

**[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**

**STANDARD INSURANCE COMPANY
NAIC # 69019 CDI # 0988-6**

AS OF FEBRUARY 28, 2009

ADOPTED OCTOBER 25, 2010

STATE OF 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 ever 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



October 25, 2010

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

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:

Standard Insurance Company
NAIC # 69019

Hereinafter, the Company listed above also will be referred to as SIC, Standard, 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 claims closed during the period from March 1, 2008 through February 28, 2009. 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. 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 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 March 1, 2008 through February 28, 2009, and a review of previous CDI market conduct claims examination reports on this Company.

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

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The claims reviewed were closed from March 1, 2008 through February 28, 2009, referred to as the “review period”. The examiners reviewed 184 Standard claims files from the population of claims in the Paid, Denied and Appeal categories. Within each category the files were randomly selected with the exception of the Long Term Disability (LTD) Denial/Appeal claims. For this category, of the 17 files reviewed, eleven were randomly selected and six were chosen based on the reason for denial in order to review a range of types of denials. Two claims were denied based on a pre-existing condition; one claim was denied as the claimant was expected to return to work; one claim was denied as the claimant was no longer disabled from any occupation; one claim was denied as the deductible income exceeded the benefits; and one claim was denied under the foreign residency exclusion. The examiners cited 66 alleged claims handling violations of the California Insurance Code and the California Code of Regulations from this sample file review.

Findings of this examination included a failure to effectuate fair and equitable settlement of claims; a failure to implement a reasonable standard for the application of deductible income; a failure to disclose applicable benefits; a failure to provide complete Explanations of Benefits (EOB); and a failure to pay benefits within 30 calendar days.

GROUP AND INDIVIDUAL DISABILITY INCOME

Findings in the Disability Income category demonstrated an improper application of the Deductible Income provision of the policy. Specifically, the Company’s claims handling procedure was to deduct the maximum State Disability Insurance (SDI) benefit allowable in the State of California regardless of the claimant’s quarterly wage.

GROUP DENTAL INSURANCE

Findings in the Group Dental category identified the Company's failure to acknowledge receipt of claim from the provider within 15 working days; failure to provide the claimant with a clear explanation of the computation of benefits and failure to pay interest on a contested and uncontested claim after 30 working days.

GROUP LIFE INSURANCE

Findings in the Group Life category identified the Company's failure to acknowledge notice of claim within 15 calendar days; failure to provide written notice of the need for additional time or information every 30 calendar days; failure to respond to communications within 15 calendar days; and failure to follow Company procedure in locating a beneficiary.

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

The result of the market analysis review revealed that during 2007, enforcement actions were taken in the states of Connecticut and Missouri. In the state of Connecticut, the Company was fined for allowing business from an agent not appointed or licensed. The enforcement action taken in the state of Missouri was the result of the following allegations: the Company issued policy forms and certificates that had not been previously approved by the Director; a failure to properly maintain a complaint register; a failure to advise the claimant within 15 working days that more time was needed for the investigation of a claim; a failure to accept or deny claims without the need for additional information; a failure to advise claimants of the acceptance or denial of claims within 15 working days; and a failure to return calls from a claimant within 10 working days. These issues were not identified as problematic in the current examination.

In regard to the lines of business reviewed in this examination, the Company was the subject of 43 California consumer complaints, 36 of which were in the Disability Income line, closed from March 1, 2008 through February 28, 2009. Of the 43 complaints and inquiries, the Department determined one complaint for wrongful denial was justified. The examiners focused on this issue during the course of the file review.

The previous claims examination reviewed a period from August 31, 2001 through September 5, 2002. The most significant noncompliance issues identified in the previous examination report were the Company's failure to include the California fraud warning on insurance forms and the Company's failure to pay interest on death benefits not issued within 30 days from the date of death. These issues were not 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:

STANDARD SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED CITATIONS
Accident and Disability (A&D) / Group Long Term Disability Income Paid	6,427	18	12
A&D / Group Long Term Disability Income Denied/Appeal	83	17	10
A&D / Group Short Term Disability Paid	5,555	8	11
A&D / Group Short Term Disability Denied	22	3	0
A&D / Group Short Term Disability Appeal	12	4	6
A&D / Individual Disability Income Paid	85	14	0
A&D / Individual Disability Income Denied	24	8	3
A&D / Individual Disability Income Appeal	5	4	3
Group Life Paid	1,858	20	0
Group Life Denied	37	16	3
Group Life Appeals	4	4	1
A&D / Health / Dental Group Paid	51,148	17	7
A&D / Health / Group Dental Denied	9,766	17	2
A&D / Health / Group Dental Appeal	224	17	4
A&D / Health / Group Dental Orthodontia	294	17	4
TOTALS	75,544	184	66

TABLE OF TOTAL CITATIONS		
Citation	Description of Allegation	SIC Number of Alleged Citations
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide an Explanation of Benefits.	32
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.	9
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	5
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.	3
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.	3
CIC §10133.66(c) *[CIC §790.03(h)(2)]	The Company failed to acknowledge receipt of claim from the provider within 15 working days.	2
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed to respond to communications within 15 calendar days.	2
CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.	1
CIC §10111.2(c) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability.	1
CIC §10123.13(b) *[CIC §790.03(h)(5)]	The Company failed to pay interest on an uncontested claim after 30 working days.	1
CIC §10123.13(c) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a contested claim after 30 working days.	1
CCR §2695.4(d) *[CIC §790.03(h)(3)]	The Company improperly required a claimant to give notification of a claim or proof of claim within a specified time.	1
CCR §2695.5(e)(1) *[CIC §790.03(h)(2)]	The Company failed to acknowledge notice of claim within 15 calendar days.	1

TABLE OF TOTAL CITATIONS		
Citation	Description of Allegation	SIC Number of Alleged Citations
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide the written basis for the denial of the claim.	1
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time every 30 calendar days.	1
CIC §10123.13(a) [General Citation] *[CIC §790.03(h)(3)]	The Explanation of Payment fails to advise the provider of their right to seek a review by the Department of a contested or denied claim.	1
CIC §10123.13(a) [General Citation] *[CIC §790.03(h)(3)]	The Explanation of Benefits on a contested or denied claim fails to include the Department's Internet Web site address.	1
Total Number of Citations		66

***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 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 CITATIONS BY LINE OF BUSINESS

ACCIDENT AND DISABILITY GROUP AND INDIVIDUAL DISABILITY INCOME 2008 Group Disability Income Written Premium: \$160,364,237 2008 Individual Disability Income Written Premium: \$28,350,915	NUMBER OF CITATIONS
AMOUNT OF RECOVERIES \$8,172.14	
CCR §2695.11(b) [CIC §790.03(h)(3)]	21
CIC §790.03(h)(3)	8
CIC §790.03(h)(5)	5
CCR §2695.4(a) [CIC §790.03(h)(3)]	3
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	3
CIC §10111.2(c) [CIC §790.03(h)(5)]	1
CIC §790.03(h)(1)	1
CCR §2695.4(d) [CIC §790.03(h)(3)]	1
CCR §2695.5(b) [CIC §790.03(h)(2)]	1
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	1
SUBTOTAL	45

ACCIDENT AND DISABILITY HEALTH GROUP DENTAL 2008 Written Premium: \$18,038,173	NUMBER OF CITATIONS
AMOUNT OF RECOVERIES \$32.69	
CCR §2695.11(b) [CIC §790.03(h)(3)]	11
CIC §10133.66(c) [CIC §790.03(h)(2)]	2
CIC §10123.13(b) [CIC §790.03(h)(5)]	1
CIC §10123.13(c) [CIC §790.03(h)(5)]	1
CIC §10123.13(a) [CIC §790.03(h)(3)] [General Citation]	1
CIC §10123.13(a) [CIC §790.03(h)(3)] [General Citation]	1
SUBTOTAL	17

LIFE GROUP LIFE 2008 Written Premium: \$91,513,522	NUMBER OF CITATIONS
AMOUNT OF RECOVERIES \$5,468.24	
CIC §790.03(h)(3)	1
CCR §2695.5(b) [CIC §790.03(h)(2)]	1
CCR §2695.5(e)(1) [CIC §790.03(h)(2)]	1
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	1
SUBTOTAL	4

TOTAL	66
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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 action in all jurisdictions.

Money recovered within the scope of this report was \$1,337,673.07 as described in sections number 3, 6, 13, 14 and 17 below. Pursuant to the findings of the examination as described in section 3, the Company is conducting a survey on Short Term Disability (STD) claims received on or after March 1, 2006, to determine if additional benefits are due. As of July 1, 2010, the partial results of this survey reported by Standard indicated \$1,091,000.00 in payments and \$233,000 in interest returned to claimants. The final results of the survey and additional payments, if any, to 45 remaining claimants shall be reported to the Department by December 31, 2010.

ACCIDENT AND DISABILITY GROUP AND INDIVIDUAL DISABILITY INCOME

1. In 21 instances, the Company failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits. In nine instances, the Explanation of Benefit (EOB) referred to the State Disability Insurance (SDI) offset as a “statutory payment”. In eight instances, the EOB failed to provide the claimant with a clear computation of the daily Hospital Benefit or a clear computation of the substitute pay offset. In two instances, the EOB failed to provide the claimant with a

clear computation of the Work Earning Offset. In one instance, the EOB failed to reference the Pre-Disability Earnings (PDE) utilized in the calculation of benefits. In the final instance, the EOB failed to explain claimant's weekly benefit amount. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of Company Response: The Company acknowledges there were instances in which the EOBs were inadequate and understands the Department's concern related to explanations of benefits paid. The Company's desire is to meet Department expectations and comply strictly with Department regulations.

Prior to the Market Conduct Examination the Company determined the claim approval letter needed to be enhanced with regard to the Daily Hospital Benefit; therefore, in April 2009, it created a new template letter with additional explanation which the Company issues with each payment.

With regard to the instances involving the substitute rate pay, the Company includes a more detailed explanation and a sample calculation of the substitute pay offset in the claim approval letter. Additionally, each time the substitute pay offset changes due to a change in deductible income, the Company provides to the claimant a new written explanation.

With regard to the two instances involving the work earning off-set, the Company has letters explaining the work earnings off-set. The Benefits department is trained to use these letters the first time a claimant receives work earnings. Claimants are also referred to their insurance certificates for additional information. As a remedial measure, the Company provided refresher training on September 30, 2009, to claims personnel reinforcing the use of these letters.

With regard to the one instance the Company failed to provide an explanation of benefits, the Company specifically failed to explain the conversion of sick leave hours to the number of days that became the Benefit Waiting Period and failed to demonstrate the computation of the claimant's weekly benefit amount. As a remedial measure, the Company has customized the approval letter for this group to fully explain the Benefit Waiting Period and how benefits are calculated. This change was implemented on September 18, 2009.

With regard to the one instance involving the PDE, the Company agrees that the computer-generated form letter does not reference the PDE upon which the calculation is based. However, the claims analysts usually review this information verbally with claimants and the approval letter currently includes a specific discussion identifying PDE upon which the disability benefit is based.

With regard to the nine instances involving use of the term on the EOB statement, "statutory payments", when referring to California SDI benefit payments, as of December 2009, the Company began to enhance letters addressing the SDI offset by

explaining that these benefits amounts are noted on the EOBs as a “statutory payment”. Additionally, the Company commits to updating its system-generated Explanation of Benefits statements to replace “statutory payment” with “State Disability Insurance” by October 31, 2010.

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

2(a). In three instances the Company failed to follow its own claims handling procedures. Specifically, in one instance the benefit analyst failed to follow Company procedures in the handling of a claim related to a Future Purchase Option (FPO) policy (a policy in which a claim can not be denied based on a pre-existing condition). As a result, the analyst wrongfully denied the claim based on a pre-existing condition that did not apply. In one instance, the Company failed to comply with its procedure to complete the review of an adverse determination within 45 days. In the remaining instance, the claims analyst failed to notify the claimant in writing that the claim was being closed.

2(b). In two instances, the Company delayed the return of premiums by more than two months.

2(c). In one instance, the initial benefit analyst failed to request medical records and failed to complete the pre-existing condition investigation. Additionally, the file was void of any investigative activity from November 2007 until the claimant called the Company in June 2008.

2(d). In one instance, the claimant submitted the necessary forms to the agent to have a policy exclusion removed. The agent forwarded the forms to the Company for processing. In order to approve the request, the Company required an original signature on the form. The Company instructed the agent to pursue an original signature, however, the agent’s efforts are undocumented. Subsequently, the claimant submitted a claim which was denied based on the exclusion the claimant had previously sought to remove.

2(e). In one instance, the Company failed to follow its procedure to request the appropriate medical records upon receiving the signed medical authorization from the claimant.

Summary of Company Response to 2(a): Although the Company does not agree that it failed to adopt and implement reasonable standards for the prompt investigation and processing of claims, in this instance involving the FPO policy, the Company acknowledges that the benefit analyst failed to follow company procedure. After the Company denied the claim initially on the basis that the policy’s Pre-Existing Condition Exclusion applied to the claimant’s disability, the benefit analyst recognized the decision was made in error and immediately paid benefits. The Company has used

this particular claim as a training opportunity for analysts who handle individual disability claims involving FPO.

Although the Company does not agree that it failed to adopt and implement reasonable standards for the prompt investigation and processing of claims, in regard to completing the review of an adverse determination within 45 days, the Company acknowledges the individual handling the adverse review did not meet Company expectations. The Short Term Disability Benefits Department has performance criteria for claims management that comply with the California timeliness requirements. As part of a corrective action, the analyst handling this claim was reminded of the requirements.

Although the Company does not agree that it failed to adopt and implement reasonable standards for the prompt investigation and processing of claims, in regard to the final instance, the Company agrees a closing letter was not forwarded to the claimant. The Company requires that all claimants be notified in writing that their claim will be or has been closed. As a result of the Department's inquiry, the analyst handling this claim was reminded of this claim requirement.

As a threshold issue the Company strongly disagrees that isolated instances of human error in failing to meet a California regulation rise to the level of a violation under §790.03(h)(3). Similarly, an employee's error or oversight in compliance with an established Company procedure which is routinely followed does not support a conclusion that the Company has failed to establish and implement appropriate procedures to reasonably and promptly manage claims.

Summary of Company Response to 2(b): The Company has conducted a review of its procedures related to the processing of premium. As a result, a new procedure was implemented whereby all premium refunds to an insured are processed within three to five business days from the date when notice of the right to a premium refund is received. On September 16, 2009, the Company conducted training on this new procedure with employees who are assigned the responsibility of refunding premiums.

Summary of Company Response to 2(c): Although the Company disagrees that it failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies, the Company agrees that in this isolated instance, the analyst did not properly investigate the issue related to a particular coverage and thereby, did not meet the Company's performance expectations that new claims will be investigated timely. As a remedial measure, the analyst was reminded of proper claims handling requirements.

As a threshold issue the Company strongly disagrees that isolated instances of human error in failing to meet a California regulation rise to the level of a violation under §790.03(h)(3). Similarly, an employee's error or oversight in compliance with an established Company procedure which is routinely followed does not support a conclusion that the Company has failed to establish and implement appropriate procedures to reasonably and promptly manage claims.

Summary of Company Response to 2(d): Although the Company does not agree it failed to adopt and implement reasonable standards for the prompt investigation and processing of claims under CIC §790.03(h)(3), the procedures in place at the time the claimant submitted their request did not allow for the processing of faxed application requests. Since that time the procedures have changed to allow submissions of forms by facsimile. As a remedial measure, the Company reconsidered this claim. As a result, benefits were paid in the amount of \$6,096.65 plus interest in the amount of \$228.81.

As a threshold issue the Company strongly disagrees that isolated instances of human error in failing to meet a California regulation rise to the level of a violation under §790.03(h)(3). Similarly, an employee's error or oversight in compliance with an established Company procedure which is routinely followed does not support a conclusion that the Company has failed to establish and implement appropriate procedures to reasonably and promptly manage claims.

Summary of Company Response to 2(e): In a letter, the Company requested that the claimant forward all of their medical records based on the Documentation provision of the STD group policy. This provision highlights that the Company has the right to request

...any other items we may reasonably require in support of your claim. If you do not provide the documentation within 60 days after we mail you our request, your claim may be denied.

Although the claimant's authorization had been received at the time the claimant was asked to provide copies of their medical records, there is no provision stating that the Company must obtain copies of the medical records specifically because the Company received the claimant's signed authorization. While not a regulatory requirement, the Company agrees the general practice is to use a claimant's authorization when appropriate to gather medical records to assess a claim. However, the Company disagrees that a failure to request medical records in one instance, if inconsistent with the Company's own procedures, rises to a violation under CIC §790.03(h)(3).

The individual who investigated this claim is no longer with the Company and therefore could not be counseled on the Company's general practice. However, the team supervisor has confirmed that the other team members understand the Company's procedure with the regard to the use of a claimant's authorization.

As a threshold issue the Company strongly disagrees that isolated instances of human error in failing to meet a California regulation rise to the level of a violation under §790.03(h)(3). Similarly, an employee's error or oversight in compliance with an established Company procedure which is routinely followed does not support a conclusion that the Company has failed to establish and implement appropriate procedures to reasonably and promptly manage claims.

3. In five instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In these instances, the Company informed the claimants that their disability income benefits had been approved. However, once the Company determined the claimant was eligible for SDI benefits, the maximum off-set was applied to the disability benefits resulting in an underpayment of the claim. After the Company applied the maximum off-set, it would instruct the claimant to send a copy of the check stub from SDI to verify the amount actually received. Once this information was received, the Company informed the claimant that an adjustment would be made to the amount of their disability benefit. However, the Department identified one of the five instances alleged in which the claimant submitted verification of the actual SDI benefit amount (an amount less than the off-set) and benefits were never adjusted. In all instances, the Company had knowledge of the claimant's pre-disability earnings (PDE) and therefore could have estimated more accurately the claimant's SDI. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of Company Response: Although the Company strongly disagrees that isolated failures to meet California regulations rise to the level of a violation under CIC §790.03(h)(5), the Company agrees that for some claimants the practice of offsetting SDI benefits at the maximum rate may have resulted in underpayments of benefits for a short period of time. However, the Company affirmatively explains to the claimant that the offset is an estimate and requests that the claimant provide documentation of the benefit amount if the offset is greater than the SDI benefit paid. Normal company practice is to adjust and pay the claim promptly when claimants provide the documentation that the SDI benefit is less than the offset amount. There is no intent to misapply offsets.

The Company believes its procedure, when originally implemented, was reasonable. However, as corrective actions, the Company issued payments plus interest in the amounts of \$413.93 and \$348.29 for two of the claims. The Company's failure to immediately adjust benefits upon receipt of the SDI benefit amount was an individual oversight. It is the Company's performance criteria to make the adjustment within 5 days of receiving additional information. As a result of this examination the Company has made the appropriate adjustment and issued a payment with interest in the amount of \$896.10.

As an additional remedial measure, by December 2009, the Company implemented and trained Benefits staff on a new procedure for estimating and deducting SDI benefits. Furthermore, the Company is conducting a survey on STD claims received on or after March 1, 2006, and pay additional benefits, with interest, that may be due. As of July 1, 2010, the partial results of this survey reported by Standard indicated \$1,091,000.00 in payments and \$233,000 in interest returned to claimants. The final results of the survey and additional payments, if any, to 45 deceased claimants shall be reported to the Department by December 31, 2010.

4. In three instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. The Company failed to inform the insureds of an applicable Daily Hospital Benefit. 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 Company Response: The Company agrees that specifics about the Daily Hospital Benefit were not included in correspondence sent to the claimant. As a remedial measure, the Company enhanced its correspondence to include additional information on the Daily Hospital Benefit.

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

Summary of Company Response: The Company agrees that its correspondence inadvertently left out the California Department of Insurance statement. It is the Company's practice to include the notice to individuals residing in California and insured under coverage issued to California employers. The Company has a written policy for appropriate inclusion of language advising claimants of their right to contact the California Department of Insurance. As a remedial measure, all Benefits Department claims analysts have received a reminder regarding this notice requirement. However, the Company strongly disagrees that isolated instances of human error in failing to meet a California regulation rise to the level of a violation under §790.03(h)(3). Similarly, an employee's error or oversight in compliance with an established Company procedure which is routinely followed does not support a conclusion that the Company has failed to establish and implement appropriate procedures to reasonably and promptly manage claims.

6. In one instance, the company failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability. The Department alleges this act is in violation of CIC §10111.2(c) and is an unfair practice under CIC §790.03(h)(5).

Summary of Company Response: The Company agrees interest was owed on this late payment. As a remedial measure, the Company issued an interest payment in the amount of \$188.36. The Company believes that a failure to pay interest on late paid benefits, which is inconsistent with Company practice and procedures, does not rise to a violation under CIC §790.03(h)(5). Furthermore, the Company strongly disagrees that isolated failures to meet California regulations rise to the level of a violation under CIC §790.03(h)(5).

7. In one instance, the Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. In one instance, the claim was denied wrongfully because the pre-existing condition

provision did not apply to the FPO. As a result, payment of the STD benefit was delayed by nearly four months. The Department alleges this act is in violation of CIC §790.03(h)(1).

Summary of Company Response: An error was committed under the policy's Pre-Existing Condition Exclusion. However, when the analyst discovered the error, they corrected it and immediately paid disability benefits with interest. The Company does not agree that this isolated failure to meet California regulations, caused by human error, rises to the level of a violation under CIC §790.03(h)(1).

8. In one instance, the Company improperly required a claimant to give notification of a claim or proof of claim within a specified time. Specifically, the Company failed to provide the claimant with a reasonable time frame upon which to submit medical records. In a letter, the claimant was instructed to submit medical records within 20 days, after which time the Company would make a claim determination with the currently available medical information in the file. The Department alleges this act is in violation of CCR §2695.4(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of Company Response: The Company agrees the 20 days stated in the letter were not reasonable in terms of how the Company expressed the time period and will reiterate that point to the Benefits department. However, the Company strongly disagrees that isolated instances of human error in failing to meet a California regulation rise to the level of a violation under §790.03(h)(3). Similarly, an employee's error or oversight in compliance with an established Company procedure which is routinely followed does not support a conclusion that the Company has failed to establish and implement appropriate procedures to reasonably and promptly manage claims.

9. In one instance, the Company failed to respond to communications within 15 calendar days. Specifically, the Company received a request for an appeal from the claimant and failed to respond 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 Company Response: The Company agrees with this instance of non-compliance. It is the Company's practice to acknowledge a request for appeal within five days of receiving the request. As a remedial action, the analyst handling the claim was reminded of the requirements and this issue will be reiterated with the Benefits department. The Company, however, does not believe that an isolated failure to meet California regulations, which was caused by human error and was inconsistent with Company procedures, rises to the level of a violation under CIC §790.03(h)(2).

10. In one instance, the Company failed to provide the written basis for the denial of the claim. The Department alleges this act is in violation of CCR §2695.7(b)(1) and is an unfair practice under CIC §790.03(h)(13).

Summary of Company Response: In this instance, the Company agrees that more explanation should have been provided to the claimant regarding the reason benefits were no longer being paid. The Company has expectations for proper claim documentation and communication with claimants. The analyst handling this claim did not comply with the Company requirements for proper documentation and communication with claimants. The analyst was reminded of this requirement upon receipt of the Department's criticism. The Company, however, does not agree that this isolated failure to meet California regulations, which was caused by human error and was inconsistent with Company procedures, rises to the level of a violation under CIC §790.03(h)(13).

ACCIDENT AND DISABILITY-HEALTH GROUP DENTAL

11. In 11 instances, the Company failed to provide to the claimant an explanation of benefits (EOB) including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

11(a). In eight instances, the provider submitted dental bills which exceeded the plan allowance for usual and customary charges. The EOB informed the claimant that the charges exceeded the plan allowance and referred the claimant to the policy or certificate booklet.

11(b). In two instances, the EOB failed to provide the claimant with a clear computation of orthodontia benefits when coverage terminated during a quarter.

11(c). In the remaining instance, the Company failed to provide the claimant and provider with an explanation of quarterly benefits for an orthodontia claim.

Summary of Company Response:

11(a). Effective on October 1, 2009, the Company revised its Dental Claim system to generate an explanation that more clearly reflects that the payment was subject to the usual and customary plan allowance.

11(b). Effective September 1, 2009, the Company changed its procedure for calculating payment of benefits when orthodontia coverage terminates during a quarter. The new procedure credits the claimant for the entire month regardless of their termination date. The payment schedule is explained in a letter to the claimant and includes the quarterly benefit amount and the dates when payment will be issued. The periodic payments are issued automatically unless the claimant's coverage changes. Should the quarterly payment be less than expected due to the termination of coverage, an explanation of the adjusted amount will be provided to the claimant.

11(c). The Company has a procedure in place to ensure that Dental Benefit Examiners set up a payment schedule for all ongoing orthodontia claims. However, in this isolated instance a payment schedule for the ongoing orthodontia services was not set up with the provider. Consequently an explanation of the quarterly payment plan was not provided to the claimant or provider. The Dental Benefits examiner was no longer an employee when the error was identified and therefore could not be reminded of the requirement. However, the Company strongly disagrees that isolated instances of human error in failing to meet a California regulation rise to the level of a violation under §790.03(h)(3). Similarly, an employee's error or oversight in compliance with an established Company procedure which is routinely followed does not support a conclusion that the Company has failed to establish and implement appropriate promptly managed claims.

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

Summary of Company Response: As a remedial measure, effective September 15, 2009, the Company changed its procedure to issue payment of benefits within 13 working days thus negating the need for a claim acknowledgment letter.

13. In one instance, the Company failed to pay interest on an uncontested claim after 30 working days. The Department alleges this act is in violation of CIC §10123.13(b) and is an unfair practice under CIC §790.03(h)(5).

Summary of Company Response: The Company agrees interest was not paid on this claim. As a remedial action, the Company issued an interest payment in the amount of \$27.57 payable to the claimant. The Company believes that a failure to pay interest on late paid benefits, which is inconsistent with Company practice and procedures, does not rise to a violation under CIC §790.03(h)(5). Furthermore, the Company strongly disagrees that isolated failures to meet California regulations rise to the level of a violation under CIC §790.03(h)(5).

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

Summary of Company Response: The Company agrees interest was not paid on this claim. As a remedial action, the Company issued an interest payment in the amount of \$5.12 payable to the claimant. The Company believes that a failure to pay interest on late paid benefits, which is inconsistent with Company practice and procedures, does not rise to a violation under CIC §790.03(h)(5). Furthermore, the Company strongly disagrees that isolated failures to meet California regulations rise to the level of a violation under CIC §790.03(h)(5).

15. In general, the Company failed to advise the provider of their right to seek a review by the Department of a contested or denied claim. The Department alleges

a general non-compliance with CIC §10123.13(a) and an unfair practice under CIC §790.03(h)(3).

Summary of Company Response: The Company agrees with the alleged citation. Effective on October 1, 2009, the Company updated its claims system to reflect current federal and state requirements. Specifically, the Company revised the EOB sent to providers to advise them of their right to contact the California Department of Insurance and to include the Department's web address.

16. In general, the Company failed to provide the claimant with an Explanation of Benefits which included the Department's Internet Website address. The Department alleges a general non-compliance with CIC §10123.13(a) and an unfair practice under CIC §790.03(h)(3).

Summary of Company Response: The Company agrees with the alleged citation. Effective on October 1, 2009, the Company updated its claims system to reflect current federal and state requirements. Specifically, the Company revised the EOB sent to claimants to include the Department's web address.

GROUP LIFE

17. In one instance, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. Specifically, the Company failed to follow its own procedure with regard to locating a named beneficiary. The Department alleges this act is in violation of CIC §790.03(h)(3).

Summary of Company Response: The Company agrees that the claims analyst does not appear to have followed Company procedure in effect at the time to locate the beneficiary. When a beneficiary is not found after a diligent search, and the Life Benefits Department has sufficient information to support payment of death benefits, the funds are forwarded to the business unit handling unclaimed funds and possible escheat to the state of the last known address of the beneficiary. In this instance, the funds were not forwarded to the unclaimed funds area as proof of loss had not been established. As a remedial action, the Company conducted additional searches and the proper beneficiary was located. The Company has concluded the claim with this beneficiary and issued payment in the amount of \$5,468.24. However, the Company strongly disagrees that isolated instances of human error in failing to meet a California regulation rise to the level of a violation under §790.03(h)(3). Similarly, an employee's error or oversight in compliance with an established Company procedure which is routinely followed does not support a conclusion that the Company has failed to establish and implement appropriate procedures to reasonably and promptly manage claims.

18. 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 Company Response: In this isolated instance, the Company agrees that it did not respond to communications from a claimant within 15 days. The Life Benefits Department has performance expectations for claims management that comply with the California timeliness requirement. As a corrective action, the analyst handling this claim was reminded of this requirement at the time of the examination. The Company, however, does not believe that this isolated failure to meet California regulations, which was inconsistent with Company policy and procedures, rises to the level of a violation of CIC §790.03(h)(2).

19. In one instance, the Company failed to acknowledge notice of claim within 15 calendar days. The Department alleges this act is in violation of CCR §2695.5(e)(1) and is an unfair practice under CIC §790.03(h)(2).

Summary of Company Response: The Company agrees with the alleged citation. The Life Benefits Department has performance expectations for claims management that comply with the California timeliness requirements. In this isolated instance, the claims examiner erroneously suppressed the claim acknowledgement letter. The analyst handling this claim was reminded of this requirement at the time of the examination. A reminder reinforcing the need for the acknowledgment letter was provided to the Life Benefits Department staff on June 16, 2009. The Company, however, does not believe that this isolated failure to meet California regulations, which was inconsistent with Company policy and procedures, rises to the level of a violation of CIC §790.03(h)(2).

20. In one instance, the Company failed to provide written notice of the need for additional time every 30 calendar days. The Department alleges this act is in violation of CCR §2695.7(c)(1) and is an unfair practice under CIC §790.03(h)(3).

Summary of Company Response: The Company agrees with the alleged citation and has indicated that the Life Benefits Department has performance expectations for claims management that comply with the California timeliness requirements. Specifically, the analyst shall send a status letter to the claimant every 30 calendar days to include an explanation of the status and the action required to resolve the claim. As a result of this examination, the analyst handling the claim was reminded of this requirement. However, the Company strongly disagrees that isolated instances of human error in failing to meet a California regulation rise to the level of a violation under §790.03(h)(3). Similarly, an employee's error or oversight in compliance with an established Company procedure which is routinely followed does not support a conclusion that the Company has failed to establish and implement appropriate procedures to reasonably and promptly manage claims.