[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 HANDLING, RATING, AND UNDERWRITING PRACTICES OF

BEST LIFE AND HEALTH INSURANCE COMPANY
NAIC # 90638 CDI # 1784-8

AS OF APRIL 30, 2013

ADOPTED OCTOBER 3, 2014

STATE OF CALIFORNIA

CALIFORNIA DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

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
Market Conduct Division
300 Capitol Mall
Sacramento, CA 95814

October 3, 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 the California Insurance Code Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04; and California Code of Regulations Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a), a limited examination was made of the claims handling, rating, and underwriting practices and procedures in California of:

Best Life and Health Insurance Company
NAIC # 90638

Hereinafter, the Company listed above also will be referred to as BLHIC 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

This limited desk examination covered the claims handling, rating, and underwriting practices of the aforementioned Company's disability/group dental line of business during the period May 1, 2012 through April 30, 2013. The limited 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.

This report pertains to Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. A separate report pertains to laws other than Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

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 identified violations result in payments by the Company to policyholders or claimants, those amounts paid are identified as recoveries 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 specified guidelines, procedures, and forms adopted by the Company for use in California.

2. 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, 2012 through April 30, 2013; a review of reports on the previous CDI market conduct examination of this Company; and a review of prior CDI enforcement actions, if any.

This limited examination was conducted at the offices of the California Department of Insurance in Los Angeles, California.

EXECUTIVE SUMMARY

This desk examination was limited in scope to market analysis information, including California consumer complaint information, to national enforcement activity and to information provided by the Company in response to the Department's data request. There was no review of underwriting or claims files during this examination.

The primary findings resulting in alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al., that were identified in the course of the examination includes the failure by the principal of the Company to sign the required certification of compliance in training, failure to include the required statement regarding false and fraudulent claims on the claim forms, and failure to comply with the required timeframes in regard to acknowledgment of receipt of a claim to the provider and the response time for pre-authorization service request. Details of the findings are provided in the Summary of Examination Results section of this report.

Best Life and Health Insurance Company reported $5,512,825 in written premiums on Disability/Group Dental Line of Business insurance coverage in California during 2012. The Company closed 15,952 California Disability/Group Dental claims during 2012.

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

The market analysis did not identify any specific issues of concern within the scope of this report.

The Company was not the subject of any consumer complaints closed between May 1, 2012 and April 30, 2013.

The previous examination was completed by the Field Claims Bureau and reviewed the period from October 1, 2007 through September 30, 2008. The most significant noncompliance issue identified in the previous examination report and within the scope of this report was the Company's failure to include the exact fraud warning language on its correspondence. A similar issue pertaining to this non-compliant practice was noted in the current exam and is described in the Summary of Examination Results section of this report.

The Department has taken no prior enforcement actions against the Company.

DETAILS OF THE CURRENT EXAMINATION

The following tables summarize the Company's responses, within the scope of this report, to the Department's data request and the alleged violations under Section 790.03 and title 10, California Code of Regulations, Section 2695 et al., that resulted from the review of that data. All "NO" answers in the Areas of Review table are addressed in the Summary of Examination Results section of this report. A summary of each of the laws cited due to a "NO" answer is provided in the Cited Statutes and Regulations table.

AREAS OF REVIEW		
SPECIFIC ISSUE REVIEWED	**INDICATION OF COMPLIANCE (YES/NO)**	**SUMMARY OF RESULTS ITEM #**
Certification by a company principal of claims training – CCR §2695.6(b) [CIC §790.03(h)(3)]	NO	1
Copy of written standards for claims – CCR §2695.6(a) [CIC §790.03(h)(3)]	YES	--
Compliance with Special Investigative Unit Regulations – CIC §1875.20 and CCR §§2698.30 through 2698.43 [CIC §790.03(h)(3)]	YES	--
Compliance of letters and forms – CIC §1879.2(a) [CIC §790.03(h)(3)]	NO	2
Acknowledgement of receipt of claim from provider within 15 days and in same form as received -- CIC §10133.66(c) [CIC §790.03(h)(2)]	NO	3
Compliance with requirements of HIPAA regulations on medical authorizations forms – CIC §791.06 [CIC §790.03(h)(3)]	YES	--
Compliance with requirements to pay interest on uncontested claims paid after 30 working days – CIC §10123.13(b) [CIC §790.03(h)(5)]	YES	--
Compliance with requirements to provide a clear EOB – CCR §2695.11(b) [CIC §790.03(h)(3)]	YES	--

AREAS OF REVIEW		
SPECIFIC ISSUE REVIEWED	**INDICATION OF COMPLIANCE (YES/NO)**	**SUMMARY OF RESULTS ITEM #**
Compliance with all requirements of – CIC §10123.13(a) [CIC §790.03(h)(3), and/or (4), and/or (13)]	YES	--
Provider contracts contain required dispute resolution provisions – CIC §10123.137(a) [CIC §790.03(h)(3)]	YES	--
Non-contracting provider accessible dispute mechanism – CIC §10123.137(b) [CIC §790.03(h)(3)]	YES	--
Compliance with dispute mechanism report submission – CIC §10123.137(d) [CIC §790.03(h)(3)]	YES	--
Compliance with requirements for providing information on Independent Medical Reviews – CIC §10169.(i) [CIC §790.03(h)(3)]	YES	--
Compliance with requirements for time limits for response to requests for pre-authorization of non-emergency services – CCR §2695.11(e) [CIC §790.03(h)(3)]	NO	4
Compliance with requirements for no pre-authorization of emergency services – CCR §2695.11(f) [CIC §790.03(h)(3)]	YES	--

CITED STATUTES AND REGULATIONS	
Citation	**Description**
CCR §2695.6(b) *[CIC §790.03(h)(3)]	The Company failed to certify under penalty of perjury by a principal of the Company.
CIC §1879.2(a) *[CIC §790.03(h)(3)]	The Company failed to include the California fraud warning on insurance claim forms.
CIC §10133.66(c) *[CIC §790.03(h)(2)]	The Company failed to acknowledge receipt of claim from the provider within 15 working days in the same manner the claim was received.
CCR §2695.11(e) *[CIC §790.03(h)(3)]	The Company failed to provide preauthorization of non-emergency medical services within five calendar days.

*DESCRIPTONS 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 its insurance policies.

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the practices, within the scope of this report, that were alleged to be non-compliant during the course of this limited examination. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

In response to each of the Department's allegations of non-compliance, the Company was 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 and maintained.

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 that it will implement the corrective actions in all jurisdictions.

Within the scope of this report, there were no claims recoveries or return premium as a result of the issues described in this report.

DISABILITY/GROUP DENTAL

1. The Certificate of Compliance for the California Fair Claims Settlement Practice Regulation that was provided to the examiner failed to include the signature of the principal of the Company certifying under penalty of perjury that thorough and adequate training was provided to all its claims agents. The incomplete certificate is in violation of CCR §2695.6(b)(1)(2)(3). The Department alleges this act is an unfair practice under CIC §790.03(h)(3).

Summary of Company Response: BLHIC provided the Department with the Certificate of Compliance dated May 12, 2014 signed by the principal of the Company.

2. The dental claim form utilized by BLHIC failed to disclose the required statement regarding false or fraudulent claims in violation of CIC §1879.2(a). The Department

alleges this act is an unfair practice under CIC §790.03(h)(3). This is a repeat criticism from BLHIC's Field Claims 2009 examination.

Summary of Company Response: BLHIC provided the Department with a copy of the dental claim form that includes the required California fraud statement. Additionally, the revised dental claim form was posted to the Company's website on June 2, 2014.

3. The Company reported its procedures did not call for acknowledgement of a claim to a provider within 15 working days of the date of receipt of the claim in the same manner in which the claim was submitted, in violation of CIC §10133.66(c). The Department alleges this act is an unfair practice under CIC §790.03(h)(2).

Summary of Company Response: BLHIC indicated effective June 11, 2014 the Company's procedure has been updated to acknowledge a claim to all providers within 15 business days from the date of receipt in the same manner as the claim was submitted. BLHIC has provided training to its claims representative regarding the new procedure.

4. The Company reported its procedures did not include a requirement to respond to a request for the pre-authorization of service immediately, but in no event more than five (5) calendar days, in violation of CCR §2695.11(e). The Department alleges this act is an unfair practice under CIC §790.03(h)(3).

Summary of Company Response: BLHIC indicated effective June 11, 2014 it has updated its policies and procedures to comply with the pre-authorization response time requirement of no more than five (5) calendar days. BLHIC has provided training to its claims representative regarding the new procedure.