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

GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
NAIC # 65536 CDI # 1686-5

AS OF MARCH 31, 2012

ADOPTED MARCH 19, 2015

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

March 19, 2015

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:

Genworth Life and Annuity Insurance Company
NAIC # 65536

Group NAIC# 4011

Hereinafter, the Company listed above also will be referred to as GLAIC 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 Long Term Care and Fixed Life claims closed during the period from April 1, 2011 through March 31, 2012. 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 examiners, 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 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 April 1, 2011 through March 31, 2012; and a review of previous CDI market conduct claim examination reports on this Company. The review of the sample of individual claims files was conducted at the offices of the Company in Lynchburg, Virginia.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The long term care and fixed life claims reviewed were closed from April 1, 2011 through March 31, 2012, referred to as the “review period”. The examiners randomly selected 140 policy files for examination. The examiners cited 44 alleged claims handling violations of the California Insurance Code from this sample file review.

Findings of this examination included the failure to disclose all benefits, coverage, time limits or other provisions of the insurance policy; attempting to settle claims by making settlement offers that were unreasonably low; the failure to effectuate prompt, fair, and equitable settlements of claims; the failure to conduct and diligently pursue a thorough, fair and objective investigation; the failure to provide necessary forms, instructions, and reasonable assistance within regulatory timelines; the failure to provide legal basis for the denial of claims; the failure to pay interest at a rate of 10% per annum on delayed claims settlements; and the Company’s failure to include reference to the California Department of Insurance on written denials.

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

Except as noted below, market analysis did not identify any specific issues of concern.

The Company was the subject of two California consumer complaints and inquiries closed from April 1, 2011 through March 31, 2012, in regard to the lines of business reviewed in this examination. There was no specific area of concern identified in the complaint review.

The previous claims examination reviewed a period from July 1, 2002 through June 30, 2003. The most significant noncompliance issues identified in the previous examination report were the Company's failure to provide a complete Explanation of Benefits; and the Company's failure to include the California Department of Insurance reference on written denials, including the telephone and address of the California Department of Insurance. 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:

GLAIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**NUMBER OF ALLEGED VIOLATIONS**
Accident and Disability / Long Term Care	160	70	43
Life / Individual Life	946	70	1
TOTALS	**1106**	**140**	**44**

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	GLAIC Number of Alleged Violations
CCR §2695.4(a) *[CIC §790.03(h)(3)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	12
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.	9
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	6
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	5
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.	3
CIC §10235.95(b) *[CIC §790.03(h)(5)]	The Company failed to pay interest at a rate of 10% per annum on the amount of any accepted claim beginning on the first calendar day after the day that the payment of the accepted claim was due.	2
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.	2
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.	2
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.	1
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed to respond to communications within 15 calendar days.	1

Citation	Description of Allegation	GLAIC Number of Alleged Violations
CIC §395 *[CIC §790.03(h)(2)]	The Company failed to provide, free of charge, a complete copy of the insured's current insurance policy or certificate within 30 calendar days of receipt of a request from the insured after a covered loss.	1
Total Number of Alleged Violations		**44**

*DESCRIPTIONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES

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.
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 VIOLATIONS BY LINE OF BUSINESS

ACCIDENT AND DISABILITY **2011 Written Premium: $4,064,843** **AMOUNT OF RECOVERIES** $210,477.26	**NUMBER OF ALLEGED VIOLATIONS**
CCR §2695.4(a) [CIC §790.03(h)(3)]	12
CCR §2695.7(g) [CIC §790.03(h)(5)]	9
CIC §790.03(h)(5)	6
CCR §2695.7(d) [CIC §790.03(h)(3)]	4
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	3
CCR §2695.7(d) [CIC §790.03(h)(3)]	2
CIC §10235.95(b) [CIC §790.03(h)(5)]	2
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	2
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	1
CCR §2695.5(b) [CIC §790.03(h)(2)]	1
CIC §395 [CIC §790.03(h)(2)]	1
SUBTOTAL	**43**

LIFE **2011 Written Premium: $367,143,524** **AMOUNT OF RECOVERIES $00.00**	**NUMBER OF ALLEGED VIOLATIONS**
CCR §2695.7(d) [CIC §790.03(h)(3)]	1
SUB TOTAL	**1**

TOTAL	**44**

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 indicates it will take corrective action in all applicable jurisdictions.

Money recovered within the scope of this report was $210,477.26 as described in sections two, three and seven below.

ACCIDENT AND DISABILITY- Long Term Care

1. In 12 instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proof of claim, the insured shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability. The Company failed to disclose all applicable benefits, coverage, time limits, and provisions to the insured and failed to assist the insured in determining the Company's additional liability in the following instances:

a) In five instances involving multiple long-term care policies owned by the insureds, the Company failed to provide disclosure of benefits and provisions on each of these policies, including the application of offsets from one policy to another.

b) In three instances, the Company failed to disclose coverage for Durable Medical Equipment (DME) upon receipt of the insureds' approved Plans of Care with DME

suitability needs. The Company failed to disclose which of the items in the Plan of Care qualified as Durable Medical Equipment (DME), the maximum limit of DME coverage, and whether the DME coverage would reduce the aggregate amount of benefits under the policy.

c) In two instances, the Company failed to disclose and consider coverage for prior eligible periods of long term care available under the policy

d) In two instances, the Company failed to disclose Homemaker Services Benefit, and policy provisions on late filing of claims. The Company received specific information to trigger these benefits and failed to disclose to the claimant the availability of this coverage.

The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees it violated the laws cited and responds as follows:

a) In five (5) of the alleged instances, the Company states that it should clearly and sufficiently explain the relevant policy provisions to insureds. A template [*script]* has been created for the Benefit Analyst to follow for the Approval Call, which will include a discussion about how two or more policies will work together, especially with respect to payment exclusions. Accordingly, the Company will update its approval letter in situations where the insured owns multiple policies where one or both have non-duplication provisions to explain that if the insured incurs a daily expense that exceeds the daily benefit amount of one of the policies, the other policy will only pay the remaining expense amount, up to its daily maximum. This information will be provided in written form to the insured.

b) In three (3) of the alleged instances, the Company recognizes opportunities to enhance an insured's understanding of a long term care insurance policy. The Company has a process in place where the Benefit Analyst makes a telephone call to the claimant at the time of claim approval to discuss benefits, coverage or other provisions that may apply to the claim. As a result of the examination, a template has been created for the Benefit Analyst to follow for the Approval Call, which will include a discussion about how two or more policies will work together, especially with respect to payment exclusions; how to seek coverage under the equipment benefit of a policy; and how to seek coverage for other services received. This information will be provided in written form to the insured. For disclosure of DME benefits, the Company has created a template [Approval Letter with Equipment Information] that it will provide to the insured with a detailed list of all DME approved benefits.

c) The two (2) alleged instances involving eligibility for all qualifying periods of care under the policy were inadvertent, unintentional errors. The Company indicates it has procedures in place to identify all periods of covered care and explain the coverage

available to the insured. The Company reinforced procedures with its staff.

d) In two (2) alleged instances, the Company's letter to the insured included inapplicable language regarding late filing of claims. The Company agrees that it did not fully disclose applicable policy provisions on Homemaker services upon initial notice. The Company states, these were isolated and inadvertent errors as it has procedures for proper explanation of benefits. The Company reinforced procedures with its staff.

The Company disagrees that the claims handling provisions of the California Insurance Code and California Code of Regulations apply to one of the instances above where the insured was a resident of another state. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California and to insureds who currently reside in California.

Summary of the Department's Evaluation of the Company's Response: Regarding the Company's response to claims involving multiple-owned policies by the same policy-owner under item 1(a) in five instances, the Company's updated template letter of explanation fails to accurately represent provisions, limitations, and conditions according to the terms of each policy. Specifically the template letter does not address policy provisions relating to "Benefits in Addition to Other Insurance" and "Non Duplication" provisions pertaining to other insurance with the Company. While the updated letter template does explain the Company's intent to apply the Non-Duplication provisions, it fails to address the other options available for the insured such as initial access to one policy and whether a policy held in reserve may be used for later dates of service or retroactively applied to the long term care claim.

This is an unresolved issue that may result in administrative action.

2. In nine instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. In seven instances, the Company failed to pay benefits on all eligible days of long-term care qualified services. In one instance, the Company did not calculate the correct Waiver of Premium benefit. In the last instance, the Company applied a 30-day elimination period instead of the appropriate 20-day elimination period resulting in 10 qualifying days of unpaid benefits. 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: The Company disagrees it violated CIC § 790.03(h)(5). The Company states as a result of the examination it reopened the pertinent claims and issued additional payments as follows:

a) In seven instances, the Company issued additional benefits including applicable interest on all eligible days of services (missed dates of service) in the amount of $1,582.27.

b) In one instance, the Company recalculated the correct Waiver of Premium and issued additional payment including interest for $640.76.

c) In one instance, the Company recalculated the correct number of days for the elimination period and issued additional payment including applicable interest for $708.00.

The Company states it has standard procedures in place to pay benefits for all days where proof of claim has been submitted. The claims staff involved in these claims were counseled and, in addition, the Company reinforced the importance of timely and accurate payment of claims with claims handling staff.

3. <u>In six instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.</u> The Company failed to effectuate prompt, fair and equitable settlement on the following claims:

a) In one instance, the Company failed to pay for qualified long-term care benefits prior to the date of the Activities of Daily Living (ADL) assessment.

b) In five instances, the insured had multiple GLAIC policies in force. On each of these claims, the insured had a policy or policies which states that benefits are payable, "*in addition to other insurance You may have with this Company, with any other insurance company or Medicare*". In these instances, the Company initially made payment under the policy which is designed to pay "in addition" to the other policies. The Company subsequently offset the full amount of the initial payment from the coverage available under the second policy. Therefore, coverage available was not paid "in addition" to the other GLAIC policies resulting in inequitable settlement of the claims.

The Department alleges these acts are in violation of CIC §790.03(h)(5).

<u>Summary of the Company's Response:</u> The Company disagrees it violated CIC § 790.03(h)(5) and responds as follows:

a) In one (1) alleged instance, the Company states that it inadvertently did not immediately investigate coverage for certain benefits. Consequently, an additional payment was issued to the claimant in the amount of $207,337.16 to cover services rendered prior to the date of the ADL assessment. This additional payment included interest and a premium refund.

b) In the five (5) instances where an insured owned multiple policies, one or both of the policies owned by the insured contained a non-duplication provision. This provision provides that "in no event will this policy's benefits, combined with those provided by any other policy or Medicare, exceed the expenses incurred". The Company adjudicates benefits under the policies concurrently consistent with California law. The Company states it does not have an obligation to artificially sequence the order in which it adjusts

claims in order to circumvent an express policy provision. Although there is a general preference under the law for handling claims in a manner that will maximize the insured's recovery, the Company is not aware of legal authority suggesting that such an obligation requires abrogation of express policy terms.

Additionally the Company states that if it were to sequence claims as the Department suggests, namely, treat the claim as if tendered under the policy that contains the non-duplication provision "first," pay the full daily maximum under that policy, and then adjudicate the claim under the other policy without the non-duplication provision, the outcome would be the same. Any payment made under the second policy that was in excess of the expenses incurred would trigger the non-duplication provision in the first policy and the Company would be obligated to adjust payment under the first policy to reflect the overpayment.

In these instances, the terms of the policies which were filed with and approved by the Department, were appropriately applied. In all five instances, the Insured correctly received benefits in the amount of the expense incurred and no claims were underpaid.

Summary of the Department's Evaluation of the Company's Response: Regarding the 3 (b) Company Response, in five instances, the insured had multiple GLAIC policies in force. On each of these claims, coverage was available with benefits payable in addition to other insurance the insured had with the Company or with any other insurance Company or Medicare. The Company did not pay benefits according to the policy provision.

This is an unresolved issue that may result in administrative action.

4. In four instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The Company failed to conduct and diligently pursue a fair and objective investigation in the following four instances:

a) In one instance, the Company failed to diligently investigate and assess home health care as qualified long-term care services prior to the filing of the claim.

b) In one instance pertaining to a non-tax qualified (NTQ) policy, the Company failed to obtain and validate alleged Medicare offsets. Claim documentation on file reflects that there was "no coverage for assisted living" under Kaiser and there was no Medicare involvement. As a result of this examination, the Company obtained the Kaiser EOB which confirmed that there was no indication of Medicare involvement and an eligible "bed hold" charge for $476.00 was not paid. The Company agrees that the information it received only by "telephone" was not accurate.

c) In one instance pertaining to another (NTQ) policy, the Company did not pay for 42 days of confinement from February 7, 2011 through March 21, 2011, and represented instead in its January 9, 2012 letter to the insured that this period of care was 100%

covered by Medicare. As a result of the Department's examination, it was discovered that Medicare did not in fact pay 100% of the charges but that charges had been paid by a private insurance carrier in coordination with Medicare. The Company indicated a Medicare offset on the Explanation of Benefits prior to investigating and documenting that Medicare had paid 100% of the skilled nursing. This policy is not a federally tax-qualified policy and is not subject to Internal Revenue Code Section 7702B on Medicare offsets.

d) In the last instance pertaining to another (NTQ) policy, the Company did not pay for benefits from October 29, 2009 through November 23, 2009 (46 days) as these were allegedly covered 100% by Medicare. This policy has a zero elimination period and the Company failed to document if the alleged Medicare payments were for qualified long-term care services. The Company failed to support if the invoice for $196.00/day has been fully reimbursed. This policy is not a federally tax-qualified policy and is not subject to Internal Revenue Code Section 7702B on Medicare offsets.

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 it violated CIC § 790.03(h)(3) and responds as follows:

a) In one (1) instance, the Company states it inadvertently failed to begin investigation immediately. The Company's standard procedures to begin investigation immediately or within a few days were not followed, and have been reinforced with appropriate staff.
b) In one instance, the Company contacted the facility and was told that the period in question was covered in full by Medicare and private insurance. Based on this information, and in accordance with the terms of the policy, it was determined that no benefits were payable. Unfortunately, the information provided by the facility was not accurate and the insured had incurred a bed hold charge. Upon receipt of this additional information, the Company issued benefits for the charges incurred. Additional training will be provided to associates regarding the application of the relevant exclusion.
c) In another instance, the Company states it confirmed with the facility by telephone that the insured did not incur any out-of-pocket expenses related to her stay at the facility. Medicare paid in full for the first 20 days and thereafter either Medicare or the insured's Medicare Supplement insurance policy covered the costs.
d) In the final instance, the Company has documentation of charges billed to Medicare by the facility for the period October 29, 2009 through November 23, 2009 at $196.00 per day. Additionally, the Company paid Nursing Home Benefits of $80.00 per day for the same period. Because any additional benefit payments would have exceeded the expenses incurred by the insured, no additional benefits were payable under the policy.

With regard to (b), (c) and (d) above pertaining to the application of the Medicare exclusion, the Company believes that the information it receives from Skilled Nursing Facilities (SNF) confirming the charges submitted to and covered by Medicare, referred to as a UB-04, is the most efficient and accurate means of confirming Medicare coverage for a SNF stay. The UB-04s include detailed information regarding the insured's prior hospitalization and current services and provide a sufficient basis for Medicare offsets. This aspect of Medicare Part A is routine to a SNF, and the billing department knows which costs will be covered by Medicare when the UB-04 is submitted. Furthermore, the Company's approval letter provides a notice to insureds that the policy will not reimburse or pay for any care or equipment paid or payable under Medicare, including co-insurance, co-payments or deductibles. The letter further states that if expenses have been incurred beyond what Medicare allows, that the insured should submit them to the Company so long as they are not a co-insurance, co-payment or deductible amount.

Summary of the Department's Evaluation of the Company's Response: The Company failed to conduct thorough investigations prior to applying offsets due to undocumented Medicare payments without validation or confirmation. With regard to the three instances pertaining to non-tax qualified policies, the Company did not secure proof of the extent of payments by Medicare and/or failed to ascertain whether there were benefits under the policy. The Company relied upon the UB-04 which documents the amounts that Medicare was billed but not the amounts that were paid by Medicare. The Company offset the full amount of the charges incurred and indicated that the offsets were due to Medicare on the Explanation of Benefits. Following the examination, the Company verbally confirmed that sources other than Medicare had paid the balance owed in two instances and in one instance that not all available benefits under the policy had been applied to the claim. As these instances reflect Non-Tax Qualified policies, any unpaid co-insurance, co-payment or deductible would be covered under these policies. The Company has not provided a resolution addressing to ensure investigation of Medicare payments prior to the application of an offset.

This is an unresolved issue that may result in additional administrative action.

5. In three instances, the Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days. In two instances, the Company failed to transmit claim forms within regulatory timelines. In the last instance, the Company failed to provide instructions to an eligible insured on how to access its Durable Medical Equipment (DME) coverage under the approved Plan of Care. 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 disagrees it violated CIC § 790.03(h)(3) and responds as follows: In two (2) of the alleged instances, the Company states that it inadvertently failed to send claim forms within the 15- day timeframe. In one (1) alleged instance regarding the equipment benefit, the Company indicates that its claim approval letter detailed the information required to receive

equipment benefits. It is the Company's practice to provide an overview of the Equipment Benefit with insureds at the initiation of a claim and more detailed information at the time a claim is approved. However, the Company will now provide an advance approval determination without requiring additional documentation, on certain pieces of equipment specified in the insured's approved Plan of Care. Effective October 1, 2012, the equipment benefit approval will be discussed with the insured verbally during the Approval Call. Effective the 1st Quarter of 2013, the Company has updated its template Approval Letter to specifically list certain equipment items in the Plan of Care that have been approved under the policy

6. <u>In two instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute</u>. In the first instance, the Company received correspondence dated July 26, 2010 from an insured's Power of Attorney (POA) inquiring about the three sets of forms to complete, and the requirement to attach three sets of billing statements every month. In the second instance, the Company required two separate claim forms from the insured to cover the same period of long-term care services. This resulted in the delay in the payment of benefits on the second policy. 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 disagrees it violated CIC § 790.03(h)(3) and responds as follows:

In both instances the insured was sent duplicate copies of claim forms. In the first instance, the Company responded to the insured's representative clarifying that only one set of claim forms would be required instead of three sets of claim forms and three sets of billing statements. In the second instance, there was an inadvertent delay in using claim forms already available in an insured's ongoing claim on another policy. The Company states these were inadvertent oversights by the claims staff. The Company indicates it has a standard operating procedure for sharing claim information between claim files which includes copying claim forms and other pertinent documents into all of the insured's multiple policies. Additionally, the Company states it has updated its process, so that claim forms will only be sent out under one claim, where the insured has multiple policies. The claims handling Associates were reminded in the Company's annual California Fair Claims training course to accept a single copy of an invoice as proof of claim under multiple policies.

7. <u>In two instances, the Company failed to pay interest at a rate of 10% per annum on the amount of any accepted claim beginning on the first calendar day after the day that the payment of the accepted claim was due.</u> In both instances, the Company failed to pay statutory interest on claims with delayed settlements. The Department alleges these acts are in violation of CIC §10235.95(b) and are unfair practices under CIC §790.03(h)(5).

<u>Summary of the Company's Response</u>: The Company disagrees it violated CIC § 790.03(h)(5) and responds as follows: The Company states that in two (2)

instances, it inadvertently failed to include interest pursuant to CIC §10235.95(b). It is the Company's standard procedure to include late interest when applicable and will reinforce its procedure with claims handling staff. As a result of this examination, the Company reopened the claim and issued additional monies owed in the amount of $205.07.

8. 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 failed to disclose the legal basis for partially denying billed charges. The Company referenced multiple exclusions without specifying the pertinent policy provision, condition or exclusion to support its denial, and/or the individual items of the charges denied. 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 it violated CIC § 790.03(h)(13) and responds as follows: The Company states in both instances, it appropriately applied the policy exclusions. Further, the Company states that it issued an EOB in each instance which addressed the payment offsets. However, in consideration of the Department's concern, the Company developed a new Explanation of Benefits which provides the insured with an explanation of the basis for charges excluded and more specific information on offsets applied to a benefit. Specifically, the new EOB provides information about the dates for which Medicare Non-Duplication was applied and additional details about the other reasons for excluding dates or amounts.

9. 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. In one instance, the Company failed to include the required CDI reference language in a denial letter dated April 20, 2012. 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 disagrees it violated CIC § 790.03(h)(3) and responds as follows: In one (1) instance, the CDI language was inadvertently omitted in the denial letter. The Company states this was an isolated error and the appropriate claims staff member involved in this claim was counseled.

10. In one instance, the Company failed to respond to communications within 15 calendar days. The Department alleges this act is in violation of CCR §2695.5(b) and is an unfair practice under CIC §790.03(h)(2).

Summary of the Company's Response: The Company disagrees it violated CIC § 790.03(h)(2) and responds as follows: The Company states that in this one (1) instance, it did not respond to the Insured's inquiry within 15 calendar days of receipt. The Company reinforced its procedure with claims handling staff to respond to communications timely.

11. <u>In one instance, the Company failed to provide, free of charge, a complete copy of the insured's current insurance policy or certificate within 30 calendar days of receipt of a request from the insured after a covered loss</u>. The Department alleges this act is in violation of CIC §395 and is an unfair practice under CIC §790.03(h)(2).

<u>Summary of the Company's Response:</u> The Company disagrees it violated CIC § 790.03(h)(2) and responds as follows: The Company states that in this one (1) instance, it was unable to provide a complete copy of the Insured's insurance policy within 30 days of receipt of a request from the Insured. The Company reinforced its procedure with claims handling staff to provide a copy of the insuring policy upon request within 30 days.

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12. <u>In one instance, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.</u> In one instance, the Company failed to follow up on a forwarding address of a beneficiary from September 6, 2011 through February 24, 2012 resulting in a delay in settlement. 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 disagrees it violated CIC § 790.03(h)(3) and responds as follows: The Company states that in this one instance, it inadvertently failed to follow up on the forwarding address for a beneficiary. The Company has modified its processes by developing a team of Claim Examiners dedicated to the searching and closing of "aging" claims. All returned mail is now processed by this team, and this dedicated team's efforts will decrease the risk of this situation occurring in the future.