

**[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**

**STERLING LIFE INSURANCE COMPANY
NAIC # 77399 CDI # 5028-6**

AS OF APRIL 30, 2014

ADOPTED MARCH 23, 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.

TABLE OF CONTENTS

SALUTATION 1

FOREWORD..... 2

SCOPE OF THE EXAMINATION..... 3

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED..... 4

**RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND
INQUIRIES, AND PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT
ACTIONS 5**

DETAILS OF THE CURRENT EXAMINATION 6

TABLE OF ALLEGED VIOLATIONS 7

TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS 9

SUMMARY OF EXAMINATION RESULTS 10

DEPARTMENT OF INSURANCE

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



March 23, 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:

**Sterling Life Insurance Company
NAIC # 77399**

Group NAIC # 1119

Hereinafter, the Company listed above also will be referred to as Sterling, SLIC, 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 Health and Individual Medicare Supplement claims closed during the period from May 1, 2013 through April 30, 2014. 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 claim 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 the Company closed by the CDI during the period May 1, 2013 through April 30, 2014; a review of previous CDI market conduct claims examination reports on this Company; and a review of prior CDI enforcement actions.

The review of the sample of individual claim files was conducted at the offices of the California Department of Insurance in San Francisco, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Group Health and Individual Medicare Supplement claims reviewed were closed from May 1, 2013 through April 30, 2014, referred to as the “review period”. The examiners randomly selected 70 Group Health and 70 Medicare Supplement claim files for examination. Prescription drug claims were not included in the claims populations and, therefore, were not reviewed. The examiners cited 508 alleged claims handling violations of the California Insurance Code and the California Code of Regulations from this sample file review.

The Company delegates the claims handling function for Group Health to Meritain Health, a third party administrator (TPA). On March 11, 2014, Sterling informed Meritain Health of its decision to terminate its contract with its underwriter, Nationcare. As a result, Sterling exited the group health market as of January 1, 2015, which ended its relationship with Meritain.

Findings of this examination included the failure to provide members and providers with required notices at the time claims are finalized, the failure to pay statutory interest, and the wrongful application of a pre-certification penalty to mental health out-patient benefits.

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

Market analysis did not identify any specific issues of concern.

There was no specific area of concern identified in the complaint review in regard to the lines of business reviewed in this examination.

There have been no prior claims examinations conducted upon this Company.

The Company was not the subject of a prior enforcement action by the California Department of Insurance.

DETAILS OF THE CURRENT EXAMINATION

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

STERLING LIFE INSURANCE COMPANY SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Accident and Disability / Group Health / Paid	14,680	66	273
Accident and Disability / Group Health / Denied	939	4	23
Medicare Supplement / Individual / Paid	3966	46	139
Medicare Supplement / Individual / Closed without Payment	1488	10	42
Medicare Supplement / Individual / Denied	1465	14	30
Accident and Disability Training and Annual Certification			1
TOTALS	22,538	140	508

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	SLIC Number of Alleged Violations
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.	140
CIC §10123.147(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.	140
CIC §10169(i) *[CIC §790.03(h)(1)]	The Company failed to prominently display in every insurer member handbook, insurance contract, insured evidence of coverage form, letters of denials and on all written responses to grievances, information concerning the right of an insured to request an independent medical review in cases where the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.	140
CIC §880 *[CIC §790.03(h)(3)]	The Company failed to conduct its business in its own name.	70
CIC §10123.13(b) *[CIC §790.03(h)(5)]	The Company failed to pay interest on an uncontested claim after 30 working days.	5
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.	4
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.	2
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.	2
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.	1

Citation	Description of Allegation	SLIC Number of Alleged Violations
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	1
CCR §2695.6(b)(3) *[CIC §790.03(h)(3)]	The Company failed to annually certify in a declaration executed under penalty of perjury that thorough and adequate training regarding the Fair Claims Settlement Practices Regulations was provided to all its claims agents.	1
CCR §2695.7(d) *[CIC §790.03(h)(5)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	1
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide a clear explanation of the computation of benefits.	1
Total Number of Alleged Violations		508

***DESCRIPTORS 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)(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 basis 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

<p align="center">ACCIDENT and DISABILITY</p> <p align="center">GROUP HEALTH</p> <p align="center">2014 Written Premium: \$742,182</p> <p align="center">MEDICARE SUPPLEMENT</p> <p align="center">2014 Written Premium: \$11,621,890</p> <p>AMOUNT OF RECOVERIES \$30,623.88</p>	<p align="center">NUMBER OF ALLEGED VIOLATIONS</p>
CIC §10123.13(a) [CIC §790.03(h)(3)]	140
CIC §10123.147(a) [CIC §790.03(h)(3)]	140
CIC §10169(i) [CIC §790.03(h)(1)]	140
CIC §880 [CIC §790.03(h)(3)]	70
CIC §10123.13(b) [CIC §790.03(h)(5)]	5
CIC §10123.13(a) [CIC §790.03(h)(5)]	4
CIC §10123.13(a) [CIC §790.03(h)(13)]	2
CCR §2695.7(g) [CIC §790.03(h)(5)]	2
CIC §790.03(h)(3)	1
CIC §790.03(h)(5)	1
CCR §2695.6(b)(3) [CIC §790.03(h)(3)]	1
CCR §2695.7(d) [CIC §790.03(h)(5)]	1
CCR §2695.11(b) [CIC §790.03(h)(3)]	1
<p align="center">TOTAL</p>	<p>508</p>

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 which are applicable in other jurisdictions.

Money recovered within the scope of this report was \$295.88 as described in section numbers 5, 8 and 10 below. Following the findings of the examination, the Company conducted two closed claims surveys as described in sections 5 and 8 below resulting in additional payments of \$30,328.00. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$30,623.88.

ACCIDENT and DISABILITY

GROUP HEALTH and MEDICARE SUPPLEMENT

1. **In 140 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.** The allegations apply to Group Health in 70 instances and to individual Medicare Supplement in 70 instances. 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: Sterling agrees that the Group Health Explanations of Benefits (EOBs) and the Medicare Supplement Explanations of Payment (EOPs) do not contain the required notice. For the Medicare Supplement line of business, the required notice language was rolled out into all EOP formats on January 22, 2015. For the Group Health line of business, Sterling directed Meritain Health to update all EOB formats to include the required language. On March 31, 2015, Meritain Health completed systemic claim programming updates to the EOB formats.

2. **In 140 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 allegations apply to Group Health in 70 instances and to individual Medicare Supplement in 70 instances. The Department alleges these acts are in violation of CIC §10123.147(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: Sterling agrees that the EOBs and EOPs do not contain the required dispute resolution language. For the Medicare Supplement line of business, language was rolled out into all EOP formats on January 22, 2015. For the Group Health line of business, Meritain Health has been required to update all EOB formats to include the required dispute resolution language. On March 31, 2015, Meritain Health completed systemic claim programming updates to the EOB formats.

3. **In 140 instances, the Company failed to prominently display in every insurer member handbook, insurance contract, insured evidence of coverage form, letters of denials and on all written responses to grievances, information concerning the right of an insured to request an independent medical review in cases where the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.** This applies to 70 instances in the Group Health and 70 instances in the individual Medicare Supplement lines of business. 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: Sterling agrees its EOPs, and the member insurance contracts do not contain the required notice regarding an insured's right to request an independent medical review (IMR). To correct the error in the

Medicare Supplement line of business, the Company incorporated the required notification into all EOP formats on January 22, 2015. To correct the error in the Group Health line of business, it incorporated the required notification into all EOB formats on March 31, 2015. To correct the failure to include the required language in the member insurance contract, Sterling created a policy rider to inform the member of the right to request an IMR. The rider was filed for approval with the California Department of insurance in January, 2015. Sterling also updated its procedures such that the required notification is included in all responses to grievances as of January 10, 2015.

4. In 70 instances, the Company failed to conduct its business in its own name. For the Group Health line of business, the third party administrator (TPA) failed to identify Sterling Life Insurance Company in all correspondence. 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: Sterling acknowledges that correspondence was issued, for a time, without Sterling Life Insurance Company's name. On September 26, 2014, corrections were made to the system. All correspondence now reflects Sterling Life Insurance Company.

5. In five instances, the Company failed to pay interest on an uncontested claim after 30 working days. These instances apply to the Group Health line of business. The Department alleges these acts are in violation of CIC §10123.13(b) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company disagrees that it violated CIC § 790.03(h)(5), but responded as follows: Sterling agrees that statutory interest was due and not paid in the five identified instances. To correct the errors, the Company paid a combined statutory interest amount of \$152.96 to the providers identified in the examination. In addition, Sterling conducted a review of uncontested claims from January 1, 2012 to January 22, 2015, via a systemic data extraction. The Company reported to the Department on March 18, 2015, that it identified 1,233 such claims and paid additional benefits totaling \$15,447.42. As a result of the examination, systemic improvements were put in place in March, 2015 as well as a long term strategy to ensure ongoing adherence to the statute and consistent application of all statutory interest payments.

6. 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. These errors apply to the Group Health line of business. 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 disagrees that it violated CIC § 790.03(h)(5), but responded as follows: Sterling agrees that the claim was not paid within the 30 working-day limit in the four identified instances. As a corrective measure, the manual process to refer a claim to a re-pricing network for a

discount will be limited to 30 working days. Training with the examiners was conducted by the supervisor on October 10, 2014.

7. In two 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 the first instance, the EOB failed to inform the member and provider the specific reason for a billed code denial. Specifically, the EOB informs the member and provider that a billed code has been rebundled, denied or transferred. The EOB message is unclear which of the remarks pertains to the denial. In the second instance, benefits were reduced and the EOB informs the member and provider that the ineligible amount was based on the pre-certification provision outlined in the member's benefit plan. The EOB failed to inform the member which portion of the pre-certification provision applied to the benefit reduction. 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 disagrees that it violated CIC § 790.03(h)(13), but responded as follows: In the first instance, the Company updated the provider EOB to reflect outcome of the claim and did not update the member EOB. In the second instance, the Company states the message used on the EOB clearly states that the denial is based on the plan provisions and referring the claimant to the plan provisions is sufficient for compliance with the statute. The EOB comment does not state that the non-covered amounts are a penalty, but it states the amount is ineligible. Additionally, the EOB provides the member with clear direction on what their appeal rights are, what they can do if they do not understand the denial or the remark code, and where to call or write to obtain help.

These issues were isolated to the Group Health product only, which was processed by the TPA. Due to Sterling's exit from the Group Health market line of business as of January 1, 2015 and its ceased relationship with the TPA handling these claims, no additional remedial measures are necessary for the Group Health line of business. While the Company disagrees with the finding in the second instance, Sterling does not anticipate the issue to exist for any of its other products.

8. In two instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. Both instances apply to the Group Health line of business. In the first instance, the Company failed to consider the modifier attached to the procedure code which resulted in an underpayment of the claim. Following two appeals submitted on the claim, the Company corrected the underpayment. In the second instance, the Company applied a pre-certification penalty in error, thereby reducing the benefit for mental health outpatient services. 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 that it violated CIC § 790.03(h)(5), but responded as follows: In the first instance, Sterling

agrees that the modifier was not considered when determining the allowable expense. In the second instance, after the Company was informed on October 29, 2013 by the California Department of Insurance of pre-authorization changes, on January 1, 2014 Sterling issued a corrected Schedule of Benefits and Amendatory Endorsements to new and renewing groups that pre-certification for mental health conditions is no longer required. To correct the error, the Company adjusted the claim and paid \$127.73 on December 30, 2014.

Furthermore, to correct past harm, the Company completed an internal survey to identify all impacted claims from January 1, 2012 to January 22, 2015 that were processed with a benefit reduction due to a pre-certification penalty. The Company reports that it identified 218 such claims and paid additional benefits totaling \$13,294.17 plus statutory interest in the amount of \$1,586.41.

As noted by the findings, these issues were isolated to the Group Health product only, which was processed by the TPA. Due to Sterling's exit from the Group Health market line of business as of January 1, 2015 and its ceased relationship with the TPA handling these claims, no additional remedial measures are necessary for the Group Health line of business. As such, Sterling does not anticipate these issues to exist for any of its other products.

9. In one instance, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. This applies to the Group Health line of business. The Company's procedure for submitting a claim for re-pricing was not followed. The original claim from a non-participating provider was sent for re-pricing which created a delay of 48 days. The Department alleges this act is in violation of CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees that it violated CIC § 790.03(h)(3), but responded as follows: Sterling agrees that the claim handling was delayed and unacceptable. The original claim was sent through re-pricing in an attempt to achieve a discount. When that was not achieved, the claim was processed using usual and customary provisions. Attempting to gain a discount should have been halted at 24 days. As noted by the finding, this issue is isolated to the Group Health product only, which was processed by the TPA. Due to Sterling's exit from the Group Health market line of business as of January 1, 2015 and its ceased relationship with the TPA handling these claims, no additional remedial measure is necessary for the Group Health line of business. As such, Sterling does not anticipate the issue to exist for any of its other products.

10. In one instance, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. This applies to the Group Health line of business. Services performed by a Doctor of Physical Therapy (DPT) were payable under the plan, but were denied under the plans chiropractic (DC) limitations. The Department alleges this act is in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The Company disagrees that it violated CIC § 790.03(h)(5), but responded as follows: Sterling agrees that the claim was not for services provided by a DC but a DPT. The claim has been adjusted to allow an additional \$15.19 on December 29, 2014. As a remedial measure, on October 9, 2014, the Provider Maintenance Department put a flag on the provider with a warning message each time the provider is selected on a claim to ensure correct claims handling. As noted by the finding, this issue is isolated to the Group Health product only, which was processed by the TPA. Due to Sterling's exit from the Group Health market line of business as of January 1, 2015 and its ceased relationship with the TPA handling these claims, no additional remedial measure is necessary for the Group Health line of business. As such, Sterling does not anticipate the issue to exist for any of its other products.

11. In one instance, the Company failed to annually certify in a declaration executed under penalty of perjury that thorough and adequate training regarding the Fair Claims Settlement Practices Regulations was provided to all its claims agents. This applies to the Medicare Supplement and Group Health lines of business. The Department alleges this act is in violation of CCR §2695.6(b)(3) and is unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees that it violated CIC § 790.03(h)(3), but responded as follows: Training materials regarding the needed training completed within Sterling Life Insurance, for the Medicare Supplement line of business was completed on December 29, 2014. Sterling has also updated its reporting calendar and has added the appropriate notations within its reporting databases. Sterling also agrees that training was not conducted in a timely fashion in 2014, for the Group Health line of business. Due to Sterling's exit from the Group Health market line of business as of January 1, 2015 and its ceased relationship with the TPA handling group health claims, no additional remedial measure is necessary for the Group Health line of business.

12. In one instance, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The member's policy provides newborn coverage for the first 30 days after birth. At the time of receipt of the newborn's first claim, the Company had not added the baby to the plan as an insured dependent which created a delay. 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 disagrees that it violated CIC § 790.03(h)(3), but responded as follows: The Company stated other insurance information was necessary to review the claim and has added language to its Claims Guide to clarify claims processing involving newborn charges effective February 12, 2015. This issue is isolated to the Group Health product only, which was processed by the TPA. Due to Sterling's exit from the Group Health market line of business as of January 1, 2015 and its ceased relationship with the TPA handling these claims, no

additional remedial measure is necessary for the Group Health line of business. As such, Sterling does not anticipate the issue to exist for any of its other products.

13. In one instance, the Company failed to provide a clear explanation of the computation of benefits. This applies to the Medicare Supplement line of business. Specifically, the EOP displayed a negative amount without an explanation of the reason. 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 Company disagrees it violated CIC § 790.03(h)(3), but responded as follows: As a corrective measure, the Company added a general remark code to the EOB stating, "This is an adjustment to a previous outcome". The new remark code was implemented on or about April 18, 2015.