Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

October 9, 2014

Patrick Carr, President
Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, IN 46278-1719

Re: Golden Rule Insurance Company NAIC# 62286
Market Conduct Examination Report Closing letter

Dear Mr. Carr:

The Department has reviewed your company's proof of compliance and deems it adequate and sufficient. Therefore, the Department is closing its file on this exam. I intend to ask the Director to make the Examination Report available for public inspection as authorized by 215 ILCS 5/132.

If you have any questions, my contact information is listed below.

Sincerely,

Miryam Ramirez
Acting Deputy Director
Consumer Outreach and Protection
Illinois Department of Insurance
122 S. Michigan Avenue, 19th Floor
Chicago, IL 60603
Phone: 312-814-2117
E-mail: Miryam.Ramirez@Illinois.gov

IN THE MATTER OF THE EXAMINATION OF

GOLDEN RULE INSURANCE COMPANY
7440 WOODLAND DRIVE
INDIANAPOLIS, IN 46278-1719

MARKET CONDUCT EXAMINATION WARRANT

I, the undersigned, Director of Insurance of the State of Illinois, pursuant to Sections 132, 401, 401.5, 402, 403 and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/401.5, 5/402, 5/403, and 5/425) do hereby appoint Mike Hager, from the Illinois Department of Insurance, as the Examiner-in-Charge, Pat Hahn and Ron Cochran, also from the Illinois Department of Insurance, as Examiners, and Victor Negron, Stephen Zellich, Timothy Nutt, William Dow, Beverly Dale, and Michael Morrissey, each from Examination Resources, LLC, as Examiners, to examine the insurance business and affairs of Golden Rule Insurance Company, NAIC #62286, and to make a full and true report to me of the examination made by them of Golden Rule Insurance Company, with a full statement of the condition and operation of the business and affairs of Golden Rule Insurance Company, with any other information as shall in their opinion be requisite to furnish me a statement of the condition and operation of its business and affairs and the manner in which it conducts its business. The costs of this examination shall be borne by the company.

The persons so appointed shall also have the power to administer oaths and to examine any person concerning the business, conduct, or affairs of Golden Rule Insurance Company. This warrant supersedes the warrant dated January 3, 2014 that was previously issued by the Illinois Department of Insurance for Golden Rule Insurance Company.

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

Done at the City of Chicago, this 17th day of January, 2014.

Andrew Boron *Director*

GOLDEN RULE INSURANCE COMPANY

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	November 12, 2013 through April 25, 2014
EXAMINATION OF:	Golden Rule Insurance Company NAIC Number: 707 62286
LOCATION:	7440 Woodland Drive Indianapolis, Indiana 46278-1719
PERIOD COVERED BY EXAMINATION:	July 1, 2012 through June 30, 2013 – Claims July 1, 2010 through the Start of the Examination – Appeals, External Independent Reviews and Complaints
EXAMINERS:	Victor Negron Stephen Zellich Ron Cochran Patricia S. Hahn C Michael Hager - Examiner in Charge

INDEX

I. SUMMARY 1-2

II. BACKGROUND 2

III. METHODOLOGY 2-4

IV. FINDINGS 5-9

A. Producer Analysis
1. Agent Production
2. Terminated Agent Review

B. Non Forfeiture Analysis
1. Extended Term / Reduced Paid Up
2. Life Cash Surrenders
3. Annuity Cash Surrenders

C. Claims Analysis
1. Paid Individual Life
2. Annuity Death Settlements
3. Paid Long Term Care
4. Denied Long Term Care
5. Paid Short Term Medical
6. Denied Short Term Medical
7. Paid Hospital Medical Surgical
8. Denied Hospital Medical Surgical
9. Paid Major Medical
10. Denied Major Medical
11. Paid Medicare Supplements
12. Denied Medicare Supplements
13. Paid Accident and Health
14. Denied Accident and Health

D. Underwriting
1. Declined Health Applications

E. Policy Form and Advertising Review
1. Policy Form Review

F. Complaint, Appeals and External Independent Reviews
1. Department of Insurance Complaints
2. Consumer Complaints/Appeals

V. INTERRELATED FINDINGS 10

VI. TECHNICAL APPENDICES 10

I. SUMMARY

1. The Company was criticized under 215 ILCS 5/154.6(b) for failure to acknowledge with reasonable promptness pertaining to communications with respect to claims arising under its policies.

2. The Company was criticized under 215 ILCS 5/154.6(c)&(d) for failure to adopt and implement reasonable standards for the prompt investigations and settlement of claims arising under its policies; and not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear.

3. The Company was criticized under 215 ILCS 5/154.6(d) for failure to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear.

4. The Company was criticized under 215 ILCS 5/224(1)(l) for failure to make payment of interest to the insured's beneficiary due to delayed payment of claims.

5. The Company was criticized under 215 ILCS 5/368a(c) for failure to process and pay interest on claims not paid within 30 days.

6. The Company was criticized under 215 ILCS 5/356z.3a(b) for denying claims when the insured utilizes a participating network ambulatory surgery center and, due to any reason, in network services for radiology anesthesiology, pathology, emergency physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician or provider, the insurer or health plan shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating physician or provider for covered services.

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

8. The Company was criticized under 215 ILCS 5/155.58(b) for failure to promptly return the premium to the entitled person.

9. The Company was criticized under 50 Il. Adm. Code 919.70(1)(A) for failing to conduct a search for additional policies or insurance coverages on the life of an insured upon notification of death of the insured.

10. The Company was criticized under 50 Il. Adm. Code 919.70(a)(2) for failing to provide the insured or, when applicable, the insured's beneficiary with a reasonable written explanation for the delay of claim payment when claims remain open for 45 days.

11. The Company was criticized under 50 Il. Adm. Code 2051.310(a)(6)(H) for denying claims when the insured has made a good faith effort to use the services of a contracted provider and where there is not equitable access to such providers. The

participating provider sent the laboratory work to a non-participating provider and the insured had no control over this.

II. BACKGROUND

Golden Rule Insurance Company (the "Company") was incorporated on June 17, 1959 and commenced business on June 23, 1961 in Lawrenceville, IL. The Company is a wholly owned subsidiary of Golden Rule Financial Corporation, which was acquired by UnitedHealth Group on November 13, 2003. It was re-domesticated to Indiana on October 2, 2006. The Company received its license to conduct business in Illinois on June 17, 1959.

The Company offers individual health and dental insurance plans with optional benefit riders including vision and term life insurance in 40 states and the District of Columbia. The Company allocates through independent agents, sponsored marketing programs, Internet, and direct selling.

In 2013, only 10 companies had a greater share of the life and health insurance market in Illinois. $92,720,000 of direct premiums written gave the Company a 1.49% market share, an increase from the previous year. In 2012, the Company ranked 12th in Illinois with a 1.25% market share on $78,001,000 of direct premiums written.

In 2013, the Company ranked 11th in the nation with a 1.10% market share on $1,993,379,000 of direct premiums written. In 2012, the Company ranked 13th with 1.03% of the life and health insurance market on $1,834,246,000 of direct premiums written.

III. METHODOLOGY

The Market Conduct Examination covered the business for the period of July 1, 2012 through June 30, 2013 and for claims and July 1, 2010 through the start date of the examination for appeals, complaints and external independent reviews. Specifically, the examination focused on a review of the following areas.

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

The review of the categories was accomplished through examination of appointed and terminated producer files, claim files and complaint files. Each of the categories was examined for compliance with Department Regulations and applicable State laws.

The report concerns itself with improper practices performed with such frequency as to indicate general practices. Individual criticisms were identified and communicated to the company, but not cited in the report if not indicative of a general trend, except to the

extent that underpayments and/or overpayments in claim surveys or undercharges and/or overcharges in underwriting surveys were cited in the report.

The following methods were used to obtain the required samples and to assure a methodical selection:

Producer Production

New business was reviewed to determine if solicitations had been made by duly licensed persons.

Claims

1. Paid Claims - Payment for claims made during the examination period.

2. Denied Claims - Denial of benefits during the examination period for losses not covered by certificate of coverage provisions.

All claims were reviewed for compliance with policy contracts and applicable Sections of the Illinois Insurance Code (Section 5/1 et seq.), the Managed Care Reform and Patient Rights Act (Section 134 et seq.) and the Illinois Administrative Code.

Median payment periods were measured from the date all necessary proofs of loss were received to the date of payment or denial to the member.

The period under review was July 1, 2012 through June 30, 2013.

Department Complaints and Consumer Appeals

The Company was requested to provide all files relating to complaints received via the Department of Insurance and those received directly from members. The Company was also requested to provide files of all member complaints and external independent reviews handled during the survey period.

Median periods were measured from the date of notification by the complainants to the date of response by the Company.

The period under review was July 1, 2010 through the start date of the examination.

SELECTION OF SAMPLE

Survey Area Reviewed	Population	# Reviewed	% Population Reviewed	# of Violations	% of Violation
Producer Review					
# Producers	2,051	2.051	100%	0	0%
# Applications	53,252	53,252	100%	0	0%
Terminated Agents	1,418	1,418	100%	0	0%
Nonforfeiture Review					
Extended Term / Reduced Paid Up	9	9	100%	17	100%
Life Cash Surrenders	81	81	100%	0	0%
Annuity Cash Surrenders	33	33	100%	0	0%
Claims Review					
Paid Individual Life	209	75	36%	2	2.66%
Annuity Death Settlements	54	54	100%	1	1.85%
Paid Long Term Care	45	45	100%	15	33%
Denied Long Term Care	17	17	100%	9	53%
Paid Short Term Medical	5,440	115	2.1%	1	0.87%
Denied Short Term Medical	2,220	110	4.9%	1	0.91%
Paid Hospital Medical Surgical	9,965	115	1.2%	0	0%
Denied Hospital Medical Surgical	8,823	115	1.3%	0	0%
Paid Major Medical	280,864	125	0.045%	0	0%
Denied Major Medical	16,036	115	0.72%	1	0.87%
Paid Medicare Supplements	21,363	115	0.54%	0	0%
Denied Medicare Supplements	1,411	110	0.78%	0	0%
Paid Accident and Health	47	47	100%	0	0%
Denied Accident and Health	29	29	100%	0	0%
Underwriting					
Declined Health Applications	2,886	112	3.8%	0	0%
Policy Forms & Advertising					
Number of Policy Forms & Advertising	41	41	100%	0	0%
Complaints & Appeals					
Dept. of Insurance Complaints	127	127	100%	3	2.36%
Consumer Complaints/Appeals	1,079	1,079	100%	9	0.83%

IV. FINDINGS

A. Producer Analysis

1. Agent Production
   A review of 2,051 producers and 53,252 applications produced no criticisms.

2. Terminated Agent Review

   A review of 1,418 terminated producers produced no criticisms. None were terminated for cause.

B. Nonforfeiture Analysis

1. Extended Term / Reduced Paid Up

   A review of nine (9) extended term and reduced paid up claim files produced 17 criticisms. Seventeen criticisms were made under 215 ILCS 5/154.6(c)&(d) for failure to investigate and pay claims on in-force reduced paid up policies when the Company was made aware that these insureds were deceased. The total underpayment amount was $6,637.08.

   No median could be established.

2. Life Cash Surrenders

   A review of 81 life cash surrender claim files produced no criticisms.

   The median for surrender was 12 days.

3. Annuity Cash Surrenders

   A review of 33 annuity cash surrender claim files produced no criticisms.

   The median for surrender was 15 days.

C. Claims Analysis

1. Paid Individual Life

   A review of 75 paid individual life claim files produced two (2) criticisms. One (1) individual criticism was made under 215 ILCS 5/224(1)(l) for

failure to make payment of interest to the insured's beneficiary due to the delayed payment of a claim. The total underpayment amount was $64.09. The second criticism was made under 215 ILCS 5/154.6(b) for failing to acknowledge with reasonable promptness pertaining to communications with respect to claims arising under its policies resulting in an underpayment of $1,716.99. The beneficiary was the sole beneficiary and the company had paid 50% of the benefit. The company paid both of the underpayments prior to the completion of the examination.

The median for payment was nine (9) days.

2. Annuity Death Settlements

A review of 54 annuity death settlement claim files produced one (1) criticism. A criticism was made under 50 Il. Adm. Code 919.70(1)(A) for failure to conduct a search for additional policies or insurance coverages on the life of an insured upon notification of death of the insured.

The median for payment was eight (8) days.

3. Paid Long Term Care

A review of the 45 paid long term care claim files produced one (1) criticism. One (1) criticism was made under 50 Il. Adm. Code 919.70(a)(2) for failure to provide the insured with a reasonable written explanation of delay beyond 45 days. Fifteen of the 45 files or 33% were found to be in violation.

The median for payment was 14 days.
The mean for payment was 15 days.

4. Denied Long Term Care

A review of 17 denied long term care claim files produced one (1) criticism. One general criticism was made under 50 Il. Adm. Code 919.70(a)(2) for failure to provide the insured with a reasonable written explanation of delay beyond 45 days. Nine of the 17 files or 53% were found to be in violation.

The median for denial was 18 days.

5. Paid Short Term Medical

A review of 115 paid short term medical claim files produced one (1) criticism. A criticism was made under 215 ILCS 5/368a(c) for failing to include interest when a claim is delayed resulting in an interest

underpayment of $4.27. The company paid the interest due prior to the completion of the examination.

The median for payment was eight (8) days.

6. Denied Short Term Medical

A review of 110 denied short term medical claim files produced one (1) criticism. An individual criticism was made under 215 ILCS 5/154.6(d) for not attempting in good faith to effectuate, fair and equitable settlement of claims submitted in which liability has become clear resulting in an underpayment of $464.92. The company has made payment on this claim prior to completion of the examination.

The median for denial was 11 days.

7. Paid Individual Hospital Medical Surgical

A review of 115 paid hospital medical surgical claim files produced no criticisms.

The median for payment was seven (7) days.

8. Denied Individual Hospital Medical Surgical

A review of 115 denied hospital medical surgical claim files produced no criticisms.

The median for denial was eight (8) days.

9. Paid Individual Major Medical

A review of 125 paid major medical claim files produced no criticisms.

The median for payment was 10 days.

10. Denied Major Medical

A review of 115 denied major medical claim files produced one (1) criticism. A criticism was made under 215 ILCS 5/154.6(d) for not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear resulting in a underpayment of $976.42. The company made payment on this claim prior to the completion of the market conduct examination.

The median for denial was eight (8) days.

11. Paid Individual Medicare Supplements

A review of 115 paid Medicare supplement files produced no criticisms. The median for payment was eight (8) days.

12. Denied Medicare Supplements

A review of 110 denied Medicare supplement claim files produced no criticisms.

The median for denial was four (4) days.

13. Paid Accident and Health

A review of 47 paid accident and health claim files produced no criticisms.

The median for payment was 11 days.

14. Denied Accident and Health

A review of 29 denied accident and health claim files produced no criticisms.

The median for denial was 16 days.

D. Underwriting Analysis

1. A review of 112 declined health applications produces no criticisms.

The median for declination was four (4) days.

E. Policy Form and Advertising Review

1. A review of 41 policy forms and advertising produced no criticisms.

F. Complaints, Appeals and External Independent Reviews

1. Department of Insurance Complaints

A review of 127 department of insurance complaint files produced three (3) criticisms. Two (2) criticisms were made under 215 ILCS 5/368a(c) for failure to pay interest due to delayed payment of claims. The total underpayment amount was $27.72. The company made these payments prior to the completion of the examination. A third criticism was made

under 215 ILCS 5/370o for failure to provide the beneficiary or insured emergency care coverage such that payment for this coverage is not dependent upon whether such services are performed by a preferred or non-preferred provider and such coverage shall be at the same level as if the service or treatment had been rendered by a plan provider. The amount of the underpayment is yet to be determined.

The median for response was eight (8) days.

2. Consumer Complaints/Appeals

A review of 1,079 consumer complaint claim files produced
Nine (9) criticisms. Six (6) criticisms were made under 215 ILCS 5/368a(c) for failing to include interest when the claim is delayed beyond 30 days.
Three of these criticisms were agreed to and paid in the amounts of $3.01, $4.51 and $1.90. Each of these three (3) were paid prior to the completion if the examination. Three (3) criticisms were disagreed to by the company and remain in the report and these should be reopened and paid in the amounts of $59.86, $3.79 and $65.33. One (1) criticism was made under 215 ILCS 5/154.6(d) for not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear. The claim amount was for $133.72 and has been resolved. One (1) criticism was made under 50 Il. Adm. Code 2051.310(a)(6)(H) for denying claims when the insured has made a good faith effort to use the services of a contracted provider and where there is not equitable access to such providers. This claim should have been paid the same as if it were an in-network provider. The amount of the underpayment was $281.50 plus interest and should be reopened and paid. One (1) criticism was made under 215 ILCS 5/155.58(b) for failing to refund premium that was deducted from the wrong account. The refund amount was $1,992.81. The company has refunded this premium. One (1) criticism was made under 215 ILCS 5/356z.3a for denying claims when the insured utilizes a participating network hospital or a participating network ambulatory surgery center and, due to any reason, in network services for radiology, anesthesiology, pathology, emergency physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician or provider, the insurer or health plan shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured or enrollee would have incurred with a participating physician or provider for covered services. The amount of this underpayment has not been determined to date. The Company should reopen and pay this claim.

The median for response was eight (8) days.

V. INTERRELATED FINDINGS

request for information was for a listing of all in-force reduced paid-up policies. Golden Rule Insurance Company (the Company) produced a listing identifying 214 policies. We then requested of the Company if they used any kind of database to cross reference if insureds were deceased, such as the Social Security Master Death List. The Company's response was: Golden Rule has a database in which it runs administrative system policy information against the Social Security Master Death List on a monthly basis, applying a "Fuzzy Matching Logic". It then applies business rules. Potential matches are then reviewed by examiners to determine if liability appears to exist. The Company uses the Accurint Lexis Nexis database (a third party public information services vendor who charges a fee for access which include the Social Security Master Death File) to identify deceased policyholders. If we find that an insured has died, we will notify the Policy Administrative Department of this issue and they will contact the policy beneficiary to start the benefit process.

Exam Resources compared the listing of the 214 in-force policies provided by the Company to the Master Social Security Master Death List and found that 17 insureds from that listing were indeed deceased. We then wrote 17 criticisms of various death benefits under 215 ILCS 5/154.6(c)&(d) for failing to promptly investigate claims for policies on the reduced paid-up non-forfeiture status. The Company disagreed with all of the criticisms with the same response on each "Section 154.6(c)&(d) of the Illinois Insurance Code 215 ILCS 5/154.6(c)&(d) requires "prompt investigation" of claims arising under an insurer's policies, Section 919.40 of the Illinois Administrative Code 50 Ill. Adm. Code 919.40 defines prompt investigation as requiring "Notification of Loss" (or death) of the insureds. Accordingly, the Company failed to comply with the prompt investigation provisions".

The Company agreed with the examiners that 16 of the 17 insureds had actually died and one is still under review as a possible non-match.

It is the examiners' opinion that if the Company used the Master Listings on a monthly basis as stated, then they should have known already that the insureds were in fact deceased and should have put in action the process of contacting the beneficiaries and paying the death benefits on the policies. Furthermore, the Company should open these 17 claims associated with the 17 criticisms and pay the appropriate death benefit. Accordingly the criticisms should stand as written and remain in the report.

VI. TECHNICAL APPENDICES

STATE OF ILLINOIS)
) ss
COUNTY OF SANGAMON)

Mike Hager, being first duly sworn upon his/her oath, deposes and says:

That he was appointed by the Director of Insurance of the State of Illinois (the "Director") as Examiner-In Charge to examine the insurance business and affairs of Golden Rule Insurance Company ., (the "Company"), NAIC #62286;

That the Examiner-In-Charge was directed to make a full and true report to the Director of the examination with a full statement of the condition and operation of the business and affairs of the Company with any other information as shall in the opinion of the Examiner-In-Charge be requisite to furnish the Director with a statement of the condition and operation of the Company's business and affairs and the manner in which the Company conducts its business;

That neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is an officer of, connected with, or financially interested in the Company nor any of the Company's affiliates other than as a policyholder or claimant under a policy or as an owner of shares in a regulated diversified investment company, and that neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is financially interested in any other corporation or person affected by the examination;

That an examination was made of the affairs of the Company pursuant to the authority vested in the Examiner-In-Charge by the Director of Insurance of the State of Illinois;

That she/he was the Examiner-in-Charge of said examination and the attached report of examination is a full and true statement of the condition and operation of the insurance business and affairs of the Company for the period covered by the Report as determined by the examiners;

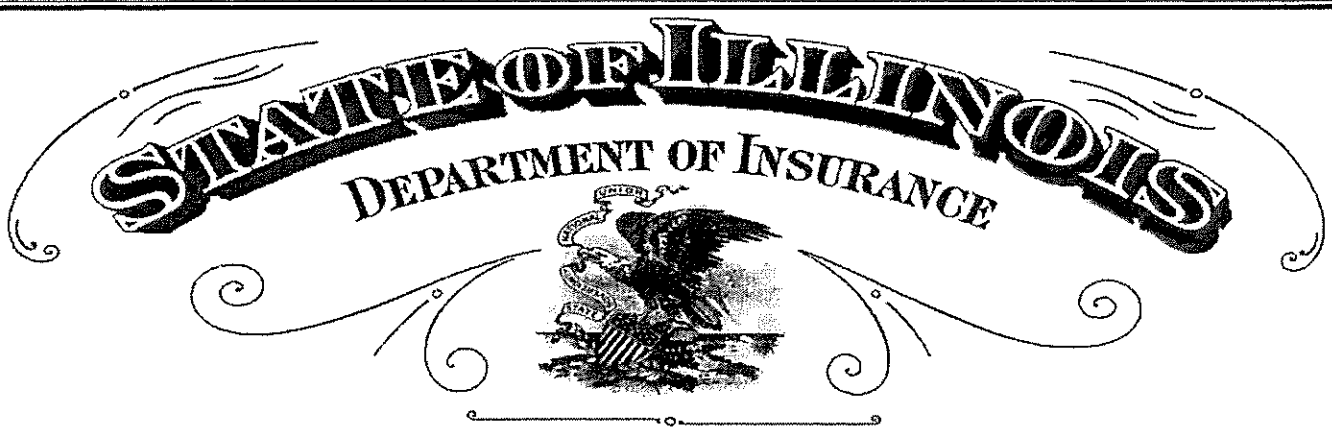
That the Report contains only facts ascertained from the books, papers, records, or documents, and other evidence obtained by investigation and examined or ascertained from the testimony of officers or agents or other persons examined under oath concerning the business, affairs, conduct, and performance of the Company.

Mike Hager
Examiner-In-Charge

Subscribed and sworn to before me
this 16th day of June, 2014.

Miryam Ramirez
Notary Public

MIRYAM RAMIREZ
OFFICIAL SEAL
Notary Public - State of Illinois
My Commission Expires
March 21, 2017



IN THE MATTER OF:

Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, Indiana 46278-1719

STIPULATION AND CONSENT ORDER

WHEREAS, the Director ("Director") of the Illinois Department of Insurance ("Department") is a duly authorized and appointed official of the State of Illinois, having authority and responsibility for the enforcement of the insurance laws of this State; and

WHEREAS, Golden Rule Insurance Company, NAIC #62286, ("the Company"), are authorized under the insurance laws of this State and by the Director to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS, a Market Conduct Examination of the Company was conducted by a duly qualified examiner of the Department pursuant to Sections 132, 401, 401.5, 402, 403, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/401.5, 5/402, 5/403, and 5/425); and

WHEREAS, as a result of the Market Conduct Examination, the Department examiner filed a Market Conduct Examination Report which is an official document of the Department; and

WHEREAS, the Market Conduct Examination Report cited various areas in which the Company was not in compliance with the Illinois Insurance Code (215 ILCS 5/1 *et seq.*) and Department Regulations (50 Ill. Adm. Code 101 *et seq.*); and

WHEREAS nothing herein contained, nor any action taken by the Company in connection with this Stipulation and Consent Order, shall constitute, or be construed as, an admission of fault, liability or wrongdoing of any kind whatsoever by the Company; and

WHEREAS, the Company is aware of and understands the various rights of the Company in connection with the examination and report, including the right to counsel, notice, hearing and appeal under Sections 132, 401, 5/401.5, 402, 407, and 407.2 of the Illinois Insurance Code and 50 Ill. Adm. Code 2402; and

WHEREAS, the Company understands and agrees that by entering into this Stipulation and Consent Order, it waives any and all rights to notice and hearing; and

WHEREAS, the Company and the Director, for the purpose of resolving all matters raised by the report and in order to avoid any further administrative action, hereby enter into this Stipulation and Consent Order.

NOW, THEREFORE, IT IS agreed by and between the Company and the Director as follows:

1. The Market Conduct Examination indicated various areas in which the Company was not in compliance with provisions of the Illinois Insurance Code and Department Regulations; and

2. The Director and the Company consent to this Order requiring the Company to take certain actions to come into compliance with provisions of the Illinois Insurance Code and Department Regulations.

THEREFORE, IT IS HEREBY ORDERED by the undersigned Director that the Company shall:

1. Institute and maintain policies and procedures to acknowledge with reasonable promptness pertaining to communications with respect to claims arising under its policies, as required by 215 ILCS 5/154.6(b).

2. Institute and maintain policies and procedures to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies; and attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear, as required by 215 ILCS 5/154.6(c)&(d).

3. Institute and maintain policies and procedures to make payment of interest to the insured's beneficiary when payment of claims are delayed, as required by 215 ILCS 5/224(l)(1).

4. Institute and maintain policies and procedures to process and pay interest on claims not paid within 30 days, as required by 215 ILCS 5/368a(c).

5. Institute and maintain policies and procedures to ensure that when the insured utilizes a participating network ambulatory surgery center and, due to any reason, in network services for radiology, anesthesiology, pathology, emergency physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician or provider, the insurer or health plan, shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating physician or provider for covered services as required by 215 ILCS 5/356z.3a(b).

6. Institute and maintain policies and procedures to provide the beneficiary or insured, emergency care coverage such that payment for said coverage is not dependent upon whether such services are performed by a preferred, or non preferred provider and such coverage shall be at the same benefit level as if the service or treatment had been rendered by a plan provider, as required by 215 ILCS 5/370o.

7. Institute and maintain policies and procedures to conduct a search for other policies or insurance coverages on the life of an insured upon notification of death of the insured as required by 50 Il. Adm. Code 919.70(1)(A).

8. Institute and maintain policies and procedures to provide the insured or, when applicable, the insured's beneficiary with a reasonable written explanation for the delay of claim payment when claims remain unresolved for 45 days as required by 50 Il. Adm. Code 919.70(a)(2).

9. Institute and maintain policies and procedures to ensure that whenever a beneficiary has made a good faith effort to utilize preferred providers for a covered service, and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, directly or indirectly, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider, as required by 50 Il. Adm. Code 2051.310(a)(6)(H).

10. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above 9 (nine) orders within 30 days of receipt of this Order.

11. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $44,500 to be paid within 30 days of the execution of this Order.

NOTHING contained herein shall prohibit the Director from taking any and all appropriate regulatory action as set forth in the Illinois Insurance Code, including but not limited to levying additional forfeitures, should the Company violate any of the provisions of this Stipulation and Consent Order or any provisions of the Illinois Insurance Code or Department Regulations.

On behalf of:

Golden Rule Insurance Company, NAIC# 62286

Signature

Michael Corne

Name

VP

Title

AMANDA GILPATRICK
MY COMMISSION EXPIRES
November 29, 2020
SEAL
SHELBY COUNTY
NOTARY PUBLIC, STATE OF INDIANA

Subscribed and sworn to before me this
30th day of September 2014.

Amanda Gilpatrick

Notary Public

DATE 10-6-14

DEPARTMENT OF INSURANCE of the
State of Illinois:

Andrew Boron
Director