

**[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**

**UNICARE LIFE & HEALTH
INSURANCE COMPANY
NAIC # 80314 CDI # 2450-5**

AS OF MARCH 31, 2009

ADOPTED NOVEMBER 12, 2010

STATE OF CALIFORNIA



**CALIFORNIA DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU**

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

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DEPARTMENT OF INSURANCE

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



November 12, 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:

UniCare Life & Health Insurance Company
NAIC # 80314

Group NAIC # 0671

Hereinafter, the Company listed above also will be referred to as UniCare, ULHIC 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 April 1, 2008 through March 31, 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’s responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the April 1, 2008 through March 31, 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 Chicago, Illinois.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The claims reviewed were closed from April 1, 2008 through March 31, 2009, referred to as the “review period”. Group health claims that were paid within 40 days of the date of service were excluded from the general population. The examiners randomly selected 66 ULHIC claims files for examination. In addition, the examiners specifically selected nine claims denied based on a preexisting condition, two appeals and 20 complaint files. The examiners cited 296 alleged claims handling violations of the California Insurance Code from this sample file review.

Findings of this examination included failure to respond to customer service inquiries, delays in claims processing, inadequate investigations and improper denials of claims based on the potential of preexisting conditions, and failure to provide written notice of the need for additional time to determine the Company’s liability.

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

The results of the market analysis review revealed that during 2007, an enforcement action was taken in the state of Missouri. The action alleged failure to respond to grievances timely, failure to provide complete responses to grievances, improper denial of claims, and failure to include interest with delayed claim payments. The examiner focused on these issues during the course of the file review. These issues also were reflected in the results of this examination.

The Company was the subject of 10 California consumer complaints and inquiries closed from April 1, 2008 through March 31, 2009, in regard to the line of business reviewed in this examination. The CDI alleged one violation of law for a claims handling delay. Of the complaints and inquiries, the CDI determined the complaint for a claims handling delay was justified. The examiners focused on this issue during the course of the file review.

The previous claims examination reviewed a period from October 1, 1999 through September 30, 2000. There was no specific area of concern identified in the previous claims examination.

DETAILS OF THE CURRENT EXAMINATION

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

ULHIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS/ FILES IN REVIEW PERIOD	SAMPLE FILES/CLAIMS REVIEWED	NUMBER OF ALLEGED CITATIONS
Accident and Disability / Group Health – Claims Paid	1,162	26	7
Accident and Disability / Group Health – Claims Not Paid	1,197	40	18
Accident and Disability / Group Health – Preexisting Condition Denied	5	5/9*	40
Accident and Disability / Group Health – Appeals	2	2	6
Accident and Disability / Group Health – Member Complaints	6	6/20*	225
TOTALS	2,372	79/97*	296

*In these categories, the sample for review was presented as a file. The file may have included more than one claim. The first number represents the number of files; the second represents the total number of claims.

TABLE OF TOTAL CITATIONS

Citation	Description of Allegation	ULHIC Number of Alleged Citations
CCR §2695.11(d) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date.	67
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed to respond to communications within 15 calendar days.	62
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.	54
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.	26
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	25
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim.	21
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue.	16
CIC §10123.13(a) *[CIC §790.03(h)(13)]	The Company failed to include in its notice of a claim being denied 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.	6
CIC §790.03(h)(2)	The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.	5
CCR §2695.3(b)(2) *[CIC §790.03(h)(3)]	The Company failed to record in the file the date the Company received, processed, transmitted or mailed every relevant document in the file.	4
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to reference the California Department of Insurance in its denial.	3
CIC §10123.13(b) *[CIC §790.03(h)(5)]	The Company failed to pay interest on an uncontested claim after 30 working days.	2

Citation	Description of Allegation	ULHIC Number of Alleged Citations
CIC §10169(i) *[CIC §790.03(h)(3)]	The Company failed to advise the insured of the right to an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.	2
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.	1
CIC §10123.13(a) *[CIC §790.03(h)(3)] (General)	The Company failed to properly identify the address of the Department of Insurance on its explanations of benefits, specifically those notices to members that a claim is contested or denied.	1
CIC §10123.13(a) *[CIC §790.03(h)(3)] (General)	The Company failed to properly identify the Internet Web site address of the Department of Insurance on its explanations of benefits, specifically those notices to members and providers that a claim is contested or denied.	1
Total Number of Citations		296

***DESCRIPTONS OF APPLICABLE
UNFAIR CLAIMS SETTLEMENT PRACTICES**

- CIC §790.03(h)(1) The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
- CIC §790.03(h)(2) The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- CIC §790.03(h)(3) The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.
- CIC §790.03(h)(5) The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has 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 CITATIONS BY LINE OF BUSINESS

ACCIDENT & DISABILITY GROUP HEALTH 2008 Written Premium: \$28,058,184 AMOUNT OF RECOVERIES \$1,106.86	NUMBER OF CITATIONS
CCR §2695.11(d) [CIC §790.03(h)(3)]	67
CCR §2695.5(b)	62
CIC §790.03(h)(3)	54
CIC §10123.13(a) [CIC §790.03(h)(5)]	26
CIC §790.03(h)(5)	25
CCR §2695.7(d) [CIC §790.03(h)(3)]	21
CIC §790.03(h)(1)	16
CIC §10123.13(a) [CIC §790.03(h)(13)]	6
CIC §790.03(h)(2)	5
CCR §2695.3(b)(2) [CIC §790.03(h)(3)]	4
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	3
CIC §10123.13(b) [CIC §790.03(h)(5)]	2
CIC §10169(i) [CIC §790.03(h)(3)]	2
CCR §2695.7(d) [CIC §790.03(h)(3)]	1
CIC §10123.13(a) [CIC §790.03(h)(3)] (General)	1
CIC §10123.13(a) [CIC §790.03(h)(3)] (General)	1

TOTAL

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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 responded that it takes its compliance responsibilities very seriously and continues to work hard to ensure it is compliant to the greatest extent possible. However, in October 2009, the Company announced that it was exiting the commercial medical insurance markets in the states of Illinois and Texas. This announcement reflected a strategic decision to discontinue most of UniCare's commercial medical insurance offerings. UniCare has been actively working to transition its commercial membership to other carriers at renewal. As of August 31, 2010, UniCare had 162 active California members and no insured contracts with a situs of California. All of these members are covered under group products issued in other states. While UniCare remains financially sound and capable of paying medical claims in a timely manner, competitive and regulatory pressures have made it increasingly difficult for the Company to maintain its high standards for excellent customer service and affordable, quality benefits. With the ongoing efforts to reduce commercial medical insurance operations, the Company must limit its systematic and policy changes to those strictly necessary to effect the smooth transition of claims run-out and other service obligations to customers. UniCare certainly understands that should it ever wish to fully re-engage in the commercial insurance business market that it must update its system capabilities to comply with any jurisdiction in which it wishes to do business.

Money recovered within the scope of this report was \$1,106.86 as described in sections number 5 and 12 below. Pursuant to the findings of the examination as described in section 5 below, the Company is conducting a closed claims survey resulting in additional payments of \$285.33. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$1,392.19.

ACCIDENT AND DISABILITY

1. **In 67 instances, the Company failed to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date.** The claims involved were incorrectly processed and denied. The members notified the Company through its customer service group that the claims required further attention. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

Summary of Company Response: CCR §2695.11(d) states in part as excerpted below:

“If the determination cannot be made until some future event occurs, the insurer shall comply with this continuing notice requirement by advising the claimant and assignee of the situation and providing an estimate as to when the determination can be made.”

When UniCare requests additional information, it advises the recipient to respond within 45 days, so that a determination can be made on the claim. This notice also states that if the requested information is not received within 45 days, the Company will make a determination within that time frame, based upon the information that it has. If UniCare does receive the requested information, the claim is processed accordingly. If the necessary information is not received within the specified time frame, the claim is rejected on that basis and the ERISA appeals language is appended to that written notice of the determination.

UniCare does provide notice of the future event (receipt of additional information) and provides an estimate as to when the determination can be made (45 days). UniCare follows through within the 45-day period and issues the applicable benefit determination. UniCare believes that the above process is compliant with the California regulation and with ERISA.

UniCare maintains a standard operating procedure for its customer service representatives to route to an appropriate queue any call records that require further review or that involve claim issues that cannot be resolved by the associate receiving the call. When such call records are routed appropriately, their aging and open status is

monitored through various queue reports utilized by management. UniCare randomly audits the job performance of its customer service representatives. Errors such as occurred with the noted claims are subject to detection and corrective action, as well as providing the basis for objective performance evaluation.

UniCare acknowledges the noted claims were mishandled. The Company has a specific Operations Bulletin that reiterates the unique pricing and procedures to be followed when claims are received from the provider associated with these claims. The procedures provided in the Operations Bulletin along with the random audits of job performance are in place as UniCare's remedial measure with respect to this issue.

2. In 62 instances, the Company failed to respond to communications within 15 calendar days. Sixty-one instances are the result of the Company's failure to respond to member's telephone inquiries into the status of claim payments. One is based on the Company's failure to respond promptly to a member's telephone appeal. These instances occurred prior to November 2008. The Department alleges these acts are in violation of CCR §2695.5(b) and are unfair practices under CIC §790.03(h)(2).

Summary of Company Response: Regarding the instances in which the Company failed to respond promptly to telephone inquiries into the status of payments and to a telephone appeal, UniCare implemented controls to assure that open inquiries are routed and handled timely. In November 2008, senior management escalated its focus on inventory levels in claims and customer service queues (adjustments, correspondence and other inquiries) in order to maintain inventories at acceptable levels and to improve customer service. Daily monitoring and accountability for the status of inventories are the responsibility of managers who report weekly to the Claims Operation Director who reports to the Claims Vice President. This process allows active management of items in queue resulting in improved response time.

Also, from January 1, 2007 through December 31, 2009, UniCare conducted a member call satisfaction program through an outside vendor that reported weekly to management on customer complaint concerns. Information developed in this process provided Company management the opportunity to take appropriate corrective action with staff and to respond more favorably to its members. The program was discontinued following UniCare's decision to exit the commercial medical insurance market.

3. In 54 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.

In 24 instances, the Company failed to follow its own procedures for responding to requests from members for contact by a supervisor following unanswered inquiries into delayed claims payments. These instances occurred prior to November 2008.

In 12 instances, the Company failed to obtain pricing for out of network services resulting in claims processing delays of greater than five months. These instances occurred prior to November 2008.

In 12 instances, the Company failed to follow up, in line with its stated procedures, on the status of pricing requests once the claims were submitted to a pricing network resulting in claims processing delays of greater than five months. These instances occurred prior to November 2008.

Four instances were the result of data entry errors, including two which resulted in the member being incorrectly assigned responsibility for 100% of the charges, one in which a billing was incorrectly recorded under the subscriber when the patient was a dependent, and one in which it failed to key a corrected claim into its system resulting in a payment delay of three months.

One instance is based on the Company's failure to recognize and process incoming documentation as proof of claims incurred in a foreign country which resulted in delayed payment of those claims.

One instance is based on the Company's failure to follow through on its promise to the member to submit the claim for adjustment following a telephone inquiry. No action was taken resulting in a payment delay.

The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of Company Response: Regarding the 24 instances in which the Company failed to follow its own procedures for requests for contact by a supervisor, UniCare has a process in place for escalated issues and calls. Representatives are to transfer escalated calls to a senior representative or manager based on the issue. If a call back is required, the call record is noted and is closed upon completion of a call back and issue resolution. UniCare acknowledges that it appears that the referenced inquiries were not handled according to this process.

As a remedial measure for these 24 instances, UniCare has implemented additional controls to manage inventories and aged items. In November 2008, senior management escalated its focus on inventory levels in claims and customer service queues in order to maintain inventories at acceptable levels and to improve customer service. Daily monitoring and accountability for the status of inventories are the responsibility of managers who report weekly to the Claims Operation Director who reports to the Claims Vice President. This process allows active management of items in queue resulting in improved response time.

Regarding the 12 instances in which the Company failed to obtain pricing for out of network services and the 12 instances in which the Company failed to follow up on the status of pricing requests once the claims were submitted to a pricing network, UniCare acknowledges that these claims were mishandled. UniCare has worked, with success, to automate the pricing of rental network claims. Claims that are received

without required re-pricing are systematically routed to a vendor and are returned with pricing within one or two days at which time the claims are processed and released. The claims in question were associated with a network that is not serviced by an automatic process. UniCare requested re-pricing on these claims but the claims were closed in error.

UniCare pursues continuous process improvement; however, there is no way to assure 100% accuracy given occasional systematic and human error. The Company's intent is to promote recognition of such outlier situations where claims and customer service staff need to manually intervene to override the systematic process to handle such exceptions. It is the Company's policy to perform random audits of claims and customer service records and to provide ongoing coaching to its associates to minimize situations which are the result, in part, of inadvertent human error. UniCare provides training resources to its associates to demonstrate its ongoing commitment to quality improvement.

As remedial measures for the 12 instances in which the Company failed to obtain pricing and the 12 instances in which it failed to follow up on pricing requests, UniCare has implemented additional controls to manage inventories and aged items. In November 2008, senior management escalated its focus on inventory levels in claims and customer service queues in order to maintain inventories at acceptable levels and to improve customer service. Daily monitoring and accountability for the status of inventories are the responsibility of managers who report weekly to the Claims Operation Director who reports to the Claims Vice President. This process allows active management of items in queue resulting in improved response time.

Regarding the four data entry errors, the referenced errors were recognized and corrected. UniCare utilizes two random, quality, daily audits to detect errors of this type. Audit results are reported monthly to management. Management uses these industry standard audits to evaluate and manage associate performance. Improved performance is achieved through coaching by management.

Regarding the failure to recognize incoming documentation as proof of claim, UniCare acknowledges this error stating that it has procedures in place for processing foreign claims, but those procedures were not followed in this instance. UniCare utilizes two random, quality, daily audits to detect errors of this type. Audit results are reported monthly to management. Management uses these industry standard audits to evaluate and manage associate performance. Improved performance is achieved through coaching by management.

Regarding the instance in which the Company failed to follow through on its promise to the member to submit the claim for adjustment following a telephone inquiry, UniCare states that controls have been implemented to assure that open inquiries are handled timely. The involvement of senior management as previously described includes weekly monitoring of items in queue and their age to promote timely turnaround and response. However, if a claim is not submitted for adjustment, the claim would not be in a queue subject to monitoring. While UniCare has gone to great lengths

to improve the integrity of this process, these controls will not prevent an inadvertent error of omission by a customer service representative.

UniCare's standard procedure for customer service representatives is to route to the appropriate queue any call records that require further review and/or adjustment that cannot be resolved by the associate who receives the call. When such call records are routed appropriately, their aging and open status is monitored through the various queue reports utilized by management. UniCare randomly audits the job performance of customer service representatives. Errors such as these are subject to detection and corrective action and provide a basis for objective performance evaluation. The procedures for routing call records, in addition to the random audits of job performance, are in place as the Company's remedial measure with respect to this issue.

UniCare has announced recently that competitive pressures have caused it to evaluate its business strategy in the states in which it does business. As a result, UniCare has decided to exit from its commercial health insurance markets in Illinois and Texas, and notices have been sent to groups and members located in those states. While UniCare continues to be financially secure, it currently is evaluating its business strategy in other states. UniCare anticipates that it will have few active medical members in the state of California by second quarter of 2011.

4. In 26 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Summary of Company Response: The Company acknowledges these errors and has implemented controls to ensure claims are routed for processing timely. In November 2008, senior management escalated its focus on inventory levels in claims and customer service queues in order to maintain inventories at acceptable levels and to improve customer service. Daily monitoring and accountability for the status of inventories are the responsibility of managers who report weekly to the Claims Operation Director who reports to the Claims Vice President. This process allows active management of items in queue resulting in improved response time.

5. In 25 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.

In 12 instances, the Company failed to take action to process out of network claims. Documentation supports that, on November 7, 2007, a Company representative recognized what action needed to be taken to process the out of network claims, but did not take the noted action. The claims remained unpaid until April 10, 2008.

In nine instances, the Company wrongfully denied claims. In eight of the instances, the Company wrongfully denied based on the preexisting condition exclusion. The remaining claim was incorrectly denied stating that the service provided was not a covered benefit when it was.

In two instances, the Company incorrectly calculated the claim payment.

In one instance, the Company improperly applied the policy deductible, resulting in the member bearing responsibility for the claim.

In one instance, the Company incorrectly closed the claim without payment after proof was received.

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

Summary of Company Response: Regarding the 12 instances in which there was a failure to process out of network claims, the Company acknowledges these outlier situations that should have been handled better. Queue backlogs that existed in this time frame have been resolved. The Company has implemented additional controls to manage inventories and aged items. In November 2008, senior management escalated its focus on inventory levels in claims and customer service queues in order to maintain inventories at acceptable levels and to improve customer service. Daily monitoring and accountability for the status of inventories are the responsibility of managers who report weekly to the Claims Operation Director who reports to the Claims Vice President. This process allows active management of items in queue resulting in improved response time.

Eight of the nine claims were wrongfully denied based on the preexisting condition exclusion. As a result of the findings of the examination, UniCare issued payments totaling \$1,013.00 on claims that were wrongfully denied based on the preexisting condition exclusion. Following the examination, the Company provided to the examiners involved additional coaching which included individual retraining in procedures relating to preexisting condition investigations. Going forward, UniCare plans to reinforce the preexisting investigation procedural training as needed. The remaining claim that was incorrectly denied was the result of a determination that the service provided was not a covered benefit. Prior to the examination the provider brought this error to the attention of the Company and the claim was paid. UniCare utilizes two random, quality, daily audits to detect errors of this type. Audit results are reported monthly to management. Management uses these industry standard audits to evaluate and manage associate performance. Improved performance is achieved through coaching by management.

In an effort to correct possible past harm for claims denied outside the examination review period, the Company has conducted an audit of claims denied based on the preexisting condition exclusion within the time frames 4/01/07 through 3/31/08 and 4/01/09 through 3/31/10. As a result of the closed claim audit, the Company reprocessed two claims resulting in additional payments to claimants totaling \$285.33.

In response to the issues of incorrect payment determinations and the improper application of a policy deductible, the Company conducts regular audits of payments.

UniCare utilizes two random, quality, daily audits to detect errors of this type. Audit results are reported monthly to management. Management uses these industry standard audits to evaluate and manage associate performance. Improved performance is achieved through coaching by management.

In response to the instance in which the Company incorrectly closed a claim without payment after proof was received, UniCare has implemented controls to ensure that claims are routed timely. In November 2008, senior management escalated its focus on inventory levels in claims and customer service queues in order to maintain inventories at acceptable levels and to improve customer service. Daily monitoring and accountability for the status of inventories are the responsibility of managers who report weekly to the Claims Operation Director who reports to the Claims Vice President. This process allows active management of items in queue resulting in improved response time.

6. In 21 instances, the Company failed to conduct and pursue a thorough, fair and objective investigation of a claim.

In nine instances involving claims denied based on the preexisting condition exclusion, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation of the member's medical history. The Company did not seek information from the member regarding his medical history in order to clarify whether a medical condition was actually preexisting.

In eight instances involving claims denied based on the preexisting condition exclusion, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation of the claims presented. Seven of the eight instances were the result of the Company incorrectly identifying the member's condition as preexisting when medical records did not support that the condition was preexisting. In the remaining instance, the member's medical history included conflicting information and did not include any specific details regarding the alleged preexisting diagnosis and treatment of the alleged preexisting medical condition.

Four instances were the result of a failure to follow up on investigation noted in its files. Two of the instances are based on file notes indicating that information was needed; however there was no documentation that the Company took any action to obtain the information. Two of the instances are based on the failure of the Medical Review Unit to pursue investigation of medical information provided to it.

The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of Company Response: Regarding the nine instances of claims denied based on the preexisting condition exclusion in which the Company failed to seek information from the member regarding his medical history, the Company has procedures in place to investigate preexisting conditions.

As a result of the examination UniCare recognized that it was not providing large group members with a notice that it was requesting medical information from a provider. The large group member would be made aware only through the closing letter to the provider if no response is received or through the EOB confirming the claim determination once the provider responds and the claim is finalized. UniCare agrees that the member should be made aware as soon as possible when additional information is required to process claims. Under normal circumstances, the Company would immediately take steps to rectify its process to address this issue. However, UniCare is exiting the medical insurance market and by the second quarter of 2011 will have few active insurance members. To address this issue, UniCare will implement a manual process to ensure the member receives a letter advising them whenever a pre-existing investigation is being initiated.

Regarding the eight instances in which claims did not receive the benefit of an investigation and were denied based on the preexisting condition exclusion, the Company has procedures in place for investigating preexisting conditions. In five of the instances, the Company had counseled the involved examiners prior to the examination. In the remaining three instances, following the examination, the Company extended one on one coaching on the appropriate preexisting investigation to the claims examiners involved. The Company conducts random audits of claims tracking all errors to the individual examiner. Initial general retraining on preexisting condition investigation and procedures for claims examiners was completed on March 5, 2009. General refresher training occurred most recently on April 5, 2010. Going forward, the Company plans to reinforce the preexisting condition investigation procedural training as needed.

With regard to the four failures to follow up on investigation noted in its files, the Company implemented controls to assure that open inquiries are routed and handled timely. In November 2008, senior management escalated its focus on inventory levels in claims and customer service queues in order to maintain inventories at acceptable levels and to improve customer service. Daily monitoring and accountability for the status of inventories are the responsibility of managers who report weekly to the Claims Operation Director who reports to the Claims Vice President. This process allows active management of items in queue resulting in improved response time.

7. In 16 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. Specifically, the Company issued to claimants benefit explanations with incorrect information.

In 12 instances, the Company incorrectly advised members in writing that claims were rejected. The claims were rejected due to the Company's incorrect processing of them.

Three of the instances are based on explanation of benefit (EOB) errors. The three errors include a message that an adjustment would be made to the claim submission when that was not the case, a message that incorrectly advised additional information was needed and the final one which provided incorrect claim calculations.

The remaining instance is based on a notice of appeal process which incorrectly notified the member to direct an appeal to the District of Columbia Department of Health rather than the California Department of Insurance which has jurisdiction.

The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of Company Response: Regarding the 12 instances in which the member was incorrectly advised that claims were rejected, UniCare pursues continuous process improvement however there is no way to assure 100% accuracy given occasional systematic and human error. UniCare has worked, with success, to automate the pricing of rental network claims. The subject claims were from a provider that presents a unique challenge to the Company's standard processes. UniCare requested re-pricing on these claims however the claims were closed in error. The Company's intent is to promote recognition of outlier situations in which claims and customer service staff need to manually intervene to handle exceptions by overriding the systematic routing process. It is UniCare's policy to perform random audits of claims and customer service records and to provide ongoing coaching to its associates to minimize similar situations that result in part from inadvertent human error. UniCare provides its associates with training resources specific to this provider as a demonstration of its ongoing commitment to quality improvement. These training resources along with the random audits of job performance are in place as the Company's remedial measure with respect to this issue. The issue involves an EOB of a secondary payer (UniCare). It has been determined that the provider EOB is printing as designed but clearly is not meeting the expectation of what should be communicated to the provider. As a result, UniCare will institute a manual process to advise the claim processor to issue a manual EOB to the provider in secondary payor COB situations to correctly reflect a breakdown of the UniCare remittance.

Two of the three instances based on EOB errors appear to have been the result of data input errors by processors. Following the examination, the processors were coached and given reference lists of codes and their definitions as enrichment training to minimize these types of errors going forward. Regarding the EOB that provided incorrect claims calculations, the error was either an input error or a system "glitch". The Company has escalated this issue to its information technology management area for investigation. Due to the uniqueness of the issue, it may not be possible to recreate the occurrence. UniCare will continue to pursue the issue and will provide the Department with a response upon resolution.

The remaining instance based on the notice of appeal process which incorrectly directed the member to appeal to the District of Columbia Department of Health rather than the California Department of Insurance was an oversight on the part of the appeal coordinator who was coached regarding the error.

8. In six instances, the Company failed to include in its notice of a claim being denied 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. Five of these instances were noted in the claims denied based on the preexisting condition exclusion. The remaining instance was observed on a claim that was denied because the service was determined to be experimental or investigative. 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 Company Response: With regard to the five claims denied based on the preexisting condition exclusion, it is the Company's position that member EOBs display the lines of service that are being denied and reference the plan exclusion upon which the denial is based. The EOB message in these cases states, "The patient's coverage is subject to a waiting period for pre-existing conditions. No benefits are payable for this service because it was rendered during the waiting period. Refer to your plan of coverage booklet for details regarding plan benefits."

With regard to the claim that was denied because the service was determined to be experimental or investigative, it is UniCare's position that the specific line of service that was denied was identified; however, the denial message was not specific but stated the procedure was not a covered expense and referred the member to the plan of coverage booklet for details.

When a member receives a denial, regardless of the information provided on the EOB, it is common for the member to contact customer service for clarification. UniCare's EOBs prominently display customer service contact information to encourage follow up calls, during which a customer service associate can provide the specific information. It is the Company's position that, to a great extent, it is compliant with this statute as EOBs provide contract provisions under which a claim is denied.

In addition, it was agreed that UniCare will mail to all its active members in the state of California a notice advising the member that they have the right to contact Unicare whenever they have questions regarding any Claim Explanation of Benefits. The notice will direct the member to call the toll free telephone number that appears prominently on the Explanation of Benefits form and on the back of their insurance ID card.

9. In five instances, the Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. Four instances are the result of the Company's failure to respond to the receipt of medical records it had requested from a provider. The remaining instance is the result of the Company's failure to respond to a provider's telephone inquiry. The Department alleges these acts are in violation of CIC §790.03(h)(2).

Summary of Company Response: The Company has implemented controls to assure that open inquiries are routed and handled timely. In November 2008, senior management escalated its focus on inventory levels in claims and customer service queues in order to maintain inventories at acceptable levels and to improve customer service. Daily monitoring and accountability for the status of inventories are the responsibility of managers who report weekly to the Claims Operation Director who

reports to the Claims Vice President. This process allows active management of items in queue resulting in improved response time.

10. In four instances, the Company failed to record the date the Company received, processed, transmitted or mailed every relevant document in the file. In these instances documents were sent to the Company by fax which recorded the sent and received date. Company processing resulted in an inaccurate recording of the receipt date of the documents. The Department alleges these acts are in violation of CCR §2695.3(b)(2) and are unfair practices under CIC §790.03(h)(3).

Summary of Company Response: UniCare acknowledges these instances in which the processor misread the Julian date. UniCare utilizes two random, quality, daily audits to detect errors of this type. Audit results are reported monthly to management. Management uses these industry standard audits to evaluate and manage associate performance. Improved performance is achieved through coaching by management.

11. In three instances, the Company failed to reference the California Department of Insurance in its claims denial. These instances were noted in the Appeals category. 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: UniCare acknowledges these instances which were oversights on the part of the coordinator who was coached regarding the errors.

12. In two instances, the Company failed to pay interest on an uncontested claim after 30 working days. Of the two instances, one is based on a late payment of benefits to a member; the other is based on an incorrect calculation of interest owed. 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 Company Response: UniCare acknowledges that the claims were not paid timely and that interest was either not included or was incorrectly calculated. As a result of the findings of the examination, UniCare issued additional payments on both claims totaling \$93.86.

13. In two instances, the Company failed to advise the insured of the right to an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(3).

Summary of Company Response: UniCare acknowledges these instances which were oversights on the part of the coordinator who was coached regarding the errors.

14. In one instance, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. In this instance, the Company issued a request for information that it already had on the referring physician, when it was actually seeking a corrected procedure code. 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 Company Response: UniCare acknowledges this instance which was the result of a logic error in its claim system that resulted in a problem with system generated letters. The systematic logic error was corrected in July 2009.

15. In general, the Company failed to properly identify the address of the Department of Insurance on its explanations of benefits. The Department alleges a general non-compliance with CIC §10123.13(a) based on the Company's failure to provide the correct street address of the Department of Insurance on explanations of benefits sent to its subscribers. 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 Company Response: While UniCare's EOBs contain a message that includes the address and telephone number of the California Department of Insurance, there was a typographical error in the street name of the CDI's address on the subscriber copies. UniCare made the correction and put it into production effective November 7, 2009.

16. In general, the Company failed to include the Internet Web site address of the Department of Insurance on its explanations of benefits. The Department alleges a general non-compliance with CIC §10123.13(a) based on the Company's failure to provide the internet web site address of the Department of Insurance on explanations of benefits sent to subscribers and providers. 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 Company Response: UniCare added the internet web address of the California Department of Insurance to the message page of EOBs for both members and providers effective January 29, 2010.