

**[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**

**SECURITY LIFE INSURANCE COMPANY OF AMERICA
NAIC # 68721 CDI # 2483-6**

AS OF APRIL 30, 2012

ADOPTED JUNE 17, 2014

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



June 17, 2014

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:

**Security Life Insurance Company of America
NAIC # 68721**

Group NAIC # 0492

Hereinafter, the Company listed above also will be referred to as SLICA 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 group Accident and Disability Dental claims closed during the period from May 1, 2011 through April 30, 2012. The examination was made to discover, in general, if these and other operating procedures of the Company conformed to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains all alleged violations of laws that were identified during the course of the examination.

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. 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 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 May 1, 2011 through April 30, 2012; a review of the previous CDI market conduct claims examination report on Security Life Insurance Company of America as of April 30, 2002; and a review of prior CDI enforcement actions.

The review of the sample of individual claims files was conducted at the offices of the California Department of Insurance in Sacramento, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The dental claims reviewed were closed from May 1, 2011 through April 30, 2012, referred to as the “review period”. The examiner randomly selected 70 claims files for examination. The examiner cited 235 alleged claims handling violations of the California Insurance Code and California Code of regulations from this sample file review.

Findings of this examination included failure 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; failure to include in its notice of a contested or denied claim the Internet Website address of the unit within the CDI that may review the denial on behalf of the insured or the provider; failure to advise the insured of the right to request 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; and failure to conduct its business in its own name.

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

The Company was the subject of zero California consumer complaints or inquiries closed from May 1, 2011 through April 30, 2012, in regard to the line of business reviewed in this examination.

The previous claims examination reviewed a period from May 01, 2001 through April 30, 2002. The most significant noncompliance issue identified in the previous examination report was the Company's failure to advise the claimant that he or she may have the claim denial reviewed by the California Department of Insurance (CDI). During the current examination, it was noted that claimant is now being notified of the right to have the claim denial reviewed by the CDI; however the CDI's internet website address was not included on the notice.

Security Life Insurance Company of America has not been the subject of a prior enforcement action by the CDI.

DETAILS OF THE CURRENT EXAMINATION

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

SLICA SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED CITATIONS
Accident and Disability / Group Health / Dental / Claims Paid	1,841	18	65
Accident and Disability / Group Health / Dental / Claims Denied / CWP	1,586	30	99
Accident and Disability / Group Health / Dental / Provider Appeals	15	15	44
Accident and Disability / Group Health / Dental / Patient Appeals	7	7	27
TOTALS	3,449	70	235

TABLE OF TOTAL CITATIONS

Citation	Description of Allegation	SLICA Number of Alleged Citations
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.	68
CIC §10123.13(a) *[CIC §790.03(h)(3)]	The Company 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.	68
CIC §10169(i) *[CIC §790.03(h)(1)]	The Company failed to advise the insured of the right to request 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.	68
CIC §880 *[CIC §790.03(h)(3)]	The Company failed to conduct its business in its own name.	26
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed to respond to communications within 15 calendar days.	2
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.	1
CIC §10133.66(c) *[CIC §790.03(h)(2)]	The Company failed to acknowledge receipt of claim from the provider within 15 working days.	1
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	1
Total Number of Citations		235

***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)(5) The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.

TABLE OF CITATIONS BY LINE OF BUSINESS

<p align="center">ACCIDENT AND DISABILITY DENTAL 2011 Written Premium: \$15,493,579 2012 Written Premiums: \$15,249,520</p> <p>AMOUNT OF RECOVERIES \$.58</p>	<p align="center">NUMBER OF CITATIONS</p>
CIC §10123.13(a) [CIC §790.03(h)(3)]	68
CIC §10123.13(a) [CIC §790.03(h)(3)]	68
CIC §10169(i) [CIC §790.03(h)(1)]	68
CIC §880 [CIC §790.03(h)(3)]	26
CCR §2695.5(b) [CIC §790.03(h)(2)]	2
CIC §10123.13(a) [CIC §790.03(h)(5)]	1
CIC §10133.66(c) [CIC §790.03(h)(2)]	1
CCR §2695.7(d) [CIC §790.03(h)(3)]	1
TOTAL	235

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 \$.58 as described in section number 6.

ACCIDENT AND DISABILITY

1. **In 68 instances, the Company 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, in these instances, the Company failed to include the Department's Internet Website address in the notice. 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 updated its explanation of benefits (EOB) to include the California Department of Insurance website. A Copy of the new EOB format was sent to the California Department of Insurance for review.

2. **In 68 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 updated its EOB to include advising of the provider's right to enter into the dispute resolution process.

3. In 68 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: The Company updated its EOB to include advising of the insured of the right to an independent medical review.

4. In 26 instances, the Company failed to conduct its business in its own name. The Department alleges these acts are in violation of CIC §880 and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The third party administrator has updated its letterhead and EOB to include Company name.

5. In two instances, the Company failed to respond to communications 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).

Summary of the Company's Response: The Company reviewed and enhanced its procedure to ensure timely acknowledgement of communications within 10 days of receipt of correspondence. The new procedure was implemented on January 15, 2013, and the internal documented procedure was revised on January 25, 2013. The procedure involves an automatic report to run starting seven days after receipt of correspondence in order to account for weekends and holidays. This will ensure acknowledgement of correspondence is done within 10 days after receipt. This is an automated process so no rollout or training was required.

6. In one instance, 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 original claim was processed timely; however, it was denied incorrectly due to a keying error. The claim was reprocessed and paid on December 9, 2011. The Company did not pay interest on the unpaid amount but has since paid the interest to the provider. The payment was made on January 11, 2013, in the amount of \$.58

7. **In one instance, the Company failed to acknowledge receipt of claim from the provider within 15 working days.** 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 reviewed and enhanced its procedure to ensure timely acknowledgement of claims within 10 days of receipt of correspondence. The new procedure was implemented on January 15, 2013, and the internal documented procedure was revised on January 25, 2013. The procedure involves an automatic report to run starting seven days after receipt of the claim, for any claim not finalized, in order to account for weekends and holidays. This will ensure acknowledgement of a claim is done within 10 days after receipt. This is an automated process so no rollout or training was required.

8. **In one instance, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.** Specifically, in the processing of an appeal, the Company delayed the request for additional medical information from the provider. 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 has taken corrective action to ensure compliance with both acknowledgements of claims/disputes within 10 days. The new procedure was implemented on January 15, 2013, and the internal documented procedure was revised on January 25, 2013. The procedure involves an automatic report to run starting seven days after receipt of a claim or correspondence in order to account for weekends and holidays. This will ensure acknowledgement of correspondence is done within 10 days after receipt. This is an automated process so no rollout or training was required.