Certificate/Policy is issued by the Company.

I acknowledge that the Agent asked each and every question on the application and that answers on the application are truthful and complete answers. I have signed the application only after a full review of the questions and answers.

I understand and agree that if any material information is incorrect or omitted from the application it could provide the basis for the Company to deny future claims, refuse coverage and to refund my premiums as though the Certificate/Policy had never been issued.

2. In signing this form, I agree that neither the Agent nor the Company is bound by any knowledge or statements made by the Agent or me, unless set forth in writing in the application. I authorize the check tendered with the application to be deposited immediately upon receipt by the home office. I agree that the Company's depositing of my check does not create coverage with the Company and should the Company fail to approve my application for coverage, I will receive a full refund of all insurance premiums given to the Agent at the time of my application. I understand that coverage is not effective unless and until the Certificate/Policy is issued by the Company.

By signing this receipt, I acknowledge that I have had adequate time to read the contents of this form and that I received a copy of the brochure and/or a copy of the outline of coverage, if applicable in my state.

3. The Insurance Agent/Field Service Representative identified below has delivered to me a copy of the Disclosures regarding The MEGA Life and Health Insurance Company and the Association Relationship document (the "Disclosures") and answered any questions I had to assure that I completely understand the information. In signing this form, I agree that I have carefully read and understand the information contained in the Disclosures.

In signing this form, I agree that I have carefully read and I understand all the statements as listed above.

\_\_\_\_\_  
Applicant's Printed Name (Last, First, MI)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

\_\_\_\_\_  
Insurance Agent/Field Service Representative Printed Name (Last, First, MI)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

\_\_\_\_\_  
Agent Number

# Exhibit 5

# CONFIDENTIAL SETTLEMENT COMMUNICATION

HEALTHMARKETS, INC.

REGULATORY ADVISORY PANEL

## OBJECTIVES AND MISSION STATEMENT

HealthMarkets, Inc. ("the Company") has established a Regulatory Advisory Panel (the "RAP") in order to ensure that the Company receives the benefit of and is provided objective, rigorous compliance advice and counsel from experienced leaders in the financial services industry.

Members of the RAP shall have the following mission:

- To provide the Company's Board of Directors (the "Board") and the Company with objective advice and guidance regarding regulatory compliance issues.
- To provide the Board and the Company information regarding regulatory trends, issues and initiatives.
- To provide the Board and the Company feedback on the Company's compliance initiatives.
- To report on a regular periodic basis to the Board regarding these issues and topics.

Members of the RAP shall be former insurance or other financial service industry regulators, compliance experts, and others who have significant and meaningful experience in legal, compliance or regulatory matters as specifically applied in the insurance and financial services industry. The RAP shall consist of no fewer than three members as determined by the Board, each of whom shall have no relationship to the Company that may interfere with the exercise of his or her independence from management and the Company.

The RAP shall meet no less frequently than quarterly and at other times as necessary or requested by the Board or the Chief Compliance Officer, during which meetings the members will hear presentations about current Company compliance and regulatory issues and initiatives, and will provide their advice and feedback. The RAP shall have the authority, to the extent it deems it necessary or appropriate, to retain special legal counsel or other consultants to advise the RAP and carry out its mission as prescribed hereby.

A member of the RAP shall report to the Board after each RAP meeting regarding the matters discussed at the RAP meeting, and the results of the discussion.

Members of the RAP shall be retained solely in an advisory capacity to the Company and the Board and shall not have statutory responsibilities or be subject to liabilities as directors under the laws of Delaware or the laws of any other jurisdiction.

# Exhibit 6

