[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938, THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]

WEBSITE PUBLISHED REPORT OF THE MARKET CONDUCT EXAMINATION OF THE CLAIMS PRACTICES OF

AETNA LIFE INSURANCE COMPANY
NAIC # 60054 CDI # 0003-4

AS OF MARCH 31, 2011

ADOPTED APRIL 25, 2016

STATE OF CALIFORNIA

CALIFORNIA DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

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DEPARTMENT OF INSURANCE
Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

April 25, 2016

The Honorable Dave Jones
Insurance Commissioner
State of California
300 Capitol Mall
Sacramento, California 95814

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims handling practices and procedures in California of:

Aetna Life Insurance Company
NAIC # 60054

Group NAIC # 0001

Hereinafter, the Company listed above also will be referred to as ALIC, Aetna, or, the Company.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).

FOREWORD

The examination covered the claims handling practices of the aforementioned Company on Accident & Disability and Life claims closed during the period from June 1, 2007 through May 31, 2008. Subsequently, the end of the period was extended from May 31, 2008 through March 31, 2011, to include the claims handling practices of solely Accident & Disability claims. In addition, the examination covered the underwriting and claims practices associated with the rescission of an individual health policy and with a rescission investigation resulting in acceptance of the policy retroactive to the effective date. The examination of policy rescissions and rescission investigations covered the period from January 1, 2006 through March 31, 2011. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer's proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. While this report contains violations of law that were cited by the examiner, additional violations of CIC § 790.03, or other laws, not cited in this report may also apply to any or all of the non-compliant or problematic activities that are described herein.

All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company's responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files, individual policy rescission files and the claims associated with those files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the period June 1, 2007 through March 31, 2011; and a review of previous CDI market conduct claims practices examination reports on this Company.

The review of the sample of individual claims files and policy rescission files was conducted at the offices of the Company in Walnut Creek, California, in Rancho Cordova, California, and at the offices of the California Department of Insurance in Sacramento, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Accident & Disability and Life claims reviewed were closed from June 1, 2007 through March 31, 2011, referred to as the "review period", with two exceptions described in the Foreword to this report. Specifically, the "review period" of closed Accident & Disability Long Term Care claims and closed Life claims was limited to June 1, 2007 through May 31, 2008; and the "review period" of Accident & Disability health policy rescissions and rescission investigations was January 1, 2006 through March 31, 2011.

The examiners randomly selected 935 ALIC claims files from the lines of business identified above. In addition, the examiners reviewed all 20 policy rescission files and eight policy rescission investigation files, for a total review of 963 files. In the Accident & Disability categories and sub-categories of Individual & Family Health, Group Health, Individual & Family Dental, Group Dental, and Student Health, the examiners drew the random sample from the general population of paid claims that were paid over 60 days following the date the claim was incurred. The examiners reviewed the selected claim and related claims that may have been affected by the handling of the selected claim. Sample claim findings and related claim findings are identified separately in the Table of Total Alleged Violations, below, in this report. The examiners cited 1,927 alleged violations of the California Insurance Code and the California Fair Claims Settlement Practices Regulations from this sample file review.

Findings of this examination reveal deficiencies in the Company's representation to claimants of pertinent facts and policy provisions; in the prompt, fair and equitable settlements of claims; in the notification of the right to an independent medical review; in the diligent, thorough, and fair investigation of claims; in the handling of member appeals and provider disputes; and in the underwriting procedures as they relate to Individual & Family health plans.

Since the time the work on this examination was conducted, provisions of the Affordable Care Act have become effective. There have been significant changes in the

state and federal laws with which health insurers must comply, and insurers, in general, have modified practices and procedures as a result of the changes in the law. As a result, some practices discussed and cited as non-compliant in this examination report may no longer be applicable. The Department has initiated a new examination of ALIC that will review compliance with state and federal mental health parity laws, and will, as part of the new examination, re-evaluate in relation to current law the practices this report identifies as non-compliant.

RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, AND PREVIOUS EXAMINATIONS

The results of the market analysis review revealed that during 2006, enforcement actions were taken in the states of Connecticut and Kentucky alleging failure to comply with claims handling and prompt pay statutes. In 2007, enforcement action was taken in the state of New York alleging failure to comply with prompt pay statutes. In 2008, enforcement actions were taken in the state of New York and Virginia alleging failure to comply with claims handling and prompt pay statutes. In 2009, enforcement action was taken in the state of Arizona, alleging failure to provide health care appeals information and in the state of Maryland following a market conduct examination. In 2010, enforcement action was taken in the states of Colorado, Virginia and New York alleging violations of the states' claims handling statutes and prompt payment statutes. These issues also were reflected in the results of this examination.

For the period June 1, 2007 through March 31, 2011, the Company was the subject of 813 California consumer complaints and inquiries in regard to the lines of business reviewed in this examination. Of the complaints and inquiries, the CDI determined 96 consumer complaints were justified. The CDI alleged 393 violations of law on the justified complaints including, but not limited to, improper claim denials, unsatisfactory settlement offers, and delays in claims handling. The examiners focused on these issues during the course of the file review.

The previous claims examination reviewed a period from January 1, 2003 through December 31, 2003. The most significant noncompliance issues identified in the previous examination report were failure to respond within 21 days to the Department's inquiry, failure to maintain hard copy claims files, failure to provide an explanation of disability income benefits, failure to reference the California Department of Insurance on a claim denial, failure to complete a prompt investigation and processing of claims, and failure to respond to communications from a claimant within 15 calendar days. With the exception of the failure to respond to the CDI inquiry within

21 days and the failure to maintain hard copy claims files, these issues were identified as problematic in the current examination.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

AETNA LIFE INSURANCE COMPANY SAMPLE FILES REVIEW							
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD**		**SAMPLE FILES REVIEWED**		**NUMBER OF ALLEGED VIOLATIONS**		**TOTAL**
Review Time Periods	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	
Individual Life / Paid	172	Not Included	12	Not Included	4	Not Included	4
Individual Life / Conversion / Paid	61	Not Included	6	Not Included	6	Not Included	6
Group Life / Paid	250	Not Included	18	Not Included	9	Not Included	9
Group Life / Denied	22	Not Included	7	Not Included	18	Not Included	18
Subtotal – Individual and Group Life					37	Not Included	37
Accident & Disability (A & D) / Group Long Term Care	6	Not Included	6	Not Included	0	Not Included	0
Subtotal –Group Long Term Care					0	Not Included	0
A & D / Group Disability Income / Short Term & Long Term / Paid	667	1,797	24	20	25	263	288
A & D / Group Disability Income / Short Term & Long Term / Denied	100	577	40	53	113	147	262

AETNA LIFE INSURANCE COMPANY SAMPLE FILES REVIEW							
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD**		**SAMPLE FILES REVIEWED**		**NUMBER OF ALLEGED VIOLATIONS**		**TOTAL**
Review Time Periods	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	
A & D / Group Disability Income / Short Term & Long Term / Appeal	15	70	8	10	55	28	83
Subtotal – Group Disability Income					193	438	631
A & D / Aetna Student Health / Paid Over 60 Days	21,850	44,384	68	20	25	21	46
A & D / Aetna Student Health / Denied / General Population	16,309	81,587	68	50	61	71	132
A & D / Aetna Student Health / Member Appeal	23	384	3	5	10	20	30
A & D / Aetna Student Health / Provider Dispute	25	748	2	10	0	17	17
Subtotal – Aetna Student Health					96	129	225
A & D / Individual & Family Health / Dental / Paid Over 60 Days	662	3,765	Sample Not Reviewed	10	Sample Not Reviewed	20	20
A & D / Individual & Family Health / Dental / Denied / General Population	3,034	17,717	15	25	33	57	90
A & D / Individual & Family Health / Dental / Member Appeal	19	74	10	5	24	15	39
A & D / Individual & Family Health / Dental / Provider Dispute	10	29	3	5	6	11	17

AETNA LIFE INSURANCE COMPANY SAMPLE FILES REVIEW							
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD**		**SAMPLE FILES REVIEWED**		**NUMBER OF ALLEGED VIOLATIONS**		**TOTAL**
Review Time Periods	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	
A & D / Group Health / Dental / Paid Over 60 Days	52,415	125,673	Sample Not Reviewed	10	Sample Not Reviewed	2	2
A & D / Group Health / Dental / Denied / General Population	54,840	156,614	15	25	7	16	23
A & D / Group Health / Dental / Member Appeal	132	739	10	10	37	3	40
A & D / Group Health / Dental / Provider Dispute	107	498	5	5	5	2	7
Subtotal – Individual & Group Health Dental					112	127	238
A & D / Individual & Family Health / Policy Rescission	13 Policies	7 Policies	13 Policies	7 Policies	84	49	133
A & D / Individual & Family Health / Policy Rescission Investigation	13 Policies	0 Policies	8 Policies	0 Policies	57	0	57
Subtotal – Individual Health Rescission					141	49	190
A & D / Individual & Family Health / Paid	29,938	139,623	10	20	8	41	49
A & D / Individual & Family Health / Denied	28,821	195,629	24	30	40	66	106
A & D / Individual & Family Health / Denied / Pre-existing Condition	269	1,206	10	20	40	117	157

AETNA LIFE INSURANCE COMPANY SAMPLE FILES REVIEW							
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD**		**SAMPLE FILES REVIEWED**		**NUMBER OF ALLEGED VIOLATIONS**		**TOTAL**
Review Time Periods	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	**6/01/2007 to 5/31/2008**	**6/01/2008 to 3/31/2011**	
A & D / Individual & Family Health / Member Appeal	296	2,888	10	10	10	20	30
A & D / Individual & Family Health / Prescription Drug / Member Appeal	8	36	5	5	6	9	15
A & D / Individual & Family Health / Provider Dispute	224	5,668	5	10	11	6	17
Subtotal – Individual Health					115	259	374
A & D / Group Health / Paid	270,970	815,481	10	20	10	13	23
A & D / Group Health / Denied	221,670	851,468	25	30	31	16	47
A & D / Group Health / Pre-existing Condition	668	1,168	10	20	33	31	65
A & D / Group Health / Member Appeal	1,511	13,343	10	15	9	28	37
A & D / Group Health / Prescription Drug / Member Appeal	70	235	8	5	6	5	11
A & D / Group Health / Provider Dispute	2,258	32,917	5	15	15	19	34
A & D / Individual & Group Health / Provider Recon	8,961	Does not apply this period	20	Does not apply to this period	16	--	16
Subtotal – Group Health					120	112	232

AETNA LIFE INSURANCE COMPANY SAMPLE FILES REVIEW							
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD		SAMPLE FILES REVIEWED		NUMBER OF ALLEGED VIOLATIONS		TOTAL
Review Time Periods	6/01/2007 to 5/31/2008	6/01/2008 to 3/31/2011	6/01/2007 to 5/31/2008	6/01/2008 to 3/31/2011	6/01/2007 to 5/31/2008	6/01/2008 to 3/31/2011	
TOTALS	716,383	2,494,318	493	470	814	1,113	1,927

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	ALIC Number of Alleged Violations	
		Sample Claim	Related Claim
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	336	
CIC §10169(i) *[CIC §790.03(h)(1)]	The Company failed to advise the insured of the right to an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.	239	10
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.	110	135
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	197	11
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide a clear explanation of the computation of benefits.	205	
CCR §2695.7(g) *[CIC §790.03(h)(5)]	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	109	13
CCR §2695.4(a) *[CIC §790.03(h)(1)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	56	
CIC §10123.13(a) *[CIC §790.03(h)(13)]	The Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim.	39	
CCR §2695.11(d) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date.	37	

Citation	Description of Allegation	ALIC Number of Alleged Violations	
		Sample Claim	Related Claim
CIC §10123.13(a) *[CIC §790.03(h)(5)]	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim.	33	1
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide in its written denial a reference to and explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions.	32	
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	31	
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.	30	
CIC §10123.13(a) *[CIC §790.03(h)(3)]	The Company failed to include in its notice of a contested or denied claim that either the insured or the provider may seek a review by the Department and/or failed to include in its notice of a claim being contested or denied the address, Internet Website address, and telephone number of the unit within the Department that may review the denial on behalf of the insured or the provider.	28	
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed to respond to communications within 15 calendar days.	26	
CIC §10384 *[CIC §790.03(h)(3)]	The Company failed to complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy. The policy was rescinded based on the practice of post claims underwriting.	25	
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.	23	
CIC §10111.2(b) *[CIC §790.03(h)(3)]	The Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim.	18	

Citation	Description of Allegation	ALIC Number of Alleged Violations	
		Sample Claim	Related Claim
CIC §10123.13(c) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a contested claim after 30 working days.	15	2
CCR §2695.4(d) *[CIC §790.03(h)(3)]	The Company improperly required a claimant to give notification of a claim or proof of claim within a specified time.	17	
CCR §2695.3(a) *[CIC §790.03(h)(3)]	The Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.	16	
CIC §790.03(h)(2)	The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.	12	
CIC §796.04 *[CIC §790.03(h)(5)]	The Company authorized payment for health care services and rescinded the authorization after the provider(s) rendered the services in good faith.	12	
CIC §10133.66(b) *[CIC §790.03(h)(3)]	The Company failed to furnish the provider with a clear explanation of the basis upon which it was believed the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.	12	
CIC §10133.66(c) *[CIC §790.03(h)(2)]	The Company failed to acknowledge receipt of claim from the provider within 15 working days.	11	
CCR §2695.5(e)(2) *[CIC §790.03(h)(3)]	The Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.	10	
CIC §10123.13(a) *[CIC §790.03(h)(3)]	The Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was contested.	9	
CCR §2695.5(e)(1) *[CIC §790.03(h)(2)]	The Company failed to acknowledge notice of claim within 15 calendar days.	6	
CCR §2695.5(e)(3) *[CIC §790.03(h)(3)]	The Company failed to begin investigation of the claim within 15 calendar days.	6	

Citation	Description of Allegation	ALIC Number of Alleged Violations	
		Sample Claim	Related Claim
CIC §10111.2(a) *[CIC §790.03(h)(5)]	The Company failed to pay benefits within 30 calendar days from receipt of information needed to determine liability.	5	
CIC §10111.2(c) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability.	5	
CIC §790.03(h)(4)	The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.	5	
CIC §10111.2(b) *[CIC §790.03(h)(5)]	The Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim, and failed to accrue interest on the benefit payment beginning the 31st day after receipt of the claim.	5	
CIC §10172.5(c) *[CIC §790.03(h)(3)]	The Company failed to notify the beneficiary of the specified rate of interest paid on the death benefit.	5	
CCR §2695.3(b)(2) *[CIC §790.03(h)(3)]	The Company failed to record in the file the date the Company received, processed, transmitted or mailed every relevant document pertaining to the claim.	4	
CIC §10123.13(a) *[CIC §790.03(h)(13)]	The Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied.	3	
CIC §10123.13(b) *[CIC §790.03(h)(5)]	The Company failed to pay interest on an uncontested claim after 30 working days.	2	1
CIC §10123.137(c) *[CIC §790.03(h)(3)]	The Company failed to resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.	3	
CIC §10172.5(a) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a claim that remained unpaid longer than 30 days from the date of death.	3	

Citation	Description of Allegation	ALIC Number of Alleged Violations	
		Sample Claim	Related Claim
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given.	3	
CCR §2695.11(d) *[CIC §790.03(h)(4)]	The Company failed, upon contesting a claim under CIC §10123.13, to affirm or deny the claim within 30 calendar days from the original notification.	3	
CIC §10123.13(a) *[CIC §790.03(h)(3)]	The Company failed to include in its notice of a contested claim the portion of the claim that was contested and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting the claim.	2	
CIC §10123.13(a) *[CIC §790.03(h)(3)]	The Company failed to include a statement to the provider in a contested or denied claim advising of its right to enter into the dispute resolution process described in CIC §10123.137.	2	
CCR §2695.3(b)(3) *[CIC §790.03(h)(3)]	The Company failed to maintain hard copy files or maintain claims files that are accessible, legible and capable of duplication to hard copy for five years.	1	
CCR §2695.7(b) *[CIC §790.03(h)(4)]	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	1	
CCR §2695.11(a) *[CIC §790.03(h)(5)]	The Company improperly sought reimbursement of an overpayment or withheld a portion of a benefit payment as a result of a claim on the basis that the sum withheld was an adjustment or correction for an overpayment made under the same policy.	1	
CCR §2695.11(a)(2)(C) *[CIC §790.03(h)(3)]	The Company failed to notify the insured of an overpayment within six months of the error.	1	
Total Number of Citations		**1754**	**173**

*DESCRIPTONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES

CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
CIC §790.03(h)(2)	The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
CIC §790.03(h)(4)	The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.
CIC §790.03(h)(13)	The Company failed to provide promptly a reasonable explanation of the bases relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS

LIFE **2007 Written Premium: $91,374,238** **2008 Written Premium: $94,161,370** **AMOUNT OF RECOVERIES $35.88**	**NUMBER OF ALLEGED VIOLATIONS**
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	7
CIC §10172.5(c) [CIC §790.03(h)(3)]	5
CCR §2695.4(a) [CIC §790.03(h)(1)]	5
CCR §2695.11(b) [CIC §790.03(h)(3)]	5
CCR §2695.3(a) [CIC §790.03(h)(3)]	3
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	3
CCR §2695.5(e)(3) [CIC §790.03(h)(3)]	3
CIC §10172.5(a) [CIC §790.03(h)(5)]	2
CCR §2695.5(e)(1) [CIC §790.03(h)(2)]	2
CCR §2695.7(b) [CIC §790.03(h)(4)]	1
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	1
SUBTOTAL	**37**

ACCIDENT AND DISABILITY **2006 Written Premium: $ 834,537,467** **2007 Written Premium: $1,088,834,028** **2008 Written Premium: $1,200,070,391** **2009 Written Premium: $1,285,510,858** **2010 Written Premium: $1,402,813,759** **AMOUNT OF RECOVERIES $216,682.25**	**NUMBER OF ALLEGED VIOLATIONS**
CIC §790.03(h)(1)	336
CIC §10169(i) [CIC §790.03(h)(1)]	249
CIC §790.03(h)(5)	245
CCR §2695.7(d) [CIC §790.03(h)(3)]	208
CCR §2695.11(b) [CIC §790.03(h)(3)]	200
CCR §2695.7(g) [CIC §790.03(h)(5)]	122
CCR §2695.4(a) [CIC §790.03(h)(1)]	51

ACCIDENT AND DISABILITY **2006 Written Premium: $ 834,537,467** **2007 Written Premium: $1,088,834,028** **2008 Written Premium: $1,200,070,391** **2009 Written Premium: $1,285,510,858** **2010 Written Premium: $1,402,813,759** **AMOUNT OF RECOVERIES $216,682.25**	**NUMBER OF ALLEGED VIOLATIONS**
CIC §10123.13(a) [CIC §790.03(h)(13)]	39
CCR §2695.11(d) [CIC §790.03(h)(3)]	37
CIC §10123.13(a) [CIC §790.03(h)(5)]	34
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	31
CIC §790.03(h)(3)	30
CIC §10123.13(a) [CIC §790.03(h)(3)]	28
CCR §2695.5(b) [CIC §790.03(h)(2)]	26
CIC §10384 [CIC §790.03(h)(3)]	25
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	24
CCR §2695.7(d) [CIC §790.03(h)(3)]	23
CIC §10111.2(b) [CIC 790.03(h)(3)]	18
CIC §10123.13(c) [CIC §790.03(h)(5)]	17
CCR §2695.4(d) [CIC §790.03(h)(3)]	17
CCR §2695.3(a) [CIC §790.03(h)(3)]	13
CIC §790.03(h)(2)	12
CIC §796.04 [CIC §790.03(h)(5)]	12
CIC §10133.66(b) [CIC §790.03(h)(3)]	12
CIC §10133.66(c) [CIC §790.03(h)(2)]	11
CIC §10123.13(a) [CIC §790.03(h)(3)]	9
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	7
CIC §790.03(h)(4)	5
CIC §10111.2(a) [CIC §790.03(h)(5)]	5
CIC §10111.2(b) [CIC §790.03(h)(5)]	5
CIC §10111.2(c) [CIC §790.03(h)(5)]	5
CCR §2695.3(b)(2) [CIC §790.03(h)(3)]	4
CCR §2695.5(e)(1) [CIC §790.03(h)(2)]	4
CIC §10123.13(a) [CIC §790.03(h)(13)]	3
CIC §10123.13(b) [CIC §790.03(h)(5)]	3

ACCIDENT AND DISABILITY **2006 Written Premium: $ 834,537,467** **2007 Written Premium: $1,088,834,028** **2008 Written Premium: $1,200,070,391** **2009 Written Premium: $1,285,510,858** **2010 Written Premium: $1,402,813,759** **AMOUNT OF RECOVERIES $216,682.25**	**NUMBER OF ALLEGED VIOLATIONS**
CIC §10123.137(c) [CIC §790.03(h)(5)]	3
CCR §2695.5(e)(3) [CIC §790.03(h)(3)]	3
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	3
CCR §2695.11(d) [CIC 790.03(h)(4)]	3
CIC §10123.13(a) [CIC §790.03(h)(3)]	2
CIC §10123.13(a) [CIC §790.03(h)(3)]	2
CIC §10172.5(a) [CIC §790.03(h)(5)]	1
CCR §2695.3(b)(3) [CIC §790.03(h)(3)]	1
CCR §2695.11(a) [CIC §790.03(h)(5)]	1
CCR §2695.11(a)(2)(C) [CIC §790.03(h)(3)]	1
SUBTOTAL	**1890**

TOTAL	**1,927**

TABLE OF ALLEGED VIOLATIONS BY CATEGORY

LIFE **2007 Written Premium: $91,374,238** **2008 Written Premium: $94,161,370** **AMOUNT OF RECOVERIES $35.88**	**NUMBER OF ALLEGED VIOLATIONS**
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	7
CIC §10172.5(c) [CIC §790.03(h)(3)]	5
CCR §2695.4(a) [CIC §790.03(h)(1)]	5
CCR §2695.11(b) [CIC §790.03(h)(3)]	5
CCR §2695.3(a) [CIC §790.03(h)(3)]	3
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	3
CCR §2695.5(e)(3) [CIC §790.03(h)(3)]	3
CIC §10172.5(a) [CIC §790.03(h)(5)]	2
CCR §2695.5(e)(1) [CIC §790.03(h)(2)]	2
CCR §2695.7(b) [CIC §790.03(h)(4)]	1
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	1
SUBTOTAL	**37**

ACCIDENT AND DISABILITY **LONG TERM CARE** **June 1, 2007 – May 31, 2008** **AMOUNT OF RECOVERIES $0.00**	**NUMBER OF ALLEGED VIOLATIONS**
SUBTOTAL	**0**

ACCIDENT AND DISABILITY **DISABILITY INCOME** **June 1, 2007 – May 31, 2008** **AMOUNT OF RECOVERIES $40,152.44**	**NUMBER OF ALLEGED VIOLATIONS**
CCR §2695.7(d) [CIC §790.03(h)(3)]	51
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	20

ACCIDENT AND DISABILITY **DISABILITY INCOME** **June 1, 2007 – May 31, 2008** **AMOUNT OF RECOVERIES $40,152.44**	**NUMBER OF ALLEGED VIOLATIONS**
CCR §2695.11(b) [CIC §790.03(h)(3)]	16
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	15
CCR §2695.4(d) [CIC §790.03(h)(3)]	13
CIC §10111.2(b) [CIC §790.03(h)(3)]	12
CCR §2695.5(b) [CIC §790.03(h)(2)]	7
CCR §2695.7(d) [CIC §790.03(h)(3)]	7
CCR §2695.7(g) [CIC §790.03(h)(5)]	7
CCR §2695.3(a) [CIC §790.03(h)(3)]	6
CIC §790.03(h)(1)	5
CIC §10111.2(a) [CIC §790.03(h)(5)]	5
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	5
CIC §790.03(h)(4)	4
CIC §790.03(h)(3)	3
CIC §10111.2(c) [CIC §790.03(h)(5)]	3
CCR §2695.5(e)(3) [CIC §790.03(h)(3)]	3
CIC §790.03(h)(5)	2
CCR §2695.3(b)(2) [CIC §790.03(h)(3)]	2
CCR §2695.4(a) [CIC §790.03(h)(1)]	2
CCR §2695.5(e)(1) [CIC §790.03(h)(2)]	2
CIC §10111.2(b) [CIC §790.03(h)(5)]	1
CIC §10172.5(a) [CIC §790.03(h)(5)]	1
CCR §2695.11(a) [CIC §790.03(h)(5)]	1
SUBTOTAL	**193**

ACCIDENT AND DISABILITY **DISABILITY INCOME** **June 1, 2008 – March 31, 2011** **AMOUNT OF RECOVERIES $127,979.01**	**NUMBER OF ALLEGED VIOLATIONS**
CCR §2695.11(b) [CIC §790.03(h)(3)]	168

ACCIDENT AND DISABILITY **DISABILITY INCOME** **June 1, 2008 – March 31, 2011** **AMOUNT OF RECOVERIES $127,979.01**	**NUMBER OF ALLEGED VIOLATIONS**
CCR §2695.7(g) [CIC §790.03(h)(5)]	71
CCR §2695.7(d) [CIC §790.03(h)(3)]	52
CIC §790.03(h)(1)	45
CCR §2695.4(a) [CIC §790.03(h)(1)]	42
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	13
CIC §790.03(h)(3)	10
CIC §10111.2(b) [CIC §790.03(h)(3)]	6
CCR §2695.5(b) [CIC §790.03(h)(2)]	5
CIC §10111.2(b) [CIC §790.03(h)(5)]	4
CCR §2695.4(d) [CIC §790.03(h)(3)]	4
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	3
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	3
CIC §790.03(h)(2)	2
CIC §10111.2(c) [CIC §790.03(h)(5)]	2
CCR §2695.3(a) [CIC §790.03(h)(3)]	2
CCR §2695.5(e)(1) [CIC §790.03(h)(2)]	2
CIC §790.03(h)(4)	1
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	1
CCR §2695.7(d) [CIC §790.03(h)(3)]	1
CCR §2695.11(a)(2)(C) [CIC §790.03(h)(3)]	1
SUBTOTAL	**438**

ACCIDENT AND DISABILITY **STUDENT HEALTH** **June 1, 2007 – May 31, 2008** **AMOUNT OF RECOVERIES $2,893.28**	**NUMBER OF ALLEGED VIOLATIONS**
CIC §790.03(h)(5)	83
CCR §2695.7(d) [CIC §790.03(h)(3)]	5
CCR §2695.4(a) [CIC §790.03(h)(1)]	3

CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	2
CIC §790.03(h)(2)	1
CCR §2695.7(d) [CIC §790.03(h)(3)]	1
CCR §2695.7(g) [CIC §790.03(h)(5)]	1
SUBTOTAL	**96**

ACCIDENT AND DISABILITY **STUDENT HEALTH** **June 1, 2008 – March 31, 2011** **AMOUNT OF RECOVERIES $18,338.83**	**NUMBER OF ALLEGED VIOLATIONS**
CIC §790.03(h)(5)	52
CCR §2695.7(d) [CIC §790.03(h)(3)]	22
CCR §2695.7(g) [CIC §790.03(h)(5)]	18
CIC §790.03(h)(3)	17
CCR §2695.11(b) [CIC §790.03(h)(3)]	5
CIC §790.03(h)(1)	3
CCR §2695.4(a) [CIC §790.03(h)(1)]	3
CCR §2695.7(d) [CIC §790.03(h)(3)]	3
CCR §2695.3(b)(2) [CIC §790.03(h)(3)]	2
CIC §790.03(h)(2)	1
CCR §2695.3(b)(3) [CIC §790.03(h)(3)]	1
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	1
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	1
SUBTOTAL	**129**

ACCIDENT AND DISABILITY **HEALTH / DENTAL** **June 1, 2007 – May 31, 2008** **AMOUNT OF RECOVERIES $1,511.23**	**NUMBER OF ALLEGED VIOLATIONS**
CIC §10169(i) [CIC §790.03(h)(1)]	31
CIC §790.03(h)(1).	27
CIC §790.03(h)(5)	8

ACCIDENT AND DISABILITY HEALTH / DENTAL June 1, 2007 – May 31, 2008 AMOUNT OF RECOVERIES $1,511.23	NUMBER OF ALLEGED VIOLATIONS
CIC §10123.13(a) [CIC §790.03(h)(13)]	6
CCR §2695.7(d) [CIC §790.03(h)(3)]	6
CIC §10123.13(a) [CIC §790.03(h)(3)]	5
CIC §10133.66(c) [CIC §790.03(h)(2)]	5
CCR §2695.5(b) [CIC §790.03(h)(2)]	5
CIC §10123.13(a) [CIC §790.03(h)(5)]	4
CIC §10123.13(c) [CIC §790.03(h)(5)]	4
CIC §10123.13(a) [CIC §790.03(h)(3)]	3
CCR §2695.11(b) [CIC §790.03(h)(3)]	3
CCR §2695.7(g) [CIC §790.03(h)(5)]	2
CIC §10123.13(a) [CIC §790.03(h)(13)]	1
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	1
CCR §2695.11(d) [CIC §790.03(h)(3)]	1
SUBTOTAL	**112**

ACCIDENT AND DISABILITY HEALTH / DENTAL June 1, 2008 – March 31, 2011 AMOUNT OF RECOVERIES $1,042.42	NUMBER OF ALLEGED VIOLATIONS
CIC §790.03(h)(1)	48
CIC §10169(i) [CIC §790.03(h)(1)]	48
CIC §10123.13(a) [CIC §790.03(h)(13)]	14
CIC §790.03(h)(5)	4
CIC §10123.13(a) [CIC §790.03(h)(3)]	3
CCR §2695.11(d) [CIC §790.03(h)(3)]	3
CIC §10123.13(a) [CIC §790.03(h)(3)]	2
CIC §10123.13(c) [CIC §790.03(h)(5)]	1
CCR §2695.7(d) [CIC §790.03(h)(3)]	1
CCR §2695.7(g) [CIC §790.03(h)(5)]	1

ACCIDENT AND DISABILITY **HEALTH / DENTAL** **June 1, 2008 – March 31, 2011** **AMOUNT OF RECOVERIES $1,042.42**	**NUMBER OF ALLEGED VIOLATIONS**
CCR §2695.11(b) [CIC §790.03(h)(3)]	1
SUBTOTAL	**126**

ACCIDENT AND DISABILITY **HEALTH / RESCISSION** **January 1, 2006 – May 31, 2008** **AMOUNT OF RECOVERIES $19.06**	**NUMBER OF ALLEGED VIOLATIONS**
CIC §790.03(h)(1)	56
CIC §10384 [CIC §790.03(h)(3)]	18
CCR §2695.7(d) [CIC §790.03(h)(3)]	16
CIC §10133.66(b) [CIC §790.03(h)(3)]	11
CIC §796.04 [CIC §790.03(h)(5)]	10
CIC §10123.13(a) [CIC §790.03(h)(5)]	8
CCR §2695.3(a) [CIC §790.03(h)(3)]	5
CIC §790.03(h)(2)	4
CIC §10123.13(a) [CIC §790.03(h)(3)]	4
CCR §2695.11(d) [CIC §790.03(h)(3)]	4
CIC §10123.13(a) [CIC §790.03(h)(3)]	2
CIC §790.03(h)(5)	1
CCR §2695.11(b) [CIC §790.03(h)(3)]	1
CCR §2695.11(d) [CIC §790.03(h)(4)]	1
SUBTOTAL	**141**

ACCIDENT AND DISABILITY **HEALTH / RESCISSION** **June 1, 2008 – March 31, 2011** **AMOUNT OF RECOVERIES $0.00**	**NUMBER OF ALLEGED VIOLATIONS**
CIC §790.03(h)(1)	31

ACCIDENT AND DISABILITY **HEALTH / RESCISSION** **June 1, 2008 – March 31, 2011** **AMOUNT OF RECOVERIES $0.00**	**NUMBER OF ALLEGED VIOLATIONS**
CIC §10384 [CIC §790.03(h)(3)]	7
CIC §10123.13(a) [CIC §790.03(h)(3)]	5
CCR §2695.7(d) [CIC §790.03(h)(3)]	3
CIC §796.04 [CIC §790.03(h)(5)]	2
CIC §10133.66(b) [CIC §790.03(h)(3)]	1
SUBTOTAL	**49**

ACCIDENT AND DISABILITY **HEALTH** **June 1, 2007 – May 31, 2008** **AMOUNT OF RECOVERIES $1,650.88**	**NUMBER OF VIOLATIONS**
CIC §10169(i) [CIC §790.03(h)(1)]	54
CIC §790.03(h)(1)	35
CIC §790.03(h)(5)	28
CCR §2695.7(d) [CIC §790.03(h)(3)]	28
CCR §2695.11(d) [CIC §790.03(h)(3)]	15
CIC §10123.13(a) [CIC §790.03(h)(13)]	11
CIC §10123.13(a) [CIC §790.03(h)(5)]	10
CCR §2695.7(g) [CIC §790.03(h)(5)]	10
CCR §2695.5(b) [CIC §790.03(h)(2)]	9
CCR §2695.11(b) [CIC §790.03(h)(3)]	6
CIC §10133.66(c) [CIC §790.03(h)(2)]	5
CIC §10123.13(a) [CIC §790.03(h)(3)]	4
CIC §10123.13(a) [CIC §790.03(h)(3)]	4
CCR §2695.7(d) [CIC §790.03(h)(3)]	4
CIC §10123.13(b) [CIC §790.03(h)(5)]	3
CIC §10123.137(c) [CIC §790.03(h)(3)]	3
CIC §10123.13(a) [CIC §790.03(h)(13)]	2
CIC §10123.13(c) [CIC §790.03(h)(5)]	2

ACCIDENT AND DISABILITY HEALTH June 1, 2007 – May 31, 2008 AMOUNT OF RECOVERIES $1,650.88	NUMBER OF VIOLATIONS
CCR §2695.11(d) [CIC §790.03(h)(4)]	2
SUBTOTAL	**235**

ACCIDENT AND DISABILITY HEALTH June 1, 2008 – March 31, 2011 AMOUNT OF RECOVERIES $23,095.10	NUMBER OF VIOLATIONS
CIC §10169(i) [CIC §790.03(h)(1)]	116
CIC §790.03(h)(1)	86
CIC §790.03(h)(5)	67
CCR §2695.7(d) [CIC §790.03(h)(3)]	24
CCR §2695.11(d) [CIC §790.03(h)(3)]	14
CIC §10123.13(a) [CIC §790.03(h)(5)]	12
CCR §2695.7(g) [CIC §790.03(h)(5)]	12
CIC §10123.13(c) [CIC §790.03(h)(5)]	10
CIC §10123.13(a) [CIC §790.03(h)(13)]	8
CIC §10123.13(a) [CIC §790.03(h)(3)]	7
CCR §2695.7(d) [CIC §790.03(h)(3)]	7
790.03(h)(2)	4
CIC §10123.13(a) [CIC §790.03(h)(3)]	2
CIC §10133.66(c) [CIC §790.03(h)(2)]	1
CCR §2695.4(a) [CIC §790.03(h)(1)]	1
SUBTOTAL	**371**

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked if it intends to take appropriate corrective action in all jurisdictions where applicable. The Company intends to implement corrective actions in all jurisdictions.

Money recovered within the scope of this report was $179,739.90 as described in section numbers 8, 12, 17, 20(a), 20(b), 23, 27, 29, 34, 45, 49, 50, 57(b), 57(c), 57(d), 57(e), 64(a), 64(b), 64(d), 65(a), 66, 79, 81, 86, 89, 96, 100, 102, 115, 126(c), 126(f), 126(h), 131, 138 141, 145(a), 145(b), 145(e), 145(g), 146, 148, and 150 below. Following the findings of the examination, a closed claims survey covering a seven-year period, as described in sections 20(a) and 37 below, was conducted by the Company resulting in additional payments totaling $28,169.21. Additionally, closed claim surveys as described in sections 27, 64(a), 64(b), 64(d), 66, 86, and 100 were conducted by the Company resulting in additional payments totaling $8,809.02. Pursuant to the findings of the examination as described in section numbers 108 and 122, the Company will be conducting closed claim surveys. The results of the surveys and additional payments, if any, shall be reported to the Department within 30 days of the completion of the project. The instances identified in the examination will be included in the surveys in the corresponding summary sections. As a result of the examination, the total amount of money returned to claimants within the scope of this report was $216,718.13.

LIFE

Review Period June 1, 2007 – May 31, 2008
Summary Sections 1 – 11

1. In seven instances, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The errors were found in the Department's review of Group Life claims. The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company reviewed compliance with this requirement in training on March 4, 2009. The analysts were directed to ensure the denial letter contains the appropriate reference to the California Department of Insurance when the contract state of the insurance is California. All denial letters located in the Group AetNet were updated and contain the appropriate California referral language. All previous versions of denial letters for California claimants are not to be used. As a result of the examination, the Company re-sent a denial letter to each of the seven identified claimants that explains how to contact the Department of Insurance.

2. In five instances the Company failed to notify the beneficiary of the specified rate of interest paid on the death benefit. The Department alleges these acts are in violation of CIC §10172.5(c) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states that benefits due under these claims were paid via a checkbook or retained asset account provided to the beneficiary. The amount of interest, the rate of interest and the time period used for calculating interest are to be included in the statement that is delivered with the payment to the beneficiary. In four instances, the checkbook vendor failed to include the information documented in the file by the claims analyst; and in one instance the claims analyst failed to follow the Company's procedure to include the information in the statement. The Company discontinued paying life claims in California via a checkbook or retained asset account as of September 2010. The Company completed mandatory training with claims analysts on December 22, 2008, to restate the requirement that the payment letter must include the interest rate paid on the claim along with an explanation of how the interest was calculated.

3. In five instances the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. The Company failed to advise the beneficiary of the settlement options afforded by the conversion policy. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges that at the time these claims were settled the settlement options were not disclosed to the beneficiaries. As a remedial measure, the Company revised the contract and removed the settlement options offering a single lump sum payment option only. The Company believed it filed the new contract wording with the CDI for approval on or about February of 2013. However, the Company was unable to locate the filing. Therefore, the Company filed the new policy form as of April 15, 2016. Once the Company receives approval, all new business will be written on the approved form and current members will receive the new policy form upon renewal.

The policy identifies three settlement options, including the option of a single lump sum payment. If a beneficiary requests an option other than the lump sum payment, the Company can accommodate such a request, but the lump sum payment is acceptable to most beneficiaries. Therefore, the Company states the past and current method of disclosure is the existing policy language. However, until the Company receives approval of the new policy form, the Company developed a new settlement option disclosure document which accompanies each claim form packet request. The Company began using this form on April 4, 2016.

4. In five instances, the Company failed to provide a clear explanation of the computation of benefits. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states that the explanation of benefits (EOB) is attached to the check stub, which is detached prior to cashing the settlement check. In four instances, the vendor of the checkbook/retained asset account failed to include the settlement details placed in the system by the claims analyst; in one instance, the claims analyst failed to follow the Company's procedure to include all settlement information in the statement that was delivered with the payment to the beneficiary. The Company discontinued paying life claims in California via a checkbook/retained asset account as of September 2010. The Company delivered mandatory training to its claims analysts on March 4, 2009, that addressed the requirement of including settlement details in the payment.

5. In three instances, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed. The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states the claims analyst did not follow the Company's procedure to scan notes and correspondence into the claims documentation system. The Company delivered mandatory training to its claims analysts on December 22, 2008, that addressed this requirement.

6. <u>In three instances, the Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.</u> In two instances, upon receipt of a claim under a group life plan, the Company directed the claimant or the claimant attorney to initiate the claim by obtaining claim forms from the group plan sponsor. As a result of referring the claimant to the employer sponsor in one such instance, the claimant's questions were unanswered for eight weeks. The third failure occurred in the handling of a claim under an individual life policy. The Department alleges these acts are in violation of CCR §2695.5(e)(2) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company states the claims analyst did not correctly follow the Company's procedure to provide necessary forms and reasonable assistance within regulatory timelines. The Company reviewed compliance with this issue with the claims staff on March 4, 2009.

7. <u>In three instances, the Company failed to begin investigation of the claim within 15 calendar days.</u> The Department alleges these acts are in violation of CCR §2695.5(e)(3) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings of three instances. The claims analysts did not follow the Company's procedure to initiate the claim investigation within 14 days of the receipt of the claim. The Company delivered mandatory training to its claims analysts on March 4, 2009, that addressed this requirement.

8. <u>In two instances, the Company failed to pay interest on a claim that remained unpaid longer than 30 days from the date of death.</u> Both errors occurred in the settlement of a claim under an individual life policy. The Department alleges these acts are in violation of CIC §10172.5(a) and are unfair practices under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> The Company agrees it failed to pay the interest that was owed. To correct the two identified errors, the Company paid $35.88 in interest on the proceeds to the named beneficiaries as a result of the examination. The Company conducted a meeting with life examiners on December 22, 2008, that restated the need to review the California Claims Regulation manual.

9. <u>In two instances, the Company failed to acknowledge notice of claim within 15 calendar days.</u> The Department alleges these acts are in violation of CCR §2695.5(e)(1) and are unfair practices under CIC §790.03(h)(2).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings of two instances. The claims analysts did not correctly follow the Company's procedure to acknowledge receipt within regulatory timelines. The Company delivered mandatory training to its claims analysts on March 4, 2009, that addressed this requirement.

10. <u>In one instance, the Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.</u> The Department alleges this act is in violation of CCR §2695.7(b) and is an unfair practice under CIC §790.03(h)(4).

<u>Summary of the Company's Response:</u> The Company states it reviewed compliance with this requirement in mandatory training with claims analysts on March 4, 2009. The analysts were reminded of the requirement to follow up for additional information every 28 calendar days and to inform the claimant the reason for the delay including a list of the missing information required to make a claim determination.

11. <u>In one instance, the Company failed to provide in its written denial a reference to and explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions.</u> Specifically, the Company failed to include the entire policy exclusion in its denial letter. The Department alleges this act is in violation of CCR §2695.7(b)(1) and is an unfair practice under CIC §790.03(h)(13).

<u>Summary of the Company's Response:</u> The Company acknowledges this finding in its response to another issue that was raised. The claim analyst failed to include all limitations that applied to this situation. This was an isolated incident.

<u>ACCIDENT AND DISABILITY</u>
<u>Long Term Care</u>
Review Period June 1, 2007 – May 31, 2008

There were no citations alleged or criticisms of insurer practices in this category within the scope of this report.

<u>ACCIDENT AND DISABILITY</u>
<u>Group Disability Income</u>

June 1, 2007 – May 31, 2008
Summary Sections 12 – 35

12. <u>In 51 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.</u> The examination revealed the Company failed to investigate clinical or other information needed to support the adverse benefit determination, failed to allow a reasonable time to receive necessary information, failed to follow up on outstanding issues in order to move claims to a conclusion, and failed to obtain the duties of the claimant's occupation. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: Effective December 20, 2008, Aetna created a suspension letter to be sent to the claimant on the 20th calendar day after receipt of the claim in the event the Company has not been able to collect the information to make a benefit determination. The Company enhanced its claims system to allow an additional 20 calendar days beyond the current 14 calendar days to receive the information. To ensure that benefits analysts are allowing a total of 34 calendar days, the Company's Disability Team Leaders will review claims that are denied due to lack of information to determine whether the suspension process was invoked. Team Leaders complete a checklist for each reviewed claim and document their feedback in the claim file.

The Company recognized an opportunity to refresh and reinforce its established procedures with claims staff. In April 2009, the Company revised its Disability & Absence Management Guide to address the issues identified in the 2007-2008 segment of the examination. The guide includes enhanced procedures for the handling of Short Term Disability (STD) and Long Term Disability (LTD) claims in compliance with California Title 10 Fair Claims Practices Regulations (Title 10).

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

The Company reopened the investigation of two claims reviewed in this segment in an attempt to obtain all pertinent information necessary to render a benefit determination. In one of these instances, the Company has not been successful in reopening the file, as the phone number on file for the claimant now appears to be a fax line and the Company does not have a valid authorization to request medical records in addition to what was obtained at the time of the initial review. In the second instance, the claim was reopened for further investigation. As a result, the Company reversed its decision based on the insured's appeal and issued a total payment of $25,864.93.

13. In 20 instances, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: As a result of these findings, the Company re-issued the denial letter containing the reference to the California Department of Insurance to all claimants whose claims had been denied for the period of June 1, 2007 through October 15, 2008.

The Company delivered training to its staff on November 4, 2008, to remind them when to include the language about claimants' rights in correspondence. Beginning February 26, 2009, Company team leaders are required to review all denied claims prior to sending letters to claimants. In April 2009, as a result of the examination, the Company revised its Disability & Absence Management Guide, which reflects this change in procedure and also contains the language referencing the California Department of Insurance.

The Company implemented a plan to convert all California claims and claims administration to its *WorkAbility* claims system which automatically inserts the language that references the California Department of Insurance in all denial letters. The conversion for California contracts commenced in the third quarter of 2009 and was completed by the end of 2011.

14. In 16 instances, the Company failed to provide an explanation of benefits. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company has two disability claims handling systems; the automated WorkAbility system and the legacy Atlas system. Each payment that is issued from its *WorkAbility* system has an EOB attached to the payment. This is true regardless of whether an actual check is issued or the claimant has elected direct deposit.

Disability claims that are managed and paid in the legacy ATLAS system require a manual process for providing the required letters and explanations of benefits to the claimant. The identified errors occurred in the legacy Atlas system. To correct this problem, the Company developed a quality check to ensure that an EOB letter is mailed when a payment is generated. The Company's Disability Quality Assurance Department is conducting focused reviews on a quarterly basis to ensure that an EOB accompanies claim payments. Team Leaders are required to review a payment report to identify claims that should have an EOB. This review will continue until all claims have transitioned to the new claim management system, in which an EOB automatically accompanies all payments. Team Leaders are required to complete a checklist for each reviewed claim and to document their feedback in the claim file.

15. In 15 instances, the Company failed to provide in its written denial a reference to and an explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions. The Department alleges

these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company recognized an opportunity to refresh and reinforce its established procedures with claims staff. In April 2009, the Company revised its Disability & Absence Management Guide to address the issues identified in the 2007-2008 segment of the examination. The procedures manual instructs the Disability Claims Analyst to quote the exact contractual definition of disability and any other provision applicable to the decision. The guide includes enhanced procedures for the handling of STD and LTD claims in compliance with California Title 10 Fair Claims Practices Regulations (Title 10). The Company's Disability Training Department revised its training module for California to include the requirement that provisions from the policy certificate must be included with the reason for denial of the claim. The Company's Disability Team Leaders review all denied claims and monitor denial letters for compliance.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

16. In 13 instances, the Company improperly required a claimant to give notification of a claim or proof of claim within a specified time. The Department alleges these acts are in violation of CCR §2695.4(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of

the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

17. <u>In 12 instances, the Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim.</u> The Department alleges these acts are in violation of CIC §10111.2(b) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company acknowledges these findings. Of the 12 instances, two claims were reopened and interest payments totaling $1,750.67 were paid.

In April 2009, Aetna created a suspension letter in which the claim analyst will include all outstanding information necessary to process the claim in the event the Company has not been able to collect the information to make a benefit determination. This letter is triggered on the 20th calendar day after the date the claim is received.

On November 12, 2011, the Company implemented a California Status Letter task in the WorkAbility (WKAB) system. The task auto-generates on the 10th day following the claim assignment in WKAB. Upon closing the task/mailing the letter, a new California Status Letter generates 25 calendar days later. This task date is locked and the task cannot be cancelled until the initial claim pay or no-pay decision is complete. This process is designed to achieve timely claim notifications to the insured.

18. <u>In seven instances, the Company failed to respond to communications within 15 calendar days.</u> The Company failed to respond to two claimants' appeals within 15 calendar days, failed to respond to a letter from the claimant attorney, failed to respond to the claimant's call to check the status of the claim, failed to respond to the claimant's telephone calls and letter requesting a review of the claim for LTD benefits, failed to acknowledge the additional information provided by the claimant, and failed to return the claimant's telephone call with questions about the amount of State Disability Insurance the Company was applying as an offset. The Department alleges these acts are in violation of CCR §2695.5(b) and are unfair practices under CIC §790.03(h)(2).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings of seven instances. The Company's remedial action included the following measures:

- The Company issued a training update to remind all claims analysts that the definition of the term *claimant* includes the claimant's attorney.
- The Company issued a mandatory training update to all claim analysts regarding the importance of forwarding promptly all appeals to the appeals unit.
- The Company reassessed one claim and found that the member did not have LTD coverage.
- The Company forwarded an appeal to its appeal unit for further review and

approved LTD benefits for an additional period of time, as identified under Summary section number 17 above.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

19. In seven instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. In one instance, the Company persisted in seeking a signed *Authorization for Release of Protected Health Information (PHI)* although it had received a standard medical authorization form signed by the power of attorney which states that eligibility for benefits and payment of services will not be affected if the claimant does not sign the authorization. In a second instance, the Company persisted in requesting all medical records from the claimant. In a third instance, the Company persisted in seeking medical records to determine eligibility for benefits for which the claimant was not entitled to receive. In a fourth instance, the Company persisted in requesting medical records from the claimant five weeks after it had already received them from the treating physician. In a fifth instance, the Company persisted in requesting information regarding automobile insurance even though the policy does not offset income from personal automobile insurance settlements. In a sixth instance, the Company persisted in conducting a pre-existing condition investigation after it had overturned the adverse benefit determination. In a seventh instance, the Company persisted in conducting a pre-existing condition investigation outside of the pre-existing condition period. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

20. <u>In seven instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.</u> The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

20(a). In three instances, the Company reduced the benefit amount the claimant was eligible to receive under the policy by the maximum weekly benefit allowed by California State Disability Insurance (CASDI) without taking into account the actual amount of CASDI the claimant was eligible to receive based on pre-disability quarterly earnings as reported by the employer-sponsor. This practice resulted in either an underpayment or non-payment of a disability benefit.

In one instance, based on pre-disability quarterly earnings, a claimant was eligible to receive $163.00 per week from CASDI. The Company offset the claimant's STD benefit under the policy by the maximum weekly CASDI benefit amount of $882.00 which reduced the claimant's benefit to zero and resulted in the denial of the claim. In a second instance, by applying the maximum CASDI weekly benefit, the Company underpaid a claim by $132.55. In the third instance, the claimant advised the amount she received from CASDI was less than the amount the Company deducted as an offset.

<u>Summary of the Company's Response to 20(a):</u> The Company states that in calculating the benefit amount, it estimates the maximum weekly benefit amount available from CASDI unless, or until, it receives a payment voucher or approval letter from CASDI that indicates the claimant is receiving a different amount. The Company estimates the maximum CASDI offset to avoid an overpayment.

In the first instance, the Company recalculated the STD claim based on the correct weekly CASDI benefit prior to the examination. In the second instance, the Company paid $132.55 to the claimant as a result of the examination. The claim analyst did not follow the Company's procedures regarding the estimation of California SDI benefits in this instance. The third instance will be corrected in the review project described below.

On December 6, 2011, the Company released a mandatory training for all Disability Benefit Managers (DBMs). The training clarified practices for offsetting CASDI by using the Employment Development Department (EDD) State of California Benefit Chart if the actual award amount is unavailable at the time of approval.

In response to the Department's concern that the Company may have underpaid policy benefits to claimants in the past, the Company conducted a seven-year look-back project to determine if California claimants were adversely impacted by the estimation

practices. The parameters and the results of the survey described in this summary section [20(a)] pertain also to summary section number 37 of this report, as both of these sections address the same issue. The dollars recovered through the survey are reported in summary section number 37 below.

20(b). In two instances, the Company failed to pay full benefits for the period of disability and failed to extend benefits to the date the claimant was released to return to full-time work as certified on the functional capacity report completed by the attending physician. In a third instance, the Company failed to pay benefits for an additional day following receipt of proof that the claimant returned to work one day later than initially reported.

Summary of the Company's Response to 20(b): The Company referred two instances back to the analyst for review to determine if full and/or partial benefits are payable to the claimant. The analyst determined that the errors were discovered internally and the amounts were paid in October 2008. In the third instance, the Company paid the claimant $93.42 for the additional day of disability, as a result of the examination.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area. The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

20(c). In one instance, the Company applied the incorrect percentage to the earnings test when determining whether or not the claimant met the definition of disability for any occupation. The Company applied a test rule of 60% instead of 80% of pre-disability earnings in determining whether or not the claimant qualified for continued benefits following the change in definition from own occupation to any occupation.

Summary of the Company's Response to 20(c): The Company reversed the denial when it discovered its error that had resulted in a wrongful denial of the claim prior to the examination.

21. In six instances, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed. The Department alleges

these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company stated the following:

> Effective February 26, 2009, the Company implemented instructions for managing correspondence. To ensure that correspondence is being retained as required, the Company implemented the following: 1) Disability Team Leaders review the correspondence storage site weekly to validate that the process is being followed; 2) the Company's Disability Quality Assurance Department is conducting quarterly focused reviews to validate that the record retention process is followed. Team Leaders are required to complete a checklist for each reviewed claim and to document their feedback in the claim file. The Company has also created a new process with its scanning vendor so that items sent for scanning are better tracked; and notification of the scanned items is more immediate. Any items for scanning that do not have required data elements used for tracking are sent to an exception queue and reported daily to the Company, so that they can be corrected. The Head of Vendor Relations is reviewing the vendor's work at its site on an as-needed basis.

22. In five instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

22(a). In three instances, the Company advised the insured of the right to bring a civil action under section 502(a) of Employee Retirement Income Security Act of 1974 (ERISA) if the plan is subject to ERISA. In these instances, the plan sponsor is a municipality and the policy does not include language pertaining to an insured's appeal rights under ERISA.

Summary of the Company's Response to 22(a): The Company agrees and addressed this error in its revised Disability & Absence Management Guide which the Company implemented in April 2009, as a result of the examination. The revised procedure instructs the Disability Claims Analyst to exclude ERISA language from an adverse benefit determination letter if it does not apply to the claimant.

22(b). In one instance, the Company misrepresented the policy definition of own occupation in correspondence to the insured claimant.

Summary of the Company's Response to 22(b): The Company agrees that the own occupation clarification noted in the denial letter is not the exact definition provided in the glossary of the LTD Summary of Coverage and Certificate of Coverage.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

22(c). In one instance, the Company misrepresented a pertinent fact of the status of the appeal. On September 17, 2007, the Company informed the claimant's spouse the appeal was still under review; whereas the Company did not begin a review of the appeal until October 2, 2007.

Summary of the Company's Response to 22(c): The Company agrees with this finding. Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

23. In five instances, the Company failed to pay benefits within 30 calendar days from receipt of information needed to determine liability. The Department alleges these acts are in violation of CIC §10111.2(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: As a result of the examination, the Company paid $1,150.35 in unpaid benefits.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the

Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

24. In five instances, the Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(e)(2) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees and addressed this issue in its revised Disability & Absence Management Guide which the Company implemented in April 2009, as a result of the examination. The procedures manual mandates that the analyst contact the claimant to explain what information is missing and to provide the claimant with forms and instructions of what is needed to provide proof of claim. The procedures also mandate the analyst document conversations in the file.

25. In four instances, the Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured. In one instance, the Company received and reviewed medical information in November 2007 and failed to affirm or deny coverage as of the date of the Department's inquiry in September 2008. In a second instance, the Company received medical records in January 2008 and failed to affirm or deny coverage as of the date of the Department's inquiry in August 2008. In a third instance, the Company received medical records in May 2007 and failed to affirm or deny coverage as of the date of the Department's inquiry in September 2008. In a fourth instance, the Company failed to complete the appeal process and failed to render a benefit determination within a reasonable time. The Department alleges these acts are in violation of CIC §790.03(h)(4).

Summary of the Company's Response: The Company agrees with the Department's findings of four instances. Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

26. In three instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. In these instances, the Company failed to administer the claim in accordance with the applicable plan documents, failed to set up an STD claim for processing when it received claims forms for both LTD and STD, and failed to follow its procedure to utilize a physician within the same or similar specialty as the condition under review. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the Department's findings of three instances. Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

27. In three instances, the Company failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability. The Department alleges these acts are in violation of CIC §10111.2(c) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company responded that CIC §10111.2(c) applies only to individual disability income policies, not to group disability income policies. As a result of the Department's second inquiry on this issue, the Company reversed its response and paid $206.34 in interest owed in two instances. In the third instance, the Company paid $91.72 in interest on May 21, 2013, for five months' benefits that were paid October 2, 2007.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams

referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

Further, the Company conducted an internal survey involving all claims closed from June 1, 2007 through March 31, 2011. As a result of the survey, the Company issued payments totaling $891.94.

28. In three instances, the Company failed to begin investigation of the claim within 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(e)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states it addressed this issue in its revised Disability & Absence Management Guide which the Company implemented in April 2009, as a result of the examination. The manual specifies the Company's standards to begin investigation of disability income claims in accordance with California Title 10 Fair Claims Practices Regulations. The Disability Quality Assurance Department and Company Team Leaders are responsible for monitoring compliance by claims staff.

29. In two instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In one instance, the Company failed to pay the Survivor Benefit upon receiving notice the claimant had died. In a second instance, the Company overturned the adverse benefit determination upon appeal without the receipt or review of new clinical information. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: Although the Company disagreed it owed the Survivor Benefit because the claimant died during the elimination period before the date benefits were to begin, the Company reversed its decision and paid the beneficiary $9,893.48 including interest as a result of the examination.

In the second instance, the Company overturned the denial and paid six months of benefits prior to the examination following the appeal for which no new medical information was reviewed.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams

referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

30. <u>In two instances, the Company failed to record the date the Company received, processed, transmitted or mailed every relevant document pertaining to the claim.</u> The Department alleges these acts are in violation of CCR §2695.3(b)(2) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings of two instances. Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area. The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

31. <u>In two instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.</u> In one instance, the Company failed to disclose the claimant's right under the appeal provision of the policy to request copies of the documents relating to the adverse benefit determination. In a second instance, the Company failed to extend coverage under the Exception to the Late Filing provision of the policy, after the basis for the initial denial no longer applied. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair under CIC §790.03(h)(1).

<u>Summary of the Company's Response:</u> The Company agrees it did not advise the claimant that if she were to appeal the decision, she may request copies of all documents, records, and other information relevant to her claim. The Company also agrees that the second claim should have been honored based on the exception to the Late Filing provision of the policy. The claim was reopened for consideration, but it was determined that no benefits were payable because the CASDI benefit paid exceeded the amount of the STD benefits.

The Company provides the required disclosure of information in the Certificate of Coverage, summary of Benefits and applicable Riders which are provided to the

insured. Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

32. In two instances, the Company failed to acknowledge notice of claim within 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(e)(1) and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response: The Company agrees. As a result of the examination, the Company recognized that an opportunity existed to refresh and to reinforce its established procedures with its claim staff. The Company addressed this issue in its revised Disability & Absence Management Guide which the Company implemented in April 2009. The manual specifies the Company's standards for the acknowledgement of disability income claims in accordance with California Title 10 Fair Claims Practices Regulations. The Disability Quality Assurance Department and Company Team Leaders are responsible for monitoring compliance by claims staff.

33. In one instance, the Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim, and failed to accrue interest on the benefit payment beginning the 31st day after receipt of the claim. The Department alleges this act is in violation of CIC §10111.2(b) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees it failed to notify the claimant in writing of the information it needed to determine liability within 30 days and failed to accrue interest on the initial benefit payment. The error was discovered internally and interest was paid in October 2008.

On November 12, 2011, the Company implemented a California Status Letter task in the WorkAbility system. The task auto-generates and is scheduled for the 10th day following the claim assignment. Upon closing the task/mailing the letter, a new California Status Letter generates 25 calendar days later. The task is locked and the task cannot be cancelled until the initial claim pay or no-pay decision is complete. This process will ensure timely notifications to the insured.

34. <u>In one instance, the Company failed to pay interest on a death claim, under a disability policy, that was paid longer than 30 days from the date of death of the insured, pursuant to CIC §10174.</u> The Company failed to include interest in the payment of the Survivor Benefit. The Department alleges this act is in violation of CIC §10172.5(a) and is an unfair practice under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> As a result of the examination, the Company paid interest to the beneficiary in the amount of $77.04.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided a copy of the procedure implemented in May 2008 for the payment of interest on death benefits under a disability policy. In addition, the Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

35. <u>In one instance, the Company improperly sought reimbursement of an overpayment or withheld a portion of a benefit payment as a result of a claim on the basis that the sum withheld was an adjustment or correction for an overpayment made under the same policy without documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting the reimbursement or withholding procedure.</u> The Company erroneously paid benefits under an STD policy and subsequently deducted the amount from a benefit payment for LTD without documenting the file as to the evidence of an overpayment or obtaining written authorization from the claimant. The Department alleges this act is in violation of CCR §2695.11(a) and is an unfair practice under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's finding of one instance. Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company also supplemented the Title 10 training with a refresher roundtable for the California-dedicated teams in Oregon, in which the regulations are reviewed verbatim. The Company continued these forums through 2013.

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36. In 168 instances, the Company failed to provide a clear explanation of the computation of benefits or failed to provide an explanation of benefits. In 162 of the instances, the EOB generated by the Company's WorkAbility (WKAB) operating system failed to demonstrate the calculation of one or more of the following components that make up the benefit payment: the weekly or monthly benefit amount as stated in the policy; the amount of pre-disability earnings; the policy percentage at which pre-disability earnings are calculated; the basis for the amount deducted for *CASDI* (California State Disability Insurance); the *T Auto Minimum Benefit*; the *Gross Benefit Non-Taxable* amount; the *Gross Benefit FITW Only* amount; and the basis for the amount deducted for *Part-Time RTW Wage Offset*. In six of the instances, in which the claim is managed in its legacy Atlas system, the Company failed to issue the explanatory letter that accompanies each benefit payment. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees that it violated the statute cited in these instances, but provided the following response.

The Company has two operating systems that manage disability income claims. The first one is the legacy Atlas system that requires the manual generation of an explanatory benefit letter by the Disability Benefits Manager (DBM). For claims that are still managed in the legacy Atlas system, the Company reinforced through training of the DBM the process of manually issuing EOB letters. On January 12, 2012, the Company enhanced the approval letters to include details of CASDI offsets for any insured working in California.

The second operating system currently used is known as WKAB which automatically generates an EOB that is attached to the benefit check. The Company developed a new EOB that provides greater detail of the insured's benefits.

In addition, on January 12, 2012, the Company enhanced WKAB approval letters to include details of CASDI offsets for any insured working in California. The Company believes the enhancement will ensure consistency and provide the insured with great

detail about their benefit computation. The Company provided the Department with a copy of the modifications made to its approval letters.

37. <u>In 71 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.</u> In 71 instances, the Company reduced the benefit amount the claimant was eligible to receive under the policy by the maximum weekly benefit allowed by CASDI without taking into account the claimant's actual pre-disability quarterly earnings as reported by the employer-sponsor. This practice resulted in either an underpayment of a disability benefit or the non-payment of a disability benefit. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> The Company disagrees that it violated the statute cited in these instances, but provided the following response.

It is not the Company's stated policy or procedure to deduct the maximum CASDI weekly benefit until such time the Company receives a *Notice of Computation* from the State agency which provides the actual CASDI benefit calculation. However, it appears that the DBM assigned to these claims did so in these instances. The Company's stated procedure is to review the claim to determine if the claimant has provided the actual CASDI benefit amount he/she is receiving or is eligible to receive under the CASDI program. If the claimant has not confirmed the actual CASDI benefit amount, the DBM will determine the estimated amount of CASDI benefits by referencing the Disability and Paid Family Leave Weekly Benefit chart on the Employment Development Department's (EDD) website in California. The estimated CASDI benefit is applied as an offset in the claim. The DBM informs the claimant of the estimated CASDI offset that has been applied, and advises the claimant to submit proof of the CASDI benefit he or she is receiving.

On December 6, 2011, the Company released a mandatory training for all DBMs. The training clarified practices for offsetting CASDI by using the EDD State of California Benefit Chart if the actual award amount is unavailable at the time of approval.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

In response to a concern the Company may have underpaid policy benefits to claimants in the past, the Company conducted a seven-year look-back project to determine if California claimants were adversely impacted by the estimation practices. The project reviewed California closed claims for STD and LTD benefits that were paid, denied, and appealed during the period January 1, 2005 through December 31, 2011. The Company identified 1,564 such claimants in this seven-year period and then sent a written notification to each of the claimants, informing them of a possible underpayment. The Company received and responded to 188 written responses. The Company issued underpayment checks totaling $28,169.21, including associated interest, to 48 claimants who provided the requested information. Of the remaining 140 claimants, the Company sent response letters to 125 claimants, advising they were not underpaid, and to 15 claimants who did not submit the proper paperwork. The Company completed the survey on October 3, 2013, and reported the results to the Department on October 18, 2013. The parameters and the results of the survey described in this summary section [37] pertain also to summary section number 20(a) of this report, as both of these sections address the same issue.

38. In 52 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The examination revealed failures in the Company's investigative procedures, as established in its Disability & Absence Management corrective action plan developed in 2009. The examination revealed the failure to allow reasonable time to receive necessary claim information, the failure to send a suspension letter in the event requested information is not received, the failure to request information from all treating physicians, the failure to investigate discrepancies in information, the failure to diligently evaluate conflicting medical opinions of the claimant's ability to perform the duties of his or her occupation, and the failure to follow up on outstanding requirements in order to move the claim to a conclusion.

The Company agreed to re-review six of the 52 identified instances in an attempt to correct investigative errors that may have caused an underpayment or non-payment of benefits. Three of the instances for re-review involve a failure to diligently pursue additional medical information outlined by the Behavioral Health Unit. Two of these instances involve a failure to investigate the start date of the disability or to resolve a discrepancy in the date the claimant returned to work, which may have caused an underpayment of benefits. In the latter instance, the Company failed to extend the benefits beyond the approved-through date after it became aware the claimant returned to work later than recorded. The Company approved the benefit period based on Medical Disability Advisor (MDA) guidelines for the primary diagnosis only instead of applying the maximum MDA guideline when surgery is involved. Therefore, the claimant was not paid additional benefits for 14 days. The final instance for re-review involves the failure to obtain the claimant's job description in order to determine whether or not the claimant met the definition of disability in the resolution of an appeal.

The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees that it violated the statute cited in these instances, but provided the following response.

The Company reopened and reviewed all six in accordance with the Department's request and determined that its failure to conduct a thorough, fair and objective investigation did not result in insufficient claim settlements. To ensure future compliance, the Company conducted refresher training to reinforce the Disability & Absence Management Guide referenced in the Company Response to Section 12 of this report.

39. In 45 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

39(a). In 19 of the instances, the Company misstated the definition of disability as it appears in the California Settlement Agreement TDI Rider under the provisions for Total Disability, Own Occupation, and Substantial and Material Acts. The Company furnished the claimant with an invalid contractual definition of disability as it was written prior to the amendment of the Group Policy.

Summary of the Company's Response to 39(a): The Company disagrees that it violated the statute cited in these instances, but provided the following response.

The Company agrees it should have included the correct policy language for Test of Disability in the identified denial letters. On May 17, 2011, the Company implemented mandatory training of its DBMs in the revised policy language. In addition, the Company hardcoded this verbiage so that it populates in the appropriate WKAB letters. Although this corrective action pre-dates the start of the 2008 - 2011 California Market Conduct exam in July 2012, most of the claim activity reviewed by the examiners occurred before this change.

39(b). In 13 instances, the Company misstated a pertinent fact or made a misleading statement in the adverse benefit determination letter or omitted a pertinent fact from the letter. In five of the instances, the Company misstated a fact of the results of its requests for additional information. In two instances, the Company failed to advise the claimant the Company needed an extension of time in which to make a claim decision as provided under the policy. In two instances, the Company included a statement in the adverse benefit determination that is misleading and confusing as to the purpose: *At this time we are requesting that you appeal this decision.* In two instances, the Company misquoted the policy benefits. In one instance, the Company communicated contradictory reasons as the bases for denial of the claim. In one instance, the Company failed to inform the claimant they could obtain coverage if CASDI benefits were denied and if the Company were to receive proof of that denial.

Summary of the Company's Response to 39(b): The Company disagrees that it violated the statute cited in these instances, but provided the following response.

On May 17, 2011, the Company implemented mandatory training in properly constructing correspondence relating to either the status of the claim or to an adverse benefit determination. The Company reinforced the requirements of making a decision within the timeframes dictated by ERISA; issuing a suspension letter 20 calendar days following a request for information that has not been received; and sending timely extension letters when a decision cannot be made within 45 calendar days due to circumstances outside of the plan's control.

In addition, the Company hardcoded the proper California denial language so that it populates automatically in an adverse benefit determination letter generated in WKAB. For the legacy Atlas system, the proper California denial language will need to be manually added to an adverse benefit determination letter.

39(c). In 13 instances, the Company referenced, in its denial letter, a statute that has no relevance to the claim denial and that misleads the claimant regarding further action on the part of the claimant. The letter references Title 22, Section 2706-5, which is a statute for the filing of an appeal to receive benefits from the State of California Employment Development Department. The filing of such appeal is not related to, and has no impact on, an appeal by the claimant of the adverse benefit determination.

Summary of the Company's Response to 39(c): The Company disagrees that it violated the statute cited in these instances, but provided the following response.

The Company agrees the language pertaining to Title 22 is not appropriate. It appears the DBM selected the incorrect correspondence template that was used to draft the denial letters. On May 17, 2011, the Company implemented mandatory training of its DBMs in properly constructing adverse decision correspondence. Although this corrective action pre-dates the start of the 2008 - 2011 California Market Conduct exam in July 2012, most of the claim activity reviewed by the examiners occurred before this change. In addition, the Company hardcoded the proper California denial language so that it populates automatically in adverse benefit determination letters generated in WKAB. For the legacy Atlas system, the proper California denial language will need to be manually added to adverse benefit determination letters.

40. In 42 instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. In these instances, the Company failed to disclose one or more of the following benefit provisions: a) coverage is for disability caused by a non-occupational disease or injury; b) the elimination period; c) the definition of disability; d) how the amount payable is determined; e) the impact of other income benefits on the weekly benefit amount or the ineligibility for benefits due to eligibility for other statutory temporary disability or cash sickness programs. The

Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company states it provides the required disclosure of information in the Certificate of Coverage, Summary of Benefits and applicable Riders which are provided to the insured. This material is also attached to and made a part of the Group Policy.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company also supplemented the training of the dedicated teams with a refresher roundtable in the verbatim review of Title 10 regulations. The Company continued these forums through 2013.

41. In 13 instances, the Company failed to provide in its written denial a reference to and an explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions. The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company disagrees that it violated the statute cited in these instances, but provided the following response.

The Company acknowledges that the 13 referenced denial letters do not state the factual and legal basis for the denial of the claim.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company also supplemented the training

of the dedicated teams with a refresher roundtable in the verbatim review of Title 10 regulations. The Company continued these forums through 2013.

42. In 10 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. With regard to the content of the adverse benefit determination letter, in eight instances, the Company failed to follow its procedures specified in the Company's Disability & Absence Management Guide that was developed in 2009. The Company failed to reference the claimant's occupation and demand level as it corresponds in the general economy, failed to link the medical outcome with the claimant's occupational demands, failed to inform the claimant the reason the medical information does not support the claimant's limited or restricted functionality, failed to notify the claimant of its attempts to get medical records, failed to provide a detailed synopsis of the received medical records, and failed to notify the claimant of what additional information is needed to perfect the claim.

In two instances, the Company failed to follow its procedures to refer the STD claim to the LTD unit and failed to send the claimant its Regular STD Approval letter. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees that it violated the statute cited in these instances, but provided the following response.

The Company acknowledges the errors that were made in the handling of the claims referenced. All 10 claims were reopened to determine whether these errors resulted in unpaid benefits. Of the 10 instances, the Company did not find any that warranted amounts that would be payable.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company also supplemented the training of the dedicated teams with a refresher roundtable in the verbatim review of Title 10 regulations. The Company continued these forums through 2013.

43. In six instances, the Company failed to notify the insured in writing, within 30 days of receipt of the claim, that additional information was needed to determine liability for the claim, or it failed to include a list of all information needed in the written notice. The Department alleges these acts are in violation of

CIC and are unfair practices under CIC §10111.2(b) and are unfair practices under VIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees that it violated the statute cited in these instances, but provided the following response. The Company states the absence of communication to the claimant does not represent the Company's standard practice.

To ensure future compliance with the time requirement to request additional information within 30 days after receipt of the claim, on November 12, 2011, the Company implemented a process in the WKAB system to ensure timely notifications are sent to the California insured. The task auto-generates a letter on the 10th day following the claim assignment. When the task is marked complete, the system generates a new status letter 25 calendar days later. The task cannot be cancelled until the initial claim pay-or no-pay decision is complete.

To ensure future compliance of including a list of all information needed in its written notice of the need for such information, in November 2011, the Company reinforced this requirement through training with the individual Disability Benefit Manager.

44. In five instances, the Company failed to respond to communications within 15 calendar days. In these instances, the Company failed to respond timely to claimants' requests for: a copy of the file following an adverse benefit determination; a copy of the Independent Medical Examiner's report; a copy of the policy; a call-back from the Company; and, clarification of the limitation of benefits. The Department alleges these acts are in violation of CCR §2695.5(b) and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response: The Company disagrees that it violated the statute cited in these instances, but provided the following response.

The Company acknowledges it failed to respond timely to the five identified requests from claimants. The Company trained and coached the analyst to be observant of the relevant time frames required under California law. Additionally, the Company developed a California refresh training that included this issue in its curriculum and which will be delivered on an annual basis going forward. The corrective action was completed by December 31, 2012.

Since April 2012, all California-*situs* cases are being handled out of the Company's Portland, Oregon claims office by designated teams specifically trained to handle these cases. The Company will also continue its practice of conducting monthly internal audits to ensure compliance in this area.

45. In four instances, the Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of

the claim, and failed to accrue interest on the benefit payment beginning the 31st day after receipt of the claim. The Department alleges these acts are in violation of CIC §10111.2(b) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company disagrees that it violated the statute cited in these instances, but provided the following response.

The Company agreed to correct the four identified errors. Two of the errors were included for correction in the seven-year look back project described in Summary numbers 20 and 37 above. In correcting a third error, the Company paid the claimant $18.24 on May 7, 2013, for interest on the initial claim payment dated April 1, 2009. The fourth error was corrected on August 20, 2013 with an interest payment of $1.28.

On November 12, 2011, the Company implemented a process in the WKAB system to ensure timely notifications are sent to the California insured. The task auto-generates a letter on the 10th day following the claim assignment. When the task is marked complete, the system generates a new status letter 25 calendar days later. The task cannot be cancelled until the initial claim pay or no-pay decision is complete.

The Company accrues and pays outstanding interest on relevant claims pursuant to its Statutory Audit Tool and Process. To monitor compliance, Company performs audits on random claim samples monthly using the tool. Company's use of this Statutory Audit Tool and Process dates back to corrective actions taken after the 2008 examination, and was implemented in 2009.

46. In four instances, the Company improperly required a claimant to give notification of a claim or proof of claim within a specified time. The Department alleges these acts are in violation of CCR §2695.4(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees that it violated the statute cited in these instances, but provided the following response.

The Company agrees it imposed a timeframe not specified in the policy; however, the time frame is used to facilitate expeditious claim determinations. The Company reinforced through training with the Intake Representative the proper construction of written communications as they relate to the claimant's policy.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

47. <u>In three instances, the Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given.</u> In these instances, the Company failed to provide the claimant with an adverse benefit determination letter. The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

<u>Summary of the Company's Response:</u> The Company disagrees that it violated the statute cited in these instances, but provided the following response.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

48. <u>In three instances, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.</u> The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company does not agree that this is an error that occurs on a regular basis. The Company's standard process is to include this statement regarding the claimant's right to contact the California Department of Insurance if they feel their claim has been wrongfully denied or rejected. While reviewing samples selected for this exam, it was discovered that the statement had been inadvertently excluded from one of the referenced letters. The Company sent a revised letter on July 8, 2011, to correct the oversight.

The Company acknowledges the second instance and reinforced through training with the Appeal Specialist the correct state mandated language to be included with adverse determinations. The third letter in question was created in a system that is

currently only utilized until all claims can be converted to its WKAB system. Since the time of this appeal, claims for this customer have transitioned to the WKAB system in 2009. All WKAB system generated letters automatically populate with the required language. Had this letter been produced from the WKAB system, this error could not have occurred.

In addition, on May 17, 2011, the Company issued an update to WKAB and ATLAS DBMs reminding of the requirement to include California Department of Insurance language on all adverse determination letters. For WKAB users, the California language is hard-coded within all adverse determination letters; for Atlas users, the California language will need to be manually added to adverse determination letters.

49. <u>In two instances, the Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.</u> In one instance, the Company failed to respond to the claimant confirming receipt of the additional information the Company needed to maintain the certification of the dates of disability. In a second instance, the Company failed to furnish a complete response to the employer's question about whether or not the claimant employee could get approval for LTD following the denial of the STD claim. The Company's answer contradicted file notes indicating that an LTD claim has not been, nor will be, set up and it failed to answer the employer's concern about whether or not the LTD policy would provide coverage for an occupational injury, when the STD policy did not provide such coverage. The Department alleges these acts are in violation of CIC §790.03(h)(2).

<u>Summary of the Company's Response:</u> The Company agrees in the first instance it did not advise the claimant that the Company maintained the certified dates of disability following the receipt and review of the provider's updated notes. The Company reinforced through training with the DBM appropriate correspondence that is to be sent to a claimant.

In the second instance, the Company recognizes that it did not resolve the LTD concern on this claim which was examined as a denied STD claim. The Company reassessed the claim on January 11, 2012 and approved LTD benefits for the member beginning November 12, 2008. A payment of $55,295.10 was issued on June 11, 2012 for the period of November 12, 2008 through December 31, 2011. Payments continued until May 1, 2013 when the claim was closed. As a result of the examination, the total amount paid in the settling of this claim was $99,772.94.

Since April 2012, all California-*situs* cases are being handled out of the Company's Portland, Oregon Claim Office by designated teams specifically trained to handle these cases. The Company developed a California refresh training that included this issue in its curriculum. The training is delivered on an annual basis going forward. The corrective action was completed by December 31, 2012. The Company will also continue its practice of conducting monthly internal audits to ensure compliance in this area.

50. <u>In two instances, the Company failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability.</u> The Department alleges these acts are in violation of CIC §10111.2(c) and are unfair practices under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> In the first instance, the Company agrees sufficient information was available to determine liability on April 30, 2010, and payment was not rendered timely upon receipt of information through that date. On May 7, 2013, the Company paid the claimant interest in the amount of $2.81 that was due on the initial benefit amount dated February 4, 2010. In the second instance, the Company agrees it failed to pay interest within the regulatory timeframe following the date of the appeal determination due to a systems issue. To correct the error, the Company calculated and paid the interest to the claimant in the amount of $14.53 as a result of the Department's inquiry.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

51. <u>In two instances, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.</u> In two instances, pertaining to the same claims file, the Company failed to retain a copy of requests for additional information it sent to the employer-sponsor and to the attending physician. The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company disagrees that it violated the statute cited in these instances, but provided the following response.

While the file notes document that requests were made to the employer and to the attending physician, a copy of the actual communications were generated outside of the system and were not scanned into the claim records. The Company has not yet been able to retrieve record of the transmission noted at the bottom of each referenced task. The Company reinforced through training with the Customer Service

Representative and with the Behavioral Health Nurse who handled this claim the requirement to comply with this regulation.

Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

52. In two instances, the Company failed to acknowledge notice of claim within 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(e)(1) and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response: The Company disagrees that it violated the statute cited in these instances, but provided the following response.

In response to one of the errors, the Company states it completed remedial action in 2009 to automatically system-generate timely claim acknowledgement letters for STD claims initiated in WKAB. In the second instance, the remedial measure is reinforcement through training with the DBM the importance of acknowledging receipt of what appears to be a subsequent notice of claim.

53. In one instance, the Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured. The Company failed to make a benefit determination on an STD claim when it had sufficient documentation that the claimant pursued a workers' compensation claim. The Company did not notify the claimant within a reasonable time that a disability caused by occupational injuries is not covered under the STD plan. The Department alleges this act is in violation of CIC §790.03(h)(4).

Summary of the Company's Response: The Company disagrees that it violated the statute cited in this instance, but provided the following response.

The Company acknowledges it could have completed the determination within 45 days based on the information received indicating this was a work-related claim. Since April 2012, all California situs claims are being handled out of the Company's Portland Oregon Claim Office by designated teams specifically trained to handle California claims. As part of the 2011 Corrective Action Plan, the Company agreed to develop a

California refresher training to capture all issues raised by the Department during the 2008 and 2011 Market Conduct Examinations, and to be conducted on an annual basis going forward, with the designated claim teams referenced above. The Company will also continue its practice of conducting monthly internal audits to address compliance in this area.

The Company provided the Department with its training curriculum and with a roster of staff who attended the training. The Company supplemented the training of the dedicated teams with a refresher roundtable in Title 10, verbatim. The Company continued these forums through 2013.

54. In one instance, the Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days. The Department alleges this act is in violation of CCR §2695.5(e)(2) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges that the letter dated September 27, 2010, does not contain a clear explanation of the forms that were attached. The Company reinforced through training with the LTD claim Technician the appropriate information to be included in a claim acknowledgement letter.

55. In one instance, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. The Company requested a copy of the Social Security Disability Insurance award which it had already received one year prior to the request. The Department alleges this act is in violation of CCR §2695.7(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company reinforced through training with this DBM the need to completely review a claim file prior to requesting any additional information believed to be outstanding and necessary for resolution of a claim.

56. In one instance, the Company failed to notify the insured of an overpayment within six months of the error. The Department alleges this act is in violation of CCR §2695.11(a)(2)(C) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees it failed to notify the insured of an overpayment within six months of the error. The Company absorbed the overpayment and did not request reimbursement from the insured. The Company trained and coached the analyst on this claim to be more vigilant in reviewing and identifying claims for possible overpayment errors within six months of the error.

ACCIDENT AND DISABILITY
Aetna Student Health

June 1, 2007 – May 31, 2008
Summary Sections 57 – 63

57. In 83 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Department alleges these acts are unfair practices under CIC §790.03(h)(5).

57(a). In 29 instances, the Company failed to pay the claim within a reasonable time following the determination of liability. In three additional instances, the Company failed to deny the claim within a reasonable time following the Company's determination of liability.

Summary of the Company's Response to 57(a): The Company states that it created a Claim Inventory Manager role in March 2011, whose responsibilities include daily monitoring of inventory reports to ensure timely handling of all claim volumes, assigning priority processing of claims at risk of delay to the examiner responsible for the school, and counseling supervisors whose examiners are not completing claims timely. The results of the claim inventory for the year 2011 indicate that 80% of claims were processed within 11 days; for the year 2012, 80% of all claims were processed within 8.5 days.

57(b). In 24 instances of claims pertaining to one member, the Company applied the improper processing code resulting in an improper denial. In one additional instance, in the reprocessing of these claims to correct the error, the Company paid 16 of 17 authorized visits. The additional error was identified in the review of the EOBs that accompanied the Company's corrective action plan submitted in June 2012.

Summary of the Company's Response to 57(b): The Company states it misinterpreted the claim file notes resulting in a wrongful denial of 24 claims for physical therapy. Due to the overlap of chiropractic services and physical therapy services on the same dates of service for the member, the claims processor erroneously applied the medical necessity determination for the chiropractic services to the physical therapy services as well. The Company reviewed additional information included in the provider's appeal on July 19, 2008, which was prompted by the denial of services under the improper processing code. The Medical Director authorized 17 of the 24 visits and the Company reprocessed the claims in accordance with the Medical Director's determination. The Company paid 16 of the 24 visits for a total of $1,547.05 on August 7, 2008, as a result of the reprocessing. The Company paid an additional $80.50 to correct the remaining unpaid claim. The Company disagrees that it did not attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

The Company also states it performed a review of the policies and procedures in place to handle these types of claim scenarios to ensure compliance. In April 2011, the Company implemented a Quality Analyst position with responsibilities for analyzing audit trends, identifying root causes, recommending process solutions, providing individual mentoring and conducting corrective action meetings monthly.

57(c). In 19 instances, the Company failed to follow its procedure to pay interest on a claim that was not paid within a reasonable amount of time after receipt of the claim or failed to calculate interest from the date liability had become reasonably clear. In 16 of the instances, pertaining to one member, the Company did not follow its procedure to include interest on the delayed payments made in the reprocessing of authorized physical therapy claims, as described in subsection 57(b) above.

Summary of the Company's Response to 57(c): As a result of this examination, the Company paid the provider Late Claim Interest (LCI) in the amount of $826.58 on 17 physical therapy claims that are the subject of subsection 57(b) above. With regard to the three additional instances, the Company recalculated the claims to include LCI which resulted in additional payments to providers of $91.66.

The Company conducted refresher training with staff on LCI procedures and calculation tools in April 2011. The Company conducted a mandatory skill check in January 2012. Analysis of LCI trends are reviewed monthly in the Claims Department staff meeting. The Company converted to a new claims processing platform where LCI calculation will be automated. The completion date of the conversion to the new platform took place in 2013.

57(d). In four instances, the Company failed to follow its procedures which resulted in an improper denial of the claim. In the first of two instances involving one member, the Company improperly conducted a pre-existing condition investigation of a claim that was incurred after the six-month pre-existing condition period had expired. In the second instance, the Company wrongly denied the claim for lack of receiving the additional information which was not required. In the third instance, the processor misread the policy benefits resulting in a wrongful denial. In the fourth instance, an error in the maintenance of Company records resulted in an improper denial.

Summary of the Company's Response to 57(d): The Company explains that, in the first of two instances involving one member, the claims processor failed to consider that the date of service for this claim occurred more than six months after the insured's coverage had become effective. In the second of the two instances, the Company overturned the improper denial and paid $55.18, including interest, as a result. In addition, the Company states it retrained the processor in the Company's requirements for a preexisting condition. The Company launched mandatory online refresher training to all examiners for completion on March 29, 2011.

In the third instance, an individual examiner error occurred whereby the examiner incorrectly denied a medical procedure which is covered by the plan. The Company

overturned the denial and paid $33.16 as a result. The Company performed a review of the policies and procedures in place to handle these types of claim scenarios to ensure compliance. In April 2011, the Company implemented a Quality Analyst position with responsibilities for analyzing audit trends, identifying root causes, recommending process solutions, providing individual mentoring and conducting corrective action meetings monthly.

In the fourth instance, the member was identified by the plan sponsor under an erroneous ID number resulting in duplicate records. The Company corrected the error after the claim was processed on May 28, 2008. The Company now has a member matching process in place whereby a series of matching queries compare all eligibility records submitted by plan sponsors against existing eligibility in all systems. This process will prevent the creation of separate duplicate records, even if the member's ID has changed.

57(e). In three instances, the Company failed to pay the claim after the Company had received the additional information to determine liability it requested from either the provider or from the member.

Summary of the Company's Response to 57(e): The Company disagrees that it violated the statute cited in these instances, but agrees it failed to process the three identified claims. As a result, the Company paid $201.18 in the processing of two unpaid claims and allowed $57.97 toward the deductible in the third claim. The claims processors associated with the original claim handling received training and counseling on ensuring that all documents received with a claim are evaluated prior to the finalization of the claim.

58. In five instances, the Company failed to conduct and pursue a thorough, fair and objective investigation. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

58(a). In three instances, the Company failed to promptly request additional information needed to adjudicate the claim or failed to request additional information prior to denial of the claim.

Summary of the Company's Response to 58(a): The Company states that, in March 2011, it created a Claim Inventory Manager role whose responsibilities include daily monitoring of inventory reports to ensure timely handling of all claim volumes, assigning priority processing of claims at risk of delay to the examiner responsible for the school, and counseling supervisors whose examiners are not completing claims timely.

58(b). In two instances, the Company failed to complete the appeal process within the amount of time specified under the Appeals Procedure provision of the policy.

Summary of the Company's Response to 58(b): The Company states that, in October 2011, the Company provided feedback to the analysts who reviewed appeals. Beginning October 2011, the Company conducts daily monitoring of internal reporting to ensure resolution, completion and timeliness.

59. In three instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. In two instances, the Company denied the claim as not medically necessary and failed to advise the insured of the right to request an Independent Medical Review (IMR), as provided by the policy. In one instance, upon being presented with a claim for mental health and substance abuse benefits, the Company failed to explain the policy provision that such benefits are provided by an independent managed care company. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: While the Company has revised its member EOBs to include notice of IMR rights, the Company believes that its prior process was consistent with California law and regulations. Notice of IMR rights was provided in member EOBs for denial, modification or delay of a service that fit the criteria for IMR. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013.

The Company also created a new remark code to disclose the policy provision that services for mental health and substance abuse benefits are not covered by the plan but are covered by an independent company. The explanatory remark directs the member to submit the claim to ValuOptions. The text was approved and implemented for use beginning May 25, 2012.

60. In two instances, the Company failed to provide in its written denial a reference to and explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions. The Company denied the claims on the basis the services are not medically necessary and failed to link the medical information submitted by the provider with the policy provisions or with the basis of the Medical Director's determination that such services are not medically necessary. The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company states the claims were denied with the Reason Code, "Services do not appear to be medically necessary based on the documentation received." The Company does not include specific policy provisions, conditions or exclusions on EOBs. In order to ensure future compliance, in March 2015, the Company created a separate denial letter that indicates the basis as to why the services were not medically necessary. A copy of the template letter was provided to the Department.

While the Company has revised its member EOBs to include notice of IMR rights, the Company believes that its prior process was consistent with California law and regulations. Notice of IMR rights was provided in member EOBs for denial, modification or delay of a service that fit the criteria for IMR. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013.

61. In one instance, the Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. The Company failed to acknowledge the member's appeal within the five-day timeframe specified under the Appeals Procedure provision of the policy. The Department alleges this act is in violation of CIC §790.03(h)(2).

Summary of the Company's Response: The Company states it provided feedback in October 2011 to the analyst who handled this appeal. Daily monitoring of internal reporting is conducted to ensure acknowledgement, completion and timeliness.

62. In one instance, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. The Company questioned the physician's claim that was submitted with a diagnostic code for cellulitis and abscess following a poisonous insect bite that was documented as a black widow, brown spider or tarantula. The Company asked the member to provide complete accident details, including whether or not the injury was work-related or related to a motor vehicle accident. The Department alleges this act is in violation of CCR §2695.7(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states the error was made by an individual examiner who is no longer with the Company. It also states that, in April 2011, the Company implemented a Quality Analyst position with responsibilities for analyzing audit trends, identifying root causes, recommending process solutions, providing individual mentoring and conducting corrective action meetings monthly.

63. In one instance, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. The Company underpaid the claim for services rendered by an out-of-network health care provider. The Company failed to determine the Reasonable Charge, as defined in the policy, for a service or supply that is rendered by an out-of-network health care provider. The Department alleges this act is in violation of CCR §2695.7(g) and is an unfair practice under CIC §790.03(h)(5).

Company's Response: The Company provided the following statement in response to this issue:

> The Company became aware in 2007 that it paid the incorrect amount on a small percentage of student health plan claims for services rendered by out-of-network health care providers. At the time the original claim was

processed the error was based on the use of outdated Ingenix MDR data by its Third Party Administrator, Chickering Claims Administrators, Inc., now known as Aetna Student Health.

The Company developed a project to reprocess student health claims that may not have processed correctly in the past beginning with the first policy underwritten by Aetna in 1998 through March 31, 2008. In April 2009, the Company provided the Department with a summary of the reprocessing of California student health plan claims for out-of-network health care providers covered under student health insurance plans administered by Chickering Claims Administrators, now known as Aetna Student Health. For California, this reprocessing project involved 5,127 insureds and 14,372 claims. The additional claim dollar amount is approximately $367,296, with estimated interest and penalties estimated to be about $171,160. The Company sent letters to both active and inactive California students by the end of April 2009 regarding each of these claims asking for help in determining whether the additional payment is due the student or the provider. The Company set up a toll-free telephone number to handle questions. When the claim was reprocessed, Aetna Student Health sent the student an explanation of benefits detailing the payment, regardless of whether the payment went to the student or the provider. The reprocessing did not lead to any additional costs for students or providers.

In August 2008, the Company adopted an Ingenix MDR Data Maintenance Procedure Review Policy requiring the updating of MDR data within 60 days of receipt. Aetna implemented a practice of requiring senior business managers regularly to sign certifications that charge data has been updated.

The Company provided an additional statement in May 2012, in response to this issue:

The Company provided the FAIR Health Pricing Data Update Procedure dated April 2011 that identifies the processes required to maintain FAIR Health Reasonable and Customary and Anesthesia pricing data on the ASH IBM I-Series Genelco Group+ claim payment system. Updated data must be loaded in the System within 30 days of receipt of updated data from FAIR Health as required by our agreement with the New York Attorney General. Updates to FAIR Health pricing data are received semi-annually, generally in February and August.

The Company also provided written certification that the Genelco claims platform was updated with the Ingenix MDR charge data effective each Spring and Fall for the years 2008, 2009, 2010 and through Winter 2011 (effective January 15, 2012), signed by the President of Aetna Student Health.

ACCIDENT AND DISABILITY
Aetna Student Health

June 1, 2008 – March 31, 2011
Summary Sections 64 – 76

64. In 52 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The Department alleges these acts are in violation of CIC §790.03(h)(5).

64(a). In 23 instances, the Company improperly contested the claim that was incurred beyond the policy's pre-existing condition exclusionary period. This resulted in the non-adjudication of the claims as the Company continued to await receipt of additional information.

Summary of the Company's Response to 64(a): To correct the errors, the Company reprocessed 23 claims that were improperly denied which resulted in the payment of $944.16 for seven of the claims, including late claim interest, and in the proper denial of the remaining 16 claims on the basis the Company never received the EOB from the primary other carrier for a coordination of benefits. The Company provided the Department with the EOBs for the reprocessed claims.

Further, the Company conducted an internal survey involving all claims closed from June 1, 2007 through March 31, 2011. As a result of the survey, the Company issued payments totaling $368.56.

The Company completed mandatory online refresher training of all examiners on March 29, 2011. The Company conducted a pre-existing condition skill-check assessment of all examiners on April 5, 2011, with a follow-up on August 16, 2011. The Company rolled out instructor-led pre-existing condition training sessions on August 5, 2011, and verified 100% achievement on the skill-check on September 29, 2011. The Company implemented a daily audit report of pre-existing related claims to spot check for accuracy on October 4, 2011.

Further remedial measures include the completion of a daily audit report to identify, review and correct those claims which are denied and/or pended for a pre-existing investigation that are outside the 180-day period. The review of this report will be conducted by a supervisor or senior claims examiner. Identified errors will be corrected within 48 hours.

64(b). In 13 instances, the Company failed to follow its procedure to include interest or penalty fees on a claim payment made later than 30 working days.

Summary of the Company's Response to 64(b): As a result of the examination, the Company paid $1,207.58 in interest due in the 13 identified instances.

The Company's states its guideline for payment of a claim, including when interest may become due, is 30 working days. In April 2011, the Company conducted refresher training on Late Claim Interest (LCI) procedures. The Company conducted mandatory skill check in January 2012.

Further, the Company implemented the following procedures in 2013 including ongoing monitoring of late claim interest:

- Performs a weekly review of claims with an interest payment of $100.00 or greater to ensure accurately calculated
- Audits are performed monthly to ensure that late claim interest was accurately applied on all claims pulled for audit.
- Monthly audits include all claim payments of $10,000.00 and greater, as well as 20 randomly selected claims per examiner per month.
- Quality analysts perform reviews of monthly quality audit results and provide feedback to examiners
- Late claim interest trends are reviewed in detail in monthly team meetings

In addition, the Company conducted an internal survey involving all claims closed from June 1, 2007 through March 31, 2011. As a result of the survey, the Company issued payments totaling $6,448.89.

64(c). In nine instances, the Company failed to follow its procedure for payment of the claim within 30 working days.

Summary of the Company's Response to 64(c): The Company's guideline for payment of a claim, including when interest may become due, is 30 working days. In these instances, the bills were not paid within the Company's guideline due to processor error.

In March 2011, the Company created a Claim Inventory Manager role whose responsibilities include daily monitoring of inventory reports to ensure timely handling of all claim volumes, assigning priority processing of claims that are at risk of delay to the examiner responsible for the school, and, counseling supervisors whose examiners are not completing claims timely.

64(d). In seven instances, the Company incorrectly denied the claim. The Company denied three of the claims for physical therapy without having considered the new medical circumstances for physical therapy following a second surgery. The Company overturned two denials without additional information, upon an appeal from

the member. The Company denied two appeals on the basis the provider failed to file the dispute within 180 days of the initial claim decision. The provider contract between the Company and Stanford Hospital & Clinics states the facility has 365 days to file a dispute.

Summary of the Company's Response to 64(d): The Company reprocessed the three claims for physical therapy and paid $399.78, including late claim interest, as a result of the examination. In two instances, the Company agrees it overturned denied claims upon appeal from the member without submission of new medical information.

With regard to two provider disputes submitted by Stanford Hospital & Clinics, the Company reversed the denial for untimely claim filing and paid $158.16, including late claim interest. The provider's contract was not located in the system that the appeals area normally uses to locate exceptions to the provider contract. As of January 1, 2012, all Aetna Student Health contracts are loaded into the system in the same manner as every other contract; therefore, this is not an issue going forward. Analysts are trained to review the provider exception database as well as the contract system for provider exceptions to the timely filing contract provisions.

The Company conducted an internal review of provider disputes received from Stanford Hospital & Clinics for the review period and reconsidered 18 provider disputes that were denied for late filing. The Company reprocessed 17 instances which resulted in the issuance of 17 corrected denial letters. It overturned one denial resulting in the payment of $285.85 to the provider, including late claim interest, as a result of the examination.

In April 2011, the Company implemented a Quality Analyst position to analyze trends, identify root causes, recommend improvements and mentor individual employees. The Company implemented a new initiative named HERO (Helping Employees Refine and Obtain Essential Skills) that provides staff with an additional vehicle to request claims instruction in specific situations and to provide coaching on actual claims in question.

65. In 22 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

65(a). In 20 instances involving claims for physical therapy, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. In six of the 20 instances, the Company failed to promptly review additional medical information it received from the treating provider. In five of the 20 instances, the Company delayed its procedure to request additional medical information. In four of the 20 instances, the Company failed to adhere to its procedure to send follow-up letters for the requested additional information. In four of the 20 instances, the Company failed to investigate whether or not the member had creditable coverage. In one of the 20 instances, the

Company failed to conduct a prompt investigation of the provider's dispute over the Company's request for reimbursement of an overpayment.

Summary of the Company's Response to 65(a): The Company states it has since liberalized protocols concerning medical necessity reviews of physical therapy for the 2011-2012 plan year and these services are no longer subject to review. The Company reprocessed claims resulting in payments to providers totaling $2,235.83, including late claim interest that was calculated from the date the initial claim was received.

The Company states that in March 2011, it created a Claim Inventory Manager role whose responsibilities include daily monitoring of inventory reports to ensure timely handling of all claim volumes, assigning priority processing of claims at risk of delay to the examiner responsible for the school, and counseling supervisors whose examiners are not completing claims timely. In addition, in April 2011, the Company implemented a Quality Analyst position to identify trends and review correct claims procedures with processors.

65(b). In two instances, the Company failed to request the proper look-back period in its request for additional information.

Summary of the Company's Response to 65(b): The Company agrees. The Company states that in March 2011, it created a Claim Inventory Manager role whose responsibilities include daily monitoring of inventory reports to ensure timely handling of all claim volumes, assigning priority processing of claims at risk of delay to the examiner responsible for the school, and counseling supervisors whose examiners are not completing claims timely. In addition, in April 2011, the Company implemented a Quality Analyst position to identify trends and review correct claims procedures with processors.

66. In 18 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. In 11 of the instances, the Company processed the claim at a lower benefit percentage or a lower tier than specified in the policy. In six instances, the Company underpaid the provider's contracted rate to two participating providers: California Emergency Physicians Medical Group and Marshall Medical Center. In one of these instances, the Company underpaid the Reasonable & Customary (R & C) rate. In one instance, the Company misapplied a deductible to the claim. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: As a result of the examination, the Company issued payments totaling $5,064.54 to correct 11 of the errors in which it failed to process claims at the correct benefit or tier level.

For the six identified instances in which it underpaid either the provider's contracted rate or the R & C rate, the Company issued corrected payments prior to the

examination as a result of a dispute filed by the provider of service. The Company agrees it did not review all of the claims submitted by California Emergency Physicians Medical Group (CEPMG) at the time the provider appeal was being resolved.

The Company states it completed an internal audit of claims from these providers in January 2012. As a result of this project, the Company issued additional payments to two CEPMG and Marshall Medical Center, totaling $725.48. The Company also conducted an internal audit of all claims submitted by the identified providers to ensure that contracts are loaded correctly and future updates to provider contracts reflect accurate claims pricing. A claims workgroup was formed to ensure that Company records are updated through provider updates on an ongoing basis. Claims were adjusted according to provider negotiated rates.

To correct the error in applying the deductible, the Company issued a $500.00 payment to the provider. The Company states it reviewed correct claims procedures with claims processors in November 2011.

67. <u>In 17 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.</u> The Department alleges these acts are in violation of CIC §790.03(h)(3).

67(a). In eight instances, the Company failed to adopt and implement a procedure to adjudicate the claim in the event the Company has not received all requested information.

<u>Summary of the Company's Response to 67(a):</u> The Company states it modified its system in February 2012 such that it automates the denial process for both members and providers when the requested information is not received within 90 days, allowing the generation and completion of three inquiry requests. In November 2011, the Company revised its procedures to ensure that a proper investigation is performed within 30 days.

67(b). In seven instances, the Company failed to adopt and implement its procedure to acknowledge a paper claim from either a provider or from a member.

<u>Summary of the Company's Response to 67(b):</u> The Company states the process for acknowledging California paper claims submitted by a provider was handled out of the Company's offices in San Diego until November of 2009, at which time the Company closed that office and moved those claim operations to other Aetna offices. In March 2011, the Company discovered that the process for acknowledgement of California provider paper claims had not been transferred when the San Diego office closed. Due to inadvertent error, neither the data in the tracking system nor the process for acknowledging paper claims was appropriately transferred to another location. The Company corrected the error effective April 2011 and implemented this process through

its Bedford, New Hampshire office. Therefore, acknowledgement records are available after that date.

During its review of the acknowledgement process for providers, the Company also discovered that there were no procedures in place for acknowledging Aetna Student Health paper claims submitted by a member. In December 2011, the Company implemented a daily report process to identify member and provider paper claims that require acknowledgement. It adopted an enterprise-wide acknowledgement letter process whereby the system automatically creates an acknowledgement letter for mailing.

67(c). In two instances, the Company failed to follow its procedure to resolve an appeal. In one of the instances, the Company's response failed to address questions raised by the member's appeal regarding continued use of medical equipment. In the second instance, the Company failed to acknowledge the provider appeal in accordance with its procedures. The provider appeal was received by the Company on August 2, 2010, and the Company responded on September 30, 2010.

Summary of the Company's Response to 67(c): The Company states it reviewed with the analyst who handled the appeal the correct procedure to respond in the resolution letter to all questions and comments raised by the appellant. The Company states it adopted an enterprise-wide acknowledgement letter process whereby the system automatically creates an acknowledgement letter for mailing.

68. In five instances, the Company failed to provide a clear explanation of the computation of benefits. The Company failed to provide the correct remark text that would explain the adjudication of the claim. In one such instance, the EOB incorrectly advises the member that the plan of benefits excludes coverage for the services of an assistant surgeon. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states it used incorrect denial codes in error that triggered incorrect or irrelevant explanatory text on the EOB. On April 18, 2012, the Company provided instruction on assigning remark codes and on sending out revised EOBs when errors in remark codes are identified. The Company also implemented a new remark code when adjusting previously processed claim and allowing additional benefits. In May 2012, the Company created a new remark code that indicates that the assistant surgeon's procedure code does not match the surgeon's procedure code.

69. In three instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

69(a). In two instances, the Company misstated the facts of the investigation to the member.

Summary of the Company's Response to 69(a): The Company states that in April 2011, it implemented a Quality Analyst position to analyze trends, identify root causes, recommend improvements and mentor individual employees. The Company implemented a new initiative named HERO that provides staff with an additional vehicle to request claims instruction in specific situations and to provide coaching on actual claims in question.

69(b). In one instance, the Company adjudicated a claim based on policy language that is unclear as to the payment of such charges. The brochure/policy states non-par anesthesia surgical expenses are covered at 60% of R&C and it also states non-par anesthesia expenses are covered at 25% of the surgery allowance. The brochure/policy does not state that the latter refers to the physician fees and the former refers to the facility and material fees. The claim was processed and the appeal was adjudicated at 25% of the surgeon's allowance. The policy language is ambiguous for anesthesia expenses.

Summary of the Company's Response to 69(b): The referenced Pepperdine University brochure is from the 2009-2010 plan year. Aetna Student Health subsequently updated the Pepperdine brochure for the following plan year, 2010 – 2011, to more clearly identify coverage of anesthesia expenses.

70. In three instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. The Company failed to disclose the policy provision that the insured has the right to an Independent Medical Review (IMR) following a denial on the basis the service is not medically necessary. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: While the Company has revised its member EOBs to include notice of IMR rights, the Company believes that its prior process was consistent with California law and regulations. The Company provided the notice of IMR rights for denial, modification or delay of a service that fit the criteria for IMR in member EOBs. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013.

71. In three instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. The Company continued to request additional information after it had received such information following an earlier request. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees it inadvertently persisted in seeking information not required to the resolution of the claim. This occurred due to claims processor error. This claims processor no longer works for the Company.

In April 2011, the Company implemented a Quality Analyst position to analyze trends, identify root causes, recommend improvements and mentor individual employees. The Company implemented a new initiative named HERO that provides staff with an additional vehicle to request claims instruction in specific situations and to provide coaching on actual claims in question.

72. In two instances, the Company failed to record the date the Company received, processed, transmitted or mailed every relevant document pertaining to the claim. The Department alleges these acts are in violation of CCR §2695.3(b)(2) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: Aetna Student Health was not on the Electronic Claims Handling System (ECHS) imaging system platform at the time of these claims. In February 2010, the Company converted to the standardized Aetna mail receipt process (allows all provider claims to be submitted electronically) to better ensure consistent capture of the received date. Paper claims are imaged by ECHS.

73. In one instance, the Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. The Company did not respond timely to an appeal from a provider regarding the Company's request for reimbursement of an overpayment. The Department alleges this act is in violation of CIC §790.03(h)(2).

Summary of the Company's Response: The Company recognizes the delay and has reviewed the correct procedures for sending an acknowledgement letter with the analyst involved in handling this appeal.

74. In one instance, the Company failed to maintain hard copy files or maintain claims files that are accessible, legible and capable of duplication to hard copy for five years. The Company failed to maintain a copy of an e-mail pertaining to the claim. The Department alleges this act is in violation of CCR §2695.3(b)(3) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states it is not able to locate the e-mail. Company now uses ECHS System to maintain and process correspondence and medical records. ECHS creates a paperless environment allowing multiple users the ability to view and route the same document for handling and consistent workflow thus eliminating reliance on emails to communicate determinations.

75. In one instance, the Company failed to provide in its written denial a reference to and explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions. The Company failed to provide the reason the services were denied as not medically necessary. The Department alleges this act is in violation of CCR §2695.7(b)(1) and is an unfair practice under CIC §790.03(h)(13).

Summary of the Company's Response: In order to ensure future compliance, in March 2015, the Company created a separate denial letter that indicates the basis as to why the services were not medically necessary. A copy of the template letter was provided to the Department.

76. In one instance, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department alleges this act is in violation of CCR §2695.7(b)(3) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that an incorrect decision letter was used by the appeal analyst. The Company has reviewed the correct procedures with the analyst involved in handling this appeal.

ACCIDENT AND DISABILITY
Individual & Group Health / Dental

June 1, 2007 – May 31, 2008
Summary Sections 77 – 92

77. In 31 instances, the Company failed to advise the insured of the right to an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: While the Company has revised its member EOBs to include notice of IMR rights, the Company believes that its prior process was consistent with California law and regulations. Notice of IMR rights was provided in member EOBs for denial, modification or delay of a service that fit the criteria for IMR. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013.

78. In 27 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

78(a). In 26 dental claims under an individual health plan, the Company provided misleading information regarding the insured's right to appeal the final determination. The EOB advises that the insured has the right to bring a civil action under section 502(a) of ERISA, if applicable. No determination was made that such individual policy is subject to ERISA.

Summary of the Company's Response to 78(a): While the Company disagrees that the ERISA rights conveyed on its EOBs misstated policy provisions, the Company has revised the language to clarify that holders of Individual health plan policies do not have a right to appeal under ERISA. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013. The new language that was implemented is:

> If you do not agree with the final determination on review, and if you are a member of a group plan, you may have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

78(b). In one instance, in responding to an appeal from the insured, the Company's Regional Manager of the Executive & Regulatory Resolution Team informed the member that his medical claim records on file do not indicate coverage was denied. The Manager advised the insured in the letter to submit claims for consideration under the medical plan. The letter contradicts the fact the Company had denied the member's medical claims two times previously.

Summary of the Company's Response to 78(b): The Company responded that this was a very complicated case in which the member filed a medical claim for teeth restoration due to radiation treatment. The claim was denied due to medical plan exclusions. An appeal was filed which was upheld and the appeals uphold letter quoted the specific medical exclusion(s) that apply. The member then filed a pre-determination with dental which was processed and approved. The situation was complicated and confusing to the member; however, ultimately the services were covered and paid. While the Company agrees that mistakes were made, those mistakes were isolated incidents due to the complex nature of this case. The Company believes there is no corrective action applicable to this unique situation.

79. In eight instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In five instances, the Company failed to promptly update its policy status records resulting in the improper denial of the claim. In three instances, the Company's Customer Service Representative (CSR) provided incorrect benefit or member-eligibility information to the provider which resulted in the improper denial of the claim. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees in five instances the members' files were not updated which resulted in the improper denial of the claims. Eligibility information for the plan is received electronically; however, in these instances, it was received via facsimile. While this does not negate the incorrect denial, it has resulted in the Company's developing additional procedures for non-standard delivery of eligibility information. Because eligibility information is received via facsimile infrequently, the Company is tracking and verifying this eligibility information to ensure that proper updates have been completed. The Company corrected three of the

errors prior to the examination in response to the member's appeal. The Company reprocessed two additional claims and paid $83.50 directly to the member on May 23, 2013.

In the three instances in which the CSR provided incorrect benefit or member eligibility information resulting in a claim denial, the Company overturned all three of the denials prior to the examination in response to an appeal from the member or provider.

As a result of these findings, the Company has reinforced policy provisions at its regularly scheduled department meetings.

80. In six instances, the Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim. Four instances pertain to the remark text on the EOB. The fifth instance pertains to the content of the May 26, 2008 appeal resolution denial letter sent to the member which fails to explain how the policy provision, Mouth, Jaws and Teeth, circumstances for treatment due to injury, applies to the claim presented for reconstructive and prosthetic dental services following radiation treatment. The sixth instance pertains to the February 12, 2008 resolution letter to an appeal for dental treatment under the member's medical plan. The appeal resolution denial letter references the policy exclusions and limitations of the member's dental plan, but fails to reference the member's medical plan. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company agrees in three instances that the claims processor applied the incorrect remark code to the EOB which does not accurately reflect the exclusion. The Company provided feedback to the claims processor who handled the case and reprocessed the claims to produce corrected EOBs. To ensure compliance, the Company reviewed policies and procedures in place to handle these types of scenarios.

In two instances identified as the fifth and six instances above, the Company referred to its response to section 78(b) indicating that it believes this was the same appeal case. In its response, the Company agrees the claim was complicated and confusing to the member although the services were ultimately covered and paid. While the Company agrees that mistakes were made, those mistakes were isolated incidents due to the complex nature of this case. The Company believes there is no corrective action applicable to this unique situation.

In one instance pertaining to a remark code, this claim was processed by one of Aetna's affiliated companies, Strategic Resources Company (SRC). The claim system used by SRC when this claim was processed in 2007 did not support detailed descriptions. Today a claim of this type would be processed by the Company's claim payment system ACAS. The ACAS claim payment system provides all claim details including the specific reason for denial. Therefore, in the event this claim was denied

today, the EOB would include a full description of the service that was performed, along with a statement explaining that the service performed is not covered by the member's plan.

81. <u>In six instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.</u> In four instances, the Company failed to request additional information that was reasonably required to resolve the claim or to resolve an appeal prior to the denial or to the adverse decision. In two instances, the Company failed to coordinate the internal communication and processing of claims between its medical and dental claim units for dental services that would fall under the medical plan. These failures resulted in processing delays and in the denial of claims. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> Regarding the four instances that were denied without requesting additional information omitted by the provider, the Company agrees that a proactive call should have been initiated at the time of processing for the additional information needed to process the claim. Aetna's standard handling is to make a proactive call to the appropriate party in order to obtain information that has been omitted by the provider. Reinforcement of the proactive call policy will occur at the regularly scheduled department meetings. Feedback has been provided to the analyst who handled this case. A review will be performed of the policies and procedures in place to handle these types of scenarios to ensure compliance. As a result of the examination in one of these four instances, the Company paid $1,070.95 for anesthesia charges plus interest.

As a result of the delays that occurred in the handling of the combined dental and medical claim in two instances, the Company revised its Policy and Procedure on December 8, 2009, regarding oral surgery dental customer service scripting. The revised procedure requires CSRs and claims processors to forward correspondence to the Oral and Maxillofacial Center of Excellence when the member has both medical and dental coverage with the Company. The Company provided the Department with a copy of the most recent revision of the procedure dated May 14, 2013.

82. <u>In five instances, the Company failed to include in its notice of a contested or denied claim that either the insured or the provider may seek a review by the Department and/or failed to include in its notice the address, the Internet Website address and telephone number of the unit within the Department that may review the denial on behalf of the insured or the provider.</u> The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees. This omission was identified and corrected by Aetna in November of 2009.

83. In five instances, the Company failed to acknowledge receipt of claim from the provider within 15 working days. The Department alleges these acts are in violation of CIC §10133.66(c) and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response: The Company agrees with the Department's findings. For claims processed on the same platform, the Company has since assigned a team to generate acknowledgement letters daily by due date. On May 23, 2013, the Company also reviewed the current acknowledgement process for claims handled by SRC, an Aetna company, and concluded the process appears compliant. However, the Company moved the process to a manager for tighter controls in ensuring letters get sent and inventory remains stabilized. In order to continue to improve the process, a quality check of a sampling of claims will be done monthly to ensure letters are being sent; if gaps continue, the Company will perform additional root cause analysis.

84. In five instances, the Company failed to respond to communications within 15 calendar days. The Company failed to respond timely to the member's appeal, failed to respond timely to a complaint letter chronicling multiple unanswered inquiries, and failed to respond timely to a pre-determination request letter from the dental provider, failed to respond to the member's written plea for assistance from the Company, and failed to respond timely to telephone inquiries from the member. The Department alleges these acts are in violation of CCR §2695.5(b) and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response: The Company agrees with the Department's findings to all five incidents. The Company routinely re-trains appeal analysts about reading appeal letters, identifying all issues in the dispute and addressing all the issues in the resolution letters. The Company conducted one of these training sessions by July 1, 2013.

85. In four instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company states the appeal process involves coordination between the appeals unit and the claim processing unit. In these instances, the appeals processor forwarded the claims to the claim area for processing; however, verification of payment was not completed timely.

The Company amended its process to track all claims, including claim reprocessing as a result of an appeal, to ensure that these payments are handled in a timely manner. The claim area Team leaders have access to several reports that are

monitored daily; and these reports focus on claim aging and identification of any potential issues that may impact claim turnaround. The appeal area also monitors the claim and reprocessing following the appeal determination.

86. <u>In four instances, the Company failed to pay interest on a contested claim after 30 working days.</u> All four instances involve the late reprocessing of denied claims that were overturned upon appeal. The Department alleges these acts are in violation of CIC §10123.13(c) and are unfair practices under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> As a result of this examination, the Company paid $344.78 in late claim interest to four providers. The Company has amended its process to track all claims, including claim reprocessing as a result of an appeal, to ensure that these payments are handled in a timely manner. The claim area Team leaders have access to several reports that are monitored daily; and these reports focus on claim aging and identification of any potential issues that may impact claim turnaround. The appeal area also monitors the claim and reprocessing following the appeal determination.

In addition, the Company conducted an internal survey involving all claims closed from June 1, 2007 through March 31, 2011. As a result of the survey, the Company issued payments identified in section 64(b) above.

87. <u>In three instances, the Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was contested.</u> The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings of three instances that a notification the claim was being contested was not sent within 30 days. The claims processor who handled the claims has been counseled regarding this requirement.

88. <u>In three instances, the Company failed to provide a clear explanation of the computation of benefits.</u> The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company agrees that the explanation of benefit statement does not clearly explain the computation of benefits. The Company implemented a new version EOB Statement in October 2011. A copy of the revised EOB was provided to the Department.

89. <u>In two instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.</u> In two instances, the Company paid less than the amount it approved for an out-of-network claim. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: As a result of the examination, the Company paid an additional $12.00 to the provider or practitioner to correct the underpayment of the approved amount for out-of-network charges. The Company believes these two incidents are isolated cases. The Company has a process in place to ensure that plans are set up correctly and timely, but the plan set-up error in this case was a single human error issue.

90. In one instance, the Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied. The Department alleges this act is in violation of CIC §10123.13(a) and is an unfair practice under CIC §790.03(h)(13).

Summary of the Company's Response: The Company agrees that the provider and the member were not notified within 30 days of the receipt of the claim that the claim was denied.

91. In one instance, the Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days. The member notified the Company in October 2007 that he wished to file a claim for dental reconstructive services. The Company provided claim forms in February 2008. The Department alleges this act is in violation of CCR §2695.5(e)(2) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that the requested claim forms were not sent in a timely manner.

92. In one instance, the Company failed to provide written notice of the need for additional time every 30 calendar days. In this instance, the Company denied the claim before requesting additional information. The Department alleges this act is in violation of CCR §2695.11(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with this finding that it did not follow the required 30-day timeframe to re-request the necessary information from the provider. The Company changed its procedure, effective August 30, 2011, for claims involving accidental injury. The current process is to consider these expenses and then to request information about the injury after the claim has been considered. The Company provided the Department a copy of its revised procedure for requesting accident details. For claims that involve situations other than accidental injury, the Company generates an initial request for information and sends follow-up requests at 30-day intervals. The Company provided a copy of its procedure for handling accident claims.

ACCIDENT AND DISABILITY
Individual & Group Health / Dental

June 1, 2008 – March 31, 2011
Summary Sections 93 – 103

93. In 48 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

93(a). In 45 claims individual health policy claims, the Company provided misleading information regarding the insured's right to appeal the final determination. The EOB advises that the insured has the right to bring a civil action under section 502(a) of ERISA, if applicable. No determination was made that such individual policy is subject to ERISA.

Summary of the Company's Response to 93(a): While the Company disagrees that the ERISA rights conveyed on its EOBs misstated policy provisions, the Company has revised the language to clarify that holders of Individual health plan policies do not have a right to appeal under ERISA. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013. The new language that was implemented is:

> If you do not agree with the final determination on review, and if you are a member of a group plan, you may have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

93(b). In two instances, the Company misstated a fact about the information needed to resolve the claim. In one instance, the Company issued an incorrect Summary Plan Document resulting in the underpayment of three claims incurred by one member.

Summary of the Company's Response to 93(b): In two instances, the Company agrees inaccurate information was provided to the member as to the reason for the denial. The information which was previously requested was requested from the member, not the provider. Effective November 16, 2009, the Company redesigned the remark to accurately display the reason for the denial on the EOB.

In the third instance, the Company issued additional payments as a result of the member's appeal. The Company does not agree that it misrepresented insurance policy provisions. The Company states that all members were provided a correct summary of benefits in their enrollment packets. The Company provided benefits for eligible expenses according to the Benefit Summary. The Benefit Summary accurately describes the coverage plan selected and purchased by the plan sponsor. The Company states it has not received additional appeals or issues raised by the plan

sponsor or the plan participants which would indicate they did not receive the coverage that they purchased.

94. <u>In 48 instances, the Company failed to advise the insured of the right to an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.</u> The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

<u>Summary of the Company's Response:</u> While the Company has revised its member EOBs to include notice of IMR rights, the Company believes that its prior process was consistent with California law and regulations. Notice of IMR rights was provided in member EOBs for denial, modification or delay of a service that fit the criteria for IMR. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013.

95. <u>In 14 instances, the Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim.</u> The Company's explanatory denial remark on the EOB states that "Filling-1 Surface" is not covered. Such remark does not explain the basis for the denial of a non-amalgam filling and it does not explain that "Filling-1" is not an amalgam restoration. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

<u>Summary of the Company's Response:</u> The Company agrees the explanatory remark code did not explain the basis for the denial of the "Filling-1 Surface". The Company implemented a complete redesign of the member explanation of benefits in October of 2011. The remark for the denial of a non-amalgam filling as "Filling-1" has been replaced with "Resin-Based Composite". The Company provided the Department with a sample of the redesigned EOB.

96. <u>In four instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.</u> Two instances involve an appeal from the member and an appeal from the provider disputing the denial because they had relied on information obtained in a telephone coverage call with the Company. The member proceeded with composite fillings to four front teeth as a result of being told that fillings were a covered benefit; the claim was denied as the policy covers only amalgam fillings. Likewise, the provider rendered orthodontic treatment as a result of a telephone benefits inquiry; however, the Company did not disclose a one-year waiting period for orthodontic treatment. The appeal resolution letter states the Company regrets any inaccuracy or misinterpretation of benefit information provided verbally or via the automated system. Therefore, these two instances were a result of detrimental reliance. In one instance, the Company applied an incorrect service code that resulted in a wrongful denial, which the Company

corrected prior to the Department's review. In one instance, the Company failed to resolve one of the issues raised in the provider's dispute. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: Regarding the first instance, the Company states it cannot confirm what question was actually asked about the types of fillings. The Company relies upon several factors: first, that the member is familiar with their plan; second, that the provider is clear about the procedure being performed; third, that the member would obtain the information needed before moving forward with the procedure. The Company states there was no clear evidence of detrimental reliance. The Company believes its records are accurate and the provider in each instance acted upon generalized questions and answers about the member's benefits. Additionally, the Company states specific services and coverages were not discussed. Nonetheless, as a result of the examination, the Company reconsidered and paid $853.48 plus interest.

Regarding the second instance, the Company provided archived telephone documents that indicate benefits for orthodontics were quoted in February 2009. There is no indication the provider requested any information about a waiting period and that only basic benefits questions were asked. On May 28, 2009, the waiting period was quoted as a result of the denial. The Company states there was no clear evidence of detrimental reliance. The Company believes its records are accurate and the provider in each instance acted upon generalized questions and answers about the member's benefits. Additionally, the Company states specific services and coverages were not discussed. Nonetheless, as a result of the examination, the Company reconsidered and paid $91.58 plus interest.

In the third instance, the Company agrees the claim should not have been denied. The Company corrected the error prior to the examination and within the review period.

In the fourth instance, Aetna agrees the services rendered on the second date of service were not addressed on the provider resolution letter dated October 13, 2009. This was identified as a result of this examination. The Company subsequently reviewed the second date of service for consideration. Although the determination was upheld, the Company resolved the provider's dispute on May 13, 2012 and provided the Department with the explanatory resolution letter and EOB that were sent to the provider and to the member.

97. In three instances, the Company failed to include in its notice of a contested or denied claim that either the insured or the provider may seek a review by the Department and/seor failed to include in its notice the address, Internet Web site address, and telephone number of the unit within the Department that may review the denial on behalf of the insured or the provider. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that each letter does not reference the CDI. This omission was identified by Aetna and corrected in November of 2009.

98. In three instances, the Company failed to provide written notice of the need for additional time every 30 calendar days. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that these claims were handled out of compliance with CCR §2695.11(d) in that the Company failed to provide an additional communication to the claimant within 30 days of the Company's notification that additional information was required for the Company to make a determination on the claim. The Company conducts weekly training sessions to refresh required processes. Weekly training refreshers include prompt-pay and interest requirements, and claim received-date processes. Any new information on regulations is also included in the Company's weekly trainings which are also ongoing.

99. In two instances, the Company failed to include in its notice of a contested claim the portion of the claim that was contested and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees the remarks on the member's EOB did not include the specific reason for the denial. The member did not receive a letter under separate cover as a letter was sent only to the provider. On December 4, 2012, the Company implemented a new remark text to read:

> We have asked your provider for more information. When we get this, we will consider this charge."

100. In one instance, the Company failed to pay interest on a contested claim after 30 working days. At the time the contested claim was re-processed, the Company failed to include interest. The Department alleges this act is in violation of CIC §10123.13(c) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: As a result of the examination, the Company paid the provider $2.06 in late claim interest. Refresher training is conducted weekly, which includes reminders about late claim interest, among other subjects.

In addition, the Company conducted an internal survey involving all claims closed from June 1, 2007 through March 31, 2011. As a result of the survey, the Company issued payments totaling $88.30.

101. <u>In one instance, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.</u> The Company failed to obtain the orthodontic history prior to denying the claim. The Department alleges this act is in violation of CCR §2695.7(d) and is an unfair practice under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company agrees that in this instance it failed to investigate as required under CCR §2695.7(d) and CIC §790.03(h)(3). Pursuant to the discovery of these errors, refresher training on the subject of orthodontic claims processing was conducted in February, April, and November of 2011.

102. <u>In one instance, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.</u> The Department alleges this act is in violation of CCR §2695.7(g) and is an unfair practice under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> The Company states the Coordination of Benefits was not administered properly on this claim. The provider's contracted rates should have been used as the allowable amount on both services; but this rate was applied to only one of the services resulting in an error in the amount paid to the provider. As a result of this inquiry, the claim was reprocessed on October 31, 2011, including interest, to release the additional $7.00 due the provider.

The Company believes this is an isolated incident. Pursuant to the discovery of this error, refresher training on the subject of Coordination of Benefits was conducted in May 2010, July 2010, and September 2010.

103. <u>In one instance, the Company failed to provide a clear explanation of the computation of benefits.</u> Specifically, the Company failed to provide the correct date of service in its original EOB issued to the provider on the subject claim. The Department alleges this act is in violation of CCR §2695.11(b) and is an unfair practice under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company acknowledges this finding. The charges associated with the sample claim required the claim processor to manually input the claim. It was determined that the procedures in place for inputting this type of claim were the cause of the date discrepancy. There were no system related issues found. The procedures were revised and will negate future date discrepancies.

<u>ACCIDENT AND DISABILITY</u>
<u>Health / Rescission</u>

January 1, 2006 – May 31, 2008
Summary Sections 104 - 117

104. In 56 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

104(a). The Department identified 38 instances in correspondence sent to the member in which the Company misrepresented the Pre-existing Conditions provision of the policy. The Pre-existing Conditions provision of the policy states a pre-existing condition is excluded during the first six months of coverage following the effective date. In each cited instance, the Company stated a pre-existing condition is excluded during the first 12 months of coverage following the effective date.

Summary of the Company's Response to 104(a): As a result of the Department's examination of the Company's health rescissions in the review period June 1, 2008 to March 31, 2011, the Company states it has removed all information about pre-existing conditions from all correspondence that is sent to the member from the rescission review team as of January 2012. Multiple resources such as the certificate of coverage, the Aetna Pre-existing Policy, and the request for the claimant's information of creditable coverage correctly define the pre-existing language.

104(b). In 18 instances, the Company provided misleading information regarding the insured's right to appeal the final determination. Specifically, the EOB advises the insured has the right to bring a civil action under section 502(a) of ERISA, if applicable. No determination was made that such individual policy is subject to ERISA.

Summary of the Company's Response to 104(b): While the Company disagrees that the ERISA rights conveyed on its EOBs misstated policy provisions, the Company has revised the language to clarify that holders of Individual health plan policies do not have a right to appeal under ERISA. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013. The new language that was implemented is:

> If you do not agree with the final determination on review, and if you are a member of a group plan, you may have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

105. In 18 instances, the Company failed to complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy. The policy was rescinded based on the practice of post claims underwriting. With regard to 18 rescinded policies, these allegations are based on the Company's response to the Department's Rescission Questionnaire and/or to an audit inquiry in conjunction with the examination of the Company's rescission procedures and claims practices. The Department alleges these acts are in violation of CIC §10384 and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company responded as follows:

Since April of 2007, Aetna has voluntarily refrained from conducting retroactive reviews of California members who are enrolled in our Aetna Advantage Plans for Individuals and Families. In light of our medical underwriting processes, as outlined below, Aetna is resuming the practice of retroactive review in California and is providing [the Department] with notice of this activity.

We feel confident that our underwriting process meets California requirements to refrain from post-claim underwriting. The following description illustrates our commitment to conducting complete medical underwriting at the time of application, and a thorough review prior to making a decision that is effective retroactively:

- Aetna resolves unanswered questions or ambiguous information with the applicant during the underwriting process.
- Aetna reviews commercially available prescription drug information for each applicant and compares it to the applicant's responses on the application to confirm accuracy and completeness.
- Aetna conducts telephone interviews with applicants and/or requests medical records to resolve questions and to evaluate an applicant's existing medical conditions, as needed. The phone interviews we conduct are performed by health care professionals, not actuaries or underwriters. We document our findings and evaluate the risk of the medical conditions that exist prior to rendering an underwriting decision.
- Following approval for individual coverage, Aetna returns a copy of the paper application to applicants and requests that they contact us immediately with any medical information they may have omitted when they submitted the application.
- When conducting retroactive review for potential rate increase or rescission, Aetna limits reviews to information voluntarily submitted by the insured immediately after approval or to claims incurred within the first 6 months of the effective date of the policy.
- Aetna has a well-documented review policy which requires our staff to promptly and consistently engage the insured during each step of the review process so we may rapidly obtain and act on all information that is relevant to the insured's case.
- If Aetna determines that a policy should be rescinded based on the findings of the retroactive review process, we supply the insured with the adverse findings in writing and provide the information he/she will need to initiate an appeal, if desired.
- As part of the appeals process, Aetna led the industry with establishing an independent third party review process for rescissions in 2008. This third party review is made available to any insured whose policy is rescinded, even if they have already elected to pursue an internal

appeal directly with Aetna. We make the independent third party review available at no cost to the applicant.

Although the Company disagrees with the Department's conclusion, given that the Company no longer performs retroactive underwriting rescissions due to the requirements of current laws under Health Care Reform, no remedial measures are necessary.

106. <u>In 16 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.</u> The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

106(a). In 15 instances, the Company did not begin an investigation within a reasonable time following the date the Company received the event that triggered an eligibility review.

<u>Summary of the Company's Response to 106(a):</u> The Company agrees that some of the investigations were not as timely as they could have been, but this type of situation no longer exists. These cases were prompted by consumers who may have misrepresented their health condition on their application. The Company investigations were triggered by claim activity that raised red flags. The Company is no longer in the Individual market in California, as has not been since 2013. This type of investigation activity is unique to that product and is therefore no longer a Company practice in California. Also, the Company no longer rescinds Individual Policies in states where it is in the market. For these reasons, the Company believes there is no corrective action that is applicable to this finding.

106(b). In one instance, the Company failed to follow its procedure to send the final advisory to the member that the policy will automatically be rescinded within 15 days for lack of cooperation.

<u>Summary of the Company's Response to 106(b):</u> The Company agrees that in one instance it failed to follow its procedure to send the final advisory to the member informing them that the policy will automatically be rescinded within 15 days for lack of cooperation. Given that the Company no longer performs retroactive underwriting rescissions as noted above, no remedial measures are necessary.

107. <u>In 11 instances, the Company failed to furnish the provider with a clear explanation of the basis upon which it was believed the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.</u> Specifically, the explanations of benefits sent to the provider following the rescission of the policy contain the following explanatory remark: *Our records show the member's coverage went into effect after the date this service was performed.* The remark fails to explain the basis for the reimbursement request. The Department alleges these acts are in violation of CIC §10133.66(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that the remark code used did not accurately address the specific situation. The remark code that should have been used reads: "Our records show that your health plan coverage ended before you received these services."

Given that the Company no longer applies pre-existing conditions to any of its individual plans, nor does it perform retroactive underwriting rescissions due to current laws as noted above, no remedial measures are necessary.

108. In 10 instances, the Company authorized payment for health care services and rescinded the authorization after the provider(s) rendered the services in good faith. The Department bases these allegations on the Company's written answers to the Department's Rescission Questionnaire and/or to an audit inquiry in conjunction with the examination of the Company's rescission procedures, policy files, and claims practices. The Department alleges these acts are in violation of CIC §796.04 and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company advised that as a result of the examination findings, it reviewed questionnaires, claim and call history, including other related records, to determine whether additional monies were due for services that were authorized. In response to the Department's request for internal survey results, the Company advised:

> The survey is complete but decisions have not been reached. At this point the Company is not prepared to agree to the violations.

In response to the Department's inquiry about whether the Company agrees with the violations as well as the results of the survey, the Company stated it continues to disagree that its actions were in violation of CIC §796.04 and CIC §790.03(h)(5).

Nonetheless, while fully reserving its legal position and rights, the Company is willing to address potential harm to providers that furnished pre-authorized services to patients whose individual policies were rescinded. The services for these claims occurred between 2006 and 2010 and the Company does not know whether the affected providers have or have not been paid. Additionally these members are not in the Company's enrollment system and, because the Company no longer has these products, the Company does not have the ability to add them into a claims system.

For these reasons the Company will take the following actions:

- Within 90 days of the close of the report, the Company will send a letter to each of the approximately 80 affected providers to inquire whether the provider's records show amounts due in connection with the services, providing the necessary detail to identify the patient and the dates of service.

- If within 90 days, the provider responds that there are monies owed, the Company will, within 90 days pay the amount that would have been payable by the Company had the policy not been rescinded, or such other amount as may be mutually agreed upon by Aetna and the provider.
- The Company will report the amounts paid to the Department within 30 days of the completion of the project.

109. In eight instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company believes these late claim payments were isolated incidents. Pursuant to the discovery of these errors, refresher training on the subject of late claims processing was conducted in February, April, and November of 2011.

110. In five instances, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed. Specifically, the Company failed to document the basis of its decision to retro-accept the policy. The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges these findings. Given that the Company no longer performs retroactive underwriting rescissions due to current laws under Health Care Reform, no remedial measures are necessary.

111. In four instances, the Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. Of the four instances: one involved the failure to acknowledge receipt of additional health history from the member for consideration following issuance of coverage; one involved the failure to resolve an appeal from the member within a reasonable amount of time; one involved the failure to acknowledge the receipt of an appeal by the member, and one involved the failure to acknowledge receipt of an appeal from a provider's attorney. The Department alleges these acts are in violation of CIC §790.03(h)(2).

Summary of the Company's Response: The Company acknowledges all findings. The Company has already carried out a corrective action plan to prevent internal delays. Specifically, as of June 24, 2008, the Company delivered a decision tree to its Customer Resolution Team regarding pathways for triaging cases for review. On an ongoing basis, the Company counsels its analysts individually when their cases are resolved beyond the timeframes of state regulatory requirements. As an additional corrective measure, in September 2010, all appeals related to underwriting decisions

were moved to the Company's centralized Complaints, Grievances and Appeals unit. As of June, 2014, this unit became responsible for all underwriting related appeals.

112. In four instances, the Company failed to include in its notice of a contested or denied claim that either the insured or the provider may seek a review by the Department and/or failed to include in its notice the address, Internet Website address, and telephone number of the unit within the Department that may review the denial on behalf of the insured or the provider. The Company did not include information in the rescission letter as to how the insured may contact the California Department of Insurance for assistance. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees. This omission was identified and corrected by Aetna in November of 2009.

113. In four instances, the Company failed to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company completed refresher training to its processors on this subject by May 30, 2013. In addition, the claims processors took the required Title 10 training during the summer of 2013. The Company provided the Department with a copy of its standard procedure on this subject.

114. In two instances, the Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was contested. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees to both instances of this finding; however, the Company believes these are isolated incidents.

115. In one instance, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Specifically, the Company failed to pay the claim for medical services rendered by a treating provider in the amount of $70.00. The basis for the continued denial is unclear in that the Company received requested information from both the member and the provider. The Company received the same information from medical records obtained through the Company vendor, RSA. The Department alleges this act is in violation of CIC §790.03(h)(5).

Summary of the Company's Response: As a result of this isolated finding, the Company re-processed and issued payment in a total amount of $19.06 including interest.

116. In one instance, the Company failed to provide a clear explanation of the computation of benefits. In this instance, two of the pages of the EOB do not explain how benefits were calculated. The Department alleges this act is in violation of CCR §2695.11(b) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The claim was paid under a case rate which is a rate that is negotiated with a facility for specific procedures. On an EOB, a case rate is reflected on one line; the other lines related to that claim appear as not paid because they are included in the case rate. To communicate case rate payments more clearly in the future, the EOBs were amended in February 2010 with the addition of two new codes, as follows:

Member EOB wording: The payment for this service is included in the Contracted and/or Case Rate paid to the provider. You are not responsible for this amount.

Provider EOB wording: This charge is included in the contracted and/or case rate. No additional payment will be made for this service.

117. In one instance, the Company failed, upon contesting a claim under CIC §10123.13, to affirm or deny the claim within 30 calendar days from the original notification. The Company notified the insured on November 7, 2006, that claims against the policy are contested and will remain unpaid subject to completion of the investigation. The Company received the insured's medical records on November 30, 2006. The Company notified the insured of the policy rescission and ensuing denial of claims on January 29, 2007. The Department alleges this act is in violation of CCR §2695.11(d) and is an unfair practice under CIC §790.03(h)(4).

Summary of the Company's Response: The Company agrees to this finding; however, the Company believes this is an isolated incident.

ACCIDENT AND DISABILITY
Health / Rescission

June 1, 2008 – March 31, 2011
Summary Sections 118 - 123

118. In 31 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue.

118(a). In 29 instances, the Company misrepresented the Pre-existing Conditions provision of the policy. Each letter stated that a pre-existing condition is

excluded during the first 12 months of coverage following the effective date. The Pre-existing Conditions provision of the policy states a pre-existing condition is excluded during the first six months of coverage following the effective date. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response to 118(a): The Company states it has removed all information about pre-existing conditions from all correspondence that is sent to the member from the rescission review team as of January 2012. Multiple resources, such as the certificate of coverage, the Aetna Pre-Existing Policy, and the request for the claimant's information of creditable coverage, correctly define the pre-existing language.

118(b). In two instances, the Company provided misleading information regarding the insured's right to appeal the final determination. Specifically, the EOB advises the insured has the right to bring a civil action under section 502(a) of ERISA, if applicable. No determination was made that such individual policy is subject to ERISA.

Summary of the Company's Response to 118(b): While the Company disagrees that the ERISA rights conveyed on its EOBs misstated policy provisions, the Company has revised the language to clarify that holders of Individual health plan policies do not have a right to appeal under ERISA. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013. The new language that was implemented is:

> If you do not agree with the final determination on review, and if you are a member of a group plan, you may have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

119. In seven instances, the Company failed to complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy. The policy was rescinded based on the practice of post claims underwriting. The cited instances pertain to the seven policies that were rescinded during the review period. These allegations are based on the Department's examination of the member's application for health coverage, the Company's underwriting guidelines, the Company's written and oral communication with the applicant prior to policy-issuance, underwriting file notes, and all other documents contained in each file.

These seven instances included: the failure to request medical information from a physician identified either on the application or during a telephone interview by the applicant as having treated or examined the applicant prior to the date of the health statement; the failure, during a pre-issuance telephone interview, to question the applicant about prescription drugs that were not disclosed on the application and which appeared on a report completed by a vendor; the failure to discuss or query the applicant in a telephone interview or conversation about medical history; the failure to contact the agent/broker as part of the investigation; the failure to confirm whether or

not prior coverage indicated by the applicant was creditable; and the failure to resolve inconsistencies or inquire into missing or incomplete information. The Department alleges these acts are in violation of CIC §10384 and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company respectfully disagrees with the Department's conclusion. Aetna's handling of these cases was consistent with a rigorous underwriting process which the Company is confident meets California requirements to refrain from post-claim underwriting. In each of these cases, Aetna reasonably believed that it had completed the underwriting process, and only after Aetna had approved the application and coverage had taken effect, did Aetna become aware of new information which led to a rescission decision. Additionally, in none of these cases would additional information about any prior coverage have affected the decision. In none of these cases was information provided on the application or during a follow-up phone interview reasonably suggesting additional questions which would somehow have resulted in Aetna's learning about the separate and independent condition which ultimately was the basis for its rescission decision.

The following description illustrates the Company's commitment to conducting complete medical underwriting at the time of application, and a thorough review prior to making a decision that is effective retroactively:

- Aetna reviews commercially available prescription drug information for each applicant and compares it to the applicant's responses on the application to confirm accuracy and completeness.
- Aetna resolves unanswered questions or ambiguous information with the applicant during the underwriting process.
- Aetna conducts telephone interviews with applicants and/or requests medical records to resolve questions and to evaluate an applicant's existing medical conditions, as needed. The phone interviews we conduct are performed by health care professionals, not actuaries or underwriters. We document our findings and evaluate the risk of the medical conditions that exist prior to rendering an underwriting decision.
- When conducting retroactive review for potential rescission, Aetna limits reviews to information voluntarily submitted by the insured immediately after approval or to claims incurred within the first 6 months of the effective date of the policy.
- Aetna has a well-documented review policy which requires our staff to promptly and consistently engage the insured during each step of the review process so we may rapidly obtain and act on all information that is relevant to the insured's case. The process includes sending four letters each of which affords the applicant the opportunity to review and respond to discrepancies between the information provided on the application and information which reasonably should have been

disclosed based upon our subsequent learning of a material health condition.

- As part of the appeals process, Aetna provides the opportunity for the applicant to request an independent third party review, at no cost, and with the understanding that Aetna will abide by the results of that independent review.

Although the Company disagrees with the Department's conclusion, given that the Company no longer performs retroactive underwriting rescissions due to current laws under Health Care Reform, no remedial measures are necessary.

120. In five instances, the Company failed to include in its notice of a contested or denied claim that either the insured or the provider may seek a review by the Department and/or failed to include in its notice of a contested or denied claim the address, Internet Web site address, and telephone number of the unit within the Department that may review the denial on behalf of the insured or the provider. Specifically, Company failed to include the street address of the Department in its denial letters to the member. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees. This omission was identified and corrected by Aetna in November of 2009.

121. In three instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The Company did not begin the rescission review process within a reasonable time following the date the Company received the event that triggered an eligibility review. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: In the beginning of 2011, the timeliness of the Rescission investigation was identified as an area for improvement. As a result, a number of improvements were developed and implemented. These improvements include:

- Implementation of enhanced reporting to identify high priority cases, thus allowing reviews to be more focused and timely
- Changes in work assignments and review criteria to support more timely reviews
- Reporting changes to organize cases by state to allow the team to prioritize reviews by state. Specific to California, in accordance with regulation, California cases are prioritized and are researched by the team first.

These changes are fully implemented and working well. The timeliness of California reviews and investigations have improved.

122. <u>In two instances, the Company authorized payment for health care services and rescinded the authorization after the provider(s) rendered the services in good faith.</u> In two rescinded policies, the Company requested and recovered payments from a provider for services authorized by the Company. In both rescission cases, the Company stated that it issued a written authorization to the requesting provider for services, that it had paid claims for the authorized services, and that it had recovered an overpayment from the provider. The Department alleges these acts are in violation of CIC §796.04 and are unfair practices under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> The Company advised that as a result of the examination findings, it reviewed questionnaires, claim and call history, including other related records, to determine whether additional monies were due for services that were authorized. In response to the Department's request for internal survey results, the Company advised:

> The survey is complete but decisions have not been reached. At this point the Company is not prepared to agree to the violations.

In response to the Department's inquiry about whether the Company agrees with the violations as well as the results of the survey, the Company stated it continues to disagree that its actions were in violation of CIC §796.04 and CIC §790.03(h)(5).

Nonetheless, while fully reserving its legal position and rights, the Company is willing to address potential harm to providers that furnished pre-authorized services to patients whose individual policies were rescinded. The services for these claims occurred between 2006 and 2010 and the Company does not know whether the affected providers have or have not been paid. Additionally these members are not in the Company's enrollment system and, because the Company no longer has these products, the Company does not have the ability to add them into a claims system.

For these reasons the Company will take the following actions:

- Within 90 days of the close of the report, the Company will send a letter to each of the approximately 80 affected providers to inquire whether the provider's records show amounts due in connection with the services, providing the necessary detail to identify the patient and the dates of service.
- If within 90 days, the provider responds that there are monies owed, the Company will, within 90 days pay the amount that would have been payable by the Company had the policy not been rescinded, or such other amount as may be mutually agreed upon by Aetna and the provider.
- The Company will report the amounts paid to the Department within 30 days of the completion of the project.

123. In one instance, the Company failed to furnish the provider with a clear explanation of the basis upon which it was believed the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. Following the rescission of the policy, the Company's request for reimbursement from the provider states that the Company's records show the member's coverage went into effect after the date the service was performed. The explanatory text is inaccurate and, therefore, does not provide a clear explanation of the basis for such request. The Department alleges this act is in violation of CIC §10133.66(b) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that the incorrect remark code was used in this instance. The code that should have been used reads: "Our records show your health plan coverage ended before you received these services." This situation no longer exists. The Company no longer applies pre-existing to any of its individual plans, nor does it perform retroactive underwriting rescissions due to current laws under Health Care Reform.

ACCIDENT AND DISABILITY
Individual and Group Health

June 1, 2007 – May 31, 2008
Summary Sections 124 – 142

124. In 54 instances, the Company failed to advise the insured of the right to an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: While the Company has revised its member EOBs to include notice of IMR rights, the Company believes that its prior process was consistent with California law and regulations. Notice of IMR rights was provided in member EOBs for denial, modification or delay of a service that fit the criteria for IMR. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013.

125. In 35 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

125(a). In 24 instances involving an Individual health plan, the Company provided misleading information regarding the insured's right to appeal the final determination. Specifically, the EOB advises the insured has the right to bring a civil action under section 502(a) of ERISA, if applicable. No determination was made that

such individual policy is subject to ERISA. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response to 125(a): While the Company disagrees that the ERISA rights conveyed on its EOBs misstated policy provisions, the Company has revised the language to clarify that holders of Individual health plan policies do not have a right to appeal under ERISA. The new language was implemented on February 10, 2013. The new language that was implemented is:

> If you do not agree with the final determination on review, and if you are a member of a group plan, you may have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

125(b). In 10 instances, the explanatory remarks on the EOB sent to the member or provider misstate the reason for the denial, misstate the information needed to resolve the claim, or misrepresent the status of the investigation.

Summary of the Company's Response to 125(b): The Company agrees in all instances that the remark code used did not accurately address the specific situation. This situation no longer exists. The Company no longer applies pre-existing to any of its individual plans, nor does it perform retroactive underwriting rescissions due to current laws under Health Care Reform.

125(c). In one instance, the Company provided the member with incorrect plan benefit information which resulted in denied and misapplied charges when the claims were processed.

Summary of the Company's Response to 125(c): The Company implemented refresher training to ensure that customer service representatives and provider service representatives communicate and clearly define details regarding benefit plans and coverage. The re-training focused on call content, documentation of calls, and established procedures for call handling. The Customer Service Center and the Provider Service Center conduct monthly call evaluations based on randomly recorded calls.

126. In 28 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Specifically, the Company incorrectly denied 28 claims. The Department alleges these acts are in violation of CIC §790.03(h)(5).

126(a). In 13 instances, the Company incorrectly denied a claim as a duplicate submission although it had not been processed previously.

Summary of the Company's Response to 126(a): The Company reprocessed the 13 referenced claims prior to the claims practices examination as a result of the provider's request for reconsideration. The Company has reiterated to all claims

processors the procedure to review Duplicate Submission guidelines and other policy guidelines before denying as a duplicate. The Company provided the Department with a copy of its coding and processing instructions.

126(b). In three instances, the Company incorrectly denied the claim for failure to obtain pre-authorization although the provider or member had obtained pre-authorization or was advised by the Company that pre-authorization was not needed.

Summary of the Company's Response to 126(b): The Company agrees it incorrectly denied claims in three instances. The Company overturned two denied claims upon appeal because the authorization record had not been transmitted from its vendor, MedSolutions, to the Company; but the services had been pre-authorized. The Company overturned the third denied claim upon appeal because the Company incorrectly told the provider the services did not require an authorization.

The Company developed an action plan to review member eligibility rosters to identify any discrepancies which may affect claims processing. Management also monitors all incoming and outgoing files to resolve issues that may have an impact on claim processing. The Company's program manager meets with MedSolutions monthly to discuss operational issues with regard to pre-authorization of services.

126(c). In three instances involving claims processed by SRC, an Aetna company, the Company incorrectly denied the claim as a treatment for a pre-existing condition after it received proof the claim was not subject to the pre-existing condition exclusion.

Summary of the Company's Response to 126(c): The Company states it coded its system incorrectly. The Preexisting Condition Policy and Preexisting Condition Diagnostic list used by SRC, an Aetna company, were not in line with Aetna policy. Policy updates were made on July 28, 2010, to the preexisting condition exclusion list of diagnostic codes and to the criteria for preexisting condition investigation. The Company reversed the coding and reprocessed one of the claims on the corrected basis prior to the examination. The Company reprocessed the two remaining claims relating to the diagnostic coding error, a result of the Department's inquiry, and issued payment of $64.88 to the provider.

126(d). In three instances, the Company incorrectly denied a claim as the result of a failure to maintain the correct premium billing record, a failure to use the correct date of service, and a failure to identify that the prescribed drug is covered under the plan.

Summary of the Company's Response to 126(d): The Company states two errors occurred due to incorrect data entry of the claim. Specifically, an incorrect date of service was input and the terminated coverage was selected instead of active coverage, although the claim form indicated the plan was active. This resulted in the claim denial. The Company provided the Department with a copy of its policy regarding

claim submissions and trouble-shooting electronic claim submissions. The third error occurred due to an eligibility issue. The Company provided a copy of its updated policy to reinforce eligibility procedures.

126(e). In two instances, the Company incorrectly denied charges incurred for complications of pregnancy on the basis of the normal pregnancy exclusion.

Summary of the Company's Response to 126(e): The Company states that an edit rule in the claims system was in place that would drop possible complications of pregnancy claims to the processor for manual review; however, the sample claim did not edit because the diagnostic codes on the claim were not contained within the edit rule. The edit rule became moot and was eliminated on July 1, 2012 because all California plans began covering maternity on that date. The Company reprocessed the claims upon appeal from the provider prior to the examination.

126(f). In two instances, involving the reprocessing of claims following an appeal, the Company failed to reprocess all charges submitted with the claim. In the first instance, upon receipt of the provider's claim resubmission, the Company failed to reprocess all related preventive care services in its payment; the member's appeal triggered the reprocessing of the remaining related charges. In the second instance, following receipt of the provider's appeal that included proof the claim was filed timely, the Company failed to reprocess charges for six of the procedures performed on the same date.

Summary of the Company's Response to 126(f): In the first instance, the Company states the member contacted the Company which triggered a second reconsideration of the claim; however, the claim recalculation did not encompass recalculation all of the related preventative care services that were previously allowed to the deductible. The additional services in the amount of $2,553.35.were paid prior to the start of the examination. This payment included interest. In the second instance, as a result of the examination, the Company paid an additional $57.13 to correct the error. The Company has reiterated with its claims processing staff adherence to the guidelines set forth in the policy document regarding preventative care. The Company provided a copy of its Preventative Care policy document to the Department.

126(g). In one instance, the Company failed to enter into its claims system the additional amount agreed upon between the provider and the vendor, Global Claim Services (GCS). The failure resulted in unpaid claims for which the provider submitted an appeal in order to receive payment of the additional amount.

Summary of the Company's Response to 126(g): The Company states it cannot explain the reason the additional payments agreed upon were not entered into the claim system for processing. The Company re-conveyed to its claims processing staff the procedure for the handling of facility charges and the reprocessing of claim resubmissions.

126(h). In one instance, the Company overturned the denial upon appeal from the member on the basis that it communicated incorrect benefit information to the provider.

Summary of the Company's Response to 126(h): The Company agrees the CSR did not communicate the 12-month waiting period requirement to the provider. As a result of the examination, the Company paid $243.11 to the provider to correct the error. To address this issue, and to ensure that Customer Service Representatives and Provider Service Representatives communicate details regarding benefit plans and clearly define coverage, the Company has implemented refresher training. The focus of this re-training is on call content, documentation of calls, and established procedures for call handling. In addition, the Company re-conveyed to its claims processing staff the procedure for the handling of facility charges and the reprocessing of claim resubmissions.

127. In 28 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The examination revealed errors in the investigation of claims, member appeals, provider disputes, and provider requests for reconsideration.

In 19 instances pertaining to a pre-existing condition investigation, the Company either failed to designate the appropriate look-back period when requesting medical information from the provider, or failed to designate the correct diagnostic code for the condition under investigation, or failed to begin a pre-existing condition investigation within a reasonable time, or failed to request medical information from both the provider and the member, or failed to resolve conflicting responses regarding a pre-existing condition. In five of these 19 instances, SRC, an Aetna company, failed to identify the date of service on the pre-existing condition questionnaire that was sent to the provider.

In eight instances involving a member appeal or a provider dispute, the Company either failed to forward the additional information promptly to the appeal area for consideration, or failed to evaluate the appeal information promptly, or failed to obtain additional information prior to the denial of claim that triggered the appeal. In one of these eight instances, the Company failed to complete an investigation of the diagnostic procedures prior to the denial of charges for Intensity Modulated Radiation Therapy (IMRT) for the treatment of cancer and failed to investigate the two provider appeals relating to this claim within a reasonable time. In one of these eight instances, the Company failed to obtain additional information prior to the denial of claim that triggered the appeal. Although the physical therapy maximum had been met, the provider submitted bills and chart notes, which were not investigated to determine medical necessity prior to the denial of claims.

In one instance, the Company failed to investigate whether the member's coverage was primary or secondary prior to denying the claim. The claim was pended to determine if there was any other coverage and then without sending any previous correspondence to the member, the claim was denied with no further investigation.

The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges it failed to conduct a thorough investigation of a pre-existing condition in 19 instances.

Of the 19 instances, the Company stated it would re-open four pre-existing condition investigations. For two of the instances, the Company stated it would forward a revised questionnaire with corrected information to the provider and re-assess the claim upon receipt of the completed questionnaire. In one of these two instances, the Company stated re-opening of this case was not indicated as the eligible amount would have been applied to the deductible if the services were determined to be non-pre-existing. If determined to be pre-existing, the charges would have been denied. In either case, no benefit was available for the services rendered. In the second instance in which a revised questionnaire was sent, the claim was reopened and paid. For the third instance in which the Company failed to resolve conflicting responses regarding a pre-existing condition, the Company (SRC handled claim) indicated it would ask the provider for additional information to resolve the inconsistency. The Company further stated it would resolve the investigation by September 30, 2013. In the Company's most recent response of March 30, 2016, the Company states that given the inconsistent responses, the claim remained in a denied status for that reason. In the fourth instance, the Company sent a letter to the referring provider and never received a response to its inquiry. Therefore, the claim remains denied for information not received.

The Company revised the pre-existing condition policy utilized by SRC on how to handle investigations when a provider or member sends in inconsistent data. The revision incorporates how to resolve inconsistencies and how to finalize investigations in a thorough, fair and objective manner. The Company also revised the content of the questionnaire including adding a field for the date of service of the claim that triggered the investigation. The revision of the SRC pre-existing condition policy and the revision to add a field for date of service to the questionnaire was completed by September 30, 2013.

The Company conducted re-training specific to the team dedicated to pre-existing condition claims, in March 2010. The Company also notes that the Affordable Care Act requires the Company to waive a pre-existing condition for members under the age of 19 which continues to be waived after their 19th birthday. This applies to insured, self-funded new business, and renewals on or after September 23, 2010, except for individual grandfathered policies.

The Company agrees in seven instances it failed to follow established investigative protocols relating to an appeal. Prior to the start of the examination, and effective June 24, 2008, the Company carried out a corrective action to prevent internal delays in the handling of appeals. The Company delivered a decision tree to its

Customer Resolution Team regarding pathways for triaging cases for review. On an ongoing basis, the Company counsels its appeal analysts individually when their cases are resolved beyond the timeframe of state regulatory requirements. The Company enhanced the systems and workflow processes regarding the handling of misdirected appeals and complaints to increase the accountability of both the complaint analyst and the appeal analyst. In addition, reports were developed to monitor the misdirected cases for the analyst to follow through to resolution. This process was scheduled to be implemented in all teams during the third quarter of 2008.

In the instance involving IMRT in which the Company agreed it failed to follow established investigating protocols relating to an appeal, the claim was denied without a review by a Medical Director because the processor did not route the claim to the Clinical Claim Review unit. In this same instance, the Company also failed to route two provider appeals to the Clinical Claim Review because the analyst did not follow the appropriate protocols. Ultimately, the Company considered the appeal and paid the claim. Effective April 30, 2007, the Company changed its procedures for handling IMRT claims. These claims no longer require Clinical Claim Review and instead are adjudicated with no processor intervention. Feedback has been provided to the claims department to review the policies in place when handling this type of service.

The Company disagrees with the one instance that it failed to obtain additional information prior to denying the claim that triggered the appeal. The claim in question was denied because the number of physical therapy visits were greater than the number allowed for the given time period. Additional visits were subject to a review for medical necessity which was conducted upon appeal. The claim was eventually paid after an appeal investigation was completed.

The Company disagrees with the one instance that it failed to investigate whether the member's coverage was primary or secondary prior to denying the claim. The Company states it pended the claim for a coordination of benefits and then denied the claim when no information was received. The claim was eventually paid as a result of the member calling in to advise the Company that there was no other coverage.

Although the Company disagrees with the one allegation pertaining to a provider dispute, and to the one allegation pertaining to investigation of primary or secondary coverage, both claims were isolated incidents and both were eventually paid. Therefore, no additional remedial measures are necessary.

128. <u>In 15 instances, the Company failed to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date.</u> The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings of 15 instances that it did not provide written notice of the need

for additional information every 30 calendar days. The Company has completed claim team Refresher Received-Date training in June of 2011. Weekly trainings now include prompt pay regulations, California interest requirements and claim received-date training. Furthermore, for claims handled by Strategic Resource Company, known as SRC, an Aetna company, refresh training of all personnel is done periodically to review workflows and policies, to ensure awareness of the need for accuracy and attention to detail, and to reinforce the importance of integrity of work product. The most recent training was conducted on January 14, 2013.

129. In 11 instances, the Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim. In seven EOBs issued to a member, the explanatory remark states that the denied charge is an expense for a pre-existing condition and also refers the member to the plan booklet for limitations. In two EOBs, the explanatory remarks do not explain that charges were denied due to the terms of the in-network provider's contract with the Company. In one EOB sent to the member, the explanatory remarks explain the time limit the provider has to submit a claim, but does not explain the time limit the member has to submit a claim. In one EOB, the Company denied the charges as experimental and, therefore, not medically necessary and failed to explain the reason the charges are considered experimental. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company acknowledges the findings in all identified instances.

The Company agrees that referring a member to their plan booklet without further explanation as to why a charge has been denied is not sufficient. The Company's current process provides details of the services which were denied and the reasons why the charges are not being covered.

The Company agrees that advising a member that a denial was due to the terms of the provider's contract is not sufficient. However, advising a member that a service is being paid at an agreed upon contracted rate, along with a statement that the member is not responsible for charges above that rate is appropriate and is currently done. The Company's current EOB messages clearly explain the member's financial responsibility, if charges are not being covered or not covered at the billed amounts, due to a provider's contract.

The Company agrees that advising a member that the provider has a time limit to submit a claim does not adequately explain that the insured has a time limit to submit a claim. However, the Company's current EOB messages clearly identify when a claim is being denied due to a time limit, and if the provider has exceeded that time limit, clearly advise the member that the claim is not their financial responsibility to pay. The member's time limit for submitting a claim is explained in their plan documents and does not apply to provider submitted claims.

The Company agrees that advising a member that a procedure is considered experimental does not explain the reason or reasons it is considered experimental. However, the EOB message together with the applicable Clinical Policy Bulletin is a complete explanation. In addition, the member's plan documents explain such denials and explain where to go for more information.

The Company reviews EOB remarks and changes are made often. Since the time period covered during this examination spans five years, and given that the end of that time frame was five years ago, the EOB's design, phrasing and remark language have gone through many changes.

130. In 10 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company provided feedback to the Customer Service Department to review the policies regarding appropriate routing procedures. The Company also completed claim team Refresher Received Date training in June of 2011. Weekly training includes prompt pay regulations, California interest requirements and claim received-date training.

131. In 10 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. Each occurrence is described below. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

- The Company denied the claim on the basis charges were provided by an out of network pharmacy after the member had first obtained the Company's approval of the pharmacy.
- The Company applied a co-payment to a service that is not subject to a co-payment.
- The Company failed to pay the full value of the claim.
- The Company underpaid the claim as a result of its having set up the employer plan sponsor records incorrectly.
- The Company underpaid the nonparticipating provider's rate.
- The Company underpaid the provider's contracted rate.
- The Company failed to process the claim in accordance with policy provisions. This instance was identified in the Company's response to an audit inquiry. The company reprocessed the claims to reflect the correct benefit level on January 20, 2008.
- The Company failed to process emergency services at the non-negotiated rate.
- The Company underpaid the amount of interest owed on a claim by basing the calculation on the date of the second submission of the claim rather than on the first date the claim was received. This instance was identified in the Company's

response to an audit inquiry.

- The Company failed to process the claim at the preferred in-network rate.

Summary of the Company's Response: The following responses correspond to each instance, presented in the same order as above:

- The Company overturned the denial upon appeal from the member and reprocessed the claim as charged by a participating pharmacy.
- The Company corrected the error internally and released a benefit of $20.79 equal to the co-payment plus interest prior to the examination.
- The Company paid an additional $520.20 prior to the examination. The Company states the claim should have been processed and the denied amounts paid when the first reconsideration occurred as part of the Company's "hold-harmless" policy. The claim processor did not follow this policy; therefore, feedback and training was provided to claim processors to avoid repeat errors.
- The Company identified that some plan sponsor records had been set up incorrectly which resulted in a subset of claims not being paid at the appropriate rate. The Company has updated those plan sponsor records and has reprocessed the affected claims resulting in additional claims payments amounting to $912.73 as a result of the examination.
- The Company reviewed the claim upon receipt of the provider's request for reconsideration and determined that the claim had not been adjudicated correctly, resulting in an underpayment of the contracted provider's rate. The Company reprocessed the claim and issued an additional payment of $24.94 prior to the examination.
- The Company reimbursed the amount it underpaid the provider's contract rate by $123.78 as a result of the examination.
- The processing error occurred after a corrected claim was received. The processor failed to rework all of the charges at 100%. The Company reprocessed the claims to reflect the correct benefit level resulting in an additional claim payment of $2,553.35 including late claim interest prior to the examination.
- The Company re-processed the claim for emergency services at the non-negotiated rate, including interest, prior to the examination.
- The Company underpaid the amount of interest owed on a claim by basing the calculation on the date of the second submission of the claim rather than on the first date the claim was received. The error was discovered internally and a supplemental payment was made prior to the examination.
- The Company subsequently reconsidered the claim at the in-network rate. The error was discovered internally and a supplemental payment was made prior to the examination.

As a remedial measure to ensure future compliance, the Company advises:

The Company has completed weekly refresher training specific to Pre-Existing conditions (emphasis on pended claims and requests for Pre-Existing information) and applying the correct benefit level (emphasis on Preferred or Non-preferred level of benefits). The claim examining staff will be reminded to refer to the attached policy and procedure documents on these subjects which clearly convey the appropriate claim processing instructions.

132. <u>In nine instances, the Company failed to respond to communications within 15 calendar days.</u> Specifically, in five of the instances, the Company failed to respond to telephone calls from a provider requesting the status of the appeal. In four of the instances, the Company failed to acknowledge receipt of the claim from the member, failed to acknowledge receipt of the appeal from the member, failed to respond to a letter from the member, and failed to respond to a telephone call from the member within 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(b) and are unfair practices under CIC §790.03(h)(2).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings. The Company's corrective action includes implementation of a process to enter all paper claims into the system at the point of receipt and route them electronically through the system rather than forward the paper claim to the correct location. This eliminates the risk of lost paper and allows for an electronic monitoring of claim to completion as the claims will appear on the inventory report from the date of its entry into the system. The Company provided the Department with a copy of this written procedure.

To correct errors made by the administrator known as SRC, an Aetna company, Aetna put in place a claims inventory manager in February 2013 specifically to scrutinize the inventory, turnaround time of claims, and to address timely response to correspondence.

133. <u>In six instances, the Company failed to provide a clear explanation of the computation of benefits.</u> In one instance, the Company failed to explain to the insured the reason charges were reconsidered. In one instance, the Company failed to explain the basis for each amount allowed as reasonable and customary for charges made by a non-participating provider. In one instance, the Company failed to explain to the member that charges were reconsidered on an in-network basis when the original claim was processed on an out-of-network basis. In one instance, the Company failed to explain the reason the member is responsible for charges. In one instance, the Company failed to provide a payment record pertaining to the receipt and the processing of claims that resulted in the first payment. In one instance, the Company failed to issue an explanatory statement to the provider. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's response: The Company agrees in the first instance that it failed to explain the reason charges were reconsidered. When performing the claim reconsideration, the claim processor did not apply the appropriate coding to generate an explanatory comment on the explanation of benefits statement.

In the remaining instances, the Company continues to believe its EOBs to be clear and complete. However, the Company's current EOB messages clearly explain the member's financial responsibility, if charges are not being covered or not covered at the billed amounts, due to a provider's contract. Additionally, the Company reviews EOB remarks and changes are made often. Since the time period covered during this examination spans five years, and given that the end of that time frame was five years ago, the EOB's design, phrasing and remark language have gone through many changes. Therefore, no additional remedial measures are necessary.

134. In five instances, the Company failed to acknowledge receipt of claim from the provider within 15 working days. The Department alleges these acts are in violation of CIC §10133.66(c) and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response: The Company agrees with the Department's finding of five instances. For claims processed on the same platform, the Company has since assigned a team to generate acknowledgement letters daily by due date. Claims management is reviewing reports of claims in date-order of receipt on a daily basis. They refer aging claims to processors for handling.

135. In four instances, the Company failed to include in its notice of a contested or denied claim that either the insured or the provider may seek a review by the Department and/or failed to include in its notice the address, Internet Website address, and telephone number of the unit within the Department that may review the denial on behalf of the insured or the provider. The Department identified the omission of this information from the Company's resolution letter sent following the processing of a provider dispute or a member appeal. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The letters were corrected in 2009 to include the dispute resolution language, which includes information on how the insured or provider may seek a review by the Department. However, the outbound correspondence system (OBC) was not updated to reflect the change at that time. Until that system could be updated, the analysts were instructed not to use that system for California letters; they were to use manual letters. However, some analysts may have used the system in error which resulted in the identified errors. The updates to OBC were made in April 2011. All California letters sent to members on insured, non-HMO plans currently have the dispute language. The Company provided the Department with a copy of its written policy and procedure to ensure the language is included in all letters.

136. <u>In four instances, the Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was contested.</u> The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company has completed claim team Refresher Received Date training in February of 2008 and in July of 2011 which includes procedures and timeframes for handling contested/unclean claims. Weekly training now includes prompt pay regulations, California interest requirements and claim received-date training. The Company provided the Department with its policy document referencing the requirements of California prompt payment laws.

137. <u>In four instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.</u> The Company's procedure in conducting a pre-existing condition investigation is to send a Pre-existing Condition Questionnaire to both the member and the provider, and it accepts a response from either party. The Company will adjudicate the claim based on which questionnaire is received first within 45 days, whether from the member or the provider. Of these four instances,

a. One involved the receipt of the questionnaire from the member, but the file was documented that adjudication would wait, pending receipt of the questionnaire from the provider.

b. One involved a questionnaire that was sent to the member, but not to the provider. As a result, the claim was denied because the Company had not received a response from the provider.

c. One involved the receipt of the questionnaire from the member, on both August 8, 2007 and on June 23, 2008. However, the Company continued to seek information from the provider.

d. One involved a questionnaire that was received from the provider. However, the Company continued to seek information from the provider.

The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company confirmed that its procedure is to adjudicate the claim based on whichever questionnaire is received first within the 45 day period, either the member's or the provider's.

The Company provided a response to one of the four instances. Regarding issue a. above, the Company advised that coverage was denied on September 12, 2007 because the Company had not received the requested information. The Company acknowledges, however, that it did receive the questionnaire from the member on

September 12, 2007, the same day as the denial. Although a response from the member had been received, the claim was not adjudicated until the Company received the questionnaire from the provider on January 17, 2008. Despite these occurrences, the Company denies that it did not follow its own procedures.

The Company did not respond to the other three instances identified by b., c., and d.

Despite the Company's disagreement with the one instance and its lack of response to the remaining three instances, given that the Company no longer applies pre-existing to any of its individual plans due to current laws under Health Care Reform, no remedial measures are necessary.

138. <u>In three instances, the Company failed to pay interest on an uncontested claim after 30 working days.</u> In three instances, the Company failed to include interest on the additional payment made on a claim as a result of a member appeal or a request for reconsideration from the provider. More specifically, the Company failed to include interest on the additional payment of $520.20 issued on March 24, 2008; failed to include interest on the additional payment of $24.94 made September 1, 2007; and failed to include interest on the claim payment made September 20, 2007. The Department alleges these acts are in violation of CIC §10123.13(b) and are unfair practices under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> The Company acknowledges these findings. As a result of the examination, all three claims were reopened and interest payments of $33.11, $76.54, and $130.44 were paid, respectively. Additionally, the Company regularly provides resources and training to claim processors to ensure that human errors are as infrequent as possible and that claims are paid accurately including payment of late claim interest.

139. <u>In three instances, the Company failed to resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.</u> The Department alleges these acts are in violation of CIC §10123.137(c) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company states that two of the requests were forwarded internally to the appropriate area for review and response; however, established protocols were not followed in these instances. To address this internal mishandling, the established protocols have been reviewed with the area handling these cases and feedback has been given to the employee who mishandled this particular case.

The Company agrees with the finding in the third instance. The initial and subsequent appeal should have been routed to Clinical Claim Review; however, the analyst did not follow the appropriate protocols. Feedback has been provided to the

Customer Service Department to review the policies regarding appropriate routing procedures. Weekly reports are generated to address appeals, from timeliness and resolution perspectives, to ensure appropriate handling and compliance.

140. In two instances, the Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company has completed claim team Refresher Received Date training in February of 2008 and in July of 2011 which includes procedures and timeframes for handling contested/unclean claims. Weekly training now includes prompt pay regulations, California interest requirements and claim received-date training. The Company provided the Department with its policy document referencing the requirements of California prompt payment laws.

141. In two instances, the Company failed to pay interest on a contested claim after 30 working days. The Department alleges these acts are in violation of CIC §10123.13(c) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees it did not pay interest on a contested claim after 30 working days in both instances. As a result of the examination, in one instance, the Company paid additional interest to providers in the amount of $8.68 to correct a failure to calculate interest from the date the claim with the updated diagnosis was received. The Company paid interest from August 20, 2007 rather than August 1, 2007. The Company provided feedback regarding the application of interest on reprocessed claims to the claim processor who handled these claims.

In the second instance involving an overturned denial of a prescription drug claim, the Company paid $.48 interest and stated it would perform a review of the policies and procedures in place to handle this type of scenario to ensure compliance with California requirements.

142. In two instances, the Company failed, upon contesting a claim under CIC §10123.13, to affirm or deny the claim within 30 calendar days from the original notification. In these instances, the Company failed to notify the insured whether or not the contested claim was accepted or denied within the regulatory timeframe. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(4).

Summary of the Company's Response: The Company agrees that it failed to notify the insured whether or not the contested claim was accepted or denied with the regulatory timeframe. These are two isolated instances due to human error. The Company has completed claim team Refresher Received Date training in February of 2008 and in July of 2011 which includes procedures and timeframes for handling contested/unclean claims. Weekly training now includes prompt pay regulations,

California interest requirements and claim received-date training. The Company provided the Department with its policy document referencing the requirements of California prompt payment laws.

ACCIDENT AND DISABILITY
Individual and Group Health

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143. In 116 instances, the Company failed to advise the insured of the right to an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: While the Company has revised its member EOBs to include notice of IMR rights, the Company believes that its prior process was consistent with California law and regulations. Notice of IMR rights was provided in member EOBs for denial, modification or delay of a service that fit the criteria for IMR. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013.

144. In 86 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

144(a). In 77 instances involving an Individual & Family health plan, the Company provided misleading information regarding the insured's right to appeal the final determination. The EOB advises the insured has the right to bring a civil action under section 502(a) of ERISA, if applicable. No determination was made that such individual policy is subject to ERISA. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response to 144(a): While the Company disagrees that the ERISA rights conveyed on its EOBs misstated policy provisions, the Company has revised the language to clarify that holders of Individual health plan policies do not have a right to appeal under ERISA. The Company provided the Department with a sample of the complete pre-printed language used on all EOBs effective February 10, 2013. The new language that was implemented is:

> If you do not agree with the final determination on review, and if you are a member of a group plan, you may have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

144(b). In nine instances, the explanatory remarks in the EOB or in an appeal resolution letter misstate a pertinent fact about the investigation of the claim or misstate a pertinent fact about the reason for the denial of the claim.

Summary of the Company's Response to 144(b): The Company agrees the EOB remark is an inaccurate statement of the status of the investigation in five instances and agrees the appeal resolution letter does not reflect proper handling of the appeal in four of the instances. During a regularly scheduled weekly training session in June of 2011, the Company re-instructed claims processing staff to access a link to assist them in selecting/applying the applicable remark code to the claim.

145. In 67 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Department alleges these acts are in violation of CIC §790.03(h)(5).

145(a). In 47 instances, the Company incorrectly denied the claim as a pre-existing condition after the Company had received proof the pre-existing condition exclusion would not apply to the claim.

Summary of the Company's Response to 145(a): The Company agrees these claims were denied in error. The Company states it misinterpreted the physician's response or incorrectly coded the member's file following its pre-existing condition investigation. As a result of this examination, the Company reprocessed the identified unpaid claims and issued payments totaling $20,234.92, of which $307.29 was allowed to members' deductibles. The payments included late-pay interest.

The Company conducted re-training specific to the claim team dedicated to pre-existing claims in April 2010. The Company also notes that the Affordable Care Act requires the Company to waive a pre-existing condition for members under the age of 19 which continues to be waived after their 19th birthday. This applies to insured, self-funded new business, and renewals on or after September 23, 2010, except for individual grandfathered policies.

145(b). In 15 instances, the Company incorrectly denied the claim as treatment for a pre-existing condition after the exclusionary period for a pre-existing condition had expired.

Summary of the Company's Response to 145(b): The Company agrees these claims were denied in error. As a result of this examination, the Company reprocessed the identified unpaid claims and issued payments totaling $1,585.23, of which $282.19 was allowed to members' deductibles. The payments included late-claim interest.

One error was an oversight of an examiner who failed to see that the member had coverage under two different plans with SRC, an Aetna company, and that prior creditable coverage existed. The Company has enhanced the system to allow searches

to be more flexible around this process. Personnel are periodically refreshed on workflows and processes to address these types of issues. The most recent refresh was completed January 14, 2013. Additionally, the Company conducted re-training specific to the claim team dedicated to pre-existing claims in April 2010.

The Company also notes that the Affordable Care Act requires the Company to waive a pre-existing condition for members under the age of 19 which continues to be waived after their 19th birthday. This applies to insured, self-funded new business, and renewals on or after September 23, 2010, except for individual grandfathered policies.

145(c). In one instance, the Company incorrectly allowed the charges to the member's deductible. The charges should have been paid without application of the deductible, according to the policy language. Following telephone contact from the member, the claim was reprocessed without application of the deductible.

Summary of the Company's Response to 145(c): The Company acknowledges this finding. The Company was contacted by the member requesting claim status and benefit inquiry. The claim processor, when reprocessing the routine claim noted that the associated anesthesia claim also required reprocessing. The anesthesia claim was reprocessed at that time.

145(d). In one instance, the Company incorrectly denied the claim due to an error of the provider's information in the Company's database.

Summary of the Company's Response to 145(d): The billing provider's information in its database was coded as a facility rather than as a group of radiologists. The Company conducted a project in 2010 to correct the billing provider's information in its database from being coded as a facility to being coded as a group of radiologists. The Company reworked all of the claims affected by this error in 2010.

145(e). In one instance, the Company appropriately denied the claim based on termination of the group policy and failed to reprocess the claim once the member's eligibility for continuous coverage was reinstated that would cover the date of service.

Summary of the Company's Response to 145(e): The Company states the claim was not reprocessed due to processor oversight in manually updating system records to reflect retroactive coverage when enrollment in continuation coverage was received. As a result of the examination, the Company reprocessed the claim and issued a payment to the provider for $136.42, including late claim interest, on May 17, 2013. The Company provided a copy of the provider's EOB as evidence of payment. The Company provided its policy on system set-up requirements, which allows eligibility to electronically pass to Aetna's eligibility and claim mainframe systems.

145(f). In one instance, the Company upheld a denial on appeal for an increased dosage of medication that was supported by documentation from the member's

physician. The Company did not review the documentation that was provided with the appeal and improperly denied the request for additional medication.

Summary of the Company's Response to 145(f): It appears the prescribing physician was attempting to put forth the opinion that Aetna's criteria for increased quantity limits were already met. Since the Medical Director who conducted the initial review is no longer with the Company, this appeal was re-evaluated by another Aetna Medical Director who states he would have approved the coverage. The Company has not approved the additional dosage as the member no longer has active coverage with Aetna.

The Company's Medical Directors are under supervision and are provided periodic training. Supervision includes audits of their decisions, including follow-ups as necessary to ensure that the Company's policies are followed. Such follow-up would have occurred in this instance if the Medical Director who made this decision were still with the Company.

145(g). In one instance, the Company improperly denied the claim on the basis the services were not covered under the plan.

Summary of the Company's Response to 145(g): As a result of the examination, the Company found that the claim had not been reprocessed following the decision to overturn the denial upon appeal from the member. The Company paid $62.40 to the provider of service including late claim interest in the amount of $14.37, as recorded in Summary section 150 below.

146. In 24 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. In 12 instances, the Company delayed the start of a pre-existing condition investigation and/or failed to request pre-existing condition information from the provider or the member. In four of these instances, the Company denied the claim as a pre-existing condition without having established that the claim was treatment for a pre-existing condition. In eight instances, the Company failed to review promptly additional information received and failed to update the system with the information received. In four instances, the Company failed to determine whether or not creditable coverage existed which could reduce or eliminate the pre-existing condition period. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the Department's findings in 12 instances and states that it did not follow its established procedures for investigating a potential pre-existing condition due to processor oversight. In April of 2010, the Company assigned an individual to handle pre-existing claims applicable to the findings associated with these instances. As of May 24, 2013, the Company is in the process of re-opening four of these claims for reconsideration that were inappropriately denied as a result of a failure to send the provider or member a questionnaire.

With regard to the review of additional information in eight instances, the Company states it did not follow its established procedure for the prompt review of additional information that is received. The Company reinforced this procedure with all claims processors handling pre-existing condition claims.

With regard to the determination of creditable coverage in four instances, the Company states that a dedicated team handles all pre-existing claims for Individual & Family health policies and that reviewing the member's application is part of the ordinary review process. In these instances, the Company states it failed to review its own records for creditable coverage and/or failed to send the member a letter/inquiry to obtain proof of prior creditable coverage. As a result of the examination, the Company verified prior coverage for one member and paid $7.71 following the reprocessing of the claim. In one instance, the Company states that while pulling claim records for this examination, the Company recognized that the member had prior coverage under an Aetna Individual & Family health plan and reprocessed the claim. The Company resolved the remaining two instances prior to the on-site examination.

For claims handled by SRC, an Aetna company, the Company has enhanced the system to allow searches to be more flexible around the process involving a pre-existing condition investigation. Personnel are periodically refreshed on workflows and processes to address these types of issues. System searches of members would be addressed during these trainings. The most recent refresh training was on January 14, 2013.

147. <u>In 14 instances, the Company failed to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date.</u> In eight instances, the Company failed to provide the written notice to the member. In six instances, the Company failed to provide the written notice to the provider. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings of eight instances that written notice of the need for additional time was not sent to the member every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date following receipt of the completed questionnaires.

The Company agrees with the Department's findings of six instances that written notice of the need for additional time was not sent to the provider every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date.

The Company provided refresher training to its processors by May 30, 2013. In addition, the claims processors took the required Title 10 training in the summer of

2013. The Company provided the Department with its policy document referencing the requirements of California prompt payment laws which includes procedures and timeframes for handling contested/unclean claims.

148. <u>In 12 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim.</u> The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5)

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings of 12 instances. As a remedial measure in one of these instances, the Company issued $42.04 to the provider, including late claim interest. The Company provided refresher training to its processors on this subject which was completed on May 30, 2013. In addition, the claims processors took the required Title 10 training during the summer of 2013.

149. <u>In 12 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.</u> Nine of the instances involve the provider's dispute that the Company underpaid the network provider's contracted rate. Seven of the nine instances pertain to one member. Upon appeal of the selected claim, the Company adjusted and paid the correct rate. Three of the instances involve the pricing of a claim. The Company sent the claim to a pricing vendor who offered to settle the claim for less than half of the amount charged. The provider declined the vendor's offer; however, the Company ultimately paid the full amount that was initially billed. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings in all instances. In the nine instances involving the provider's dispute, the Company stated it underpaid the provider's contracted rate due to processor oversight in applying the appropriate contracted rate. However, upon appeal, the Company adjusted and paid the correct rate. In the three instances involving the pricing of a claim, the Company indicated there were actually four instances. The provider signed the agreement, but because the provider altered the agreement to include the phrase "if paid in full", the Company states it should have considered the agreement to be null and void. This would have allowed consideration for all claims at the full billed charges. In actuality, the Company paid two of the claims at the negotiated rate and two at full billed charges. Because the member's coinsurance is a percentage of the allowed amounts, the member actually saved money on the two that were paid at the negotiated rate.

To ensure future compliance, the Company provided refresher training to its processors on this subject on May 30, 2013. In addition, the claims processors took the required Title 10 training during the summer of 2013 and every year thereafter.

150. <u>In 10 instances, the Company failed to pay interest on a contested claim after 30 working days.</u> In the reprocessing of a contested claim following receipt of information necessary to determine liability or in the reprocessing of a denied claim that is overturned on appeal, the Company failed to calculate interest from the correct date liability was determined or failed to include interest in the reprocessed claim payment that was not paid within 30 working days after it was determined to be payable. Specifically, in six instances, the Company failed to calculate the correct amount of interest because it utilized an incorrect date it received the claim as the basis for payment. In four instances, the Company failed to include interest on the reprocessed claim that was not paid within 30 working days of the date it determined liability. The Department alleges these acts are in violation of CIC §10123.13(c) and are unfair practices under CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings of all identified instances. In six of the instances, the Company agrees it underpaid or failed to pay interest because it used an incorrect date as the basis for the calculation at the time the claim was reprocessed for payment. As a result of the examination, the Company reprocessed claims in six instances and paid a total of $980.85 in interest to the provider. The Company re-emphasized the appropriate receipt date policy with the processor and also with all claims processing staff. In four of the instances, the Company agrees interest was not included in the reprocessing that was more than 30 working days from the date of acceptance. As a result of the examination, the Company paid $45.53 in interest to providers.

The Company conducts weekly training sessions to refresh required processes. Weekly training refreshers include prompt pay, interest requirements, and claim received-date processes. Any new information on regulations is also included in the Company's weekly trainings. To ensure additional compliance, effective August 1, 2014, the Company made improvements to its pre-certification process. The Company also modified its coordination of benefits handling guidelines effective August, 31, 2010, April 9, 2013, April 30, 2013, and July 7, 2015.

Additionally, in response to a concern the Company may have failed to pay interest in contested claims outside the sample files in the review period, the Company fully analyzed the root cause of the issue. Once the analysis was complete, the Company stated the application of an incorrect received date was not the root cause. Therefore, because the Company did not identify a systemic issue, but rather miscellaneous processor errors, the Company did not identify a unique claim set or a process to correct. Most situations were linked to research for pre-existing condition exclusions which are now prohibited under plans subject to the Affordable Care Act. For situations that currently exist, the Company believes that the weekly training sessions described above were the most effective way to provide prevent errors.

151. <u>In eight instances, the Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for</u>

denying the claim. In three instances, the explanatory text sent to the member and to the provider state that the expense is for a pre-existing condition and instructs the member and the provider to refer to the plan booklet for limitations. In one of these instances, the explanatory text states that pre-existing conditions are not covered during exclusion period.

In two instances, the EOB informs the member and the provider that the denial of the charges was based on information requested but not received, which was not the intended reason for the denial.

In two instances on the same claim, the Company failed to explain to the member and to the provider the specific reason(s) it determined the services were considered experimental or investigational and failed to reference the Company's Clinical Policy Bulletin (CPB) upon which it based its denial.

In one instance, the remark code on the EOB states the amount is not payable either because it is not a covered expense or because the member has already exceeded the maximum amount allowed.

The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company acknowledges the findings in all identified instances.

In the three instances pertaining to pre-existing claims, the Company stated the basis for the errors made on these three claims were due to the pre-existing pending/review/denial process. As this process no longer exists, because claims are no longer subject to a pre-existing condition review, there is no applicable corrective action the Company can take that would address the errors.

The Company agrees in two instances that the correct reason for the denial was not provided to the member and to the provider. Due to processor oversight, the sample claim should have been denied as not medically necessary, and not because additional information was not received. As a corrective measure, the Company reprocessed the claim and included the correct reason. The claim processing staff has been re-instructed to access a link to assist them in selecting and applying the applicable denial code to the claim. This link breaks down denial reasons by code and by category and clearly conveys the codes applicable to medical necessity denials.

In the two instances where the Company based the denial on the criteria found in the CPB, but failed to provide that criteria in the denial, the Company advises that today its handling of this claim would be different and would include the required detail.

In the one instance that a denial was issued because the member had reached the plan's annual dollar limit, the Company agrees that the explanation provided at the

time was insufficient. The situation that generated this EOB remark code no longer exists as no such limits exist on current member's plans.

152. <u>In seven instances, the Company failed to include in its notice of a contested or denied claim that either the insured or the provider may seek a review by the Department.</u> The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company agrees. This omission was identified and corrected in November 2009.

153. <u>In seven instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.</u> In three of the instances, the Company persisted in seeking additional information that was not required as it had received, or had access to through its own internal records, creditable coverage that would preclude the need for additional information. In three instances, the Company persisted in conducting a pre-existing condition investigation after it had paid uncontested claims submitted by the same provider for dates of service before and after the dates of service in question. In one instance, the Company persisted in seeking accident-related information for a claim that was submitted solely with an illness diagnosis. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of the Company's Response:</u> The Company agrees with the Department's findings of seven instances that information was requested and not required for the resolution of the dispute. The Company has a centralized pre-existing condition investigation team that is responsible for locating creditable coverage forms from previous carriers. The Company also updated its pre-existing policy on February 5, 2008. Additional training was completed in 2007 and in 2010 specific to pre-existing conditions. As noted elsewhere in this report, the law with respect to pre-existing conditions has changed since this time these corrective actions were taken.

154. <u>In four instances, the Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.</u> In these instances, the Company failed to respond to issues raised in the provider's dispute. More specifically, the Company failed to address the provider's status as a non-contracted physician, failed to respond to the provider's request for the name and board certification of the physician who makes the appeal determination, failed to respond to the provider's request for clinical documentation that was used by the deciding physician in the determination of the appeal, and failed to address whether or not the correct rate was used in the processing of the disputed claim. The Department alleges these acts are in violation of CIC §790.03(h)(2).

<u>Summary of the Company's Response:</u> The Company agrees the analyst did not address the issues raised in the providers' disputes. The Company states its policy requires a complete response to the substance of the appeal. The Company routinely

re-trains appeal analysts about reading appeal letters, identifying all issues in the dispute and addressing all the issues in the resolution letters. The Company conducted the next training session on this subject by July 1, 2013.

155. In two instances, the Company failed to include a statement to the provider in a contested or denied claim advising of its right to enter into the dispute resolution process described in CIC §10123.137. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that two resolution letters sent in response to a provider dispute did not include the notice of the provider's right to enter into the dispute resolution process. This omission was identified by Aetna and corrected in November 2009. However, the outbound correspondence system was not updated to reflect the change until April 2011 and analysts were instructed to use manual letters in the meantime. The analyst may have used the system in error which resulted in the two errors in June 2010 and March 2011.

156. In one instance, the Company failed to acknowledge receipt of claim from the provider within 15 working days. The error involves a paper claim processed by the administrator SRC, an Aetna company. The Department alleges this act is in violation of CIC §10133.66(c) and is an unfair practice under CIC §790.03(h)(2).

Summary of the Company's Response: The Company agrees this claim was not acknowledged within 15 working days; however, the Company believes this is an isolated incident. On May 13, 2013, the Company performed a review of the claim acknowledgement process and believes it is working effectively. In addition, the Company has assigned the process to a manger for tighter controls in ensuring letters are sent timely. In order to continue to improve the process, a quality-check of a sampling of claims will be done monthly, beginning in June 2013.

157. In one instance, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. When answering the member's questions during a telephone call, the Company did not disclose that assigning a policy effective date of November 15, 2010, would cause a lapse in creditable coverage. The member indicated on the application that prior coverage terminated on August 31, 2010. The Department alleges this act is in violation of CCR §2695.4(a) and is an unfair practice under CIC §790.03(h)(1).

Summary of the Company's Response: The Company has a centralized pre-existing condition investigation team that is responsible for locating creditable coverage forms from previous carriers. The Company also updated is pre-existing policy on February 5, 2008. Additional training was completed in 2007 and in 2010, specific to pre-existing conditions. As noted elsewhere in this report, the law with respect to pre-existing conditions has changed since this time these corrective actions were taken.