FLORIDA DEPARTMENT

OF

INSURANCE

TARGET MARKET CONDUCT REPORT
OF
UNITED BENEFIT LIFE INSURANCE COMPANY, INC.
AS OF
DECEMBER 31, 2000

DIVISION OF INSURER SERVICES

BUREAU OF LIFE AND HEALTH

INSURER SOLVENCY AND MARKET CONDUCT

MARKET CONDUCT SECTION

Debora Finn, AIE, FLMI
Independent Contract Analyst
10722 Cordage Walk
Columbia, MD 21044

Debora Finn, AIE, FLMI
10722 Cordage Walk, Columbia MD 21044
Phone No. (410) 964-5754 E-Mail: deborafinn@aol.com

May 16, 2005

Honorable Tom Gallagher
Treasurer and Insurance Commissioner
State of Florida
The Capitol, Plaza Level Eleven
Tallahassee, FL 32390-0300

Dear Commissioner Gallagher:

Pursuant to the provisions of Section 624.3161, Florida Statutes, and in accordance with the Agreement for Market Conduct Services dated March 26, 2001, a Target Market Conduct Examination has been performed on:

United Benefit Life Insurance Company
17800 Royalton Road
Strongsville, OH 44136

The examination was conducted at the offices of the Company's Third Party Administrator, Health Plan Services, located in Tampa, Florida. The report of such examination is herein respectfully submitted.

Sincerely,

Debora Finn, AIE, FLMI
Independent Contract Analyst

Table of Contents

Scope of Examination

The Florida Department of Insurance (Department) conducted a target market conduct examination of United Benefit Life Insurance Company, hereinafter referred to as UBL or the Company. The examination was conducted pursuant to §624.3161, Florida Statutes. The examination covers the period from October 1, 1999 through December 31, 2000.

The examination commenced under the services of Lou Penn, an independent contract analyst, on December 14, 2000 at the administrative offices of UBL in Strongsville, Ohio. In January 2001 the examination was moved to the offices of UBL's contracted third party administrator, Health Plan Services, located at 3501 East Frontage Road, Tampa, Florida. On February 23, 2001 the examination was suspended. On March 28, 2001 the examination resumed under the services of independent contract analyst Debora Finn, FLMI, AIE. The examination concluded on June 8, 2001.

The purpose of this Target Market Conduct Examination was to determine if UBL's practices and procedures conform to Florida Statutes and the Florida Administrative Code.

Procedures and conduct of the examination were in accordance with the Department's Field Examination Guidelines and the National Association of Insurance Commissioners (NAIC) Market Conduct Examiners Handbook. The NAIC handbook standards of a seven percent (7%) error factor for claim resolution procedures and a ten percent (10%) error factor for other procedures were given consideration and applied where appropriate.

The examination was limited to assessing compliance and overall procedures used by UBL to administer Association Group Preferred Provider Organization (PPO) health plans sold to Florida residents who were or became members of out of state association groups.

The primary areas reviewed were as follows:

- Notices of Cancellation and Premium Refunds;
- Claim Handling;
- Consumer Complaint Handling;
- Third Party Administrator Licensing.

Introduction

UBL was organized in 1957 as an Indiana domestic insurance company named Laymen Life Insurance Company. It was admitted to write business in Florida in 1981. The name was changed to United Benefit Life Insurance Company on December 30, 1991.

Effective August 1, 1998, UBL entered into a 100% Indemnity Reinsurance Agreement with Central Reserve Life (CRL), an Ohio domestic insurance company. The agreement provided that CRL would assume 100% of UBL's existing block of business, as well as 100% of all new business written after August 1, 1998. UBL and its affiliated agency, Insurance Advisors of America, were obligated for reserve shortfalls on business transferred in connection with the agreement.

During 1999 a reserve shortfall of approximately $20 million was discovered by CRL, caused in part by fraud committed with claims administration at UBL. On July 21, 1999, due to the increasing reserve shortfall, and after receiving approval and authorization from the Indiana Department of Insurance, CRL acquired UBL by foreclosing on the stock and renewal commissions owed to Insurance Advisors of America to pay off the reserve shortfall. On December 17, 1999, UBL was redomesticated to Ohio.

Prior to and at the time of the acquisition of UBL by CRL, UBL was under regulatory supervision by both the Indiana and Texas Insurance Departments; several other state insurance departments had suspended UBL's writing authority. Effective September 12, 2000, UBL entered into a Consent Agreement with the Florida Department of Insurance to discontinue writing new business.

On September 1, 1999, the claim processing function was moved from UBL's Fort Worth, Texas, office to Health Plan Services (HPS), a Third Party Administrator located in Tampa, Florida. Since that time, all other administrative functions have also been moved to HPS. In accordance with the administrative services agreement, UBL paid HPS an initial payment of $800,000 prior to the commencement of the agreement to prepare to take over the claims administration on September 1, 1999.

At the time UBL transferred the administrative functions to HPS, there were known inventory backlogs of unprocessed claims and complaints for all of UBL's in-force business. As previously mentioned, Texas and Indiana Insurance Departments were monitoring the business activities of UBL. Additionally, UBL was receiving an increasing number of complaints filed by consumers and insurance departments of several states. UBL is authorized to write in 38 states.

Certificate of Authority

The Company is authorized to write the following lines of business in the State of Florida, subject to compliance with all orders, applicable laws and regulations of Florida:

- Life;
- Group Life and Annuities; and
- Accident and Health.

Notice of Cancellations and Premium Refunds

The Examiner conducted a review of cancellations and premium refunds to determine if the Company had provided timely notification of policy cancellations and promptly returned the unearned portion of premiums to the policyholder in accordance with §627.6043, Florida Statutes which reads in part:

> *(2) In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid.*

Examination procedures included tests on a sample of 10 policies cancelled at the request of the policyholder. UBL does not cancel policies for reasons other than death, policyholder request, non-payment of premium, or failure to maintain membership in the association.

UBL's cancellation procedures indicate requests to cancel policies must be in writing. Refunds are processed on a pro-rata basis, excluding policy administrative fees.

The examination findings indicated UBL processed cancellation refunds between 1 and 43 days, and refund amounts were computed correctly. While Florida law specifies that carriers should "promptly" refund unearned premium to policyholders who cancel their policy, a required processing time is not defined. The examiner determined that UBL should decrease the processing time for cancellation refunds to ensure refunds are mailed within 20 days after cancellation requests are received. Other examination findings indicate six of the files did not include a written request to cancel, which is required pursuant to UBL's procedures.

Additional findings indicated four of the cancellation requests included in the sample were from policyholders who purchased replacement policies, yet UBL continued to deduct premiums for both policies. Notes in one of the files documenting the phone conversation between an HPS service representative and the policyholder calling to cancel their old UBL policy included the following:

- The policyholder was advised by their agent that the old policy would be cancelled when the replacement policy was issued;
- HPS representative advised the caller they could not process the cancellation request without a written authorization from the policyholder;
- HPS representative advised that evidence of the duplicate coverage did not guarantee a refund of premiums back to the effective date of the replacement policy, and the issue of the refund should be taken up with agent.

The file indicates that UBL did backdate cancellation requests to the effective date of the UBL replacement policy; however, there is evidence that UBL/CRL conducted research to determine whether Florida law required the carrier to process the refund for premiums deducted for duplicate UBL coverage.

While Florida does not have a legal requirement that carriers refund health premiums paid for duplicate coverage, it was determined that UBL failed to include adequate procedures for canceling policies that were known or should have been known to be replacement policies submitted by their agents. The action resulted in UBL's continued automatic collection of premiums for up to nine months after the replacement policy was effective in violation of §626.9541(1)(o)(2), Florida Statutes.

The Company should implement procedures designed to terminate policies and premium collections upon the effective date of all internally replaced policies.

Claim Handling

The Examiner reviewed claims to determine if Company procedures complied with Florida laws and with provisions outlined in policyholder contracts. The examiner conducted tests on samples of paid, denied and pended claims. The tests included:

- Time studies to assess compliance with provisions outlined in the certificate and §626.9541, Florida Statutes - Unfair methods of competition and unfair or deceptive acts or practices defined;
- Verification that claim payments were made to the correct provider, at the correct amount, and on the date indicated in the claim history;
- Verification that claims were processed appropriately in accordance with policy provisions as well as with the mandated benefits outlined in §627.6515, Florida Statutes.

Time Studies

Claim processing times are listed in the following table. The percentages depicted essentially mirror one another for both the samples and population data files.

Processing Times	Pended Claims	Paid Claims	Denied Claims
0-45 Days	36%	70%	44%
46-120 Days	22%	23%	22%
More than 120 Days	42%	7%	34%
Total Percentage	100%	100%	100%

While claim processing delays existed at the time CRL acquired UBL, the Examiner detected considerable evidence that claims continue to experience long processing delays under the administration of HPS. It was noted that claims submitted for chiropractic and physical therapy services experienced long delays because medical necessity reviews were being reviewed by UBL after every 12th visit. These medical reviews were not common practice prior to CRL's acquisition of UBL, and it was noted that several complaints involved claim delays or denials based on medical necessity. Many of the complaints were from providers who had rendered continuing treatment to UBL insureds prior to and after the acquisition of UBL by CRL. The Examiner found that while UBL was exercising due diligence by reviewing the services, they had failed to promptly communicate with insureds and providers the exact reason for the claim delay or why the information was needed to process the claim(s). It was further noted by the Examiner that additional claim delays were caused when UBL switched provider networks in 1999 and again in 2000.

Paid Claims

The "Payment of Claim" section outlined in UBL's policy certificate reads in part:

5. Upon receipt of the required proof of loss, claims will be paid generally within thirty (30) days.

Because neither UBL's policy certificate nor claim procedures provided specificity regarding claim processing times for denied or contested claims, the examiner selected the processing standard of 45 days.

The data file of paid claims included 121,733 claims paid between October 1, 1999 and December 31, 2000. The audit sample included 25 randomly selected claim files.

The following exceptions were noted:

1. Claim #9319234601, which was received at HPS on 11/13/99, was initially and inappropriately denied as a terminated policy on 11/17/99. The claim was reprocessed on 4/17/00 for payment. Total processing time was 156 days. Upon Examiner inquiry regarding the denial and subsequent payment of this claim, the Vice-President of Government Relations for CERES Group, advised that the insured had converted from a Community Choice plan to a Fundamental Choice plan effective 9/1/99. The CERES Group representative further advised that Fundamental Choice conversion policies were administered by CRL until February 2000 when the policy information was transferred to HPS. Upon further review it was learned that the provider sent the claim to the UBL claims post office box in Tampa, Florida, administered by HPS. Therefore, without having specific policy information concerning the converted policy, HPS's denial of the claim would have been unavoidable based on information contained in their system. It was determined that UBL did not communicate alternate procedures for handling claims that would necessarily be remitted to HPS on behalf of policyholders who converted their UBL coverage; in so doing, they failed to adopt and implement standards for the proper investigation of claims. This is a violation of §626.9541(1)(i)(3)(a), Florida Statutes.

2. Claim E0011274502 received on 1/7/00 was inappropriately denied by HPS 1/13/00 as an "untimely filed" claim. On 3/16/00 UBL reprocessed the claim for payment after receiving evidence the claim had been previously received by UBL in 1998. It was determined that UBL failed to adopt and implement standards for the proper investigation of claims in violation of §626.9541(1)(i)(3)(a), Florida Statutes.

Denied Claims

The examiner reviewed denied claims to determine if the Company processed the claims in accordance with the terms of the policy and any state mandated benefits.

The data file of denied claims included 49,232 claims denied between October 1, 1999 and December 31, 2000. The audit sample included 50 randomly selected claim files.

Other than processing delays, there were no exceptions noted while reviewing denied claims.

Pended Claims

The data file of claims included 999 claims pended as of January 5, 2001. The audit sample included 50 randomly selected claim files.

The claims included in the inventory were pended for the following reasons:

- Medical necessity investigation;
- Pre-existing conditions;
- Rescission investigations; and
- Provider network repricing.

Many of the claims were pended upon receipt because the claimant had an existing claim under investigation. That is, once an investigation has been initiated, all subsequent claims received will automatically pend and become part of the investigation. The procedures used by UBL to process an investigation result in long processing delays.

Additionally, it was noted that while UBL generally acknowledged receipt of a claim, they failed to provide notice to the insured or provider when a claim was being contested, or provide specific reasons for contesting the claim. In nearly all cases where a claim was submitted by an ancillary service provider such as a laboratory or x-ray services facility, and an existing investigation was being conducted, no notices were sent to advise of a claim delay or that a claim was being contested. These claims were simply put aside to be processed upon completion of the investigation.

The examiner determined that procedures used to process claims (paid, denied and pended) resulted in unnecessary processing delays, and that UBL committed or performed these procedures with such frequency as to indicate a violation of the following unfair claim settlement practices:

- §626.9541(1)(i)(3)(c), Florida Statutes – Failing to acknowledge and act promptly upon communications with respect to claims;
- §626.9541(1)(i)(3)(f) Florida Statutes – Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise;
- §626.9541(1)(i)(3)(g) Florida Statues – Failing to promptly notify the insured of any additional information necessary for the processing of a claim; and
- §626.9541(1)(i)(3)(h) Florida statutes – Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

The Company should submit a corrective action plan that addresses late processed claims, and immediately review all claims in the pended inventory that are more than 120 days old.

Consumer Complaint Handling

The examiner conducted a review of consumer complaints to determine if the Company maintained complaint procedures and a complete record of complaints received during the survey period. Additionally, the examiner conducted tests to determine if UBL was adequately and timely resolving complaints.

Upon reviewing the complaint registers, the examiner determined that UBL maintains and processes complaints received from the Department separate from those received from policyholders and other non-Department sources.

The examiner conducted tests on a sample of complaints received from both the Department and other non-Department sources. Approximately 65% of complaints were inquiries related to claim delays and/or denials. As previously stated in the claims section of this report, UBL conducts lengthy pre-existing and rescission investigations to determine whether a claim can be denied. Many of the complaints were inquiries related to claims being investigated, however UBL failed to notify the insured or provider of any additional information necessary to process the claim, or explain the reasons why such information was needed to process the claim as required by §626.9541(1)(i)(g) & (h), Florida Statutes. Upon Examiner requests for copies of correspondence sent to providers and insureds for many of the delayed claim complaint files, HPS provided copies of acknowledgment letters referred to as a "delay letter." The "delay letter" simply acknowledges receipt of the claim, but does not ask for additional information. The typical "delayed claim" letter was sent to a provider who had other pended claims; upon receipt of subsequent claims, UBL failed to provide appropriate notice of the reason for a claim delay.

Examination findings indicated processing times for complaints from non-Department sources took considerably longer than those received from the Department. The table below presents the processing times noted for consumer complaints. It was noted that all non-Department complaints are processed for UBL by HPS and all Department complaints are processed for UBL by CRL.

Complaint Source	1-30 Days	31-126 Days
Department	96%	4%
Non-Department	50%	50%

While reviewing complaint files, the Examiner determined that UBL had numerous operational deficiencies resulting in:

- Improperly processed claims;
- Missing documents;
- Cancellation or conversion of coverage without the knowledge or consent of the policyholder; and
- Distribution of "disapproved" forms or use of non-filed forms.

Improperly processed claims

While reviewing complaint files, it was noted by the Examiner that in order to resolve 28% of the sample complaint files, UBL had to reprocess claims that were initially processed incorrectly and in violation of §626.9541(1)(i)(3)(a), (b), (c), and (d), Florida Statutes. Exhibit A attached to this report lists the referenced files.

Conversion with policyholder's knowledge or consent

Four of the complaint files indicated that UBL converted coverage without the knowledge or consent of the policyholder. It was noted that upon request of the policyholder, UBL did convert the coverage back. Exhibit A attached to this report lists the referenced files.

Use of disapproved or non-filed policy forms

Eleven of the complaint files reviewed indicated UBL distributed forms between 1996 and 1998 that were not filed with the Department for informational purposes prior to their use. In addition to distributing non-filed forms, UBL distributed form GHSC-FL END that was specifically disapproved by the Department. UBL filed a revised version of GHSC-FL END with the Department on March 9, 2001. Upon Examiner request for information regarding when and to whom the forms were distributed, UBL indicated they were uncertain because prior to CRL's acquisition of UBL, policy form records were inadequately maintained. The list of forms violations is attached as Exhibit A to this report. This is a violation of §624.410, Florida Statutes.

Third Party Administrator Licensing

The Examiner conducted a review of UBL's administrative services agreements to determine if administrators were properly licensed in the State of Florida, and that agreements contained provisions outlined in §626.882, Florida Statutes.

The following table lists the agreements in effect during calendar years 1998 - 2000. While the survey period did not include calendar year 1998, a review of agreements in effect during 1998 was included when it was discovered that late paid claims and complaints reviewed by the examiner may have involved claims adjudicated by a UBL claim administrator during that time.

Name of Administrator	Contract Dates	TPA Services	Licensed Date
Health Plan Services	7/29/99 – 8/31/02	Yes	1/9/84
International Benefit Services	3/1/99 – 7/1/99	Yes	2/18/87
Sparrow Business Services	3/17/98 – 9/1/99 & 6/1/00 – 8/1/00	Yes	None

As noted in the table above, UBL utilized the services of Sparrow Business Services on two separate occasions. UBL's agreement with Sparrow provided that Sparrow would complete remote claims processing services for UBL. The agreement describes a processed claim as an item that is paid, denied or pended for external additional information.

It was determined that UBL utilized the services of an unlicensed administrator in violation of §624.418(1)(b), Florida Statutes.

The Company should cease entering into agreements with unlicensed administrators.

Other Findings and Subsequent Events

Other Findings

On June 21, 1999, Mr. Jerry Clark of UBL sent a letter to the Department concerning outstanding form filing Number: FLH-99-6205. In the letter, page 3 #19, Mr. Clark indicates UBL will immediately prepare and file the basic conversion file. Upon examiner request for a copy of UBL's conversion policy, issued pursuant to §627.6515(2)(c), Florida Statutes, a representative of UBL advised that the Company did not have an approved individual conversion policy. She further stated that if an insured made a request to exercise their conversion privilege they would receive their same policy. In reviewing the conversion section outlined in UBL's policy certificate(s), it was noted that the contract language did not agree with the provisions outlined in §627.6675, Florida Statues – Conversion on termination of eligibility. Specifically, UBL's certificate indicates that in order to be eligible for conversion, the member must be insured under the policy for at least twelve (12) consecutive months prior to the qualifying event. This contradicts the statute, which provides for conversion eligibility for an insured that had coverage for at least 3 months prior to the qualifying event.

The Company should immediately file a correction to the conversion section of their policy certificates with the Department to comply with the provisions of §627.6515, Florida Statutes, and upon Departmental approval, send out corrected copies of the certificate to all affected certificate holders. Additionally, the Company should immediately file a standard plan conversion policy pursuant to §627.6675, Florida Statutes.

Subsequent Events

On May 30, 2001 UBL sent a letter to the Department outlining the Company's plan to discontinue and replace all in-force major medical insurance business in every state. The plan indicates that existing UBL policyholders will be offered substantially similar out-of-state group coverage through Provident American Life Insurance Company, a CRL subsidiary. In addition, the letter indicates that CRL has entered into an agreement to sell the stock of UBL to an independent investment group with a closing date anticipated for the Second or Third Quarter of 2001.

Conclusion

The customary practices and procedures promulgated by the National Association of Insurance Commissioners (NAIC) were followed in performing this Target Market Conduct Examination of United Benefit Life Insurance Company, Inc., as of December 31, 2000, with due regard to the Insurance Laws of the State of Florida.

Respectfully submitted,

Debora Finn, AIE, FLMI
Independent Contract Analyst

Findings and Recommendations

The following findings were made in the report:

Page 8 - 10 Notice of Cancellations and Premium Refunds

The examiner determined that UBL should decrease the processing time for cancellation refunds to ensure refunds are mailed within 20 days after cancellation requests are received.

UBL continued to collect premiums for up to nine months after replacement policies were in effect, violating §626.9541(1)(o)(2), Florida Statutes.

The Company should implement procedures to ensure the termination of policies and premium collections for all internally replaced policies.

Page 11 - 16 Claim Handling

It was determined that procedures used to process claims (paid, denied and pended) resulted in unnecessary processing delays:

- §626.9541(1)(i)(3)(c), Florida Statutes – Failing to acknowledge and act promptly upon communications with respect to claims;
- §626.9541(1)(i)(3)(f) Florida Statutes – Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise;

- §626.9541(1)(i)(3)(g) Florida Statues – Failing to promptly notify the insured of any additional information necessary for the processing of a claim; and
- §626.9541(1)(i)(3)(h) Florida statutes – Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

The Company should submit a corrective action plan that addresses late processed claims, and immediately review all claims in the pended inventory that are more than 120 days old.

Page 17 Disapproved or non-Filed Policy Forms

It was determined the Company used untitled policy forms, which is a violation of §627.410, Florida Statutes.

Page 18 Third Party Administrator Licensing

It was determined that UBL utilized the services of an unlicensed administrator, which is a violation of §624.418(1)(b), Florida Statutes.

The Company should cease entering into administrative service agreements with unlicensed administrators.

Page 19 Other Findings

It was determined the Company failed to file the basic conversion policy required by §627.6675, Florida Statutes.

The Company should immediately file a correction to the conversion section of their policy certificates with the Department to comply with the provisions of §627.6515, Florida Statutes, and upon Departmental approval send out corrected copies of the certificate to all affected certificate holders. Additionally, the Company should immediately file a standard plan conversion policy pursuant to §627.6675, Florida Statutes.

Exhibit A – Complaint File Violations

Audit #	File #	Policy #	Forms Violation	Claim processing violations	Processing errors related to "converted coverage"	Improperly denied claim, reprocessed
2	S-99000021531	055013857	Form UBL446	626.9541(1)(i)(3)(b)		x
4	S990000333553	374543340	GHSC-FL END	626.9541(1)(i)(3)(a)&(d)		x
5	S99000032156	587282748	CRL 105	626.9541(1)(i)(3)(a)&(d)		x
6	S990000038030	589079990	CRL 105, GHSC-FL END	626.9541(1)(i)(3)(a)&(d)	x	x
7	S-9900-35130	281788339		626.9541(1)(i)(o)(1)		
8	S-9900-41356	055111103	GHSC-FL END		coverage converted without insured's knowledge or consent	
10	S9900-0041311	086341872		626.9541(1)(I)(3)(c),(g)&(h)		
11	2-9900-50223	264086700	GHSC-App-FL PPO (1/98)	626.9541(1)(I)(3)(b)		x
12	S-9900-49347	200429007	GHSC-FL END, UBL 446	626.9541(1)(i)(3)(c),(g)&(h)	coverage converted without insured's knowledge or consent	
13	74805C	265698950				
14	S99000059656	045747790		626.9541(1)(i)(3)(a)&(d)		
16	S-9900-64854	040703819		626.9541(1)(i)(3)c)		
19	S-9900-68959	343589928		626.9541(1)(I)(a),(b)&(d)		x
22	S-0001-11679	205524638	UBL446	626.9541(1)(i)(3)(c),(g)& (h)		
23	S-0001-0017883	261789998		626.9541(1)(i)(3)(c),(g)& (h)	coverage converted without insured's knowledge or consent	
24	S-0001-22088	057508157		626.9541(1)(i)(3)(c),(g)& (h)		
25	S-0001-26694	055001406	UBL 446		coverage converted without insured's knowledge or consent	

Exhibit B – Pended Claims[1]

Item #	Clm #	Case #	DOS	PED	Dt Recv	Process Date	Process Time
17	E0364072400	04386C	7/28/2000	4/1/1997	12/27/2000	2/2/2001	37
33	E1003077000	76542B	12/18/2000	8/1/1995	12/28/2000	2/6/2001	40
24	E1003070000	71273C	12/18/2000	11/1/1999	12/28/2000	2/8/2001	42
9	E1003082901	90094B	12/14/2000	9/1/1996	12/29/2000	2/13/2001	46
20	E0356197201	08850C	11/21/2000	6/1/1997	12/19/2000	2/5/2001	48
21	E0356141600	93097B	11/19/2000	11/1/1996	12/19/2000	2/9/2001	52
35	E0361042700	66056C	12/12/2000	11/1/1999	12/21/2000	2/12/2001	53
41	E1003114900	68078C	11/17/2000	1/1/2000	12/29/2000	2/20/2001	53
38	E0348157600	00963C	9/17/2000	3/1/1997	12/11/2000	2/16/2001	67
39	E1003138300	77264C	12/19/2000	2/1/2000	12/29/2000	3/12/2001	73
23	E0325007800	76983B	10/3/2000	10/1/1995	11/16/2000	2/14/2001	90
8	E0347138600	66664C	11/18/2000	11/1/1999	12/8/2000	3/9/2001	91
31	E0361046300	33153C	10/17/2000	3/1/1998	12/21/2000	3/23/2001	92
4	E1003154300	78715B	12/15/2000	1/1/1996	12/29/2000	4/2/2001	94
27	E0349003700	86900B	12/5/2000	8/1/1996	12/12/2000	3/21/2001	99
26	E0333058800	13529C	10/3/2000	8/1/1997	11/22/2000	3/5/2001	103
47	E0347168000	19335C	11/20/2000	10/1/1997	12/9/2000	3/23/2001	104
13	E1003232900	77476C	12/2/2000	2/1/2000	12/18/2000	4/3/2001	106
7	E0292020900	11797C	10/4/2000	7/1/1997	10/16/2000	1/31/2001	107
40	3075003402	26660C	7/19/2000	1/1/1998	10/30/2000	2/16/2001	109
49	E0287009600	04579C	1/4/1999	5/1/1997	10/10/2000	1/31/2001	113
12	3625072400	70849C	11/30/2000	12/1/1999	12/26/2000	4/20/2001	115
14	E0306016900	94622B	10/18/1999	12/1/1996	10/27/2000	2/22/2001	118
30	E0284145001	22589C	5/22/2000	11/1/1997	10/6/2000	2/20/2001	137
5	E0319070600	02004C	10/23/2000	3/1/1997	11/10/2000	4/3/2001	144
2	E1003045600	64562C	12/15/2000	11/1/1999	12/28/2000	5/24/2001	147
3	E0262011701	18173C	9/6/2000	10/1/1997	9/14/2000	2/8/2001	147
32	E0244000700	09821C	12/22/1998	7/1/1997	8/28/2000	1/31/2001	156
11	E0294046300	17995C	10/4/2000	10/1/1997	10/17/2000	3/23/2001	157
50	E0073108501	69259C	2/29/2000	12/1/1999	3/9/2000	8/24/2000	168
45	E0238014200	54053C	8/16/2000	7/1/1999	8/22/2000	2/9/2001	171
22	E0224011903	83595B	8/2/2000	5/1/1996	8/9/2000	1/31/2001	175
46	E0242004800	84554B	5/3/2000	6/1/1996	8/25/2000	2/21/2001	180
1	E0327129400	74782C	10/11/2000	1/1/2000	11/20/2000	5/24/2001	185
18	2235074709	07970C	7/15/2000	6/1/1997	8/10/2000	2/13/2001	187
43	E0220021001	51717C	7/31/2000	4/1/1999	8/3/2000	2/9/2001	190
28	E0223128900	84554B	11/2/1999	6/1/1996	8/9/2000	2/21/2001	196
15	E0196007200	24808C	1/9/2000	12/1/1997	7/12/2000	2/1/2001	204
37	E0294081000	34304C	9/29/2000	4/1/1998	10/18/2000	5/11/2001	205
34	E0241001000	87002B	8/25/1998	8/1/1996	8/23/2000	3/21/2001	210
25	E0249081506	83750B	8/5/2000	5/1/1996	8/31/2000	4/2/2001	214
42	E0200089100	03900C	4/17/2000	4/1/1997	7/14/2000	3/5/2001	234
16	E0213056100	88557B	7/5/2000	8/1/1996	7/27/2000	4/2/2001	249
29	2085108500	39508C	4/20/2000	6/1/1998	7/28/2000	4/11/2001	257
36	E0159187402	34304C	5/22/2000	4/1/1998	6/5/2000	3/22/2001	290
10	E0214226606	10770C	1/12/2000	7/1/1997	7/29/2000	5/24/2001	299

[1] The "Process Time" in this table is derived from a calculation using the computer-generated data supplied to the examiner by subtracting the "Process Date" from the "Received Date." The examiner did not review each file to determine if all information needed to process this claim was received by the "Date Received" date entered into the Company's database.

Item #	Clm #	Case #	DOS	PED	Dt Recv	Process Date	Process Time
6	E0108137200	77049B	1/20/2000	11/1/1995	4/13/2000	3/14/2001	335
44	E0041019400	69303C	1/25/2000	12/1/1999	2/5/2000	4/6/2001	426
48	E0038041601	47280C	1/21/2000	12/1/1998	2/2/2000	4/9/2001	432

Exhibit C – Denied Claims[2]

Seq Nr	Claim Number	Case Nbr	Dt of Service	Dt Received	Dt Deny	Process Time
19813	E0053200700	19729C	2/10/2000	2/16/2000	4/26/2000	6
27265	E9292116100	90579B	10/7/1999	10/14/1999	11/19/1999	7
17368	E0067294100	28063C	2/23/2000	3/2/2000	3/8/2000	8
1915	E0038207300	37457C	1/25/2000	2/3/2000	2/9/2000	9
14896	E9298099800		10/11/1999	10/21/1999	11/8/1999	10
4873	E0075153604	52989C	2/29/2000	3/13/2000	6/7/2000	13
27732	E0168090300	12387C	6/1/2000	6/14/2000	7/18/2000	13
34029	E0203091600	07416C	7/5/2000	7/19/2000	7/24/2000	14
32473	E9344004700	92201B	11/22/1999	12/9/1999	12/20/1999	17
36317	E0159144901	04129C	5/17/2000	6/5/2000	6/28/2000	19
1398	E0217010100	52045C	7/12/2000	8/2/2000	8/9/2000	21
34013	E0178062400	98326B	5/31/2000	6/22/2000	7/6/2000	22
49044	0243H748700	08643C	8/1/2000	8/23/2000	9/22/2000	22
18847	E0040041900	40559C	1/14/2000	2/7/2000	2/10/2000	24
28343	E9285034600	71410C	9/13/1999	10/7/1999	10/15/1999	24
26231	E0067069400	09308C	2/5/2000	3/1/2000	3/9/2000	25
17387	0039U460000	03005C	7/18/1999	8/25/1999	2/18/2000	38
10667	E0097117600	79723B	2/24/2000	4/5/2000	4/13/2000	41
4665	E9348007800	51518C	10/18/1999	12/10/1999	12/28/1999	53
19715	E0139091000	92892B	3/21/2000	5/15/2000	6/5/2000	55
20207	E0284212302	71881C	8/12/2000	10/6/2000	12/1/2000	55
39019	E9312208601	06218C	8/16/1999	11/2/1999	11/10/1999	78
44180	E0004069601	27784C	10/9/1999	1/3/2000	2/15/2000	86
41516	E0237090800	67163C	5/10/2000	8/21/2000	8/30/2000	103
32128	E0140147501	34773C	1/28/2000	5/17/2000	6/22/2000	110
46668	E0140050600	48473C	1/21/2000	5/17/2000	7/7/2000	117
48662	E9250507804	81646B	4/27/1999	8/26/1999	2/10/2000	121
31285	E0166202201	77310B	2/7/2000	6/12/2000	7/14/2000	126
2863	E9322062101	53898C	7/2/1999	11/16/1999	12/1/1999	137
18027	E9274022200	53260C	5/10/1999	9/28/1999	11/8/1999	141
27572	E0063088900	99353B	9/24/1999	2/28/2000	3/7/2000	157
40972	92875248500	31942C	5/6/1999	10/14/1999	11/3/1999	161
10380	E0062066000	52741C	9/10/1999	2/26/2000	3/6/2000	169
14376	E0189135600	53146C	1/11/2000	7/5/2000	8/28/2000	176
17068	E0062105701	11523C	8/30/1999	2/26/2000	9/19/2000	180
43594	1055231100	84045C	11/16/1999	5/29/2000	5/30/2000	195
11522	E0241195000	00121C	2/10/2000	8/24/2000	8/29/2000	196
16360	E0194101800	16830C	12/9/1999	7/10/2000	7/13/2000	214
45975	E9319015100	99940B	3/12/1999	11/4/1999	12/2/1999	237
6296	E0313076000	25976C	2/22/2000	11/6/2000	11/14/2000	258
47142	E9280380400	76927B	12/29/1998	10/1/1999	10/8/1999	276
36001	E0214237100	32415C	7/16/1999	7/29/2000	8/24/2000	379
19748	9313U052600	16688C	9/3/1998	10/19/1999	11/9/1999	411
52	E0348145200	44693C	10/13/1999	12/11/2000	12/26/2000	425
37008	9300U752802	83599B	6/30/1998	10/28/1999	4/4/2000	485
37134	E9293094207		4/29/1998	10/16/1999	10/21/1999	535
23707	E0287015600	66282C	1/15/1999	10/10/2000	10/19/2000	634
37389	0098H750504	78523B	5/21/1998	4/4/2000	4/4/2000	684
1622	E9314002100	11714C	9/10/1997	11/2/1999	11/11/1999	783
21819	E0055285400	82000B	8/12/1997	2/19/2000	3/1/2000	921

[2] The "Process Time" in this table is derived from a calculation using the computer-generated data supplied to the examiner by subtracting the "Process Date" from the "Received Date." The examiner did not review each file to determine if all information needed to process this claim was received by the "Date Received" date entered into the Company's database.

Exhibit D – Paid Claims[3]

Seq Nbr	Claim Nbr	Case Nbr	Dt of Service	Dt Received	Dt Paid	Process Time
116880	E0011056400	46302C	12/3/1999	1/10/2000	1/13/2000	3
9740	E0010136500	11871C	9/1/1999	1/6/2000	1/11/2000	5
73050	E0227057000	23689C	8/4/2000	8/10/2000	8/15/2000	5
68180	E0231061600	48218C	7/31/2000	8/16/2000	8/22/2000	6
92530	E0054072600	55701C	1/13/2000	2/18/2000	2/24/2000	6
97400	E0032114401	52895C	1/18/2000	1/28/2000	2/3/2000	6
14610	E0278052700	70005C	9/26/2000	9/29/2000	10/6/2000	7
24350	E0109098300	32861C	2/24/2000	4/14/2000	4/21/2000	7
53570	E9306086900	05536C	8/12/1998	10/28/1999	11/5/1999	8
102270	E0230022800	83543B	8/10/2000	8/15/2000	8/23/2000	8
4870	E0063121600	46339C	1/29/2000	2/28/2000	3/8/2000	9
19480	E0320136200	78556B	10/16/2000	11/13/2000	11/22/2000	9
43830	E0325044300	54056C	11/7/2000	11/16/2000	11/27/2000	11
112010	E9326033600	46290C	10/26/1999	11/18/1999	12/9/1999	21
121750	E9326144600	58755C	5/7/1999	11/18/1999	12/9/1999	21
63310	E9362141700	55439C	12/30/1998	12/22/1999	1/20/2000	29
87660	E9300045000	84277B	10/8/1999	10/23/1999	11/24/1999	32
48700	E9279000801	37907C	9/27/1999	10/6/1999	11/15/1999	40
82790	E9333263002	46313C	10/11/1999	11/23/1999	1/3/2000	41
77920	E0133011501	30392C	7/29/1999	5/10/2000	6/21/2000	42
29220	E0152049801	87867B	1/23/1999	5/26/2000	7/12/2000	47
38960	E0129087100	54096C	4/27/2000	5/4/2000	6/30/2000	57
107140	E0011274502	75989B	8/31/1998	1/7/2000	3/16/2000	69
34090	E9319234601	83831C	11/3/1999	11/13/1999	4/17/2000	156
58440	E0091021501	53054C	12/20/1999	3/29/2000	11/28/2000	244

[3] The "Process Time" in this table is derived from a calculation using the computer-generated data supplied to the examiner by subtracting the "Process Date" from the "Received Date." The examiner did not review each file to determine if all information needed to process this claim was received by the "Date Received" date entered into the Company's database.