Illinois Department of Insurance

JB Pritzker
Governor

Robert H. Muriel
Director

VIA ELECTRONIC MAIL
VIA USPS CERTIFIED MAIL

July 14, 2020

Ms. Paula A. Steiner
President & CEO
Health Care Service Corporation, A Mutual Legal Reserve Company
300 E. Randolph Street
Chicago, IL. 60601-5099

Re: Health Care Service Corporation, A Mutual Legal Reserve Company, NAIC 70670
Market Conduct Examination Report Closing Letter

Dear Ms. Steiner:

The Department has received your Company's proof of compliance. Therefore, the Department is closing its file on this exam.

I intend to ask the Director to make the Examination Report and Stipulation and Consent Order available for public inspection as authorized by 215 ILCS 5/132. At the Department's discretion, specific content of the report may be subject to redaction for private, personal, or trade secret information prior to making the report public. However, any redacted information will be made available to other regulators upon request.

Please contact me if you have any questions.

Sincerely,

Erica Weyhenmeyer

Erica Weyhenmeyer
Chief Market Conduct Examiner
Illinois Department of Insurance
320 West Washington St., 5th Floor
Springfield, IL 62767
Phone: 217-782-1790
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ILLINOIS DEPARTMENT OF INSURANCE
MENTAL HEALTH PARITY MARKET CONDUCT EXAMINATION
REPORT OF
HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY

MENTAL HEALTH PARITY MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	April 16, 2018 through December 28, 2018
EXAMINATION OF:	Health Care Service Corporation, a Mutual Legal Reserve Company NAIC #70670
LOCATION:	300 E. Randolph Street Chicago, IL 60601-5009
PERIOD COVERED BY EXAMINATION:	January 1, 2017 through December 31, 2017
EXAMINERS:	Lucinda Woods Elizabeth Harvey John Clark Art Kusserow Bithia Anderson Kirk Stephan André Mumper-Ham, Examiner-in-Charge Shelly Schuman, Supervisory Insurance Examiner Erica Weyhenmeyer, Chief Market Conduct Examiner, DOI

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I. SCOPE OF TARGETED EXAMINATION

Pursuant to the Director's authority as provided under Articles IX, XXIV, and XXVI, Sections 132, 401, 401.5, 402, 403 and 425 of the Illinois Insurance Code, a mental health parity targeted market conduct examination was called on Health Care Service Corporation, a Mutual Legal Reserve Company (hereinafter referred to as the "Company" or "HCSC").

The primary purpose of the examination was to verify the Company's compliance with the Illinois Insurance Laws and Departmental Regulations. The scope of the examination included, but was not limited to, activities as they pertained to parity in mental health and substance use disorder (MH/SUD) benefits within the Company's health insurance business. The examination encompassed the period from January 1, 2017 through December 31, 2017.

The objective of the examination was to evaluate if the Company designed, implemented, and managed MH/SUD benefits no less favorably than medical/surgical benefits. The objectives of the specific areas of review for the examination included, but were not limited to, the following:

1. Review the procedures and guidelines related to utilization review to ensure that such guidelines and utilization review processes on MH/SUD services are no more stringently applied than those applied to medical/surgical services.

2. Evaluate a sample of MH/SUD claims during the examination period to compare services to medical/surgical services and to ensure denials were appropriate based on medical necessity criteria.

3. Evaluate the universe of appeals during the examination period to determine if the appeal decisions were based on appropriate clinical criteria and policies.

4. Evaluate the medical necessity criteria, policies, and procedures to ensure the Company was not imposing more restrictive requirements and determinations for MH/SUD treatments and services than on medical/surgical treatments and services.

5. Determine that the MH/SUD benefits provided in the classifications identified by 45 CFR § 146.136(c)(2)(ii)(A): inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care and prescription drugs, are paid in parity with benefits in the same medical/surgical classifications.

6. Evaluate financial requirements and quantitative treatment limitations (QTL) to ensure that any such requirements and limitations were consistently applied through MH/SUD and medical/surgical benefits and that any financial requirements and QTLs imposed meet the two-thirds threshold of substantially all requirements outlined in 45 CFR § 146.136(c)(3)(i).

7. Evaluate non-quantitative treatment limitations (NQTL) to ensure that such limitations were consistently applied through MH/SUD and medical/surgical benefits and that the Company was not being more restrictive as outlined in 45 CFR § 146.136(c)(4)(i) and 45 CFR § 146.136(c)(4)(ii).

8. Evaluate pre-certification/prior-authorization, step therapy policies, and procedural requirements for MH/SUD treatments to ensure that any such requirements were no more restrictive than the comparable medical/surgical policies and procedural requirements.

9. Determine that the policies and procedures for the selection, tier placement, and quantity limitations of MH/SUD treatment drugs on the formulary were no less favorable to the insured than policies and procedures used for the selection, placement, and limitations of medical/surgical drugs.

For this targeted examination, a MH/SUD subject matter expert and a pharmacist assisted in the interpretation of the documentation provided with respect to MH/SUD parity and pharmacy benefits.

II. SUMMARY OF FINDINGS

A targeted mental health parity market conduct examination was performed to determine compliance with Illinois statutes, the Illinois Administrative Code, as well as federal statutes and rules related to the Mental Health Parity and Addiction Equity Act of 2008. The following table represents general findings with specific details in each section of the report.

Table of Total Violations

Criticism Number	Statute/Rule	Description of Violations	Population	Files Reviewed	No. of Violations
01-Utilization Reviews	215 ILCS 5/370c (5.5)	Failed to state if American Society of Addiction Medicine criteria was used to make medical necessity determinations for substance use disorders.	4,620	115	1
02- Paid Claims	215 ILCS 5/370c.1(a)(1), and 215 ILCS 5/370c.1(e) and Federal Laws 45 CFR § 146.136(c)(2)(i) and 29 CFR § 2590.712(c)(2)(i)	Failure to provide benefits for MH/SUD that are no more restrictive than the predominant financial requirements applied to substantially all hospital and medical benefits covered by the policy and that there are no separate cost-sharing requirements that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits.	1,004,260	109	3
06-Formulary Design	215 ILCS 5/370c.1(a)(2), 215 ILCS 5/370c.1(e), 45 CFR § 146.136 (c)(4)(i), 45 CFR § 146.136 (c)(4)(ii)(B).	Imposed an NQTL with respect to MH/SUD benefits not in parity with medical/surgical benefits (application of prior authorization restrictions on MH/SUD buprenorphine-containing medications.)	N/A	N/A	N/A
Interrelated Finding 1 - Appeals	215 ILCS 134/45(c)	Failed to verbally contact all parties of its appeal decision.	N/A	530	378
Interrelated Finding 2 - Appeals	215 ILCS 134/45(c)	Failed to render a decision on appeals within 15 business days after receipt of the required information.	N/A	530	32

Table of Total Violations					
Criticism Number	**Statute/Rule**	**Description of Violations**	**Population**	**Files Reviewed**	**No. of Violations**
Interrelated Finding 6 – Appeals	215 ILCS 180/20(b)(3)	Failed to respond to an expedited internal appeal within the required 48 hours.	N/A	530	3

III. METHODOLOGY

The targeted market conduct examination process placed emphasis on an insurer's systems and procedures used in dealing with insureds and claimants.

The review of the MH/SUD operations included the following areas:

A. Company Operations and Management
B. Complaints
C. Appeals
D. Underwriting
E. Utilization Reviews
F. Claims
G. Substantially All/Predominant Cost-Sharing Testing in Health Plans
H. Formulary Designs

The review of these categories was accomplished through examination of material related to the Company's operations and management, plans, complaint files, claim files, as well as interviews with various Company personnel and Company responses to the coordinator's handbook, interrogatories and criticisms.

The following method was used to obtain the required samples and to ensure a statistically sound selection. Surveys were developed from Company-generated Excel spreadsheets. Random statistical file selections were generated by the examiners from these spreadsheets. In the event the number of files was too low for a random sample, the sample consisted of the universe of files.

Company Operations and Management

A review was conducted of the Company's underwriting and claims guidelines and procedures, policy forms, third party vendors, internal audits, certificate of authority, previous market conduct examinations and annual statements. There were no exceptions noted.

Complaints

The Company was requested to identify MH/SUD consumer and Illinois Department of Insurance complaints received during the examination period and to provide copies of the complaint logs. All complaint files and logs were received. The files were reviewed for compliance with Illinois statutes and the Illinois Administrative Code. There were no exceptions noted.

Appeals

The Company was requested to identify MH/SUD appeals for the experience period. These appeal files were received and reviewed for compliance with Illinois statutes and the Illinois Administrative Code and the Mental Health Parity and Addiction Equity Act of 2008.

Underwriting

The Company was requested to provide a sample of a health policy including all disclosures for each plan written in Illinois. The policies were reviewed for compliance with Illinois statutes and the Illinois Administrative Code. There were no exceptions found.

Utilization Reviews

The Company was requested to provide a list of all utilization reviews for the experience period. The Company identified the universe of MH/SUD utilization reviews for health. Random samples of the files were made by the examiners and submitted to the Company. These utilization review files were received and reviewed for compliance with Illinois statutes, the Illinois Administrative Code and the Mental Health Parity and Addiction Equity Act of 2008.

Claims

The Company was requested to provide a list of all claims during the examination period, to include paid and denied. The Company identified the universe of MH/SUD claims for health and pharmacy. Random samples of the files were made by the examiners and submitted to the Company. Due to various disqualifying factors, some files in the samples were replaced with another file. The files and responses to information requests and interrogatories were reviewed to ensure the claims were processed in compliance with the policy, Illinois statutes, the Illinois Administrative Code, the Mental Health Parity and Addiction Equity Act of 2008 and related regulations.

Substantially All/Predominant Cost-Sharing Testing in Health Plans

The Company was requested to provide the mental health parity testing of its health plans and the benefit classifications for medical/surgical and MH/SUD categories. The benefits, as classified accordingly, were evaluated for financial requirements and quantitative treatment limitations (QTL) compliance. The parity analyses of the health plans were reviewed for compliance with Illinois statutes, the Illinois Administrative Code, the Mental Health Parity and Addiction Equity Act of 2008 and related regulations.

Formulary Designs

The Company was requested to identify and provide all formulary designs and pharmacy policies and procedures used during the experience period for MH/SUD requirements. In accordance with the requirements of the examination, the data and responses to follow up information requests were reviewed. The pharmacy documentation and responses to follow up information requests and interrogatories were reviewed for compliance with Illinois statutes, the Illinois Administrative Code, the Mental Health Parity and Addiction Equity Act of 2008 and related regulations.

IV. SELECTION OF SAMPLES

Survey	Population	Number Reviewed	Percentage Reviewed
Complaints			
Consumer Complaint – ILDOI	34	34	100%
Consumer Complaints – Received by the Company	127	127	100%
Appeals			
Appeals	1,115	530	47.5%
Utilization Reviews			
Utilization Reviews	4,620	115	2.5%
Claims			
Health – Paid	1,004,260	109	<1%
Health – Denied	27,336	109	<1%
Pharmacy – Paid	5,120,600	109	<1%
Pharmacy – Denied	1,118,345	109	<1%

V. COMPANY BACKGROUND

Health Care Service Corporation, a Mutual Legal Reserve Company - NAIC #70670

Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), was created by the merger of Hospital Service Corporation (licensed in Illinois on October 1, 1936) and Illinois Medical Service, and it commenced operations as HCSC under the provisions of The Non-Profit Health Care Service Plan Act on October 1, 1975.

Effective December 20, 1982, the Illinois Director of Insurance approved HCSC's election to become subject to Article III of the Illinois Insurance Code, which governs mutual insurance companies. At that time, HCSC adopted the name "Health Care Service Corporation, a Mutual Legal Reserve Company."

The Company's 2017 NAIC Annual Statement for Illinois reflects the following information for accident and health:

Direct Premiums Written	Direct Premiums Earned	Direct Loss Incurred	Pure Direct Loss Ratio
$ 14,897,958,906	$ 14,862,865,896	$ 12,668,224,521	100%

VI. MENTAL HEALTH PARITY FINDINGS

A. COMPLAINTS

1. Department of Insurance Consumer Complaints

   There were no criticisms in the Department of Insurance consumer complaints survey.

2. Consumer Complaints Received Directly by the Company

   There were no criticisms in the consumer complaints survey.

B. APPEALS

There were no criticisms in the appeals survey.

C. UTILIZATION REVIEWS

1. Utilization Reviews

   The Company failed in one instance to state if American Society of Addiction Medicine (ASAM) Criteria was used to make medical necessity determinations for substance use disorders. This is a violation of 215 ILCS 5/370c(5.5).

D. CLAIMS

1. Paid

   There were no criticisms in the health paid claims survey.

2. Denied

   There were no criticisms in the health denied claims survey.

3. Pharmacy – Paid

   There were no criticisms in the pharmacy paid claims survey.

4. Pharmacy – Denied

   There were no criticisms in the pharmacy denied claims survey.

E. SUBSTANTIALLY ALL AND PREDOMINANT COST-SHARING TESTING IN HEALTH PLANS

The Mental Health Parity and Equity Addition Act generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder benefits are no more restrictive than those for medical or surgical benefits. This is commonly referred to as providing mental health/substance use disorder benefits in parity with medical/surgical benefits. Companies assess compliance by utilizing "predominant" and "substantially all" tests to determine if they are in parity. The Department found no criticism in its substantially all and predominant cost-sharing testing on health plans. The Department's position would be for the Company to perform its testing prior to the implementation of the plans in order to confirm parity exists under 215 ILCS 5/370c.1(a)(1), 215 ILCS 5/370c.1(e), 45 CFR § 146.136(c)(2)(i) and 29 CFR § 2590.712(c)(2)(i).

F. FORMULARY DESIGNS

Prior Authorization Restrictions on Substance Abuse Medications

For the first 45 days of 2017, the Company's prior authorization restriction on substance abuse medications (MH/SUD, buprenorphine containing medications) violated the Mental Health Parity and Addiction Equity Act and Illinois Compiled Statutes. The Company imposed the nonquantitative treatment limitation (NQTL) as part of restrictions on a prior authorization process which created an additional step to obtain/renew these necessary medications for treating opioid dependence, and which was more restrictive than the Company's predominant usage of prior authorization for the drug as a medical/surgical benefit. Placing a prior authorization on this class of medications could delay or prevent a member from seeking treatment.

In order for a member to obtain/renew any buprenorphine containing medication prior to 2/13/17, the Company required all new and maintenance treatment to have all of the following:

- a diagnosis of opioid dependence,
- the provider meets the certification criteria of DATA 2000 (by having a unique waiver number and qualified to prescribe these medications),
- the member is 16 years old or older, and the member is abstinent from illicit drug use (including problematic alcohol and/or benzodiazepine use),
- the member is compliant with all elements of the treatment plan (including recovery-oriented activities, psychotherapy, and/or other psychosocial modalities),
- the provider is drug testing for compliance (no diversion of the medication and checking PDMP database if applicable),
- if the member is receiving any other opioid (tramadol or tapentadol), the provider has submitted a medical necessity plan of treatment (specific pain being treated and duration of treatment), and
- is dosed appropriately (in accordance to FDA guidelines, quantity prescribed is less than or equal to the program's quantity limit, or
- for higher dosages the provider submitted necessary information for the treatment plan and duration, and/or buprenorphine only exceptions such as pregnancy/intolerance/contraindication/allergy to naloxone/naltrexone).

While the Company's prior authorization restrictions for substance abuse medications were based on federal guidelines, the Company was more restrictive in their implementation of those guidelines for MH/SUD purposes than it was for MED/SURG benefits.

By placing a more restrictive prior authorization on all buprenorphine containing medications for treatment of opioid dependency the Company was in violation of 215 ILCS 5/370c.1(a)(2), 215 ILCS 5/370c.1(e), 45 CFR § 146.136(c)(4)(i), 45 CFR § 146.136(c)(4)(ii)(B).

G. ASSOCIATED MENTAL HEALTH/SUBSTANCE USE DISORDER FILES

A listing was compiled from the universes of claimants with multiple health and pharmacy claims, utilization reviews, appeals and complaints. From this listing, three (3) claimants were selected for a high-level review of the process and procedures involved in adjudicating the various submissions for each of these subscribers in order to receive the benefits of the health plan.

1. An adult subscriber was diagnosed with major depressive disorder and cocaine dependence. The review for the subscriber included 17 paid claims, pharmacy claims and health utilization reviews (all were approved). The pharmacy claims and health utilization reviews were appropriately paid in a timely manner with no treatment limitations or restrictions. The review consisted of no denied clams.

2. An adult dependent of the subscriber was diagnosed with sedative, hypnotic or anxiolytic dependence. The review for the adult dependent included two pharmacy paid claims, 20 health claims (10 paid and 10 denied) and one (1) health utilization review that was approved. The pharmacy claims, health claims and the utilization reviews were treated in parity and were no more restrictive than the handling of medical claims or utilization reviews. In addition, four (4) pharmacy utilization reviews were examined and in the 10 health claims denied, the denial reason was due to the physician failing to approve the treatment and it was handled within parity.

3. An adult subscriber was diagnosed with bipolar disorder and major depressive disorder. The review for the subscriber included three pharmacy paid claims, 10 health claims (10 paid), and utilization reviews. The claims and utilization reviews were found to be treated in parity and were no more restrictive than the handling of medical/surgical claims or medical/surgical utilization reviews.

VII. INTERRELATED FINDINGS

During the review of the MH/SUD appeal files, it was determined that in 32 instances of the 530 appeal files reviewed, for an error percentage of 6.04%, the Company failed to render a decision on appeals within 15 business days after receipt of the required information. This is a violation of 215 ILCS 134/45(c). Also, it was determined that in 378 instances of the 530 MH/SUD appeal files reviewed, for an error percentage of 71.32%, the Company failed to verbally contact all parties of its appeal decision and relied on the provider to relay the information. This is a violation of 215 ILCS 134/45(c). Lastly, it was determined that in three (3) instances of the 530 MH/SUD appeal files reviewed, for an error percentage of 0.56%, the Company failed to respond to an expedited internal appeal within the required 48 hours. This is in violation of 215 ILCS 180/20(b)(3).

EXAMINATION REPORT SUBMISSION

The courtesy and cooperation of the officers and employees of the Company during the examination are acknowledged and appreciated.

Lucinda Woods
Elizabeth Harvey
John Clark
Art Kusserow
Bithia Anderson
Kirk Stephan
André Mumper-Ham, Examiner-in-Charge
Shelly Schuman, Supervisory Insurance Examiner

Respectfully submitted,

André Mumper-Ham
ANDRÉ MUMPER-HAM
EXAMINER-IN-CHARGE

Shelly Schuman
SHELLY SCHUMAN
SUPERVISING EXAMINER

STATE OF MARYLAND)
) ss
COUNTY OF HOWARD)

André J. Mumper-Ham, 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 HEALTH CARE SERVICE CORPORATION a MUTUAL LEGAL RESERVE COMPANY NAIC 70670.

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 Companies 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 Companies' business and affairs and the manner in which the Companies conduct their 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 Companies nor any of the Companies' 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 Companies 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 Companies 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 Companies.

André J. Mumper-Ham
Examiner-In-Charge

Subscribed and sworn to before me

this 14 day of July, 2020

MARK JOSEPH KRIEGER, JR.
NOTARY PUBLIC
BALTIMORE CO., MD

MARK JOSEPH KRIEGER, JR.
Notary Public, State of Maryland
County of Baltimore
My Commission Expires July 16, 2022

Notary Public

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

Health Care Service Corporation
300 E. Randolph Street
Chicago, IL 60601-5009

STIPULATION AND CONSENT ORDER

WHEREAS, the 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, Health Care Service Corporation ("the Company"), NAIC 70670, is 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, 402, 403, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 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 limited 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 their various rights in connection with the examination and report, including the right to counsel, notice, hearing and appeal under Sections 132, 401, 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, they waive any and all rights to notice and hearing under Sections 132, 401, 402, 407, and 407.2 of the Illinois Insurance Code and 50 Ill. Adm. Code 2402; 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 limited 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 whereby the Company shall orally notify all parties involved in the appeal of its decision as required by 215 ILCS 134/45(c).

2. Maintain policies and procedures whereby the Company shall implement treatment limitations applicable to mental, emotional, nervous, or substance use disorder or condition benefits which are no more restrictive than the predominant treatment limitations applied to substantially all hospital and medical benefits covered by the policy per 215 ILCS 5/370c.1.

3. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above two (2) orders within 30 days of execution of this Order.

4. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $325,000 as a contribution to the Parity Advancement Fund created under 215 ILCS 5/370c.1(i) to be paid within 10 days of 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 Health Care Service Corporation

Signature

STEPHEN F. HAUMAN
Name

PRESIDENT, BCBSIL
Title

Subscribed and sworn to before me this
20th day of March 2020.

Notary Public

OFFICIAL SEAL
SHEILA L WILLIAMS-SMITH
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/28/21

DEPARTMENT OF INSURANCE of the
State of Illinois:

DATE 3-27-20

Robert Muriel MR
Robert H. Muriel
Director