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BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

SAN FRANCISCO

In the Matter of the Certificate of Authority of: BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY, Respondent.	CDI File No. OSC-2007-00067 OAH No.: 2008020772 SECOND AMENDED ORDER TO SHOW CAUSE (Insurance Code §§790.03, 790.05, and 790.06 and California Code of Regulations, Title 10, §§2695.1 et seq.; ACCUSATION (Insurance Code §§700(c), 704(b), 790.03, 790.05, 790.06, 796.04, 10113, 10123.13, 10123.131, 10169, 10380, 10381.5, 10384, and 10400 and California Code of Regulations, Title 10, §§2695.1 et seq.; NOTICE OF NONCOMPLIANCE AND HEARING (Insurance Code §§700(c), 704(b), 790.03, 790.05, 790.06, 796.04, 10113, 10123.13, 10123.131, 10169, 10380, 10381.5, 10384, and 10400 and California Code of Regulations, Title 10, §§2695.1 et seq.; and, DEMAND FOR MONETARY PENALTY (Insurance Code §§790.035, 790.08, and 12976).

The Insurance Commissioner of the State of California ("Insurance Commissioner") in his official capacity alleges that:

JURISDICTION AND PARTIES

1. From July 1, 1954 to the present, Respondent, BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY ("BLUE SHIELD"), has been the holder of a Certificate of Authority issued by the Insurance Commissioner authorizing Respondent to transact the business of life and disability insurance in the State of California, pursuant to §700 et seq. of the California Insurance Code.[1]

2. Respondent, BLUE SHIELD, is a California corporation and a wholly-owned subsidiary of Blue Shield of California.

3. On or about August 2005, the California Department of Insurance's ("Department") Field Claims Bureau commenced a routine Market Conduct examination of BLUE SHIELD'S claims practices and procedures in California, pursuant to §§730, 733 and 735.5, to determine whether BLUE SHIELD'S denial of claims and claims handling practices during the twelve-month period from June 1, 2004 through May 31, 2005 conformed to its contractual obligations and applicable law. The examination occurred in BLUE SHIELD'S corporate offices in San Francisco. The investigation included an examination of claims files and related records involving Group and Individual Preferred Provider Organization product lines, Individual Short-Term Health products, and Group and Individual life insurance product lines; and an examination of BLUE SHIELD'S guidelines, policies and procedures, training plans, and forms adopted by BLUE SHIELD for use in California. The examination also covered the work practices of BLUE SHIELD'S third-party administrator for BLUE SHIELD'S Short-Term Health product, Comprehensive Benefits and Claims Administrators, located in Minneapolis, Minnesota.

[1] All citations are to the California Insurance Code unless otherwise indicated.

4. Concurrent with the Department's initial routine examination of BLUE SHIELD'S claims handling practices, the Department conducted a targeted Market Conduct examination focusing on BLUE SHIELD'S rescission practices during the same twelve-month period from June 1, 2004 through May 31, 2005. The targeted examination regarding rescissions covered Individual and Family Plan health insurance products to determine whether such rescission practices and related claims settlement practices conformed to contractual obligations and applicable law.

5. The Department's Public Report of the Market Conduct Examination As of May 31, 2005 stated the manner and extent to which BLUE SHIELD'S noncompliance with Insurance Code §790.03 and California Code of Regulations, title 10, §§2695.1 et seq. (attached hereto as Exhibit 1),[2] and specified a reasonable time thereafter in which such noncompliance may be corrected.

6. The Department's Report of the Market Conduct Examination As of May 31, 2005 stated the manner and extent to which BLUE SHIELD'S noncompliance with violations of laws other than §790.03 and California Code of Regulations, title 10, §§2695.1 et seq., is alleged (attached hereto as Exhibit 2),[3] and specified a reasonable time thereafter in which such noncompliance may be corrected.

7. California Insurance Code §700(c) provides that, after the issuance of a certificate of authority, the holder must continue to comply with all requirements set forth in the Insurance Code and all other applicable laws of this State.

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[2] The Public Report of the Market Conduct Examination As of May 31, 2005, attached as Exhibit 1, contains only alleged violations of Cal. Ins. Code §790.03 and Cal. Code Regs. , tit. 10, §§2695 et seq. identified in the combined initial and targeted examinations.

[3] The Report of the Market Conduct Examination As of May 31, 2005, attached as Exhibit 2, contains only alleged violations of laws other than Cal. Ins. Code §790.03 and Cal. Code Regs., tit.10, §2695 et seq. identified in the combined initial and targeted examinations.

8. California Insurance Code §704(b) provides that the Commissioner may suspend an insurer's certificate of authority, after hearing, for not carrying out its contracts in good faith.

9. California Insurance Code §10400 provides, in pertinent part, that the Commissioner may suspend an insurer's certificate of authority for willfully engaging in postclaims underwriting, in violation of Insurance Code §10384, or willfully violating any other provision of Chapter 4, Part 2, Division 2 of the Insurance Code.

10. California Insurance Code §§730, 733, 734, and 790.04 authorize the Commissioner access to all records of an insurer and the power to examine the affairs of every person engaged in the business of insurance to determine whether such insurer or person has complied with all laws applicable to insurance transactions.

11. California Insurance Code §790.02 prohibits any insurer from engaging in this State "in any trade practice which is … an unfair method of competition or an unfair or deceptive act or practice in the business of insurance."

12. California Insurance Code §790.03 defines unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. Section 790.03(h) enumerates sixteen (16) claims settlement practices that, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices, and are thus prohibited.

13. California Code of Regulations ("CCR"), Title 10, Chapter 5, Subchapter 7.5, Article 1 contains Fair Claims Settlement Practices Regulations "to promote the good faith, prompt, efficient and equitable settlement of claims." These regulations delineate certain minimum standards for the settlement of claims which, when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code §790.03(h).

Other acts or practices not specifically delineated in this set of regulations may also be unfair claims settlement practices subject to Insurance Code §790.03. All licensees are required to have thorough knowledge of such regulations.

14. CCR, title 10, §2695.1(g) provides that failure of a licensee to provide the commissioner with requested information sufficient to examine the licensee's claims handling practices may justify a finding that the licensee was in noncompliance with these regulations or California Insurance Code §790.03.

15. CCR, title 10, §2695.3(a) requires all insurers to maintain all documents, notes and work papers, including copies of all correspondence, pertaining to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined.

16. CCR, title 10, §2695.5(a) requires a licensee to respond immediately to an inquiry from the Department concerning a claim, but in no event more than twenty-one (21) calendar days of receipt of that inquiry. This section is not intended to permit delay in responding to inquiries by Department personnel conducting an examination on the insurer's premises.

17. CCR, title 10, §2695.7(b) (1) requires a licensee to provide to a claimant, in writing, the factual and legal basis for denial of a claim. Section 2695.7(b) (3) further requires a licensee 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, and must include the address and telephone number of the unit of the Department which reviews claims practices.

18. CCR, title 10, §2695.7(d) provides that every insurer must conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required or material to the resolution of a claim dispute.

19. California Insurance Code §790.035 provides that "any person who engages in any unfair method of competition or any unfair or deceptive act or practice defined in §790.03 is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars ($5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act. The commissioner shall have the discretion to establish what constitutes an act."

20. California Insurance Code §790.06 provides for the prosecution of unfair methods of competition and unfair and deceptive acts or practices in the business of insurance that are not defined in §790.03.

21. California Insurance Code §790.08 states that "The powers vested in the commissioner in this article shall be additional to any other powers to enforce any penalties, fines or forfeitures, denials, suspensions or revocations of licenses or certificates authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive."

22. California Insurance Code §796.04 provides that a health insurer "that authorizes a specific type of treatment for services covered under a policyholder's contract by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract...."

23. California Insurance Code §10113 provides that "Every policy of life, disability, or life and disability insurance issued or delivered within this State... shall contain and be deemed to constitute the entire contract between the parties and nothing shall be incorporated therein by reference to any constitution, by-laws, rules, application or other writings, of either of the parties thereto or of any other person, unless the same are indorsed upon or attached to the policy...."

24. California Insurance Code §10169 provides, in pertinent part, that, under the Legislature's establishment of an Independent Medical Review System in the Department of Insurance, commencing January 1, 2001, every disability insurer must provide an insured with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the insurer...if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. Subsection (i) of §10169 requires that "every disability insurer shall prominently display in every ...insurance contract, ...on copies of insurer procedures for resolving grievances, on letters of denials issued by either the insurer or its contracting organization, and on all written responses to grievances, information concerning the right of an insured to request an independent medical review" from the Department of Insurance "in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer or by one of its contracting providers."

25. California Insurance Code §10123.13 requires that "Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses...shall reimburse claims..., whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the insurer." If the claim is contested or denied by the insurer, the claimant shall be notified in writing within 30 working days after receipt of the claim. Such notice must identify the portion of the claim that is contested or denied and the specific reasons including the factual and legal basis for contesting or denying the claim. The insurer shall provide a copy of such notice to the insured's health care provider that provided the services at issue. If an uncontested claim is not reimbursed within 30 working days after receipt, or if the insurer has received all of the information necessary to determine payer liability for a contested claim that is determined to be payable and has not reimbursed the claim within 30 working days

of receipt of that information, interest shall accrue and shall be payable at the rate of 10 percent per annum beginning with the first calendar day after the 30 working day period.

26. California Insurance Code §10123.131 provides, in pertinent part, that an insurer shall not request information that is not reasonably necessary to determine liability for payment of a claim.

27. California Insurance Code §10380 provides that the falsity of any statement in the application for insurance shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insured.

28. California Insurance Code §10381.5 provides, in pertinent part, that "the insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof."

29. California Insurance Code §10384 prohibits an insurer issuing any policy of disability insurance covering hospital, medical, or surgical expenses from engaging in the practice of postclaims underwriting. "Postclaims underwriting" is defined as "rescinding, canceling, or limiting of a policy or certificate due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application *before* issuing the policy or certificate."

FACTUAL ALLEGATIONS

30. On or about August 2005, the Department conducted a routine Market Conduct examination of BLUE SHIELD'S claims handling practices during the period of June 1, 2004 through May 31, 2005. The examination focused primarily on whether BLUE SHIELD'S claims handling and claims settlement practices were effectuated promptly, fairly, and equitably, in conformance with contractual obligations and California law.

31. Concurrently, the Department conducted a targeted examination of Blue Shield's rescission practices during the same twelve month period from June 1, 2004 through May 31, 2005. The targeted examination covered only Individual and Family Plan health insurance policies.

32. Between June 1, 2004 and May 31, 2005, Blue Shield rescinded one hundred eighty-five (185) Short-Term-Health insurance policies and forty-four (44) Individual and Family Plan health insurance policies, totaling two hundred twenty-nine (229) policies.

33. During the initial Market Conduct examination, the examiners reviewed two hundred eighty-six (286) claims files involving various Blue Shield lines of business, including Group and Individual Preferred Provider Organization health insurance products, Individual Short-Term Health products, and Group and Individual life insurance products. The initial examination included ten (10) rescinded and cancelled Individual and Family Plan health insurance policies. During the concurrent targeted examination, the examiners reviewed the remaining thirty-four (34) rescinded Individual and Family Plan health insurance policies during that time period. In sum, the examiners reviewed three hundred twenty (320) files.

34. Based on the combined examinations, the Department alleges that BLUE SHIELD has engaged in the following five hundred seventy-five (575) unfair or deceptive acts or practices,[4] in violation of California Insurance Code §790.03 and/or the Fair Claims Settlement Practices Regulations, as more fully described in the attached Market Conduct reports:

Failure to Act Reasonably Promptly Upon Communications Regarding Claims

(a) In one hundred seventy-six (176) instances, BLUE SHIELD failed to respond to an inquiry by the Department's examiners within 21 calendar days, in violation of CCR, title 10,

§2695.5(a). In many of those instances, BLUE SHIELD took 22 to 100 days to respond.

(b) In at least one (1) instance, BLUE SHIELD failed to acknowledge and act reasonably promptly to a provider appeal with respect to claims arising under insurance policies, in violation of California Insurance Code §790.03(h)(2).

(c) In two (2) instances, BLUE SHIELD failed to acknowledge to the claimant receipt of a notice of claim within fifteen calendar days, in violation of CCR, title 10, §2695.5(e)(1).

(d) In three (3) instances, BLUE SHIELD failed to act reasonably promptly in providing and/or maintaining all documents and records requested by Department examiners, as required by California Insurance Code §734, in violation of California Insurance Code §790.03(h)(2).

Failure to Adopt and Implement Reasonable Standards for the Prompt Investigation and Processing of Claims

(e) In one hundred twenty-five (125) instances, BLUE SHIELD failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies, in violation of California Insurance Code §790.03(h)(3).

(f) In fifty-eight (58) instances, BLUE SHIELD failed to maintain all documents, notes, correspondence, and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined, in violation of CCR, title 10, §2695.3(a).

(g) In seventeen (17) instances, BLUE SHIELD failed to respond at all or failed to properly evaluate responses from policyholders who appealed rescission of their coverage and denial of their claims, in violation of California Insurance Code §§790.02 and 790.03(h)(3). In one instance, an insured who applied for a plan transfer was underwritten and thereafter rescinded

[4] Of the 531 claims handling violations cited in the Market Conduct Examination Reports, 519 were identified in the initial examination and 12 in the targeted examination.

when he should not have been underwritten at all. In three instances, points that led to a rescission were assigned for symptoms in which there was no evidence of the underlying diagnosis that generated the points. In seven instances, policyholders appealed rescission of their coverage attaching statements from their health care providers refuting BLUE SHIELD'S basis for rescission, which BLUE SHIELD did not address.

Misrepresentation of Pertinent Facts or Insurance Policy Provisions to Claimants

(h) In sixty-one (61) instances, BLUE SHIELD failed to represent correctly to claimants pertinent facts or insurance policy provisions relating to a coverage at issue, in violation of California Insurance Code §790.03(h)(1). Four of these instances involved life insurance products, in which BLUE SHIELD notified claimants of life insurance benefits that a beneficiary was not designated yet BLUE SHIELD could not locate a copy of the application in the files to support such a statement.

(i) In five (5) instances, BLUE SHIELD failed to advise policyholders of their right to seek an Independent Medical Review from the Department of Insurance on letters of denials and other written materials, as required by California Insurance Code §10169(i), in violation of California Insurance Code §790.03(h)(1).

Not Attempting in Good Faith to Effectuate Prompt, Fair and Equitable Settlements

(j) In thirty-five (35) instances, BLUE SHIELD failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongly denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, along with the address and telephone number of the unit of the Department which reviews claims practices, in violation of CCR, title 10, §2695.7(b)(3). BLUE SHIELD was previously cited for violation of this section in the Department's Market Conduct Examination Report As of August 31, 2002.

(k) In twenty-six (26) instances, BLUE SHIELD failed to conduct and diligently pursue a thorough, fair and objective investigation by persisting in seeking information not reasonably required for or material to the resolution of a claim dispute, in violation of CCR, title 10, §2695.7(d) (prior to 10/04 CCR revision).

(l) In three (3) instances, BLUE SHIELD failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim, in violation of CCR, title 10, §2695.7(d)(after 10/04 CCR revision).

(m) In seventeen (17) instances, BLUE SHIELD did not attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear, in violation of California Insurance Code §790.03(h)(5). BLUE SHIELD agreed to these findings and, at the insistence of the Department, conducted a survey of claims during 2004-2006, resulting in payment of an additional $986,401.93 to claimants.

(n) In thirteen (13) instances, BLUE SHIELD failed to provide to the claimant an explanation of benefits for each claim payment including, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits, in violation of CCR, title 10, §2695.11(b).

(o) In five (5) instances, BLUE SHIELD failed to provide to the claimant, in writing, the factual and legal bases of the reason for the denial of a claim, in violation of CCR, title 10, §2695.7(b)(1).

(p) In four (4) instances, BLUE SHIELD failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured, in violation of California Insurance Code §790.03(h)(4).

(q) In at least one (1) instance, BLUE SHIELD attempted to settle a claim by making a settlement offer that is unreasonably low despite evidence submitted by the claimant to support the value of the claim, in violation of CCR, title 10, §2695.7(g).

(r) In at least one (1) instance, BLUE SHIELD failed to reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer, in violation of CCR, title 10, §2695.11(g). BLUE SHIELD agreed to this finding and, at the insistence of the Department, conducted a survey of claims paid during 2003-2006, resulting in payment of an additional $974.65 to claimants and/or medical service providers.

(s) In three (3) instances, BLUE SHIELD failed to return premium to beneficiaries at the time of claims settlement, as required by California Insurance Code §481, in violation of California Insurance Code §790.03(h)(5). BLUE SHIELD agreed to these findings and, at the insistence of the Department, conducted a survey of claims during 2004-2006, resulting in payment of an additional $15,104.24 to claimants.

(t) In seven (7) instances, BLUE SHIELD failed to pay interest on an *uncontested* claim after thirty working days, as required by California Insurance Code §10123.13((b), in violation of California Insurance Code §790.03(h)(5). BLUE SHIELD was previously cited for violation of this section in the Department's Market Conduct Examination Report As of August 31, 2002.

(u) In five (5) instances, BLUE SHIELD failed to pay interest on a contested claim that had not been paid within thirty days of a determination of payer liability, as required by California Insurance Code §10123.13(c), in violation of California Insurance Code §790.03(h)(5). BLUE SHIELD agreed with these findings and paid the interest due.

(v) In four (4) instances, BLUE SHIELD failed to reimburse or notify insureds that BLUE SHIELD was contesting or denying the claim within thirty working days, as required by

California Insurance Code §10123.13(a), in violation of California Insurance Code §790.03(h)(4). BLUE SHIELD was previously cited for noncompliance with California Insurance Code §10123.13(a) in the Department's Market Conduct Examination Report As of August 31, 2002.

Failure to Certify Adequate Training of Claims Agents

(w) In one (1) instance, BLUE SHIELD failed to maintain a copy of the certification that the company had provided thorough and adequate training of its claims agents regarding the Fair Claims Settlement Practices Regulations, in violation of CCR, title 10, §2695.6(b)(4).

Failure to Disclose Policy Provisions and Benefits

(x) In two (2) instances, BLUE SHIELD failed to disclose to a claimant or beneficiary all benefits, coverage, time limits or other provisions of an insurance policy that may apply to the claim presented, in violation of CCR, title 10, §2695.4(a).

35. The Commissioner has alleged that each act identified in paragraph 34 constitutes an unfair method of competition or unfair or deceptive act or practice within the meaning of California Insurance Code §790.03; and,

36. As a result of the combined examinations, the Department also alleges that BLUE SHIELD has engaged in activities related to rescissions in violation of the following provisions of the Insurance Code, as more fully described in the Market Conduct Reports:

Failure to Attach or Endorse the Application to the Insurance Policy When Issued

In two hundred twenty-nine (229) instances, BLUE SHIELD failed to attach or endorse the application on the policy when it was issued yet used statements in the application as the basis for all forty-four (44) Individual and Family Plan rescissions and cancellations and one hundred eighty-five (185) Short-Term Health policy rescissions, in violation of California Insurance Code §10113.

In two hundred twenty-nine (229) instances, BLUE SHIELD used insured's statements in an application for a health insurance policy as the basis for rescission without attaching or endorsing such application on the policy when it was issued in all of the Individual and Family Plan and Short-Term Health insurance policies rescinded between June 1, 2004 through May 31, 2005, in violation of California Insurance Code §10381.5.

Failure to Establish Material Misrepresentation to Bar Recovery Under the Policy

In two hundred twenty-nine (229) instances, BLUE SHIELD failed to establish that an incorrect or incomplete response on the application constituted material misrepresentation or intent to deceive, under applicable law, in each of the forty-four (44) Individual and Family Plan policies and one hundred eighty-five (185) Short-Term Health insurance policies rescinded between June 1, 2004 through May 31, 2005 to bar recovery under the policies, in violation of California Insurance Code §10380. The Department's examiners found no evidence that BLUE SHIELD made a good faith effort to determine whether the policyholder was aware of the true facts of his or her medical history and appreciated the significance of information related to him or her or contacted the agent to determine all the facts surrounding any alleged misrepresentation in a rescission investigation.

BLUE SHIELD Engaged in Prohibited Postclaims Underwriting

In two hundred twenty-nine (229) instances, BLUE SHIELD engaged in postclaims underwriting in each of the forty-four (44) Individual and Family Plan policies and one hundred eighty-five (185) Short-Term health insurance policies rescinded between June 1, 2004 through May 31, 2005, in violation of California Insurance Code §10384, by failing to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application *before* issuing the policy. As examples,

(1) YV's health insurance policy was rescinded after a request for prior authorization of medical care and claims were received by BLUE SHIELD. BLUE SHIELD'S postclaims investigation revealed inconsistencies in YV's application when compared to medical records which were only obtained *after* issuance of the policy for the postclaims investigation. Specifically, YV's application reported treatment for a bladder infection on 2/1/04 in Part 7 of the application, which was an incorrect section of the application for reporting this information. In spite of the bladder infection and bladder pain reported in Part 7, YV provided conflicting information in Part 4 when she answered "no" to the following question: "Have you ever received any professional advice or treatment for or had any of the symptoms pertaining to any of the following:...Question 6: Urinary Tract: Such as: renal,...bladder...infections." Further, YV did not list any medication she presumably would have taken for a bladder infection. YV's application also provided no information on details of her medical condition in Part 5 even though she reported it in Part 7, making this application incomplete. BLUE SHIELD failed to contact the applicant or take any other steps to obtain the missing responses. Thus, BLUE SHIELD was put on notice that the applicant had suffered bladder pain and a bladder infection but chose not to complete medical underwriting and resolve the obvious inconsistencies prior to issuing the policy.

Further, the structure of the question in Part 7, which inquires about the Last Physician Visit, provides no opportunity for the applicant to supply information about visits prior to the last physician visit and is confusing and difficult to understand. It would be difficult for an applicant to report recurring visits or problems when the question asks only about the last physician visit. Yet BLUE SHIELD would need this information to properly apply its own underwriting guidelines and to complete medical underwriting.

BLUE SHIELD failed to consistently apply its underwriting guidelines and processed YV's incomplete application as a "clean" application. Had BLUE SHIELD ordered a copy of

medical records from the doctor who treated her bladder infection *prior* to issuing coverage, it would have obtained the additional information needed to complete medical underwriting to determine eligibility. Instead, BLUE SHIELD waited until medical services were needed and provided to conduct a postclaims investigation that resulted in rescinding the policy. During the postclaims investigation, BLUE SHIELD obtained the medical records at no cost within four days of its request.

(2) VH completed an application for health insurance and BLUE SHIELD issued the policy without reviewing or requesting medical records during the pre-enrollment medical underwriting process. BLUE SHIELD asked the insurance agent (holding an appointment from BLUE SHIELD) involved in selling the policy to obtain two pieces of missing information regarding applicant's cigarette smoking and last menstrual period. In a large handwritten note, initialed at the bottom of VH's application, the agent wrote "Suggest APS." An "APS" is an Attending Physician Statement and is an important part of the medical underwriting process when there is any question about the applicant's medical information which is self-reported. In Part 11 of the application, the agent is required to provide written yes or no answers to a series of questions. On VH's application, in the section where the agent signs, every single "YES" response had clearly been scratched out and replaced with a "NO" response. By failing to contact its appointed agent to inquire about the changed answers and the agent's recommendation to obtain an Attending Physician Statement, BLUE SHIELD failed to complete medical underwriting. The Department could find no evidence of an Attending Physician Statement or documentation of an inquiry to the agent regarding the recommendation in the pre-enrollment underwriting file.

(3) MQ submitted an application for individual health insurance on October 2, 2004. The application showed a "NO" response in Part 4 to the following question: "Have

you...EVER...received any professional advice or treatment for or had any symptoms pertaining to any of the following?... Question 19. Counseling or treatment for symptoms of depression, manic depression, anxiety, ...or for any other reason?" In Part 6, MQ indicated ongoing use of the medication Propanolol as of 2/27/04. MQ reported using this medication for anxiety and indicated no end date for use of this medication. In Part 7, which asked to List your Last Physician Visit, MQ reported the same 2/27/04 visit to her physician with the finding of Anxiety and Present Status of "None." The information provided by MQ in these three different parts of the application produced clear conflicts. In two answers, she reported anxiety but answered "NO" to a direct question about anxiety in her Medical History. She provided no information in Part 5 asking for Medical Condition Details. The Department's examiners did not find any evidence that BLUE SHIELD requested additional information from the applicant or medical records in the pre-enrollment underwriting file to resolve these apparent conflicts and inconsistencies in the application before issuing the policy.

MQ also indicated on the application that she drank five alcoholic beverages per week for five years with a stop date of 9/26/04, which was only *five* days prior to the date of her application for health coverage. These contradictory and inconsistent responses to an experienced underwriter clearly call for additional information to complete medical underwriting and resolve apparent questions. Nothing was done. However, once health care providers requested prior authorization for medical care and claims for medical services were submitted for payment, BLUE SHIELD immediately initiated a postclaims investigation during which it obtained underwriting information that led to rescission of MQ's coverage.

(4) NB submitted her application for individual health insurance on 8/25/04. Even though her application was incomplete due to the omission of the diagnosis that led to her surgery in 2002, BLUE SHIELD issued a policy. NB's application also contained obvious

inconsistencies that were not resolved prior to issuance of coverage. In the part asking about Medical Conditions, NB listed treatment for stress due to a divorce from 7/03 and ending 9/03. However, in the part asking about her Last Physician Visit, NB listed a referral to counseling on 03/10/04, that her present status was "good," and that the reason for the physician visit was "follow up." BLUE SHIELD did not comply with its own guidelines that call for the applicant to provide written documentation of missing information such as a diagnosis. The Department's examiners could find no evidence that BLUE SHIELD sought medical records or took other measures to properly complete medical underwriting and resolve the patent inconsistencies in NB's application *prior* to issuing a policy.

(5) FH applied for health coverage, requesting an effective date of 4/1/04. She answered "YES" to the question "Have you...EVER received any professional advice or treatment for or had any symptoms pertaining to any of the following? Question 1: Brain or nervous system – such as: dizziness, headache, etc.?" FH reported, in Part 5, a diagnosis of hormonal migraines that was ongoing and that she was continuing to take a medication for this diagnosis. FH did not complete the question regarding frequency of her migraines nor did she complete the application's inquiry regarding the Present Status of her migraines. BLUE SHIELD did not follow up to obtain the missing information and issued a policy. Five months after the effective date, a prior authorization request triggered a postclaims investigation. Thereupon, BLUE SHIELD requested medical records and received them within **three** days. FH also filed a complaint with the Department stating that she had fully disclosed her medical history but her coverage was still rescinded.

(6) MM, KD, BZR, and JC reported prior coverage with BLUE SHIELD or one of its affiliates. Nonetheless, in spite of easy access to claims history and medical information detail for these four individuals, there was no record that BLUE SHIELD reviewed such information to

complete medical underwriting *before* issuing the policies to assure that the responses were accurate and complete. BLUE SHIELD processed MM's application as a "clean" application, yet it had prior claims history to show that it had paid claims for treatment of conditions that were not reported on the application. BLUE SHIELD ignored its own guidelines which instruct that an application should not be treated as "clean" if there is prior BLUE SHIELD health coverage.

(7) CC submitted an online application to BLUE SHIELD requesting a plan change, from a PPO plan with a $5,000 deductible to a PPO plan with a $750 deductible. BLUE SHIELD issued coverage under the new plan on 8/15/04, but shortly thereafter initiated a postclaims investigation on 9/9/04. On his transfer application, CC reported a normal healthy routine exam on 7/29/02, followed by an emergency room visit seven days later and a one-week hospitalization for the diagnosis of hyperhydrosis on 8/6/02. BLUE SHIELD'S underwriting guidelines call for additional underwriting if a diagnosis is not on its "clean application" list. CC's diagnosis of hyperhydrosis was **not** on this list, yet BLUE SHIELD failed to complete such underwriting before issuing coverage on 8/15/04 under the new PPO plan. BLUE SHIELD rescinded CC's coverage on 9/19/04.

STATUTORY ALLEGATIONS

37. The facts alleged in Paragraph 34 herein demonstrate that BLUE SHIELD has engaged in acts which constitute an unfair method of competition and/or unfair or deceptive acts or practices in this State, in violation of California Insurance Code §790.03 and/or the Fair Claims Settlement Practices Regulations. BLUE SHIELD'S conduct constitutes grounds for the Insurance Commissioner to assess a monetary penalty pursuant to California Insurance Code §790.035.

38. The facts alleged in Paragraphs 34 and 36 herein demonstrate that BLUE SHIELD has not carried out its contracts in good faith, and constitute grounds for the Insurance

Commissioner to suspend BLUE SHIELD'S Certificate of Authority pursuant to Insurance Code §704(b).

39. The facts alleged in Paragraph 36 herein demonstrate that BLUE SHIELD has engaged in postclaims underwriting, in direct contravention of California Insurance Code §10384, and, if willful, constitute grounds for the Insurance Commissioner to suspend or revoke BLUE SHIELD'S Certificate of Authority pursuant to California Insurance Code §10400.

40. The facts alleged in Paragraph 36 herein demonstrate that BLUE SHIELD has engaged in conduct that violates California Insurance Code §§10380 and 10381.5, and, if willful, constitute grounds for the Insurance Commissioner to suspend or revoke BLUE SHIELD'S Certificate of Authority pursuant to California Insurance Code §10400.

41. The facts alleged in Paragraph 36 herein demonstrate that BLUE SHIELD has engaged in activities related to rescission practices which constitute an unfair method of competition and/or unfair or deceptive acts or practices in the marketplace affecting consumers and disability insurance competitors in this State that are not defined in California Insurance Code §790.03, in violation of §790.06(a) of the California Insurance Code. BLUE SHIELD'S conduct constitutes grounds for the Insurance Commissioner to enjoin such practices if not discontinued.

42. The Insurance Commissioner hereby notifies BLUE SHIELD that, based upon the facts alleged herein, BLUE SHIELD is in violation of California Insurance Code §§700(c), 704(b), 790.02, 790.03, 790.06, 796.04, 10113, 10123.13, 10123.131, 10169, 10380, 10381.5, and 10384, and the Fair Claims Settlement Regulations contained in California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, commencing with §2695.1.

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DEMAND PURSUANT TO CALIFORNIA INSURANCE CODE §§790.035, 790.05, 790.08, and 12976

43. PLEASE TAKE NOTICE that the Insurance Commissioner may, as a result of BLUE SHIELD'S actions as set forth hereinabove, and pursuant to California Insurance Code §790.035, seek monetary penalties up to:

a. Two million eight hundred seventy-five thousand dollars ($2,875,000.00), if each of the five hundred seventy-five (575) acts of unfair competition or unfair or deceptive practices alleged above is established and such acts are non-willful, based on a penalty of five thousand dollars ($5,000.00) for each act; or

b. Five million seven hundred fifty thousand dollars ($5,750,000.00), if each of the five hundred seventy-five (575) acts of unfair competition or unfair or deceptive practices alleged above is established and such acts are willful, based on a penalty of ten thousand dollars ($10,000.00) for each act.

44. PLEASE TAKE FURTHER NOTICE that, as a result of the actions of BLUE SHIELD as set forth hereinabove, and pursuant to California Insurance Code §§790.06, 790.08, 10380, 10113, 10381.5, and 10384, demand is hereby made for such other equitable relief, including restitution, as may be necessary to redress BLUE SHIELD'S violations of enumerated California statutory law and regulations and for such other and further relief as may be just and proper.

ORDER TO SHOW CAUSE PURSUANT TO CALIFORNIA INSURANCE CODE §§790.03, 790.05 and 790.06

45. WHEREAS, the Insurance Commissioner has reason to believe, based upon the facts set forth herein, that BLUE SHIELD has engaged in or is engaging in unfair methods of competition and/or unfair or deceptive acts or practices in this State as defined in California Insurance Code §790.03(h) and/or the Fair Claims Settlement Practices Regulations; and,

46. WHEREAS, the Insurance Commissioner has reason to believe, based upon the facts set forth herein, that BLUE SHIELD has engaged in or is engaging in a method of competition and/or an act or practice in the conduct of its business in this State that is not defined in California Insurance Code §790.03, and that the method is unfair and/or the act or practice is unfair or deceptive pursuant to California Insurance Code §790.06; and,

47. WHEREAS, the Insurance Commissioner has reason to believe that a proceeding by the Insurance Commissioner would be in the public interest, he hereby issues the herein Order to Show Cause, pursuant to California Insurance Code §790.05, containing a statement of the charges and BLUE SHIELD'S potential liability; and,

48. WHEREAS, the Insurance Commissioner has reason to believe that a proceeding by the Insurance Commissioner would be in the public interest, he hereby issues the herein Order to Show Cause, pursuant to California Insurance Code §790.06, containing a statement of the methods, acts or practices alleged to be unfair or deceptive; and,

49. THEREFORE, the Insurance Commissioner hereby notifies BLUE SHIELD that a hearing shall be held at a time and place to be determined by the Commissioner which shall not be less than 30 days after service of the herein Order to Show Cause to determine whether the alleged methods, acts or practices set forth herein should be declared to be unfair or deceptive and whether the Commissioner should issue an Order to pay the penalty imposed by California Insurance Code §790.035 and to cease and desist from such acts or practices.

50. THEREFORE, the Insurance Commissioner hereby notifies BLUE SHIELD that a hearing shall be held at a time and place to be determined by the Commissioner which shall not be less than 30 days after service of the herein Order to Show Cause to determine whether the alleged methods, acts or practices set forth herein should be declared to be unfair or deceptive and whether the Commissioner should issue a report so declaring.

WHEREFORE, the Insurance Commissioner prays for the following:

1. An Order to Cease and Desist against BLUE SHIELD from engaging in unfair methods of competition and unfair and deceptive acts or practices in the business of life and disability insurance in violation of California Insurance Code §§790.03 and 790.06; and,

2. An Order to Cease and Desist against BLUE SHIELD from engaging in activities in the business of life and disability insurance in violation of California Insurance Code §§700(c), 704(b), 796.04, 10113, 10123.13, 10123.131, 10169, 10380, 10381.5, and 10384; and

3. The suspension of BLUE SHIELD'S Certificate of Authority to act as a Life and Disability insurer in the State of California for not exceeding one year, pursuant to California Insurance Code §704(b); and,

4. The suspension or revocation of BLUE SHIELD'S Certificate of Authority to act as a Life and Disability insurer in the State of California, pursuant to California Insurance Code §10400; and,

5. The imposition of Notice on BLUE SHIELD that, after conclusion of the hearing, upon a finding of violation of California Insurance Code §700(c), BLUE SHIELD will be subject to the possible revocation of its Certificate of Authority pursuant to California Insurance Code §701; and,

6. The imposition of monetary penalties as provided by law, pursuant to California Insurance Code §790.035, of up to (a) two million eight hundred seventy-five thousand dollars ($2,875,000.00) if each of the five hundred seventy-five (575) acts of unfair competition or unfair or deceptive practices alleged above is established and such acts are non-willful, based on a penalty of five thousand dollars ($5,000.00) for each act; or (b) five million seven hundred fifty thousand dollars ($5,750,000.00) if each of the five hundred seventy-five (575) acts of unfair

competition or unfair or deceptive practices alleged above is established and such acts are willful, based on a penalty of ten thousand dollars ($10,000.00) for each act; and,

7. The imposition of such other equitable relief, including restitution, as may be necessary to redress BLUE SHIELD'S violations as set forth above; and

8. The imposition of such further relief as may be just and proper.

Dated: October 2, 2008

STEVE POIZNER
Insurance Commissioner

By: _____
Mary Ann Shulman
Senior Staff Counsel

PROOF OF SERVICE
Blue Shield of California Life & Health Insurance Company
Case No. OSC-2007-00067

I am over the age of eighteen years and am not a party to the within action. I am an employee of the Department of Insurance, State of California, employed at 45 Fremont Street, 19th Floor, San Francisco, California 94105. On October 2, 2008, I served the following document(s):

CALIFORNIA DEPARTMENT OF INSURANCE'S SECOND AMENDED ORDER TO SHOW CAUSE AND STRIKEOUT VERSION

on all persons named on the attached Service List, by the method of service indicated, as follows:

If **U.S. MAIL** is indicated, by placing on this date, true copies in sealed envelopes, addressed to each person indicated, in this office's facility for collection of outgoing items to be sent by mail, pursuant to Code of Civil Procedure Section 1013. I am familiar with this office's practice of collecting and processing documents placed for mailing by U.S. Mail. Under that practice, outgoing items are deposited, in the ordinary course of business, with the U.S. Postal Service on that same day, with postage fully prepaid, in the city and county of San Francisco, California.

If **OVERNIGHT SERVICE** is indicated, by placing on this date, true copies in sealed envelopes, addressed to each person indicated, in this office's facility for collection of outgoing items for overnight delivery, pursuant to Code of Civil Procedure Section 1013. I am familiar with this office's practice of collecting and processing documents placed for overnight delivery. Under that practice, outgoing items are deposited, in the ordinary course of business, with an authorized courier or a facility regularly maintained by one of the following overnight services in the city and county of San Francisco, California: Express Mail, UPS, Federal Express, or Golden State overnight service, with an active account number shown for payment.

If **FAX SERVICE** is indicated, by facsimile transmission this date to fax number stated for the person(s) so marked.

If **PERSONAL SERVICE** is indicated, by hand delivery this date.

If **INTRA-AGENCY MAIL** is indicated, by placing this date in a place designated for collection for delivery by Department of Insurance intra-agency mail.

If **EMAIL**, by electronic mail transmission this date to the email address(es) listed.

Executed this date at San Francisco, California. I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Jean Hipon

SERVICE LIST
Blue Shield of California Life & Health Insurance Company
Case No. OSC-2007-00067

Name/Address	Phone/Fax Numbers	Method of Service
Cheryl R. Tompkin Administrative Law Judge OFFICE OF ADMINISTRATIVE HEARINGS 1515 Clay Street, Suite 206 Oakland, CA 94612	Tel.: (510) 622-2722 Fax: (510) 622-2743	U. S. MAIL
John C. Holmes BARGER & WOLEN LLP 633 W. Fifth Street, 47th Floor Los Angeles, CA 90071 jholmes@barwol.com	Tel.: (213) 680-2800 Fax: (213) 614-7399	U. S. MAIL
Gregory N. Pimstone MANATT, PHELPS & PHILLIPS, LLP 11355 W. Olympic Boulevard Los Angeles, CA 90064 gpimstone@manatt.com	Tel.: (310) 312-4000 Fax: (310) 312-4224	U. S. MAIL

PUBLIC REPORT OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY
NAIC # 61557 CDI # 1450-6

CAREAMERICA LIFE INSURANCE COMPANY
NAIC # 71331 CDI # 1927-3

AS OF MAY 31, 2005

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

EXHIBIT 1

TABLE OF CONTENTS

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

Steve Poizner, *Insurance Commissioner*

September 10, 2007

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 practices and procedures in California of:

Blue Shield of California Life & Health Insurance Company

NAIC # 61557

CareAmerica Life Insurance Company

NAIC # 71331

Group NAIC # 2798

Hereinafter referred to as BSL, CLI, the Company or, collectively as the Companies.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

SCOPE OF THE EXAMINATION

The report documents the results of two separate file review processes. The initial routine examination covered the claims handling practices of the aforementioned Companies during the period June 1, 2004, through May 31, 2005. A targeted review of BSL's Rescission and Cancelled files also was examined for the window period of June 1, 2004, through May 31, 2005. The combined examination was made to discover, in general, if these and other operating procedures of the Companies conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. The alleged violations of other relevant laws which resulted from this examination are included in a separate report which will remain confidential subject to the provisions of CIC Section 735.5.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Companies for use in California including any documentation maintained by the Companies in support of positions or interpretations of fair claims settlement practices.

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

3. A review of consumer complaints received by the California Department of Insurance (CDI). The Companies were the subject of 145 consumer complaints in 2004 and 2005. The review of complaints showed a trend with respect to the timeliness of claims handling and finalization of claims received.

The examination was conducted primarily at the offices of the Companies in San Francisco, California. This included the work product of BSL's Third Party Administrator (TPA) for its Short Term Health product, Comprehensive Benefits and Claims Administrators (CBCA).

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 only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer's proposals for correcting the deficiencies. When a

violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and 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 on or criticize activities does not constitute acceptance of such activities.

Any alleged violations identified in this report and any criticisms of practices have not undergone a formal administrative or judicial process.

CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners initially reviewed files drawn from the category of Closed Claims for the period June 1, 2004, through May 31, 2005, commonly referred to as the "review period". The examiners reviewed 286 BSL claim files and 10 CLI claim files. In the initial review, the examiners cited 519 claim handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report. In addition, the targeted review involved the remaining 40 rescinded and 4 cancelled BSL policies for the period of June 1, 2004, through May 31, 2005, that were not included in the initial review. As a result of the BSL targeted review, the examiners cited 12 claim handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

Blue Shield of California Life & Health Insurance Company *Initial Review*			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Accident and Disability (AD) / Individual-Short Term Health (STH)- General Population of Claims	19,546	68	133
AD / Individual-STH-Rescissions	185	10	54
AD / Individual-STH-Member Appeals	129	10	75
AD / Individual-STH-Provider Appeals	466	10	53
AD / Individual-STH-Denied	40,170	10	8
AD /Individual-STH-Pre-existing Condition	7,769	10	37
AD / Individual Family Plan (IFP)- General Population of Claims	82,029	34	1
AD / IFP-Rescissions	39	9	58
AD/IFP-Cancellations	5	1	10
AD / IFP-Provider-Member Appeals	320	20	36
AD / IFP-Denied	24,150	10	7
AD / IFP -General Category			2
AD / Group Preferred Provider Organization (PPO) General Population of Claims	35,865	34	2
AD / Group PPO-Provider Member Appeals	53	20	12
AD / Group PPO-Denied	14,212	10	4
AD / Vision	86,740	10	0
Life / Individual	19	13	24
Life / Group	359	7	3
TOTALS	312,056	286	519

CareAmerica Life Insurance Company			
LINE OF BUSINESS/CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
AD / Medicare Supplement	361	10	0
TOTALS	361	10	0

Blue Shield of California Life & Health Insurance Company *Targeted Review*			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
AD / IFP-Rescissions	39	30	7
AD / IFP-Cancellations	5	4	5
TOTALS	44	34	12

TABLE OF TOTAL CITATIONS
Initial Review

Citation	Description	BSL	CLI
CCR §2695.5(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days.	175	0
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.	116	0
CCR §2695.3(a)	The Company failed to maintain all documents, notes and work papers in the claim file.	58	0
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.	59	0
CCR §2695.7(b)(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.	35	0
CCR §2695.7(d)	The Company persisted in seeking information not reasonably required for or material to the resolution of a claim dispute. (Prior to 10/04 CCR revision.)	26	0
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	17	0
CCR §2695.11(b)	The Company failed to provide an explanation of benefits.	13	0
CCR §2695.7(b)(1)	The Company failed to provide the written basis for the denial of the claim.	5	0
CIC §790.03(h)(4)	The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.	4	0
CCR §2695.7(d)	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim. (After 10/04 CCR revision.)	3	0
CCR §2695.4(a)	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	2	0
CCR §2695.5(e)(1)	The Company failed to acknowledge notice of claim within 15 calendar days.	2	0
CIC §790.03(h)(2)	The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.	1	0
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	1	0

TABLE OF TOTAL CITATIONS *Initial Review*			
Citation	Description	BSL	CLI
CCR §2695.11(g)	The Company failed to reimburse for the reasonable expenses incurred in copying medical records requested by the Company.	1	0
CCR §2695.6(b)(4)	The Company filed to maintain a copy of the certification required by CCR §2695.6(b)(1), (2) or (3) at the principal place of business.	1	0
Total Citations		519	0

TABLE OF TOTAL CITATIONS *Targeted Review*		
Citation	Description	BSL
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)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.	2
CCR §2695.5(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days.	1
Total Citations		12

TABLE OF CITATIONS BY LINE OF BUSINESS

Initial Review

ACCIDENT AND DISABILITY	NUMBER OF CITATIONS
CCR §2695.5(a)	175
CIC §790.03(h)(3)	112
CIC §790.03(h)(1)	55
CCR §2695.3(a)	43
CCR §2695.7(b)(3)	35
CCR §2695.7(d)	26
CIC §790.03(h)(5)	17
CCR §2695.11(b)	13
CCR §2695.7(b)(1)	5
CIC §790.03(h)(4)	4
CCR §2695.7(d)	3
CIC §790.03(h)(2)	1
CCR §2695.7(g)	1
CCR §2695.11(g)	1
CCR §2695.6(b)(4)	1
SUBTOTAL	492
AMOUNT OF EXAMINATION RECOVERIES	$16,988.02
AMOUNT OF SURVEY RECOVERIES	$987,376.58

LIFE	NUMBER OF CITATIONS
CCR §2695.3(a)	15
CIC §790.03(h)(1)	4
CIC §790.03(h)(3)	4
CCR §2695.5(e)(1)	2
CCR §2695.4(a)	2
SUBTOTAL	27
AMOUNT OF EXAMINATION RECOVERIES	$0
AMOUNT OF SURVEY RECOVERIES	$0

TOTAL CITATIONS *Initial Review*	519

TABLE OF CITATIONS BY LINE OF BUSINESS

Targeted Review

ACCIDENT AND DISABILITY	NUMBER OF CITATIONS
CIC §790.03(h)(3)	9
CIC §790.03(h)(1)	2
CCR §2695.5(a)	1
SUBTOTAL	12
AMOUNT OF TARGETED EXAMINATION RECOVERIES	$0
AMOUNT OF SURVEY RECOVERIES	$0

TOTAL CITATIONS *Targeted Review*	12

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. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. Regardless of the remedial actions taken or proposed by the Company, it is the Company's obligation to ensure that compliance is achieved. As referenced in sections 7, 13 and 14 below, money recovered within the scope of this report was $16,988.02. As referenced in sections 7 and 13 below, following the findings of the examination, the Company conducted four closed claim surveys which resulted in additional payments of $41,237.24 for the STH Product and $946,139.34 for the IFP Product. As a result of the examination, the total amount of money returned to claimants to date within the scope of this report was $1,004,364.60.

ACCIDENT AND DISABILITY

Initial Review

1. In 175 instances, the Company failed to respond to a Department of Insurance inquiry within 21 calendar days. The Department alleges these acts are in violation of CCR §2695.5(a).

1(a). For the Short Term Health product, in 146 of the 175 instances, BSL did not respond to a Department of Insurance inquiry within 21 calendar days.

1(a)(I). In 52 of the 146 instances, at the start of the examination and during the file review, BSL did not provide one or more of the following: the entire file, a copy of the member application, the member eligibility, the explanation of benefits (EOB) for member or provider or both, x-ray reports, accident details, the original claim, the adjusted explanation of benefits, the physician explanation of benefits, the pricing sheet, medical review decisions, the proof of eligibility investigation and system notes.

Summary of Company Response to Section 1(a)(I): In an effort to operate efficiently for the benefit of its insureds, BSL stores many of its records electronically rather than on paper. At the outset of the examination, the examiners were trained on and given access to BSL's systems so that they could access various records on that system at their convenience. Although the examiners thus had free access over BSL's systems to many of the records that were allegedly not provided, they expressed a preference for paper copies.

Regarding EOBs, although they are printed and sent to insureds and subscribers on paper, they are created and stored on BSL's computer systems. The information

presented on the hard copies sent to insureds and providers is drawn and printed directly from the cells viewable onscreen on BSL's systems. Thus, although copies of the actual paper EOBs were not provided, the information communicated in the EOBs to insureds and providers was available for review by the examiners at their convenience. That information could also be viewed on paper by printing the system screen on which it is displayed. Nonetheless, BSL will work with its third party administrator to institute a process by which paper copies of non-pay EOBs can be obtained on a timely basis.

Some of the items mentioned in this allegation (*e.g.*, member eligibility, system notes) are records that are created and kept on the systems and never exist as paper records. As to these records, in the future BSL will provide paper print outs of its claim-related electronic records when it provides the hard copy portion of a claim file. For those of its records which are not associated with a particular claim (such as eligibility investigations), BSL will develop a procedure for identifying and making those records available in connection with the Department's review of a claim under the same policy. Similarly, BSL will work to identify those of its records pertaining to a particular policy which it does not consider part of the claim file and develop a procedure for providing those records to the Department on a timely basis in connection with its review of a claim under the that policy.

Finally, BSL attempted to address issues identified in a prior examination by retaining a third party administrator to handle claims under its Short Term Health policies. The third party administrator's inability to respond to requests for materials within required time frames contributed to the issues raised here. Because BSL no longer issues Short Term Health policies and the third party administrator does not administer claims under any of BSL's other products, this should not be an issue in the future.

BSL notes that, in many of the instances in which a response took longer than 21 days, BSL personnel spoke to the onsite examiners, explained the reasons for the BSL's inability to respond within 21 days and obtained agreed upon extensions of the deadlines for responding. These instances did not impede the examination and do not constitute violations of CCR § 2695.5(a).

1(a)II. In 94 of the 146 instances, BSL responded to a Department inquiry in 22 to 100 days, not in the required 21 days.

Summary of Company Response to Section 1(a)(II): Many of the inquiries which are the subject of this allegation related to information or materials not associated with a particular claim (such as eligibility investigations). BSL will develop a procedure for identifying and making that information available with the Department's review of a claim under the same policy. Similarly, BSL will work to identify its records pertaining to a particular policy which it does not consider part of a claim file and develop a procedure for providing those records to the

Department on a timely basis in connection with its review of a claim under the that policy.

BSL attempted to address issues identified in a prior examination by retaining a third party administrator to handle claims under its Short Term Health policies. The third party administrator's inability to respond to requests for information and materials within required time frames contributed to the issues raised here. Because BSL no longer issues Short Term Health policies and the third party administrator does not administer claims under any of BSL's other products, this should not be an issue in the future.

BSL notes that, in many of the instances in which a response took longer than 21 days, BSL personnel spoke to the onsite examiners, explained the reasons for the BSL's inability to respond within 21 days and obtained agreed upon extensions of the deadlines for responding. These instances did not impede the examination and do not constitute violations of CCR § 2695.5(a).

1(b). For the Individual Family (IFP) and Group products, in 29 of the 175 instances, BSL did not respond to a Department of Insurance inquiry within 21 calendar days.

1(b)(I). In 27 of the 29 instances, at the start of the examination and during file review, BSL did not provide one or more of the following: the EOB, the Medical Management referral to the Underwriting Investigation Unit (UIU), the documents sent to providers and members verifying pre-certification, the claims purged from history, the pre-existing condition investigation, correspondence and a copy of the policy.

EOBs were part of the Company's claims handling and were subject to review by the Department. BSL may have had separate departments which specialized individually in only one portion of claims handling, but that specialization did not release the Company from providing documentation timely from all departments that had an effect on its claims handling practices. Additionally, the Department would not have knowledge of the specific units that would contain the information needed and relied on the Company to provide the claims handling data from its various units.

Further, prior to the examination and during the examination process, the Department communicated the information required to the designated Company representative. During the process if the required information was not provided the Department notified the Company. The Individual and Group products were the final products reviewed during this examination. The examination process was in its ninth month when the review of the final two products began. The Company was aware at that point in the examination of the documentation necessary to complete the review because of prior requests for that information in other products.

Because online policy review created delays in the review process, hard copies of the policies were requested at the beginning and during the review process in order to expedite the examination.

Summary of Company Response to Section 1(b)(I): In 24 instances, BSL disagrees. The Claim files provided for this product were complete. Additional information, which not part of these files or the rescission process, was requested by the Department and provided in a timely manner following that request.

Member policies were available online on BSL's intranet at the start of the examination. The files under review and in question were rescission files. EOBs were not part of rescission files or part of the Company's Underwriting Investigation Unit (UIU) process for a rescission. Although hard copies of provider and member EOBs and Medical Management letters were requested by the Department on May 23, 2006, this was an additional request for information. This information was not part of the Company's UIU process. Medical Management letters regarding pre-authorization are not part of a rescission file or part of the Company's UIU process for a rescission.

Nonetheless, for all 27 instances, in the future BSL will provide paper print outs of its claim-related electronic records when it provides the hard copy portion of a claim file. The company will also develop a process by which copies of non-pay EOBs can be obtained on a timely basis. Finally, for those of its records which are not associated with a particular claim under a policy (such as UIU investigations), BSL will develop a procedure for identifying and making those records available in connection with the Department's review of a claim under the same policy.

BSL notes that, in many of the instances in which a response took longer than 21 days, BSL personnel spoke to the onsite examiners, explained the reasons for the BSL's inability to respond within 21 days and obtained agreed upon extensions of the deadlines for responding. These instances did not impede the examination and do not constitute violations of CCR § 2695.5(a).

1(b)(II). In two of the 29 instances, BSL took over 21 days to respond to a Department inquiry.

Summary of Company Response to Section 1(b)(II): Many of the inquiries which are the subject of this allegation related to information or materials not associated with a particular claim (such as UIU investigations). BSL will develop a procedure for identifying and making that information available when the Department reviews a claim under the same policy. Similarly, BSL will work to identify those of its records pertaining to a particular policy which it does not consider part of the claim file and develop a procedure for providing those records to the Department on a timely basis in connection with its review of a claim under the that policy.

BSL notes that, in many of the instances in which a response took longer than 21 days, BSL personnel spoke to the onsite examiners, explained the reasons for the BSL's inability to respond within 21 days and obtained agreed upon extensions of the deadlines for responding. These instances did not impede the examination and do not constitute violations of CCR § 2695.5(a).

The Department's Response to the Company Responses to 1:

These are unresolved issues and may result in further administrative action.

2. In 112 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). For the Short Term Health product, in 97 of the 112 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims.

2(a)(I). In 40 of the 97 instances, there was no documentation in the file of an ongoing investigation.

Summary of Company response to Section 2(a)(I): The Company agrees that appropriate follow-up was not done. The Company will review its procedures with the third party administrator.

2(a)(II). In seven of the 97 instances, at the start of a pre-existing condition investigation, the Company did not have a procedure in place to access information about previous insurance or names of treating physicians which was available on the application.

Summary of Company response to Section 2(a)(II): The Company agrees that at the start of a pre-existing condition investigation the TPA did not have a procedure in place to request from BSL a copy of the application. BSL revised its procedures on December 30, 2005, to review routinely the application for physician information before requesting additional information from the member. The TPA now is provided with copies of applications and any information contained therein, including certificates of previous coverage. This information is accessed prior to any requests being made of the member. If the certificate of previous health insurance coverage is attached to the application, the information on it will be used and a request will not be made to the member to submit another one. This process was changed for policies that are effective on or after March 1, 2006.

2(a)(III). In six of the 97 instances, the Company did not follow its own procedures. In two of these instances, the Company started a pre-existing

condition investigation for a diagnosis listed in the company procedures in a code range that would not initiate a pre-existing condition investigation.

In two of these instances, the procedure for stopping a second system-generated letter from being sent after a response was received was not followed. Another letter was sent when the requested information already had been received.

In one of these instances, the Company guideline for claims processing when multiple procedures are billed was not followed.

In one of these instances, the Company's procedure for handling receipt of premium payment was not followed thereby causing a delay in claim processing.

Summary of Company response to Section 2(a)(III): In the two instances of a pre-existing condition investigation conducted when the diagnosis according to Company procedure would be waived, BSL agrees that pre-existing condition investigations should not have been conducted for the diagnoses presented. This was an examiner error. This was reinforced with the third party administrator and refresher training was held with claims examiners on July 15, 2006.

BSL agrees that it did not adhere to protocols regarding system generated letters. Discussions have been held with the TPA reinforcing the requirement and the TPA completed refresher training with its claims staff on June 15, 2005, and August 24, 2005, in order to reinforce the established protocols.

The Company agrees that the charge should not have been rebundled and this appears to have been a claims examiner error. A refresher training session for the claims examiner staff to review the procedure was completed by January 31, 2006.

The Company agrees that the receipt-of-premium-payment computer system was not in synch with the claims computer system and created delays. The member submitted two applications for insurance plus the member's social security number was entered incorrectly which created a discrepancy between the two systems. A corrective action was identified, developed and implemented by the end of May 2006.

2(a)(IV). In six of the 97 instances, the final benefit determination was incorrect. In one of the six instances, a charge was denied as routine when the corresponding office visit was payable.

In another instance, claims related to an injury were processed as dental and denied when the claims should have been processed under medical.

In one instance, the Company received physician's billings that contained a code that supported allowance of another code billed. A report was attached to the

original claim that clearly provided the necessary information to allow both codes billed on the same day.

In three instances, the Company received billings with an office visit code and a modifier code. The modifier code indicated that the office visit was not a routine office visit. Consideration was not given for the modifier assigned to the office visit code.

Summary of Company response to Section 2(a)(IV): In the instance of the charge denied as routine, BSL agrees. By the end of June 2006, BSL developed claims processing guidelines around claims billed with routine diagnoses so that other claims received with medical diagnoses that are related would be considered.

In the instance of claims originally put through as dental, this was an examiner error. A refresher training session for claims examiners was completed by June 15, 2006, to ensure they understand how to handle claims of this type and to ensure that they understand how to differentiate between a dental and medical claim.

In the instance of the information available at the time of claims processing, the claims system allows only one modifier code to be entered. In order to correct this situation, the third party administrator is considering a system enhancement for 2007 that would allow the claims examiner to enter more than one modifier per claim. In the meantime, the process has been re-configured so that bills with multiple modifiers are routed to the code review queue for manual review and handling. The claims examiner reviews the claims with multiple modifiers and makes the processing decision on the appropriate benefit.

In the final three instances, effective January 25 2005, the practice was changed, to allow office visits billed with a modifier code.

2(a)(V). In six of the 97 instances, Customer Service received calls from a member or physician who requested a return call. There was no documentation that the callers received calls back from BSL within 48 hours. The Company did not follow its 48-hour call-back procedure.

Summary of Company response to Section 2(a)(V): The Company agrees that its call-back procedures were not followed. Refresher training sessions for the supervisory staff were conducted in January 2006 and June 2006 in order to review standard procedure regarding member and provider call backs and documentation of such calls.

2(a)(VI). In five of the 97 instances, BSL did not follow its procedures to release claims for payment once the benefit determination had been made. In four of these instances, upon conclusion of the pre-existing condition investigation, the Company did not reprocess timely all claims to reflect the outcome of its decision.

In one of the five instances, once the decision had been made to allow previously denied claims, not all of the claims associated with the decision were reprocessed at the same time.

Summary of Company response to Section 2(a)(VI): BSL agrees with the findings and as a corrective action asked its TPA to retrain its claims staff on the procedure to adjudicate all claims associated with a diagnosis after the decision has been made to pay for treatment for the diagnosis. This training was completed by July 27, 2005. Additional retraining was conducted on October 19, 2005, and on November 11, 2005. Reminders were given on November 30, 2005, December 15, 2005, and in March 2006.

2(a)(VII). In four of the 97 instances, the time period for which the Company requested medical records was an inaccurate time period for the policy. In the first instance, previous health carrier information was provided which shortened the members pre-existing condition time period. BSL did not provide credit for previous insurance and denied claims within a payable time period.

In the second instance, the policy pre-existing condition look-back period was six months. The Company requested one year of records when six months should have been requested resulting in claims being denied in error.

In the final two instances, the Company requested from providers five years of medical records when six months of medical records should have been requested.

Summary of Company response to Section 2(a)(VII): With regard to the first instance, the Company conducted refresher training to ensure that information available in the file is thoroughly reviewed and taken into account in investigating claims. That training was conducted in March and June 2006.

In the second instance, the pre-existing condition investigation should not have applied and the claims should have been processed. This was an examiner error. Refresher training was conducted at the end of July 2006, with the claims examiners to ensure they understand the pre- existing condition policy and how it is to be applied in situations like this.

In the two remaining instances, BSL agrees that accurate periods were not provided in correspondence or by its Customer Service Department. These instances resulted from individual errors. Refresher training was conducted at the end of July 2006, with the claims examiners to ensure they understand the pre-existing condition policy and how it is to be applied, including the correct pre-existing condition exclusion period.

2(a)(VIII). In three of the 97 instances, the Company continued to conduct a pre-existing condition investigation even though the records documented that the diagnosis was not pre-existing. In the first instance, the member's records

provided that the member had a work related injury. The records also provided that a medical condition was diagnosed after the member's effective date when the member was treated for the work related injury.

In the second instance, the Company received billings with diagnoses codes that prompted a pre-existing condition investigation. The medical records for those service dates did not support the originally billed diagnoses. Although the member contacted Customer Service 28 days after the Company received the medical records and informed the Company that the billing received contained an incorrect diagnosis, BSL did not pursue additional information from the billing physician or other providers until 47 days after receiving the medical records. The Company did not process the claims until three months after receipt of the records.

In the third instance, the Company received billings with diagnoses codes that prompted a pre-existing condition investigation. The medical records for those service dates did not support the originally billed diagnoses.

Summary of Company response to Section 2(a)(VIII): In the first instance, BSL agrees. In this instance, there were some additional complexities due to a work related injury which was excluded from the policy. This should not have delayed payment of the claim. The TPA's examiner and supervisor have been re-instructed on how to handle instances that involve work related injuries and non-work related claims.

In the second instance, BSL disagrees. It is company policy to collect all of the medical records so an accurate pre-existing determination can be made. The decision was made that the physician's records were not adequate to finalize the investigation. It is BSL's policy to investigate and process claims on a timely basis. BSL will issue reminder instructions to the TPA's examiners that they are to promptly follow up on issues that arise during investigations and process claims when pre-existing investigations are completed.

In the third instance, BSL agrees and will issue instructions requiring examiners to compare medical record descriptions with diagnoses codes to identify possibly erroneous diagnosis codes and conduct appropriate follow up, including contacting the provider and/or requesting additional medical records where the codes appear erroneous. In addition, BSL's TPA for its Short Term Health policies will conduct refresher training on this matter.

2(a)(IX). In two of the 97 instances, the Company either rescinded or denied claims without supporting documentation. In the first instance, there was no supporting documentation to deny the members pharmacy claims as pre-existing.

In the other instance, there was no documentation of the basis for denying claims as pre-existing conditions.

Summary of Company response to Section 2(a)(IX): In the first instance, the Company agrees that there was no documentation to support this denial. This was a result of an examiner error and the claim should not have been denied. This appears to be an isolated mistake and not a routine error of this examiner. The error has been discussed with the examiner to raise awareness for future reviews.

In the remaining instance, the Company agrees that the office visits were somewhat unrelated and separate, but disagrees that at that time the pre-existing condition denial was incorrect.

The Department's Response to the Company Response to Section 2(a)(IX): Regarding the second instance, records received at the time of the denial did not support that the member was treated prior to the effective date. Additionally, the pre-existing condition denial was overturned at a later date when additional medical records were received.

This is an unresolved issue and may result in further administrative action.

2(a)(X). In two of the 97 instances, the Company had the necessary documentation to release benefits, but did not follow procedures to do so. In one of the instances, the Company had accident details in the file but did not pay benefits.

In the other instance, the claim was closed due to lack of an emergency room report when one was not necessary for the processing of the claim. The company policy was to request and close the claim, even when the diagnosis did not warrant the need for an emergency room report.

Summary of Company response to Section 2(a)(X): In both instances the Company agrees. The first instance was an examiner error. Additional refresher training was conducted on July 27, 2005, October 19, 2005, and a reminder was given on November 30, 2005, to ensure that claims are released timely when information is in the file.

In the second instance, as a matter of procedure on emergency room claims, BSL routinely collected emergency room reports to determine if the claim was a result of an accident. BSL requested this information regardless of the diagnosis code. The Company agrees with the finding that this may not be warranted on those claims that clearly contain diagnoses codes that are not related to an accident. On December 15, 2005, BSL revised its practice on emergency room reports not to require them unless the diagnosis code is accident related or is a trigger for a pre-existing condition investigation.

2(a)(XI). In two of the 97 instances, the Company received telephone calls to verify that the Company had received certain documents. In the first instance, the

member's agent contacted BSL on two separate occasions regarding information faxed to BSL, which BSL stated it had not received. The agent contacted BSL a third time and again was informed that the fax had not been received. In BSL's system notes it was indicated that the issue would be brought to a supervisor's attention. The file does not reflect that additional information was ever received and the member's coverage was rescinded without the information the agent faxed three times to BSL.

In the second instance, after electronic submission of a claim, for which the provider had a confirmation number, BSL was unable to verify receipt of the claim when the provider called.

Summary of Company response to Section 2(a)(XI): The Company agrees. In the first instance, this issue was addressed in refresher training conducted on June 15, 2005, and August 24, 2005, to ensure that claims examiners understand the requirements for completing an investigation and for established follow-up protocols.

In the second instance, a refresher training session was completed by June 1, 2006, with the Customer Service Representatives to ensure they understand how to handle inquiries relating to electronic claim submissions and the verification that needs to occur if a provider indicates that they have submitted an electronic claim and it is not showing in the system.

2(a)(XII). In two of the 97 instances, there were system documentation errors. In one instance, the BSL system noted the amount that should be paid on an appealed charge. The amount noted by BSL was incorrect.

In one instance, there was no documentation for the basis for reversing the previously denied claims.

Summary of Company response to Section 2(a)(XII): In both instances, the Company agrees. In the first instance, the examiner used an incorrect fee schedule when she reviewed the file.

In the remaining instance, additional claims examiner training to reinforce internal procedures was conducted in March 2006.

2(a)(XIII). In one of the 97 instances, the overpayment amount sent to the provider was incorrect.

Summary of Company response to Section 2(a)(XIII): BSL conducted a refresher training session with the claims examiners who identify and process overpayments to ensure they understand how to handle overpayments and how to identify the correct amounts. Additionally, the TPA conducted a limited audit of previous overpayments to see if this was a trend. The audit did not play out that

this was a pervasive issue. The refresher training and the limited audit were both completed by February 15, 2006.

2(a)(XIV). In one of the 97 instances, the appeal received in the Company's El Dorado Hills office took over 30 days to be received by the TPA's office.

Summary of Company response to Section 2(a)(XIV): BSL has worked with the El Dorado Hills claims office to ensure the staff know how to get misrouted claims to the Short-term Health claims processor in a timely manner, including faxing the claims when they are received. In addition, BSL provided the TPA claims department with a list of the date stamps used by the Blue Shield Medical Claims Department so the TPA staff is able to recognize the correct date stamp receipt date. Direction on this was relayed to the TPA during December 2005. A formalized document was provided by the end of February 2006.

2(a)(XV). In one of the 97 instances, the Company sent letters requesting the same medical information from multiple providers who were members of the same medical group when only one request to the medical group was necessary.

Summary of Company response to Section 2(a)(XV): BSL agrees that it should not request the same information from a single source more than once, except to follow up on an initial request to which a response has not been received. Sending three letters was redundant and unnecessary. Refresher training was given to the examiners instructing them to attempt to determine from the information available to them whether multiple providers are in practice together at the same location before separately requesting information from each of them and to not send separate requests to providers who practice together at the same location. That refresher training was conducted multiple times on August 11, 2004, September 22, 2004, December 1, 2004, March 23, 2005, July 13, 2005, October 19, 2005 and November 30, 2005.

2(a)(XVI). In one of the 97 instances, Customer Service System did not document that the caller was advised that the member's eligibility was under investigation at the time.

Summary of Company response to Section 2(a)(XVI): BSL agrees that when a provider calls to check the status of claims, the provider should be advised that there is a potential eligibility issue that is being investigated and claims cannot be paid until the eligibility issue is resolved. A refresher training session was completed January 30, 2006, with the Customer Service staff to ensure that they provide complete information when a provider or member calls. This includes advising the member or provider that a potential eligibility issue has been identified and is being investigated and that claims will not be processed until the investigation is completed.

2(a)(XVII). In one of the 97 instances, the member was not informed by the Company that it required the emergency room records.

Summary of Company response to Section 2(a)(XVII): The Customer Service record did not reflect that the member was advised that the emergency room report was required when the member called Customer Service. Refresher training was done in February 2006, with Customer Service to ensure that staff know what details are required.

2(a)(XVIII). In one of the 97 instances, the Company sent a request for medical information which stated that the Company had received charges from the physician. Charges from the physician were never received for this time period. In this instance, the provider previously had responded to the Company that it did not treat the patient prior to the date the Company requested. Even though this information was provided to the Company, BSL continued to request prior treatment information two more times from the provider on an assumption that the provider may or may not have records from another provider. These requests were 20 days and three and a half months after initially being told by the provider that it did not treat the member during that time period.

Summary of Company response to Section 2(a)(XVIII): The Company disagrees. Although BSL sought medical information for a broad time period, provider groups often maintain consolidated patient records that include records transferred from previous providers covering periods of time prior to when the patient began treating with that provider group. It cannot be assumed that the physician would not have records on the patient predating the patient's first consultation with that physician. Therefore it was not unreasonable to inform the doctor of the time period the Company was reviewing in the request for all records in the provider's possession.

The Department's Response to the Company Response to Section 2(a)(XVIII):

This is an unresolved issue and may result in further administrative action.

2(a)(IXX). In one of the 97 instances, the Company did not respond to an appeal until eight months after the provider stated his records were sent.

Summary of Company response to Section 2(a)(IXX): BSL agrees. An audit of the TPA was completed December 30, 2005, to ensure that agreed upon protocols for follow-up on requested medical records are being followed. As a result of this audit, effective December 30, 2005, a follow-up will occur 28 days after the initial request is sent and if a response is still not received within 28 days, the claim will be closed.

2(a)(XX). In one of the 97 instances, the Company received and acknowledged a bill by issuing an EOB with a message code that stated additional information was needed but failed to state what information was required.

Summary of Company response to Section 2(a)(XX): This was a claims examiner error. Refresher training was completed by June 15, 2006, to ensure that claims examiners understand the proper procedures on how to select the proper EOB messages.

2(a)(XXI). In one of the 97 instances, the Company had in the file the necessary information to allow a benefit to be paid for almost two months prior to receipt of the appeal. At the time of the appeal even though the documentation to support a benefit payment was in the file, the Company denied benefits.

Summary of Company response to Section 2(a)(XXI): The Company disagrees. The letter sent stated that the Company upheld the original determination. The previously received information this allegation references was not sufficient to show that the claim involved an accident and qualified for a deductible waiver. Later the Company received additional medical records which provided the accident details. As a result of the subsequently received records, the claim was adjusted and deductible waived.

The Department's Response to the Company Response to Section 2(a)(XXI): The additional information referenced was received prior to the appeal, not after the appeal. The Company's response did not address the issue.

This is an unresolved issue and may result in further administrative action.

2(a)(XXII). In one of the 97 instances, the Company made a request for information from the anesthesiologist which was not necessary to resolve its investigation.

Summary of Company Response to 2(a)(XXII): BSL agrees that it was not necessary to collect medical records from the anesthesiologist during the course of the investigation. This was a claim examiner error and refresher training was conducted in May 2006. The refresher training focused on these provider types from which medical records should not be requested.

2(a)(XXIII). In one of the 97 instances, two similar letters were sent to the same physician on the same day requesting additional information.

Summary of Company Response to 2(a)(XXIII): The Company agrees that the two letters sent on the same day were not necessary. This was an examiner error and refresher training was completed June 1, 2006, to ensure examiners know how to use the letters and understand that sending two letters out on the same day is not acceptable.

2(a)(XXIV). In one of the 97 instances, at the time of the original denial, the Company did not provide all the information required for consideration until the provider appealed the denied claim.

Summary of Company Response to 2(a)(XXIV): As set forth in BSL's October 17, 2005 referral response, item 4, BSL agrees that all information needed from a provider should be requested at the time of the first denial. Claims examiners were provided additional training on how to thoroughly review the claims file to ensure that all of the needed information is requested at the time of the first claims review. Additional efforts will be made when conducting claims quality audits to make sure this requirement is followed. The additional training and auditing was completed before the end of 2005.

2(b). For the Individual Family (IFP) Product, in 15 of the 112 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims.

2(b)(I). In four of the 15 instances, the Customer Service System was not completely documented.

In the first instance, the Customer Service System notes did not identify the provider of service. Other claim files reviewed provided this information in the Customer Service System. BSL provided six pages from its CustomView User Guidelines, but the material provided was not in effect for the claim in question.

In the second instance, the Customer Service screen did not follow BSL required procedure and document a phone call from a member.

In the final two instances providers were not notified of an ongoing investigation when the providers called for benefit information.

Summary of Company response to 2(b)(I): In the first instance, the Company disagrees. The Customer Service notes documented a telephone inquiry from a provider regarding a claim. The claim number was provided so therefore BSL had documentation of the identity of the provider. BSL will re-instruct its examiners to clearly document provider' identities within claim files in the future.

Summary of Company response to 2(b)(I): In the second instance, this issue was not raised in the referral on this claim. The phone call from the member was documented and BSL disagrees that its procedure was not followed. Nonetheless, BSL will refresh its examiners training to document all member communications in the system.

Summary of Company response to 2(b)(I): In the final two instances, BSL disagrees. "...a UIU investigation is a confidential process and is not specifically discussed by the Customer Service Representatives with the caller.

There is no requirement under the law that a UIU investigation be disclosed; however, BSL will inform the caller that there is an ongoing review."

The Department's Response to the Company Response to Section 2(b)(I): The Department inquiry questioned whether or not when a provider called the Company for benefit information, the caller was notified of an ongoing investigation. The Company provided a copy of its guideline from a procedure manual which stated that callers are advised when there is an Underwriting review and that they will be notified as soon as the review is complete. The Company had procedures in place that were not followed.

This is an unresolved issue and may result in further administrative action.

2(b)(II). In three of the 15 instances, the Company did not follow its own procedures. In one instance, the procedure for Medical Management to notify UIU was not followed after the first phone call was received.

In the second instance, the portion of the application which required the signature and date from the producer was left blank. The Company provided a page from its guidelines to support accepting an application without the producer's date and signature, but the document provided was not in effect at the time of the member's application. The document provided by BSL had been updated two years after the member applied for coverage.

In the final instance, the BSL procedures for requesting and obtaining medical records for review to determine if coverage is rescindable were not followed. The Company's procedure was to follow up every two weeks if records were not received. In this instance, there was no indication in the file that during a two and a half month period, BSL followed its own procedure.

Summary of Company response to Section 2(b)(II): In the instance in which Medical Management did not notify UIU, BSL agrees that the case was not handled according to the Company's documented procedures. The notes should have indicated that "UIU may apply" and the case should have been forwarded to UIU. BSL disagrees as to a violation of §790.03(h)(3) because as explained above, BSL has a process in place for handling of such issues as is required by the statute. The process was not implemented in this instance.

In the instance in which the producer did not sign and date the application, the Company disagrees. The requirements related to producers pertain to outside brokers and not Direct Sales Agents. In this case the application received was completed by a Direct Sales Agent, an employee of BSL. Direct Sales Agents were not required to complete the Producer information as long as they had supplied their name and/or Direct Sales M number and their Marketing Code.

In the final instance, the Company disagrees. UIU received a referral from Medical Management. At that time, the UIU assistant requested a copy of the original application and the copy was received two months later. The UIU underwriter reviewed the application and 14 days later determined that an investigation of this member's medical history was necessary. The UIU underwriter then requested medical records from six providers on that date.

The Department's Response to the Company Response to Section 2(b)(II): In the second instance, the Company has not provided documentation to support its response regarding the producer's signature.

In the final instance, the Company response does not address that BSL's two-week follow up procedure was not followed.

These are unresolved issues and may result in further administrative action.

2(b)(III). In two of the 15 instances, there were delays in rescission investigations. In the first instance, at the onset of the rescission investigation, BSL did not request records from the provider listed on the application until two and a half months after the start of the investigation. BSL had the provider's information available so it was unreasonable for there to have been a delay of this length if those records needed to be ordered. The Company had information in its possession on the application to expedite its investigation but did not utilize the information at hand.

In the second instance, after the referral from Medical Management to UIU, there was no documentation of an ongoing investigation by UIU until 75 days later when records were requested. There was no documentation in the file to support that the application was requested by UIU. During the 75 day period, the Company received seven claims. While the claims received may not have been affected by the Medical Management pre-certification, they were affected by the delays in the UIU. There was a 75 day delay from the date of the Medical Management referral until the UIU unit's first requests for medical records.

Summary of Company response to Section 2(b)(III): In both instances the Company disagrees. In the first instance, it is not a standard or required procedure to request records from providers listed on the application.

In the second instance, UIU received a referral from Medical Management. At that time, the UIU assistant requested a copy of the original application and the copy was received. The UIU underwriter reviewed the application and determined that an investigation of this member's medical history was necessary. The UIU underwriter then requested medical records from six providers on that date. Additionally, the call received in Medical Management was to request authorization for services. A UIU investigation is not tied to the review of a request for authorization of services by Medical Management (in other words, it

does not delay any Medical Management review) and therefore there is no impact on the prompt investigation of claims requirement of CIC §790.03(h)(3). Additionally, there is no violation of CIC §790.03(h)(3) related to the Company's claims practices because no claim was yet received.

Nonetheless, BSL will provide refresher training to its examiners to emphasize the importance of conducting rescission investigations in a timely fashion.

The Department's Response to the Company Response to Section 2(b)(III): The Company did not address the delay issues presented by the Department.

These are unresolved issues and may result in further administrative action.

2(b)(IV). In one of the 15 instances, Medical Management sent a referral to UIU on February 7, 2005, and claims were paid March 18, 2005, 30 working days after referral.

Summary of Company response to Section 2(b)(IV): BSL finalized processing on March 22, 2005, and issued payment to the provider on March 23, 2005. On March 23, 2005, the UIU investigation was initiated and the Claims Department was notified to hold payment of claims. A Medical Management referral to UIU does not trigger a hold on claims. Rather, a hold on claims will occur if a UIU investigator pursues an investigation of an issue that has been referred. Otherwise, there could be an unnecessary hold on claims if the UIU investigator determines a UIU investigation is not warranted. The UIU investigation commenced on March 23, 2005, and that is when a hold on claims was placed.

Following a Medical Management referral, the UIU underwriter will request a copy of the application, and conduct an initial review of the application and any available medical information to determine whether further review is required. If it is determined that a further review is required, then a file is opened and additional medical records, etc are requested for a more detailed review. In this instance, this preliminary process took place between the February 7, 2005 Medical Management referral and the March 23, 2005 decision to proceed with a UIU investigation.

The Department's Response to the Company Response to Section 2(b)(IV): The Company has not addressed the issue that it took over 30 days after Medical Management referred the member to UIU, for the UIU to determine if it would investigate or not investigate the member's eligibility. During the over 30 day period, claims were received and paid which created an overpayment.

This is an unresolved issue and may result in further administrative action.

2(b)(V). In one of the 15 instances, after overturning the rescission, the Company failed to reprocess claims to reflect the outcome.

Summary of Company response to Section 2(b)(V): BSL agrees that the Claims Department did not adjust all claims after the UIU investigation was complete. By July 21, 2006, the Company changed the UIU process to finalize outstanding claims received prior to and during a rescission investigation. On a monthly basis, UIU sends a report to the Claims Department notifying it of completed UIU investigations so that the Claims Department can finalize any claims associated with UIU investigations.

2(b)(VI). In one of the 15 instances, BSL sent letters to the member and provider requesting additional information. Two days later, BSL sent EOBs informing the provider/member that it had not received a response to its request for additional information and that processing was discontinued. The EOBs were misleading because the Company had not discontinued its review process.

Summary of Company response to Section 2(b)(VI): BSL disagrees. The standard message to the provider and member on the EOBs sent two days after letters requesting information was not misleading in any way and provided additional detailed information to the provider/member that an investigation was underway so that each understood why the claim was not being finalized.

The Department's Response to the Company Response to Section 2(b)(VI):

This is an unresolved issue and may result in further administrative action.

2(b)(VII). In one of the 15 instances, a member contacted BSL appealing his co-pay to be either paid or removed. Although BSL responded to the member that the appeal had been forwarded to its Medical Management Department for a review and that the concerns would receive complete investigation and appropriate follow-up, BSL did not provide the member with the outcome of the Medical Management review. The file does not reflect if the co-payment was reimbursed and/or removed as the member requested.

Summary of Company response to Section 2(b)(VII): The member filed an appeal regarding quality of care and BSL sent an acknowledgement letter. The letter sent was the final decision and notification to the member. The letter explained that Quality of Care issues are protected under the Peer Review process and the results of the investigation were considered privileged and confidential under state law.

The Department's Response to the Company Response to Section 2(b)(VII):

This is an unresolved issue and may result in further administrative action.

2(b)(VIII). In one of the 15 instances, the member had an accident which required dental services. BSL was notified prior to receipt of the claim of the accidental injury and pre-authorized the services. When the claims were received, the services were denied for no dental benefits even though some services were pre-authorized. BSL failed to document its system to allow pre-authorized benefits when the charges were received. The Company previously had approved certain services for payment and the policy did afford coverage. Although the claim was submitted without the approval code, since BSL had pre-authorized dental services and could have documented its system to allow the services, the charges were payable upon initial submission.

Summary of Company response to Section 2(b)(VIII): The claim was submitted without the approved code. Upon appeal, the claim was adjusted to pay as an exception.

The Department's Response to the Company Response to Section 2(b)(VIII):

This is an unresolved issue and may result in further administrative action.

2(b)(IX). In general, due to BSL's business structure of having the Pre-existing Condition Unit and the UIU act independently of each other [described in section 2(b)(I) on pages 25 and 26 of this report], investigations may not be conducted promptly as required.

Members and providers may be subjected to two separate investigations in which the same information may be requested separately by each unit. The documentation gathered for one investigation is not utilized by both units.

The Pre-existing Condition Unit may conduct a pre-existing condition investigation and determine that the billed diagnosis is not a pre-existing condition (six month contestability). The procedure used by BSL would not refer the member to the UIU to investigate even when the diagnosis may be rescindable (two year contestability). Claims for the member would continue to be paid until the point when and if Medical Management becomes involved and refers the case to UIU. UIU may conduct its own investigation with the possible result that a rescission will be made. The result of this lack of a coordinated process is that the member and provider are subjected to delay in commencing the ultimate UIU investigation.

Summary of Company response to Section 2(b)(IX): BSL has responded to other inquiries regarding the two units working separately and independently that it does not agree with the Department's criticism.

The Department's Response to the Company Response to Section 2(b)(X):

This is an unresolved issue and may result in further administrative action.

3. In 55 instances, the Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

3(a). For the Short Term Health Product, in 27 of the 55 instances, the Company failed to represent correctly to claimants pertinent facts or insurance policy provisions relating to a coverage at issue.

3(a)(I). In 13 of the 27 instances, the explanation of benefits (EOB) contained inaccurate messages which were misleading to the provider and member. Specifically, the remark code indicated that additional information was needed from the provider when no additional information had been requested from the provider.

Summary of Company response to 3(a)(I): The Company agrees. The remark code on the EOB was misleading by indicating that additional information had been requested from the provider when in fact no information was requested. Refresher training was conducted on November 30, 2005, to ensure that claims examiners understand which message codes to use.

3(a)(II). In five of the 27 instances, at the start of the pre-existing investigation, the Company asked the member for 12 months of medical history instead of six months as specified in the policy contract.

Summary of Company response to 3(a)(II): The Company agrees. This was a claims examiner error and only six months of medical information should have been requested. This issue was identified prior to the Department's review and extensive refresher training was conducted in multiple sessions with the claims examiner staff on September 22, 2004, June 15, 2005, and August 24, 2005.

3(a)(III). In three of the 27 instances, a no-pay EOB provided unbundling information which was incorrect.

Summary of Company response to 3(a)(III): The Company agrees. These were incorrect remark codes and should not have been used. Unbundling would not apply when no payment was being made. Refresher training for claims examiners on the unbundling remark code was completed by June 1, 2006.

3(a)(IV). In two of the 27 instances, original claims and their appeals were denied incorrectly. The provisions within the policies that BSL referenced to support the Company denials did not apply to the claims submitted.

Summary of Company response to 3(a)(IV): The Company agrees. In both instances, the policy wording referenced in the denials was incorrect. In one instance, the claim was reprocessed. In the other instance, the claims submitted were not a benefit of the policy regardless of the incorrect wording.

In addition, by the end of December 2005, BSL completed additional training with claims examiners to ensure they know how and when to apply policy provisions.

3(a)(V). In one of the 27 instances, on the same day that the Company received a billing, it sent an EOB closing the claim due to lack of information.

Summary of Company response to 4(a)(V): The Company agrees that the EOB contained an inappropriate remark code. On June 1, 2005, and on November 30, 2005, refresher training was conducted with the claims examiners on the proper usage of remark codes.

3(a)(VI). In one of the 27 instances, the information provided by the member's physician on three separate occasions did not support the denial of benefits.

Summary of Company response to 3(a)(VI): The Company agrees. The information provided by the physician did not support the denial of benefits. Additional training on making pre-existing condition decisions was provided to the claims examiner staff at the end of March 2006.

3(a)(VII). In one of the 27 instances, in a 2004 denial letter to a member, the Company specifically quoted pre-existing condition wording that was no longer a part of the pre-existing condition wording in the policy. A policy amendment on January 1, 2002, removed the wording the Company referenced in its denial letter.

Summary of Company response to 3(a)(VII): The Company disagrees. The only change in the changed definition was the substitution of "health care practitioner" for "health practitioner," and the capitalization of certain defined terms. No wording was eliminated from the policy definition and the correct definition was used.

The Department's Response to the Company Response to Section 3(a)(VII):

This is an unresolved issue and may require further administrative action.

3(a)(VIII). In one of the 27 instances, the insured's appeal was denied even though prior to the denial, all pertinent information to support the appeal was provided by both the member and the provider. The member appealed a deductible taken when the policy had a deductible waiver if the service was in connection with an accident. The services provided were due to an accidental injury.

Summary of Company response to 3(a)(VIII): The Company disagrees. The x-ray report contained in the file at the time appeal was denied did not provide enough information to show that the claim involved an accident and qualified for a deductible waiver. Later the Company received additional medical records which

provided the accident details. As a result of the records received after the appeal was initially denied, the claim was adjusted and deductible waived.

The Department's Response to the Company Response to Section 3(a)(VIII): The Company did not address the issue that at the time the Company denied the member's appeal, the Company had in the file not only the members appeal, but also an appeal from the provider which contained the information to verify the accidental injury. When responding to the member's appeal, the Company did not take into consideration the provider appeal it had in the file and denied the member's appeal.

This is an unresolved issue and may require further administrative action.

3(b). For the Individual Family Plan (IFP) Product in 28 of 55 instances, the Company failed to represent correctly to claimants pertinent facts or insurance policy provisions relating to a coverage at issue.

3(b)(I). In 20 of the 28 instances, all Company correspondence (EOBs, rescission letters, letters from Medical Management, letters from Grievance and appeals etc.) included Employee Retirement Income Security Act (ERISA) wording applicable to Group products. The ERISA wording was not applicable to this Individual product and therefore was misleading.

Summary of Company response to 3(b)(I): The Company disagrees. The ERISA notice was required for the group business product. It appeared at the end of the correspondence and was set apart in a box from the rest of the notice. It began, "If your employer's health plan", so anyone reading that part of the notice would be able to tell easily if it applied to their plan. The use of this language in no way misrepresented pertinent facts or insurance policy provisions relating to this IFP coverage at issue and therefore has no impact on the Plan's compliance with CIC §790.03(h)(1).

The Department's Response to the Company Response to 3(b)(I):

This is an unresolved issue and may result in further administrative action.

3(b)(II). In three of the 28 instances, Medical Management letters informed the member/providers that BSL was conducting pre-existing condition investigation when such an investigation was not being conducted.

Summary of Company response to 3(b)(II): There was no pre-existing condition investigation. This verbiage was used by Medical Management when the patient was within their pre-existing condition time period.

The Department's Response to the Company Response to 3(b)(II):

This is an unresolved issue and may result in further administrative action.

3(b)(III). In three of the 28 instances, there was no procedure in place for Customer Service to advise a caller that there was a pending investigation.

Summary of Company response to 3(b)(III): BSL disagrees. The Customer Service system noted that eligibility and benefits were discussed. The CSR might discuss that there was an administrative review, etc, if appropriate, in order to respond to issues raised in a call; however as a matter of policy, the Company did not disclose specifically a UIU investigation.

The Department's Response to the Company Response to 3(b)(III): The Department does not suggest that the Company needed to disclose to callers when there was a UIU investigation. The Department contends that a caller should have been provided with the information requested and notified if there was a pending investigation which might affect benefits paid.

This is an unresolved issue and may result in further administrative action.

3(b)(IV). In one of 28 instances, in a letter to the provider explaining the interest payment, BSL incorrectly identified a Department of Managed Health Care citation (California Health & Safety Code §1371) when it should have identified the Department of Insurance and CIC §10123.13(b).

Summary of Company response to 3(b)(IV): The Company disagrees. The correct interest was calculated as required by CIC 10123.13(b). Also, the letter with an incorrect citation was a mistake and was not consistent with established business policies. BSL will conduct refresher training to reinforce for examiners that its products are regulated by the Department under the Insurance Code and that they should verify that there correspondence references the correct agency and code.

3(b)(V). In one of the 28 instances, BSL paid claims for a diagnosis which the UIU had placed on "hold" in the system during its UIU investigation.

Summary of Company response to 3(b)(V): BSL agrees that claims were paid when UIU had placed a "hold" in the system during its UIU investigation. The Claims Department received training by August 4, 2006, that included a review of the process to follow when a notice from UIU is received to hold claims.

4. In 43 instances, the Company failed to maintain all documents, notes and work papers in the claim file. The Department alleges these acts are in violation of CCR §2695.3(a).

4(a). For the Short Term Health product, in 24 of the 43 instances, complete files were not provided. The missing information included:

(I) documentation to support when and where BSL obtained the U. S. conversion for out-of-country claims;
(II) copies of the documents determining the outcome of an appeal;
(III) documentation that BSL acknowledged a request for information;
(IV) documentation to support the date an authorization to obtain medical records was sent;
(V) a copy of the member's certificate of insurance;
(VI) documentation of requests for applications;
(VII) documentation of the basis for reversing a rescission;
(VIII) the original claim;
(IX) documentation of when BSL requested a copy of the creditable coverage certificate showing that such was performed in a timely manner;
(X) pertinent provider no-pay EOBs and member EOBs;
(XI) documentation of the name of a caller with an inquiry;
(XII) notations in the Customer Service System of the identity callers;
(XIII) copies of Medical Management reviews;
(XIV) documentation of telephone calls; and
(XV) documentation of information conveyed in telephone calls.

Summary of Company response to Section 4(a):

4(a)(I). In the instance of the U. S. conversion, as a matter of practice, the conversion amount was verified by the claims examiner using an internet website application or the website was used to obtain the conversion amount. This information should have been included in the file. A refresher training session was completed by June 15, 2006, to ensure that claims examiners know to include a copy of the conversion information in the file.

4(a)(II). In the instance of a copy of the documents determining an appeal, the Company agrees. BSL will conduct refresher training to reinforce the process of transmitting documents to its third party administrator for inclusion in the file.

4(a)(III). In the instance of the response to an inquiry, BSL's standard procedure required an acknowledgement or letter of response. Refresher training was completed in December 2005.

4(a)(IV). In the instance of the documentation of the date for requesting medical records, the standard practice was to document the file with this information. Refresher training was conducted with the claims examiner by the end of December 2005.

4(a)(V). In the instance of the copy of the certificate of coverage, the Company agrees. BSL provided the additional information.

4(a)(VI). In the two instances, BSL agrees. Effective October 2005, procedures were implemented to obtain copies of the application and to document the date the

application was requested and the date it was received. BSL completed additional training to remind staff of documentation procedures at the end of June 2006.

4(a)(VII). In the instance of the administrative review for a rescission reversal, BSL agrees. A training refresher session was conducted in March 2006, with the claim staff to ensure they understand what documentation requirements are needed for reinstatements.

4(a)(VIII). In the instance of the missing original claim, BSL provided copies of the claims the member submitted upon appeal, rather than copies of the original claim.

The Department's Response to the Company Response to Section 4(a)(VIII):

This is an unresolved issue and may result in further administrative action.

4(a)(IX). In the instance of the request regarding previous insurance coverage, although the request was not documented in the file, a request was made. This lack of documentation was not consistent with BSL procedures. Nevertheless, the BSL disagrees that CCR §2695.3(a) applies because pertinent events could be reconstructed without the documentation of the specific date upon which the request for records was made. Nonetheless, BSL will issue instructions reminding its third party administrator examiners of the requirement that all requests and communications concerning a claim be documented in the claim file.

4(a)(X). The Company disagrees that provider and member EOBs were not provided.

The Department's Response to the Company Response to Section 4(a)(X):
While the Company provided EOBs, they were not the EOBs pertinent to the issues in the files reviewed.

This is an unresolved issue and may result in further administrative action.

4(a)(XI). Regarding the undocumented telephone call, BSL procedures in October 2004 did not require that the caller's name be documented for every call. However, in August 2005, BSL revised its procedures and currently requires that caller information be captured for every call.

4(a)(XII). The process at that time did not include documenting the name of the provider. This process was changed in August 2005, when the Customer Service Representatives (CSR) began to include in the documentation the name of the provider calling. CSRs were trained on this new requirement on December 22, 2005.

4(a)(XIII): The Company agrees: In the one instance, services were reviewed by BSL's Medical Management Department for pricing of the charges billed. The EOB associated with the claim reflected the outcome of Medical Management's review. There was no hard copy of how Medical Management determined the pricing for the billed charges. In another instance, the Company was unable to locate a copy of its Medical Management review.

4(a)(XIV): In the instances of undocumented telephone calls, BSL concurs that the file did not include documentation of the agent's calls. This was a CSR oversight and refresher training was conducted by June 15, 2006, to ensure that the CSRs understand the requirements for all calls received.

4(a)(XV): In the final instance, a refresher training for supervisors was held in January 2006. This training included material on the requirements for completing call backs and for the documentation of such calls.

4(b). For the Individual Family Plan and Group products, in 19 of the 43 instances, complete files were not provided.

4(b)(I). In five instances, EOBs were not provided.

Summary of Company response to 4(b)(I): In the first instance, BSL intended to and believes it did attach the EOB to its referral response as Attachment A.

In the second instance, the actual EOBs were attachment 1 to BSL's referral response.

In two instances, BSL did not provide a response because it did not receive referrals for on the claims in question.

In the remaining instances, the data from which the paper EOBs were printed was available for viewing on screen. BSL will work to develop a process by which paper copies of non-pay EOBs can be provided on a timely basis.

The Department's Response to the Company Response to Section 4(b)(I):

These are unresolved issues and may result in further administrative action.

4(b)(II). In two instances, the UIU file did not document the date a copy of the application was requested. The Company responded that a copy was requested after the referral from Medical Management was received, but did not provide proof of the requests.

Summary of Company response to 4(b)(II): On the date that the referral was received a request for the application was routinely made, but BSL did not

have documentation that this was done in these two instances. The process has been changed so that the date on which the application is requested is documented. In addition, BSL will conduct refresher training for its examiners to emphasize that investigations should be conducted diligently.

4(b)(III). In two instances, the provider's office or the copy service provided a billing for its services. The file did not reflect that the copy service fees were paid by BSL. BSL responded that with participating providers, there is an agreement that records are to be provided without a copy fee. The Company did not provide a copy of this written agreement.

Summary of Company response to 4(b)(III): BSL disagrees. BSL explained the contracted providers' obligation to provide records and a copy of the agreement was not requested by the examiner. In one of the two instances, it was BSL's process to call the provider and tell them that BSL would not reimburse the provider for the charges. BSL referenced its cover sheet when making the request for records which stated that the requested information was to be provided at no charge.

The Department's Response to the Company Response to Section 4(b)(III):

This is an unresolved issue and may result in further administrative action.

4(b)(IV). In one instance, the underwriting file for a rescission lacked a copy of the request for medical records.

Summary of Company response to 4(b)(IV): The documentation requested by Underwriting was not part of the rescission process and was located in another department/file. Therefore, that information was not part of the rescission file and was not provided as a part of the review.

The Department's Response to the Company Response to Section 4(b)(IV): The medical records in question prompted the underwriter to send this member to the UIU for a rescission investigation. Therefore, any file documents regarding the records were a part of the rescission process.

This is an unresolved issue and may result in further administrative action.

4(b)(V). In one file, BSL responded to the Department that six benefit payments were based on BSL's medical consultant's review but BSL failed to provide a copy of the referenced review to support its response.

Summary of Company response to 4(b)(V): There was no medical consultant review of this claim and, accordingly, no copy of a review to provide. Rather, BSL requested additional information from the provider and the provider

complied, which led to the referenced payments. (The Company representative) discussed this with the examiner on July 20, 2006 in San Francisco.

The Department's Response to the Company Response to Section 4(b)(V):

This is an unresolved issue due to lack of response and may result in further administrative action.

4(b)(VI). In one instance, the member appealed a rescission by email. A copy of the email was not provided.

Summary of Company response to 4(b)(VI): The Company was unable to locate the email appeal. The Company agrees that the appeal email was not copied to the file as required by company policy; however, it is not clear how this prevents the Department from reconstructing pertinent events and dates pertaining to the claim for purposes of compliance with claims practices requirements as is the requirement of 2695.3(a).

4(b)(VII). In one instance, the file lacked the documentation to support a cancellation decision. BSL did not provide the documentation to support a cancellation of a policy when the file was noted to rescind coverage. Although there were two internal documents within the file that noted to rescind coverage, the member's policy was not rescinded but instead cancelled as of the date of a cancellation letter to the member. The file contained no documentation as to how the Company changed its position and determined not to rescind coverage back to the effective date.

Summary of Company response to 4(b)(VII): This was an administrative decision. The documentation in the file stating to rescind coverage was in error.

The Department's Response to the Company Response to Section 4(b)(VII):
BSL did not provide the documentation to support its decision.

This is an unresolved issue and may result in further administrative action.

4(b)(VIII). In one instance, the file lacked the date that BSL was contacted by the member's broker regarding the broker's concerns. The file documented the BSL Director of IFP Sales referral to UIU for investigation, but the file did not document when the Director was contacted regarding the broker's concerns.

Summary of Company response to 4(b)(VIII): The Company disagrees. Because there was no written correspondence forwarded from the broker who was seeking anonymity, it was concluded from BSL employee email that the BSL Director of Sales received a call from the broker. This executive sales position required telephone calls and meetings with brokers on a regular basis. Issues

received by phone or in person were referred for handling via phone or email. Therefore the email was the documentation contained in the file.

The Department's Response to the Company Response to Section 4(b) (VIII):

This is an unresolved issue and may result in further administrative action.

4(b)(IX). In one instance, the member's application contained a diagnosis and a prescription drug taken for that diagnosis. The underwriting tool used at the time of the application rated the prescription drug, but for a completely different diagnosis. The file did not contain a rating for the diagnosis provided by the member at the time of application and therefore due to the diagnosis discrepancy, did not document if the member was rated correctly.

Summary of Company response to 4(b)(IX): The Company disagrees. The underwriter referred to the points assigned to the medication and assigned the points. The underwriter was aware that medication could be used to treat two separate identifiable diagnoses.

The Department's Response to the Company Response to Section 4(b)(IX):

This is an unresolved issue and may result in further administrative action.

4(b)(X). In one instance, the Company did not provide a copy of its complete procedure manual for pre-existing investigations.

Summary of Company response to 4(b)(X): BSL disagrees. (The Company representative) provided full copies of BSL's pre-existing condition investigation procedure manual to the examiner on June 22, 2006, July 27, 2006, and July 31, 2006, at which point the examiner informed (The Company representative) that she did not need to receive further copies of the manual.

The Department's Response to the Company Response to Section 4(b)(X):

This is an unresolved issue due to lack of response and may result in further administrative action.

4(b)(XI). In one instance, the provider of service sent to BSL a request for dental services to be reviewed and pre-authorized before services were performed. The provider's pre-authorization request and any documents submitted were not provided.

Summary of Company response to 4(b)(XI): BSL disagrees. Pre-service letters are not normally part of the Appeals file. The pre-service determination is in the Managed Care Notes.

The Department's Response to the Company Response to Section 4(b)(XI):

This is an unresolved issue and may result in further administrative action.

4(b)(XII). In one instance, a copy of the BSL Dental Director's review referenced in the July 9, 2004, BSL notes were not provided with the file.

Summary of Company response to 4(b)(XII): BSL disagrees, the Dental Director's review is in the notes within the Managed Care notes. These notes were available to the examiner on the system and also printed out and provided on paper. Dental Director's review and the Managed Care notes were provided as part of the Appeal packet provided to her.

The Department's Response to the Company Response to Section 4(b)(XII):

This is an unresolved issue and may result in further administrative action.

4(b)(XIII). In one instance, during the review of a rescission file, it was noted that BSL also conducted a pre-existing condition investigation and determined that the member's condition was not pre-existing. A copy of the pre-exist unit investigation file was requested but BSL declined to provide the file.

Summary of Company response to 4(b)(XIII): The requested documentation is not part of a UIU investigation and therefore is not part of the rescission file. The complete rescission file was provided and made available to the CDI auditor at the start of the audit following the guidance provided in the "Coordinator's Information Guide" and "Claims Operation Questionnaire" provided to the company upon initial notice of audit. This document is part of a pre-existing condition review which is handled by the company as a completely separate and distinct process, unrelated to a UIU investigation.

The Department's Response to the Company Response to Section 4(b)(XIII): Prior to the examination and during the examination process, the Department communicated the information required to the designated Company representative. During the process if the required information was not provided the Department notified the Company. The IFP product was one of the final products reviewed during this examination. The examination process was in its ninth month when the review of the product began. The Company was aware at that point in the examination of the documentation necessary to complete the review because of prior requests for that information in other products.

This is an unresolved issue and may result in further administrative action.

5. In 35 instances, 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. The Department alleges these acts are in violation of CCR §2695.7(b)(3).

5(a). In seven of the 35 instances for the Short Term Health Product, correspondence from the Company, EOBs, and pre-existing condition letters did not contain the required wording.

Summary of Company Response to 5(a): BSL used standardized remark codes in its denial letters. By the end of January 2006, BSL audited its standardized EOB remark codes and revised them as necessary to provide for the specific policy provisions that were the basis of a denial. The necessary corrective actions to the remark codes were implemented by the end of June 2006. Additionally, programming to modify the EOB to include the appropriate language was completed by the end of August 2006.

5(b). In 28 of the 35 instances for the IFP Product, correspondence such as explanation of benefits, rescission letters, response to appeal letters, and Medical Management correspondence did not contain the wording required by CCR §2695.7(b)(3).

Summary of Company Response to 5(b): The Company agrees. Corrections to the EOBs were completed by August 18, 2006. Form rescission letters that contained Department of Managed Health Care wording were corrected on June 9, 2005. Letters in response to appeals were corrected on July 12, 2005, and Medical Management/Authorization letters were updated on July 15, 2006.

6. In 26 instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claim dispute. [This CCR §2695.7(d) wording was effective for claims handling prior to the October 2004 regulation update.] The Department alleges these acts are in violation of CCR §2695.7(d).

6(a). For the Short Term Health Product, in 25 of the 26 instances, the Company requested information it already had in the file.

6(a)(I). In four of the 25 instances, the members suffered injuries from an accident. This information was on file when claims were received. Even with this information the Company conducted pre-existing condition investigations.

Summary of Company Response to 6(a)(I): BSL agrees that letters should not have been sent as the diagnoses clearly indicate accident related injuries. The policy at the time was to send out letters for this type of diagnosis and to gather verification of an accidental injury. The policy was changed in January 2005, and letters no longer are sent if the diagnosis is clearly accident related.

6(a)(II). In three of the 25 instances, the information available on the application was not utilized during an investigation thereby resulting in delays by obtaining the information a second time.

Summary of Company Response to 6(a)(II): Upon the initiation of an eligibility investigation, the TPA would request a copy of the application from BSL. The Company recognizes that in some instances, names and addresses of treating physicians and previous insurance coverage information might have been provided in the member's application. Requesting the application prior to requesting information directly from the member was not part of its procedure because many times the information provided on the application was incomplete and a member request was not avoided because additional or different information was still required. BSL revised its procedures in December 2005, to review routinely the application for physician information before a request for additional information is made to the member.

6(a)(III). In one of the 25 instances, the Company requested the outcome of the pathology report when the information was contained in the medical records in the file.

Summary of Company Response to 6(a)(III): The Company agrees that the request was not necessary. Quarterly audits will be conducted with the TPA. BSL audited a sampling of claims to ensure that the correct process was followed. BSL identified where there were discrepancies and implemented corrective steps as needed by January 30, 2006.

6(a)(IV). In one of the 25 instances, BSL received the physician's notes it had requested but requested the same notes again seven months later.

Summary of Company Response to 6(a)(IV): The Company agrees. This was a mistake in processing made by the claims examiner. The Company has procedures in place to review documents received and retraining took place by December 5, 2005, to reinforce how to thoroughly review a member's claim file to ensure that information is not being re-requested when it is already contained in the file. In addition, since the examination, BSL has changed its process to require examiners to check the queue of incoming material before sending out second requests for information.

6(a)(V). In one of the 25 instances, after the physician's response was received, the Company requested the information again 19 days after receipt.

Summary of Company Response to 6(a)(V): There was a backlog and additional information was needed from other providers. Since the examination, BSL has made changed its process to require examiners to check the queue of incoming material before sending out second requests for information. BSL will also instruct its third party administrator to ensure that examiners are familiar with the contents of the file and the information available before requesting information from provider's to avoid redundant requests.

6(a)(VI). In one of the 25 instances, the Company received previous insurance information from the member which provided a credit toward the member's pre-existing condition time period under the plan. This credit eliminated this member's time period but BSL continued to pursue a pre-existing condition investigation.

Summary of Company Response to 6(a)(VI): This was not a typical scenario as normally responses are worked faster to prevent this from occurring. This was an unusual time when some backlog existed. BSL reviewed the process for automatically sending a follow-up. Modifications to the work process were completed by the end of June 2006 and now require the examiner to review the file and queue to determine whether responses and information are already available before re-requesting information.

6(a)(VII). In one of the 25 instances, the Company sent a letter to the member requesting accident details after receipt of the police report which contained the details of the accident.

Summary of Company Response to 6(a)(VII): BSL provided a response regarding this instance in its May 26, 2006 referral response. BSL responded that it agreed that the pre-existing letter should not have been sent and that the letter was sent as a result of examiner error. As indicated in BSL's referral response, refresher training was completed by June 15, 2006 to reinforce that pre-existing condition letters are not sent on claims when the claim is clearly related to an accident. BSL will re-instruct its third party administrator to ensure that examiners are familiar with the contents and substance of claim files before requesting additional information in order to avoid requests for information that is already available. "

6(a)(VIII). In one of the 25 instances, a police report was received which contained accident details. The accident occurred after the member's effective date of coverage which verified this was not a pre-existing condition. Even with this information in file, the Company sent a pre-existing condition letter to the member eight days after receiving the police report.

Summary of Company Response to 6(a)(VIII): This was a claims examiner error and refresher training was conducted in June 2006, to ensure the staff understands that pre-existing condition letters are not sent on claims that are clearly caused by an accident.

6(a)(IX). In one of the 25 instances, the Company requested an answer from the member although it had paid benefits two days prior.

Summary of Company Response to 6(a)(IX): This was an examiner oversight because the file was not reviewed thoroughly. Refresher training was conducted June 1, 2005, June 15, 2005 and October 19, 2005, with the examiners

to ensure they are aware of how to review a file thoroughly and to not generate unnecessary letters.

6(a)(X). In one of the 25 instances, the Company requested the diagnosis code or an itemized bill when the information was already in the file.

Summary of Company Response to 6(a)(X): These records requests were unnecessary because the information was available in the plan records. Under BSL's procedures, the file should have been checked before information was requested. Training of the claims processing staff was completed by the end of December 2005, to ensure they know how to review a claims file thoroughly in order to avoid requesting information already available.

6(a)(XI). In one of the 25 instances, an itemized bill already in the file was requested again.

Summary of Company Response to 6(a)(XI): In error, the claims examiner put an incorrect remark code on the EOB. The information was available through a claim that had been received already. Under BSL's procedures, the file should have been checked before the information was requested. The Company directed its TPA to provide training to claims processing staff to ensure they know how to review a claims file thoroughly in order to avoid requesting information already available. The training was completed in December 2005.

6(a)(XII). In one file, the Company requested information from a member stating that the information had not been received from the provider when, in fact, the information had been received by BSL 14 days prior to the request.

Summary of Company Response to 6(a)(XII): Refresher training was completed in March 2006, with examiners to ensure they know how to thoroughly review a file to locate information that has come in as a result of requests to providers and members.

6(a)(XIII). In one of the 25 instances, the Company sent a second request for emergency room records when the records had been received by BSL nine days prior.

Summary of Company Response to 6(a)(XIII): Refresher training was conducted with the claims examiners on October 6, 2004, and again on March 8, 2006, concerning the proper desk procedures for searching the file for medical records before making another request.

6(a)(XIV). In one of the 25 instances, the physician provided the requested five years of medical information. Nine days later the Company made another request for six months of medical information.

Summary of Company Response to 6(a)(XIV): Refresher training was conducted with the claims examiners on October 6, 2004, and again on March 8, 2006, concerning the proper desk procedures for searching the file for medical records before making another request.

6(a)(XV). In one of the 25 instances, the Company had in the file records from the member's physician that named the prescription drug and the diagnosis for the member. BSL requested additional information from the provider when the information was in file.

Summary of Company Response to 6(a)(XV): BSL disagrees. BSL's research did not show that the drug was indicated for the diagnosis given.

The Department's Response to the Company Response to 6(a)(XV): The Department was able to locate information on the internet that would verify what the doctor had already provided in the medical records which the Company had in its possession.

This is an unresolved issue due to the lack of response and may result in further administrative action.

6(a)(XVI). In one of the 25 instances during the course of an investigation, the Company received a billing for medical services from a physician. The billing listed the name of the physician who referred the member to the treating physician. The Company requested additional information from the provider who billed for services and not from the listed referring physician.

Summary of Company Response to 6(a)(XVI): The Company agrees. Refresher training was conducted in late January 2006, which covered when such information should be requested from providers.

6(a)(XVII). In one instance, two months after receipt of the requested information from the member, the Company requested the information again from the member.

Summary of Company Response to 6(a)(XVII): The additional request to the member should not have been made as the member had already responded. This was an examiner error and refresher training has been conducted to ensure the claims examiner staff knows how to search the file for information received before making additional requests. The refresher training was provided and reinforced in multiple sessions on June 30, 2004, August 11, 2004, September 22, 2004, March 23, 2005, June 1, 2005 and March 8, 2006.

6(a)(XVIII). In one of the 25 instances, the Company sent a letter requesting additional information from the member's provider even though the information had been received 11 days prior.

Summary of Company Response to 6(a)(XVIII): Since the examination, BSL has made changed its process to require examiners to check the queue of incoming material before sending out second requests for information. BSL will also instruct its third party administrator to ensure that examiners are familiar with the contents of the file and the information available before requesting information from provider's to avoid redundant requests.

6(a)(XIX). In one of the 25 instances, even though the medical records confirmed that the member was not diagnosed until after coverage became effective, the Company continued to conduct a rescission investigation.

Summary of Company Response to 6(a)(XIX): BSL addressed issue in its September 25 response to the re-referral on this matter. This was an examiner error. BSL will instruct its third party administrator to ensure that examiners are familiar with the contents of the file and the information available before requesting information from provider's to avoid redundant requests.

6(a)(XX). In one of the 25 instances, after receipt of a completed form from the member's provider, the Company requested a completed form 18 days later from a physician who was in the same medical group. The physician noted in the response to the Company "this is the second form I have filled out".

Summary of Company Response to 6(a)(XX): The Company disagrees. BSL was unaware of this provider and requested records. The physician's office was incorrect in its assertion that this was the second form filled out by the doctor.

The Department's Response to the Company Response to 6(a)(XX): The Department noted that the Company agreed with the Department on another member when during an investigation, BSL requested records from each provider within a medical group.

This is an unresolved issue and may result in further administrative action.

6(b). For the Individual Family (IFP) Product, in one of the 26 instances, the Company requested information it already had in the file. During a UIU investigation, the UIU Unit requested medical information from two physicians that the Pre-Exist Unit had previously requested during its pre-existing investigation. BSL considers the investigations conducted by the two units to be completely separate and unrelated. Information obtained during an investigation by either unit is not shared between the two units which can create duplicate requests to providers.

Summary of Company Response to 6(b)(I): The claims are not part of the UIU investigation or rescission file. They are part of the preexisting condition file, which is unrelated.

The Department's Response to the Company Response to 6(b):

This is an unresolved issue and may result in further administrative action.

7. In 17 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Department alleges these acts are in violation of CIC §790.03(h)(5).

7(a). For the Short Term Health product, in 16 of the 17 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.

7(a)(I). In five of the 16 instances, the Company had sufficient information in the file to allow benefits to be paid but did not release the claims. In the first instance, the emergency room report was received but the claim was not paid. In the next instance, the Company had enough accident details in the file to pay but did not pay benefits. In the third instance, medical records were in the file, but benefits were not released. In the fourth instance, a charge was denied that was payable. In the final instance, one claim was not released for benefit payment at the time other claims were paid.

Summary of Company Response to 7(a)(I): The Company agrees and benefits in the amount of $4,749.47 have been paid, which included $362.06 towards the calendar year deductible.

7(a)(II). In two of the 16 instances, at the conclusion of a pre-existing condition investigation, not all claims were released for payment. In the first instance, at the conclusion of the pre-existing investigation, benefits were released but one claim was not released for payment. In the other instance, after concluding a pre-existing condition investigation, benefits were not released for payment.

Summary of Company Response to 7(a)(II): In both instances, the Company agrees and benefits in the amount of $814.31 have been paid, which included $250.00 toward the calendar year deductible. Additionally, the Company conducted and completed a survey for the period of 2004-2006. An additional $39,801.95 ($7,095.34 of which was applied towards the deductible) was paid to claimants as a result of the survey.

7(a)(III). In two of the 16 instances, the Company initiated a pre-existing condition investigation for a diagnosis that is listed as a condition for which the Company would not conduct an investigation.

Summary of Company Response to 7(a)(III): The Company agrees and reprocessed the claims applying a combined total of $252.65 towards the members' calendar year deductibles.

7(a)(IV). In one of the 16 instances, claims were denied originally and upon appeal by referencing a policy limitation regarding accidental injury and a

member's blood alcohol level. The policy limitation BSL used to deny the charges did not apply to the claims submitted.

Summary of Company Response to 7(a)(IV): The Company agrees that the original denial and the appeal denial were in error. The claims were reprocessed and the member's $2,000.00 deductible was satisfied and a benefit in the amount of $1,524.75 was paid. Additionally, the Company conducted and completed a survey for the period of 2005-2006. An additional $460.64 was paid as a result of the survey.

7(a)(V). In one of the 16 instances, a claim was denied and the provider was advised that the procedure code billed was not appropriate for the diagnosis. The provider appealed and the appeal was denied and the Company requested additional information not previously requested in its first denial. The Company allowed the benefits after the matter was brought to its attention as a result of this examination.

Summary of Company Response to 7(a)(V): After review of the Department's inquiry, the Company contacted the provider and a benefit payment of $3,603.00 was made.

7(a)(VI). In one of the 16 instances, the file did not contain documentation to support the denial of claims.

Summary of Company Response to 7(a)(VI): The Company agrees and has adjusted for benefits. An additional $2,115.87 has been paid.

7(a)(VII). In one of the 16 instances, a claim for a member was denied as routine when it was not.

Summary of Company Response to 7(a)(VII): BSL agrees and a benefit payment of $24.97 has been made.

7(a)(VIII). In one of the 16 instances, a charge was denied as routine when the corresponding office visit was payable.

Summary of Company Response to 7(a)(VIII): BSL agrees that the charge was payable and a benefits payment of $2.84 has been made.

7(a)(IX). In one of the 16 instances, an incorrect pre-existing condition time period was applied to a member's claims which resulted in claims denials.

Summary of Company Response to 7(a)(IX): The Company agrees and reprocessed claims applying $107.91 towards the member calendar year deductible.

7(a)(X). In one of the 16 instances, the corresponding X-Rays for a hospital visit were not paid.

Summary of Company Response to 7(a)(X): The Company agrees and a benefit payment of $18.72 has been made.

7(b). For the Individual Family (IFP) Product, in one of the 17 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Company paid the wrong provider. When the Company reprocessed the claim to pay benefits to the correct provider, interest was due.

Summary of Company Response to Section 7(b): The Company agrees and an interest payment in the amount of $1,726.71 has been paid. Additionally, on July 21, 2006, a process was implemented to make changes to the UIU process in order to finalize outstanding claims received prior to and during a rescission investigation. On a monthly basis, UIU now sends a report to the Claims Department notifying it of completed UIU investigations so that the Claims Department can finalize any claims associated with the UIU investigation.

Additionally, the Company conducted a closed claims survey of claims on this issue for the period of 2004-2006. Claims were adjusted to pay benefits totaling $827,259.44 plus $118,879.90 in interest.

8. In 13 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. The Department alleges these acts are in violation of CCR §2695.11(b).

8(a). In 11 of the 13 instances, the violations occurred in the Short Term Health Product.

8(a)(I). In six of the 11 instances, the member EOB provided did not contain the amount paid to the provider.

Summary of Company Response to 8(a)(I): Two issues resulted in blank fields on reprinted EOBs. These problems were corrected effective April 15, 2006.

8(a)(II). In four of the 11 instances, the portion of the EOB which contained the computation of benefits was blank.

Summary of Company Response to 8(a)(II): BSL revised its EOB to contain the required information.

8(a)(III). In one instance, a remark code on an EOB did not provide an accurate explanation for the current status of the claim.

Summary of Company Response to 8(a)(III): This was an examiner error. The remark code used should not have been used. Refresher training on the remark code was conducted with the claims examiners in June, 2006.

8(b). In two of the 13 instances, the violations occurred in the IFP Product. The EOB to the member did not provide the amount paid in the computation of benefits but the EOB to the provider did. CCR §2695.11(b) requires a clear explanation and computation of benefits. Not providing the member with the amount paid is a violation.

Summary of Company Response to 8(b): The Company could not disclose the total amount it paid because this would disclose a confidential contractual term with that provider and it would be in breach of its agreement. BSL revised its processes in 2005 and a subsequent revision to the EOB now includes this additional information.

9. In five instances, the Company failed to provide the written basis for the denial of the claim. The Department alleges these acts are in violation of CCR §2695.7(b)(1).

9(a). Four of the five instances were in the Short Term Health product. In the first instance, the Company used the invoice date from the bill received, not the service date and inaccurately denied the claim as coverage terminated.

In the second instance, two EOBs for the same member stated, "Your policy does not cover services for this condition" but did not state the factual and legal basis for the denial, including reference to specific policy language.

In the third instance, in its denial of appeal letter, the Company cited an exclusion for pre-existing conditions that no longer existed in the policy.

In the fourth instance, the denial did not reference the specific policy exclusion.

Summary of Company Response to 9(a): In the first instance, the Company agrees. The billing did not contain a date of service for the two charges in question, however, it did contain an invoice date and that was the date that was used.

In the second instance of the EOBs not providing the specific reason for the denial, the Company agrees. BSL used standardized remark codes in its denial letters. The Company audited in January 2006, its standardized EOB remark codes and revised them as necessary to provide for the specific policy provisions that are the basis of a denial. The necessary corrective actions to the remark codes were implemented by the end of June 2006.

In the third instance, the Company disagrees. The only change in the definition was the substitution of "health care practitioner" for "health practitioner," and the capitalization of certain defined terms. No wording was eliminated from the policy definition and the correct definition was used. The definitions of pre-existing condition are not conflicting.

Regarding the fourth instance, as mentioned above, by the end of January 2006, BSL audited its standardized EOB remark codes and revised them as necessary to provide for the specific policy provisions that were the basis of a denial. The necessary corrective actions to the remark codes were implemented by the end of June 2006. Additionally, programming to modify the EOB to include the appropriate language was completed by the end of August 2006.

The Department's Response to the Company Response to 9(a):

This is an unresolved issue and may result in further administrative action.

9(b). In one instance in the IFP Product, three EOB denials for one insured included this language: "This service is not a benefit of the subscriber's health plan" and "This service is specifically excluded from coverage under the subscriber's Blue Shield Plan". This language did not reference the specific policy exclusion.

Summary of Company Response to 9(b): The Company did not provide a response.

The Department's Response to the Company Response to 9(b):

This is an unresolved issue due to lack of response and may result in further administrative action.

10. **In four instances, the Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.** For the IFP Product in four instances, once the decision was made to rescind coverage, claims were not processed to show that coverage was rescinded. The Department alleges these acts are in violation of CIC §790.03(h)(4).

Summary of Company Response to 10: The Company agrees. New procedures were implemented by July 21, 2006. On a monthly basis, UIU now sends a report to the Claims Department notifying them of rescissions, so that the Claims Department can finalize any claims associated with those rescissions.

11. **In three instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim.** [This CCR §2695.7(d) wording became effective for claims handling conducted after the October 2004 CCR revisions.] The Department alleges these acts are in violation of CCR §2695.7(d).

In one instance, UIU requested medical information from a provider. Records were not received and UIU did not follow up for 38 days. The Company provided the Department with a document that stated, "UIU cases must be worked very quickly to avoid unnecessary delays and to meet legislative time-frames for claims reimbursement." A delay of over 30 days for medical records necessary in the Company rescission investigation is unreasonable and does not reflect that the Company "worked quickly" or diligently pursued the information requested to resolve its investigation timely. Additionally, the Company responded to this issue, "Follow-up phone calls

and fax requests were made to the providers. Phone calls are made about every 2 weeks or sooner if possible, to follow-up on fax requests for medical records. As previously explained, such phone calls are not documented as a business practice; however, medical records were received within a reasonable period of time.". The documentation in the file does not reflect that the Company diligently pursued this investigation.

In the second instance, medical records were not requested until 45 days after receipt of the Medical Management referral.

In the third instance, UIU requested medical information from a provider but did not follow up for an additional 35 days. BSL did not follow its own practice to follow up quickly when requesting records from a provider.

Summary of Company Response to 11: BSL disagrees. In the first instance, BSL was not in violation of the regulatory requirement. Providers who did not respond to the initial request received a second request within 38 days, which indicated no unreasonable delay and demonstrated the Company's diligent efforts to pursue required information to perform a thorough, fair and objective investigation.

In the second instance, the UIU received a medical Management referral on February 76, 2005 and requested a copy of the original application. The application was received and led the UIU to decide to pursue an investigation on March 23, 2005. Medical records were requested from the two providers that same day, March 23, 2005. The UIU received the requested records on April 26, 2005 and April 29, 2005.

In the third instance, the records were received 35 days after BSL's initial request. BSL will conduct refresher training to reinforce the need to conduct investigations diligently.

The Department's Response to the Company Response to 11:

These are unresolved issues that may require further administrative action.

12. In one instance, the Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. For the Short Term Health Product, BSL did not respond to a provider appeal received on March 28, 2005, until the Department reviewed the file on May 11, 2006. The Department alleges this act is in violation of CIC §790.03(h)(2).

Summary of Company Response to 12: The provider dispute resolution request came in with a claim and due to an oversight, was missed by the claims staff. It was not recognized as a provider appeal. Refresher training was conducted at the end of May 2006, with claims staff to ensure they understand what a provider appeal looks like and the proper handling procedures.

13. In one instance, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. For the Short Term Health Product, the Company determined that a physician should not have billed separately for a procedure that was included in another

procedure also billed by the physician. The Company denied the charge without supporting documentation. The Department alleges this act is in violation of CCR §2695.7(g).

Summary of Company Response to 13: The Company has changed its policy and paid an additional $9.83 benefit.

14. In one instance, the Company failed to reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer. For the Short Term Health Product, the Company notified the member that charges incurred for copying medical records were not a covered benefit. The Department alleges this act is in violation of CCR §2695.11(g).

Summary of Company Response to 14: The Company agrees and has paid the fee of $36.99. Additionally, the Company conducted a survey of claims paid for the period from February 1, 2003 to April 26, 2006, and as a result paid an additional $974.65.

15. In one instance, the Company failed to maintain a copy of the certification required by §2695.6(b)(1), (2) or (3) at the principal place of business. For the period of September 1, 2004 through August 31, 2005, BSL was unable to produce a copy of the required certification. The Department alleges this act is a violation of CCR §2695.6(b)(4).

Summary of Company response to Section 15: BSL was not able to produce the Entity Licensee Certification for this time period, however the training occurred. Beginning in 2006, the required certification is now completed annually prior to September 1st.

ACCIDENT AND DISABILITY

Targeted Review

16. In nine 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).

16(a). In three instances, the files do not reflect that BSL conducted a timely UIU investigation.

In two of the three instances, the members submitted an application to transfer to another plan. The requests were denied. In each instance, the member's submission of a request for a transfer in plans prompted the UIU investigation. The UIU investigations did not commence timely. One investigation started over two months and the other over a month and a half after the request for a plan transfer was denied. During the delay, BSL allowed claims to be processed which misled the member into believing there was no coverage problem.

In the third instance, there was a period of almost two months in which there was no activity in the rescission investigation. It is noted that in previous files reviewed, the UIU would send a follow up fax to the provider within two weeks or less if records

were not received. In this instance, there was no follow up fax or any other indication that BSL had contacted the provider to obtain the medical records or that BSL had contacted its copy service to obtain the providers records when BSL did not receive a response to its requests.

Summary of Company response to 16(a): In the first two instances, BSL disagrees. A review of a transfer application is not related in any way to the Company's claims procedures and processing of claims.

In the instance of a request for medical records, the UIU's business practice is to call providers every two weeks. These calls were not documented in this instance. The UIU may send follow-up fax requests. Fax requests are not used in every case, but if there was a fax request for a particular file, a copy of the fax request would be in the file provided to the Department. If the provider fails to respond to BSL requests, BSL will refer the request to its copy service.

BSL will conduct refresher training to reinforce the importance of documenting information requests and other communications and follow ups in the file.

The Department's Response to the Company Response to 16(a):

These are unresolved issues and may result in further administrative action.

16(b). In five instances, claims were received with a diagnosis which, according to BSL guidelines, would prompt a pre-existing condition investigation. In all five instances, a pre-existing investigation was not done.

Summary of Company response 16(b): No pre-existing condition investigation was conducted. Claims should have pended for a pre-existing condition investigation, and it appears that a system programming error at the time was responsible for the claims not stopping. The error has since been eliminated through reprogramming.

16(c). In one instance, BSL initiated a pre-existing condition investigation but did not provide documentation of the reason it began or ended the investigation. Two letters were sent to providers by the pre-existing unit. One provider responded and noted that the member was referred by another physician. At that time, BSL did not continue the pre-existing investigation by requesting medical information from the referring physician listed. Also, BSL had no record that a response was received from the second provider to whom the initial letter was sent.

Summary of Company response to 16(c): BSL agrees that records were not requested from the physician listed as the referring doctor and that there is no record that BSL received a response from a physician from whom it had requested medical information. BSL states that the complete file was provided to the Department.

The Department's Response to the Company Response to 16(c): BSL has not verified to the Department that it conducted and completed a pre-existing investigation for this member. BSL provided no documentation as to why it initiated a pre-existing condition investigation and then failed to complete the pre-existing investigation it initiated.

This is an unresolved issue and may result in further administrative action.

17. In two instances, the Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. In one instance, when UIU determined that it would pursue an investigation, it made the decision not to place a hold on claims during its investigation. A hold means that claims/benefits are not released for payment until the UIU investigation is completed. Due to this decision, claims were paid during the UIU investigation. Allowing benefit payments during an investigation is misleading to the member and the provider as it appears that BSL does not have an issue with coverage even though it is investigating coverage.

In another instance, BSL conducted a pre-existing condition investigation and a UIU investigation at the same time. The pre-existing unit and the UIU do not work together at the time of investigations. When the units completed their separate investigations, the pre-existing unit sent its denial letter and the next day the UIU sent a rescission letter. Sending a pre-existing denial and then a rescission denial is misleading to the member. First, the member is told they have coverage except for a specific condition during a certain time frame. Within days, the member is then informed that they no longer have health insurance. When BSL simultaneously conducts pre-existing condition and rescission investigations, a determination letter should not be sent to a member until BSL has concluded its UIU investigation. If UIU has determined that coverage is rescindable, the rescission letter should also include the outcome of the pre-existing condition investigation if it determined that conditions were pre-existing. If UIU determined that coverage was not rescindable, but the pre-exist unit determined that a condition was pre-existing, the pre-exist unit should send the pre-exist denial letter. Due to the two units conducting separate eligibility investigations and sending separate letters, the pre-existing denial letter sent first to the member was misleading. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of Company response to 17: In the first instance, there is no requirement that a hold be placed on claims not to release/pay during a UIU investigation. The UIU underwriter has the authority and discretion to make the determination whether to place a claims hold based on the unique situation under investigation.

In the second instance, there was no misrepresenting facts or insurance policy provisions relating to coverage at issue. Both notices were in fact accurate, and although close in time, the rescission letter was sent after the pre-existing condition denial letter. The UIU narrative was posted the same day the pre-existing condition letter was sent regarding the claim under review. Neither process could have been halted or delayed without compromising that process. The UIU will review claims history or worksheets in the future to verify whether there is an ongoing pre-existing condition investigation at the time UIU is sending out its notice.

The Department's Response to the Company Response to 17:

In the first instance, allowing claims to pay during a UIU investigation is misleading to the provider and member regarding the status of the member's insurance.

In the second instance, BSL does not address what UIU will do once it verifies if there is an ongoing pre-existing condition investigation during the time UIU is sending out its notice.

These are unresolved issues and may result in further administrative action.

18. **In one instance, the Company failed to respond to a Department of Insurance inquiry within 21 calendar days.** In one instance, the file failed to contain a copy of the member's previous claims history with BSL. The Department alleges these acts are in violation of CCR §2695.5(a).

Summary of Company response to 18: BSL provided a complete response to the Department with the information known at that time. The checklist to the file has a handwritten note on page 2 that purged claims history was provided to the Department. Given the note it was believed that all purged data was provided in the file. As the Department is aware, BSL was only allowed a short period of time to gather these files together for this audit, and had to pull data from several sources.

The Department's Response to the Company Response to 18: When the Department notified BSL that the file did not contain the missing data, BSL had an obligation to check its file for the missing information. At that time, BSL only reviewed its check list and did not recheck its file for the missing data and responded to the Department that the missing data was in the file, which caused further delays.

This is an unresolved issue and may result in further administrative action.

LIFE

Initial Review

19. **In 15 instances, the Company failed to maintain all documents, notes and work papers in the claim file.** The Department alleges these acts are in violation of CCR §2695.3(a).

19(a). Thirteen of the 15 instances were in the Individual Life Product. In five of the 13 instances, the file was not documented when notice of claim was first received.

In three of the 13 instances, a copy of the application could not be located.

In three of the 13 instances, the files were not documented that forms were sent.

In one of the 13 instances, there was no documentation in BSL's file of a telephone conversation referenced in an agent's letter.

Summary of Company Response to 19(a): In all of the 13 instances, the Company agrees. Effective April 15, 2006, the date that notice of claim was received will be documented in the file. Refresher training was completed in April 2006, with the Life claims examiners to ensure they understand the requirements for thoroughly documenting the file with the date that BSL is contacted and with responses relating to the claim. In two of the instances, BSL was unable to obtain copies of the applications from Blue Shield of California (BSC), which was the keeper of the applications when life coverage was sold with the Blue Shield of California medical insurance. As of June 1, 2006, BSL has worked out a process with BSC to secure copies of applications as needed. Effective April 15, 2006, BSL changed its policy and began to document the date that a claim form was sent.

19(b). Two of the 15 instances were in the Group Life Product. In one instance, correspondence from a provider referenced a telephone conversation with BSL that was not documented in the file. In the second instance, a report contained an asterisk but did not provide its meaning.

Summary of Company Response to 19(b): In the first instance, BSL agrees. In April 2006, a refresher training discussion was held with the life claims examiner reinforcing the need to document any and all conversations regarding a claim.

In the second instance, BSL concurs that the explanation for the asterisk should have been documented in the file to clear up any possible confusion. On May 15, 2006, refresher training was conducted with the life claims examiners to ensure they understand the need to document this type of information in the file.

20. In four instances, the Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. In four instances, the Company notified individuals who claimed the life insurance benefit that the member had not assigned a beneficiary; therefore, a Life Insurance Preference Beneficiary form was required. The Company did not know if the member had or had not assigned a beneficiary because BSL could not locate a copy of the application. The statement made in the letters to the individuals who notified the Company of the member's death was false and misleading. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of Company Response to 20: The Company agrees that the statement made in the letter to the beneficiaries was not true. Because BSL was unable to locate a copy of the applications it could not be sure whether an assignment was included or not. This was a life claims examiner error and a refresher training session was conducted by the end of April 2006 to reinforce the need of accuracy in letters sent to beneficiaries.

21. In four 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).

21(a). In three instances, the Company required beneficiaries to obtain a notarized statement when BSL could not locate the form upon which the member had designated a beneficiary. The Company's inability to locate the document created an unnecessary out-of-pocket expense for the beneficiary and a delay in bringing the claim to settlement.

Summary of Company Response to 21(a): "BSL agrees that the out-of-pocket cost incurred for obtaining a notarized beneficiary affidavit should not be the beneficiaries'. The practice in the past has been to have the beneficiary pay for the notary services." This is no longer a practice of the Company. BSL conducted a survey for notary public charges for the period of January 1, 2006 to June 15, 2006. There was only one policy in which the beneficiary was instructed to obtain a notarized statement. The beneficiary advised that there was no charge incurred for obtaining the notarized affidavit.

21(b). Company follow-up procedures were not followed. There was a gap in file activity from December 16, 2003, to July 4, 2004.

Summary of Company Response to 21(b): BSL agrees that follow-up did not occur in this case. There was a follow up system in place and it was not followed. At the end of April 2006, a refresher training session was held with the life claims examiners to ensure they understand the follow-up protocols.

22. In two instances, the Company failed to acknowledge notice of claim within 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(e)(1).

Summary of Company Response to 22: In the first instance, BSL agrees that the acknowledgement letter was sent after the 15-day requirement. This was a life claims examiner error and oversight. A refresher training session was held in April 2006, with the life claims examiners to review the requirements for sending out a claims acknowledgement within 15 days.

In the second instance, the Company disagrees. According to its records, a letter was sent to the beneficiary on February 11th. The first notice was received on February 3rd. BSL contends that an acknowledgement was sent within the 15-day requirement.

The Department's Response to the Company Response to 22: Regarding the second instance, the file documented that the broker contacted BSL on January 3rd with notice of death. At that time BSL discovered an eligibility issue. The eligibility issue was resolved a month later on February 3rd, when BSL realized its system dropped the member's life insurance in error. The acknowledgement letter was due 15 days after January 3rd, not February 3rd.

This is an unresolved issue and may result in further administrative action.

23. In two instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. The Department alleges these acts are in violation of CCR §2695.4(a).

Summary of Company Response to 23: BSL's procedure had been to default to the lump sum settlement if the beneficiary did not identify an option for settlement. The majority of the time this was what the beneficiary wanted. Beginning April 2006, as an interim solution, BSL changed its process so it clarifies with the beneficiary what they want their settlement option to be. BSL now makes contact with the beneficiary to identify the option and documents the file accordingly. For a long term solution, as of the end of June 2006, BSL made a revision to its death claim form to include a settlement option box for the beneficiary to select an option. BSL included on the claim form that the default will be the lump sum settlement if a specific option is not identified.

REPORT OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY
NAIC # 61557 CDI # 1450-6

CAREAMERICA LIFE INSURANCE COMPANY
NAIC # 71331 CDI # 1927-3

AS OF MAY 31, 2005

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

EXHIBIT 2

NOTICE REGARDING CONFIDENTIALITY

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code 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 provisions of Section 12938 of the California Insurance Code require the publication of certain legal documents and examination reports.

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

September 7, 2007

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 practices and procedures in California of:

Blue Shield of California Life & Health Insurance Company

NAIC # 61557

Careamerica Life Insurance Company

NAIC # 71331

Group NAIC # 2798

Hereinafter referred to as BSL, CLI, the Company or, collectively as the Companies.

This report is to be maintained as a confidential document pursuant to California Insurance Code section 735.5.

SCOPE OF THE EXAMINATION

The report documents the results of two separate file review processes. The initial routine examination covered the claims handling practices of the aforementioned Companies during the period June 1, 2004, through May 31, 2005. A targeted review of BSL's Rescission and Cancelled files was also examined for the window period of June 1, 2004, through May 31, 2005. The combined examination was made to discover, in general, if these and other operating procedures of the Companies conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains only alleged violations of laws other than Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. A report of violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. will be made available for public inspection and published on the Department's web site pursuant to Section 12938 of the California Insurance Code.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Companies for use in California including any documentation maintained by the Companies in support of positions or interpretations of fair claims settlement practices.

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

3. A review of consumer complaints received by the California Department of Insurance (CDI). The Companies were the subject of 145 consumer complaints in 2004 and 2005. The review of complaints showed a trend with respect to claims not released timely when information was in file.

The examination was conducted primarily at the offices of the Companies in San Francisco, California. This included the work product of BSL's Third Party Administrator (TPA), Comprehensive Benefits and Claims Administrators.

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 only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer's proposals for correcting the deficiencies. When a violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and 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 on or criticize activities does not constitute acceptance of such activities.

Any alleged violations identified in this report and any criticisms of practices have not undergone a formal administrative or judicial process.

CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners initially reviewed files drawn from the category of Closed Claims for the period June 1, 2004, through May 31, 2005, commonly referred to as the "review period". The examiners reviewed 286 BSL claim files and 10 CLI claim files. The examiners cited 29 claim handling violations of the California Insurance Code within the scope of this report. In addition, the targeted review involved the remaining 40 rescinded and 4 cancelled BSL policies for the period of June 1, 2004, through May 31, 2005. As a result of the targeted BSL review, the examiners cited 27 violations of the California Insurance Code. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

Blue Shield of California Life & Health Insurance Company
Initial Review

LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Accident and Disability (AD) / Individual-Short Term Health (STH)-General Population of Claims	19,546	68	9
AD / Individual-STH-Rescissions	185	10	1
AD / Individual-STH-Member Appeals	129	10	0
AD / Individual-STH-Provider Appeals	466	10	5
AD / Individual-STH-Denied	40,170	10	0
AD /Individual-STH-Pre-existing Condition	7,769	10	0
AD / Individual Family Plan (IFP)-General Population of Claims	82,029	34	0
AD / IFP-Rescissions	39	9	7
AD/IFP-Cancellations	5	1	1
AD / IFP-Provider-Member Appeals	320	20	0
AD / IFP-Denied	24,150	10	0
AD / IFP-General			2
AD / Group Preferred Provider Organization (PPO)	35,865	34	0
AD / Group PPO-Provider Member-Appeals	53	20	0

Blue Shield of California Life & Health Insurance Company *Initial Review*			
LINE OF BUSINESS / CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
AD / Group PPO Denied	14,212	10	1
AD / Vision	86,740	10	0
Life / Individual	19	13	3
Life / Group	359	7	0
TOTALS	312,056	286	29

CareAmerica Life Insurance Company			
LINE OF BUSINESS / CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
AD / Medicare Supplement	361	10	0
TOTALS	361	10	0

Blue Shield of California Life & Health Insurance Company *Targeted Review*			
LINE OF BUSINESS / CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
AD / IFP-Rescissions	39	30	22
AD / IFP-Cancellations	5	4	1
AD / IFP-General			4
TOTALS	44	34	27

TABLE OF TOTAL CITATIONS

Initial Review

Citation	Description	BSL	CLI
CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days.	7	0
CIC §10123.13(c)	The Company failed to pay interest on a contested claim after 30 working days.	5	0
CIC §10169(i)	The Company failed to advise insureds of their right to an independent medical review.	5	0
CIC §10123.13(a)	The Company failed to notify the claimant in writing within 30 working days of receipt of the claim that the claim was contested or denied.	4	0
CIC §481	The Company failed to return premium.	3	0
CIC §10384	The Company failed to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate.	3	0
CIC §10113	The Company failed to issue, deliver or endorse the entire contract	1	0
CIC §10381.5	Due to the Company's failure to attach a copy of the application and/or failure to endorse on the policy at the time of issue, the insured shall not be bound by any statements made in an application for a policy.	1	0
Total Citations		29	0

TABLE OF TOTAL CITATIONS *Targeted Review*		
Citation	**Description**	**BSL**
CIC §790.02	The Company engaged in an unfair or deceptive act or practice in the business of insurance.	17
CIC §10384	The Company failed to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate.	7
CIC §734	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined.	3
Total Citations		27

RESULTS OF PREVIOUS EXAMINATIONS

The most recent prior claims examination included a review period between September 1, 2001, and August 31, 2002. Significant noncompliance issues identified both in that examination report and this examination report were failure to pay interest on an uncontested claim after 30 working days [page 10, #1(a)] and failure to reimburse claims as soon as practical [page 12, #4].

TABLE OF CITATIONS BY LINE OF BUSINESS
Initial Review

ACCIDENT AND DISABILITY	NUMBER OF CITATIONS
CIC §10123.13(b)	7
CIC §10123.13(c)	5
CIC §10169(i)	5
CIC §10123.13(a)	4
CIC §10384	3
CIC §10113	1
CIC §10381.5	1
SUBTOTAL	**26**
AMOUNT OF EXAMINATION RECOVERIES	**$14,416.65**
AMOUNT OF SURVEY RECOVERIES	**$1,912.28**

LIFE	NUMBER OF CITATIONS
CIC §481	3
SUBTOTAL	**3**
AMOUNT OF EXAMINATION RECOVERIES	**$164.60**
AMOUNT OF SURVEY RECOVERIES	**$15,104.24**

TOTAL CITATIONS *Initial Review*	**29**

TABLE OF CITATIONS BY LINE OF BUSINESS *Targeted Review*	
ACCIDENT AND DISABILITY	**NUMBER OF CITATIONS**
CIC §790.02	17
CIC §10384	7
CIC §734	3
SUBTOTAL	**27**
AMOUNT OF EXAMINATION RECOVERIES	**0**
AMOUNT OF SURVEY RECOVERIES	**0**

TOTAL CITATIONS *Targeted Review*	**27**

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. Regardless of the remedial actions taken or proposed by the Company, it is the Company's obligation to ensure that compliance is achieved. As referenced below in sections 1, 2 and 11, money recovered within the scope of this report was $14,581.25. As referenced below in sections 2 and 11, following the findings of the examination, closed claim surveys for the period from 2004 to 2006 conducted by the Company resulted in additional payments of $17,016.52. As a result of the examination, the total amount of money returned to claimants within the scope of this report was $31,597.77.

ACCIDENT AND DISABILITY

Initial Review

1. **In seven instances, the Company failed to pay interest on an uncontested claim after 30 working days.** The Department alleges these acts are in violation of CIC §10123.13(b).

1(a). In six of the seven instances, interest was not paid on Short Term Health Product claims. Non-compliance with this part of the regulation was identified also in the Department's Claims Practices Report as of August 31, 2002.

1(a)(I). In three of the six instances, uncontested claims received were not released for payment within 30 working days and therefore interest was due.

Summary of Company Response to Section 1(a)(I): These instances were examiner errors. The Company has paid interest on these claims in the amounts of $14.99. Refresher training was conducted on July 27, 2005 and October 19, 2005. A reminder was provided to staff on November 30, 2005.

1(a)(II). In three of the six instances, after BSL received an appeal and determined that benefits were payable, the claim was paid but did not include interest.

Summary of Company Response to Section 1(a)(II): In the three instances, the Company has paid interest in the amount $2.10. Refresher training was conducted on July 27, 2005 and October 19, 2005. A reminder was provided to staff on November 30, 2005.

1(b). In one of the seven instances, interest was not paid on a Group Health Product on an uncontested claim paid after 30 working days.

Summary of Company Response to Section 1(b): The Company reprocessed the claims to allow benefits and paid $28.31 in interest. Refresher training was conducted on

July 27, 2005 and October 19, 2005. A reminder was provided to staff on November 30, 2005.

2. **In five instances, the Company failed to pay interest on a contested claim after 30 working days.** The Department alleges these acts are in violation of CIC §10123.13(c).

2(a). In two instances, for the Short Term Health Product, claims were not released timely and interest was not paid.

Summary of Company Response to Section 2(a): Retraining of the claims staff was completed on October 19, 2005. The Company paid $13,595.11 in interest on these two claims.

Additionally, the Company completed a survey of claims for the years of 2004 through 2006 for claims that were not released once a benefit determination had been made. An additional $1,912.28 was paid as a result of the survey.

2(b). In three of the five instances for the Short Term Health Product, there were gaps in the investigation which delayed benefit payments and interest was not included in the payment.

Summary of Company Response to Section 2(b): BSL agrees and issued interest checks totaling $776.14. Refresher training was conducted on September 22, 2005, June 15, 2005 and August 24, 2005, and the issue will continue to be reinforced.

3. **In five instances, the Company failed, to provide to the insured the correct information concerning the right of an insured to request an independent medical review.** In these five Individual Family Plan (IFP) Product claims, letters and explanations of benefits referenced the Department of Managed Care rather than the Department of Insurance. The Department alleges these acts are in violation of CIC §10169(i).

Summary of Company Response to 3: Explanations of independent medical reviews (IMR) use standard language provided to all members regarding their grievance options. The requirement within the law of when to provide IMR rights is extensive, and therefore the language is typically provided with other grievance rights available to the member as standard process. It was inconsequential and had no impact on the member in these instances because IMR relates only to decisions about medical necessity; however, this language was corrected on June 9, 2005.

4. **In four instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim or the Company failed to notify the claimant in writing within 30 working days of receipt of the claim that the claim was contested or denied.** In one instance for the Short Term Health product, the Company failed to reimburse claims as soon as practical. In three instances for the Short Term Health Product, the Company failed to notify the claimant in writing within 30 days of receipt of the claim. Non-compliance with this part of the regulation was identified also in the Department's Claims Practices Report as of August 31, 2002. The Department alleges these acts are in violation of CIC §10123.13(a).

Summary of Company Response to 4: In the instance of the claim not reimbursed as soon as practical, BSL agrees. The claim initially was received by Blue Shield of California at its El Dorado Hills office and not at an office of BSL or of BSL's TPA. The claimant's error in sending the claim to the wrong company at the wrong address created a delay in processing. In January 2006, the Company worked with the El Dorado Hills office to ensure that the staff knows how to get misrouted claims to the TPA in a timely manner.

In the second instance, BSL disagrees. The chronology of letters sent out on the file demonstrates that the claimant was notified in a timely manner.

In the two instances in which the Company failed to notify the claimant in writing within 30 days of receipt of the claim, BSL agrees. These were examiner errors made when the claims were reinstated for payment and its protocols and requirements were not followed by the TPA. The Company held a refresher training session with all claims examiners on procedures for reinstating claims and doing a thorough file review. This training was completed by January 30, 2006, following the earliest of the referrals on these matters.

The Department's Response to the Company Responses to 4:

These are unresolved issues that may result in further administrative action.

5. **In three instances, the Company failed to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate.** The Department alleges these acts are in violation of CIC §10384.

In three out of the ten rescission files reviewed in the Individual Family Plan Product, at the time of underwriting, BSL did not resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate.

In one of the three instances, the broker wrote on the application that an attending physician's statement (APS) was needed. The notation on the application should have prompted the Company to investigate further. BSL did not obtain an APS at the time of underwriting and proceeded to afford coverage. Later after paying benefits, coverage was rescinded.

In the second instance, BSL accepted an incomplete application. The member answered no to question #6, in Part 4 of the application for bladder condition. If the member had disclosed the condition in Part 4, BSL requires completion of Part 5. Part 5 requests specific medical information regarding the condition disclosed in Part 4. The member disclosed the condition in Part 7 which does not contain the specific information required in Part 5. Part 7 does not request the following medical information, but Part 5 does ask: Does the condition still exist? Date condition began and ended? Treatment given? Hospitalized or emergency room visits and any applicable dates?. Additionally, due to the disclosure of a bladder infection at the time of application, this application did not meet the BSL "medical clean" guide. For the condition of bladder infection, the BSL guidelines for this condition to be considered "medical clean" would be a single occurrence, after one year. The condition disclosed was three months prior to the application being signed, which is not one year free of bladder infections. There is no

documentation of further steps taken to comply with the BSL guideline in light of the information disclosed at the time of application. Further, the Milliman Guide utilized by BSL for underwriting lists five "Development" points and "Rating" criteria for this condition. Without obtaining additional medical information, the "Development" and "Rating" portions of Milliman can not be accurately assessed.

In the third instance, at the time of application, the member disclosed the current use of a prescription drug for a specific diagnosis. When Underwriting reviewed and rated the applicant, it did not use the diagnosis that the applicant disclosed, rather it used a diagnosis that the applicant did not have.

Summary of Company Response to 5: In the instance of the broker writing on the application that an APS was needed, the Company disagrees. Because the applicant did not report a medical condition, the broker's response would not have raised a question to be resolved by Underwriting.

In the second instance, the Company disagrees. "As noted by the Department, this application for coverage would not have met the "Clean Application" policy & procedure for the Installation & Membership Department. This only means that the application continued being processed and therefore this application was forwarded to an underwriter for review. It does not mean that the application could not be considered "clean" by an underwriter. Blue Shield Life procedures for processing an application were followed." Listing a past condition and reporting no current problems raises no reasonable question for purposes of underwriting. Underwriting's review of this application was consistent with its guidelines.

There are a variety of places in the application for an applicant to identify any medical complications or conditions associated with a bladder infection. If an applicant indicates through her responses to specific questions that she is not suffering from a condition or has no ongoing symptoms (pain, etc), there is no reason to require an APS, unless Blue Shield Life is required to disbelieve the applicant – which it is not. Any medical conditions associated with a bladder infection were sought and answered by information provided by the applicant in her application, which indicated that there was no ongoing problem.

In the third instance, the Company disagrees. The underwriter reviewed the application and noted the responses. The underwriter rated the applicant based on the points assigned to the medication. The underwriter was aware that medication could be used to treat two separate identifiable diagnoses. Based on the information provided by the applicant there were no reasonable questions raised by the application that required resolution, the underwriter used the information provided in the application, and based on that information, the applicant qualified for coverage.

The Department's Response to the Company Responses to 5: In the instance of the broker writing on the application that an attending physician's statement was needed, the Company was put on notice by this written statement to either contact the broker or obtain the attending physician's statement as noted. The Company did neither and later rescinded coverage. The underwriting file does not contain documentation to support affording coverage when the broker clearly indicated that the Company needed to investigate further prior to affording coverage.

In the instance of the incomplete application, Part 4 of BSL's application lists specific conditions for which it requires additional medical information in Part 5. In this instance, the applicant should have disclosed the medical condition in Part 4 as the condition was listed in Part 4. The applicant, according to BSL's application, is then required to complete Part 5, which this applicant did not do. There is no documentation in the file to confirm at the time of application what treatment the applicant received for the reported condition, when the condition began, if the applicant had been hospitalized or if there were emergency room visits.

In the final instance, at the time of application, the applicant disclosed usage of a medication for a specific diagnosis. BSL's Underwriting Department rated the individual based on the medication listed on the application using a different diagnosis than what was listed on the application. BSL provided documentation to support its rating points used at the time of underwriting for the medication the applicant used but the points were based on a diagnosis the member did not have. BSL has not provided that this member was rated correctly for the conditions disclosed at the time of application.

These are unresolved issues that may result in further administrative action.

6. **In general, the Company failed to issue, deliver or endorse the entire contract.** The Department alleges this act is in violation of CIC §10113.

For the Short Term Health (STH) and the Individual Family Plan (IFP) Products, prior to June 1, 2006, when mailing the contract to the member, BSL did not attach a copy of the member application to the contract but rather sent the application under separate cover to the member.

Summary of Company Response to Section 6: BSL now attaches a copy of the completed application when mailing a policy to the insured. However, BSL disagrees that it previously violated Insurance Code § 10113. BSL's policy (then and now) specifically incorporates by reference the application into the policy, and makes the application a part of the policy issued. Under judicial decisions existing at the time, BSL's practices satisfied the "indorsed on" portion of Insurance Code § 10113.

The Department's Response to the Company Responses to 6:

These are unresolved issues that may result in further administrative action.

7. **In general, due to the Company's failure to attach a copy of the application and/or failure to endorse on the policy at the time of issue, the insured shall not be bound by any statements made in an application for a policy.** The Department alleges this act is in violation of CIC §10381.5

In instances of rescinded and cancelled contracts for the STH and IFP Plans, BSL was not in compliance with CIC §10113 and therefore the use of the applications to rescind or cancel 185 STH contracts and 44 IFP contracts is a violation of CIC §10381.5.

Summary of Company Response to Section 7: "The 'endorsed on' language of Section 10381.5 means 'incorporated by reference.' Because BSL's policies incorporated the application by reference (and, indeed, the application itself references that fact), that policy completely

satisfies Section 10381.5. Under judicial decisions existing at the time, BSL's practices satisfied Section 10381.5. In addition, Blue Shield Life now attaches a copy of the application to the policy when it is mailed to the insured, the alternative prong of Section 10381.5 is satisfied. Blue Shield Life's practice satisfies, and always has satisfied, the requirements of Section 10381.5."

The Department's Response to the Company Responses to 7:

This is an unresolved issue and may result in further administrative action.

ACCIDENT AND DISABILITY

Targeted Review

8. In 17 instances, the Company engaged in an unfair or deceptive act or practice in the business of insurance. The Department alleges these acts are in violation of CIC §790.02

8(a). In seven of the 17 instances, members submitted appeal letters in response to BSL rescinding their health insurance coverage. The member appeals specifically addressed the issues BSL cited in its rescission letters and in some instances, members also attached statements from providers. In BSL's response to the member appeals, BSL did not address the specific issues brought forth in the member appeals, and upheld its original decision to rescind the member's health insurance coverage.

Summary of Company response to 8(a): BSL disagrees. BSL's decision remained unchanged and the letters documented the facts that BSL relied upon in upholding its decision.

The Department's Response to the Company Response to 8(a): The original rescission letters sent to the members provided BSL's interpretations of the members' medical histories. In the member appeal letters, the members disputed BSL's interpretation and provided BSL with their understanding of their medical conditions. BSL's rescission files contained neither documentation that at the time of appeal, BSL re-evaluated its original decision to rescind coverage nor documentation that BSL conducted a medical re-review based upon the statements made in the appeal by the member or provider. Further, BSL's written response to the member appeals did not address specifically the member's issues or physician's statements provided at the time of the appeal

This is an unresolved issue and may result in further administrative action.

8(b). In three of the 17 instances, BSL assigned points erroneously for symptoms for which there was not a diagnosis.

Summary of Company response to 8(b): BSL provided responses regarding these instances by referral responses dated May 22, 2007, June 17, 2007, and June 17, 2007. In each instance, the application had inquired, not just about diagnoses, but about professional advice, treatment and symptoms. In each instance, the points assigned were consistent with the Milliman guidelines.

The Department's Response to the Company Response to 8(b):

This is an unresolved issue that may require further administrative action.

8(c). In one of the 17 instances, BSL's rescission letter to the member listed conditions it had knowledge of at the time of initial underwriting. The conditions listed in the rescission letter were conditions for which claims were presented by the member under previous coverage with BSL.

Summary of Company response to 8(c): BSL responded regarding this instance by referral response dated June 21, 2007.

The initial underwriter's review includes the review of prior claims history as documented in the LDIU screen. Underwriting practice is to review prior claims history and consider the condition, the number of claims, and the dollar amount of the claims in that review. This insured's prior coverage was not with BSL, but with Blue Shield of California, in a group plan January 1, 1997 to August 1, 2001. When *the applicant applied for coverage some of her prior claims history had purged from the system because of her history under the prior coverage extended back 5 years. The history that was not yet purged was considered at the time of application.

The UIU underwriter includes all medical conditions in the rescission letter. A condition on its own may not be of significant underwriting risk. This same condition, alongside other conditions, may be of significant underwriting risk. The rescission letter to this insured listed conditions existing during the time she did not have coverage with Blue Shield of California as well as when she had coverage. This insured did not provide information on several material conditions that were diagnosed and/or treated during the time she did not have coverage with Blue Shield. Had she disclosed these matters on her application, it would have been declined.

Although the rescission letter also listed conditions that may have existed during the time she had coverage with Blue Shield of California, an insured has a duty to disclose such matters in applying for coverage. Insurance Code § 332. BSL was entitled to ask her to do so on her application rather than search through purged claims data from an affiliated but legally distinct entity.

Moreover, she not disclose on her application for coverage several serious conditions that had only recently been discovered or treated at the time of her application. BSL did not have access to that significant information because this insured did not provide it on her application.

Finally, given that it had been over 2.5 years since this insured had had coverage with Blue Shield of California, BSL was entitled to determine her current condition and history through its application and there was no reasonable question raised in the information provided on her application.

* Name redacted 9/19/08

The Department's Response to the Company Response to 8(c):

This is an unresolved issue that may require further administrative action.

8(d). In one of the 17 instances, the page of the application that contains the guarantee issue option and the "producer" signature is missing.

Summary of Company response to 8(d): The complete record for this individual was provided to the Department. There is no broker section applicable for this application. All necessary information regarding the broker has been provided. At the top of each page it is stamped with the Direct Sales Name. The IFP Direct Sales Department is a department of BSL and the stamp identifies one of its employees.

The Department's Response to the Company Response to 8(d): This is the only application examined involving a direct sales broker that did not contain the page of the application that includes both the "broker" and the guarantee issue information. Therefore the Department concludes that BSL did not provide the applicant with the option of a guarantee issue plan which was available at the time of application.

This is an unresolved issue that may require further administrative action.

8(e). In one of the 17 instances, BSL, during the course of an Underwriting Investigation Unit (UIU) investigation, rescinded coverage without attempting to obtain all of the member's medical history. BSL based its decision to rescind coverage upon medical records from two physicians who provided service nine and 16 months prior to the member's effective date of coverage.

The medical records that were nine months prior indicated that the member was seen for a "kind of pelvic pain" with a final diagnosis of "bloating and abdominal pain". A CT scan was set up at that time. For the "kind of pelvic pain" the member told the physician that she had had a workup at Kaiser 10 months prior to this visit and a left ovarian cyst had been diagnosed by ultra sound. Kaiser recommended treatment with birth control pills which the member had declined.

The records also noted that the patient had some mild urinary stress incontinence that seemed to be getting worse.

The member was seen by another physician 16 months prior to the effective date for an elective/cosmetic procedure. The patient was seen for a consultation regarding a possible breast lift. This would be cosmetic surgery and not a covered benefit under the health insurance plan with BSL. The medical records are clear that the member did not want a breast reduction but a breast lift.

BSL rescinded coverage without obtaining medical records from Kaiser, a statement from the member and or medical records for the nine-month period prior to the member's effective date of coverage.

Summary of Company Response to 8(e): BSL disagrees. BSL is not required by law or otherwise to review all medical records of the individual in order to complete its rescission investigation. BSL's rescission investigation was completed with the information in the available medical records in its possession. There was no reason to request additional medical records and cause an unnecessary delay in the decision once there was enough information to make the decision.

The member's visit nine months prior was significant regarding her current medical problems as well as her medical history that was disclosed to the physician. At the time of the office visit, the member indicated a chief complaint of a kind of pelvic pain. The member disclosed that earlier in the year, she had a workup at Kaiser for pelvic pain which included a pelvic examination and ultrasound which showed a cyst on the left ovary with recommended treatment of birth control pills. Although the member did not want to restart the usage of birth control pills, the left ovarian cyst did exist and she declined the recommended treatment. Declining treatment does not eliminate the underwriting risk. She disclosed her history of a left ovarian cyst to the physician, but did not disclose this condition on her application for health insurance coverage. BSL did not have the opportunity at the time of initial underwriting to determine if the ovarian cyst was present as the member did not disclose this significant medical history at the time of application for coverage.

The member disclosed mild urinary stress incontinence that "seemed to be getting worse". This indicated an ongoing condition. It was also a known condition that she disclosed to her physician but not to BSL at the time of application. Had she disclosed this condition on her application, BSL would not have afforded coverage if surgery was recommended and rated 100 points if she had not had a urological evaluation and report of present status.

A breast lift is a breast reconstruction type of surgery: Although not the same as breast reduction it is still a breast surgery. BSL underwriting refers to breast reduction in the rating of this surgery. The underwriting guide on this is "Breast Implantation, Reconstruction and Reduction" and if surgery is pending, 125 points apply. Declining medical treatment has no impact on underwriting risk. Had this condition been disclosed on the application, BSL would not have afforded coverage.

The Department's Response to the Company Response to 8(e): The UIU rating relied on medical records nine and 16 months prior to the member's effective date to rescind coverage. There is no documentation in the file that the member, during the nine months prior to the effective date continued to receive treatment for or still had a left ovarian cyst, continuing pelvic pain or mild urinary stress incontinence. Ovarian cysts can be treated with birth control pills (which the member declined) or ovarian cysts can go away without any medical treatment. Rating this as a postponement is unreasonable without attempting to obtain the member's medical history for the nine month period prior to the effective date of coverage. BSL may not have had the opportunity at the time of underwriting to determine if the condition was present, but it did have the opportunity at the time of the UIU investigation to obtain the medical records.

BSL rated "mild urinary stress incontinence" as an ongoing condition when the physician only briefly noted it in the medical records. It is unreasonable to rate the member for an

ongoing condition when the physician records neither reflect the condition in the final diagnosis nor provide a treatment plan.

The BSL rescission letter to the member noted that the member was seen for a "breast reduction", which the member's medical records do not reflect. In response to the Department, BSL noted that the 125 points assigned for a breast reduction also applies for breast reconstruction. BSL has determined that its underwriting guideline for breast reduction with no implantation, pending surgery would apply for the member's office visit for a consultation on breast lift. The underwriting guideline for breast reconstruction would not apply. Breast reconstruction is the rebuilding of a breast and is normally associated with breast cancer patients who have had a mastectomy. A breast lift is an elective/cosmetic procedure which is not a rebuilding of or reconstruction of a breast. BSL's assignment of 125 points for the consultation on a breast lift is incorrect.

At the time of the UIU investigation, BSL did not attempt to obtain the member's complete medical history prior to rescinding coverage.

This is an unresolved issue that may require further administrative action.

8(f). In one of the 17 instances, the file does not document that BSL followed its own procedure for the rating of a diagnosis that is not listed in its underwriting guide. UIU neither: requested additional information from the applicant or physician nor referred to a medical dictionary or other medical text for cross-referencing to find a similar condition that is listed. UIU neither referred the diagnosis to the medical director, who could either point to a similar condition or help assign a rate appropriate to the condition, nor referred the diagnosis for an administrative/medical review. BSL has not verified that, at the time of the UIU investigation, BSL procedures for evaluating a diagnosis not listed in its underwriting guideline were followed.

Summary of Company Response to 8(f): BSL provided a response regarding this instance by referral response dated May 22, 2007. As set forth in that referral response, BSL procedures were followed. If there is no specific guideline on a condition, underwriters are instructed to "rate as," and to use a condition most similar to the diagnosis, based on symptoms and treatment type. Based on the symptoms and treatment type, BSL applied the appropriate guideline, and the points assigned were the points that would have been assigned initially had the condition been reported as requested on the application.

The Department's Response to the Company Response to 8(f):

This is an unresolved issue and may result in further administrative action.

8(g). In one of the 17 instances, the member requested a transfer in policy plans. In some instances, when a member requests a transfer to another plan, BSL does not conduct an underwriting investigation. BSL provided its written procedure and Plan Matrix to underwrite at the time of a plan transfer request. In this instance, the Plan Matrix provided to the Department to support the underwriting was not in effect at the time the member made the request.

Summary of Company response to 8(g): BSL disagrees. The transfer matrix applicable at the time of the request required underwriting from the PPO 5000 plan to the PPO 750 plan. Generally, underwriting is required when a request for lowest rates or an upgrade to a lower deductible plan is made. The free (or non-underwritten) transfer matrix is updated as new plans are added or as needed. Updated matrices are distributed as desktop tools for underwriting, I&M, etc. but not retained.

The Department's Response to the Company Response to 8(g): The applicable Plan Matrix was not provided to the Department to support underwriting of this plan transfer request.

This is an unresolved issue that may require further administrative action.

8(h). In BSL responses addressing the issue of IFP applicants who had previous BSL coverage, BSL has provided three inconsistent responses to the Department when providing its procedure for the evaluation of an applicant's previous health history at the time of underwriting.

Summary of Company response to 8(h): This issue was not presented to BSL through a referral and BSL has not had a previous opportunity to respond. The Department has not identified the responses that it believes are inconsistent with one another or revealed the manner in which it believes those responses are inconsistent. BSL's practices in evaluating previous health history are sound and reasonable from an underwriting standpoint and are consistently applied. BSL believes that any inconsistencies the examiners perceive arise from the unavoidable exercise of underwriting judgment as applied to varying situations and health histories.

The Department's Response to the Company Response to 8(h):

This is an unresolved issue that may require further administrative action.

8(i). In the 34 files reviewed, BSL rescinded 30 individuals' coverage and cancelled four individuals' coverage after completing its UIU investigation. BSL has not provided it's guideline to support rescinding coverage versus cancellation of coverage.

Summary of Company response to 8(i): BSL allows the UIU underwriter to determine a prospective termination date in their discretion and on a case-by-case basis. There is no written policy & procedure because this is only done by exception. At BSL's discretion are various factors that may be (but are not ever required to be) considered, including the length of time coverage was in effect, claims that have been received to date, any gap in coverage created by a rescission, ability to recover payment from providers for claims already paid, or any other information deemed relevant in a particular case by the underwriter.

The Department's Response to the Company Response to 8(i): BSL has not provided how its underwriters determine to rescind coverage and not to cancel coverage.

This is an unresolved issue that may require further administrative action.

9. **In seven instances, the Company failed to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate.** The Department alleges these acts are in violation of CIC §10384.

9(a). In four of the seven instances, at the time of application BSL had access to or knowledge of prior BSL health insurance coverage, claims or medical information which was not disclosed by the applicant on the application. There is no documentation that BSL, at the time of application, made any attempt, prior to affording coverage, to access the additional information available, to obtain medical records or to question an applicant regarding a medical history not disclosed on the application. With the knowledge that the individuals had provided false or incomplete medical histories, BSL afforded coverage without obtaining statements from the members, medical records from treating physicians or attending physician statements.

Summary of Company Response to 9(a): In general, BSL disagrees. The underwriting policy and procedure for the review of applications with prior Blue Shield coverage history require the underwriter to evaluate any claims to determine, in part, if unstated risk is a possibility. An underwriter would further evaluate if there is a claims history indicating claims are ongoing, indicating a chronic condition by a repetitive claims pattern, and/or indicating claims are recent (just previous to the date of the IFP application for coverage). Use of BSL's resources available at the time of underwriting is standard practice. "Use of" does not always equate a negative decision or a request for medical records. Each case is individually evaluated on its own merits based on any information known or being disclosed by the applicant, and BSL relies on the applicant statements in conjunction with prior membership history.

In one instance, BSL disagrees. Prior BSL Short Term Health (STH) coverage is not available to IFP underwriting. BSL has discontinued issuing STH policies.

In one instance, the system showed a total of three purged claims with the total amount of each claim billed under $1,000. Therefore, underwriting was complete and the approval of health coverage was appropriate based upon the responses to the health questions in the application, the response that the last physician visit was "normal," and the purged claims data in BSL's system.

In another instance, when the applicant applied for coverage, some of her prior claims history had purged because of the length of time and a total of 11 claims were showing. All these claims were under $10,000.

In another instance, the claims history and application showed less than $2,000.00 in claims had been paid in over 14 months; no repetitive claims history; provider visits occurred seven to 12 months prior to application for IFP coverage; at the time of IFP application, the applicant reported his last examination results as "good"; and all health questions on the application were answered "no". Based on the information available to

BSL through its claims history and the lack of information provided at the time of application, the application was finalized without the need for further information concerning claims under the previous coverage.

The Department's Response to the Company Response to 9(a): In the instance of the prior STH coverage being unavailable to IFP underwriting, BSL needs a procedure to obtain access to the claims histories of applicants who had prior coverage under any BSL product.

In the instances in which BSL did review the prior BSL medical history, BSL responds that its procedures were followed, but has not provided the Department with a copy of the procedures it references in its response. Additionally, the individual responses were inconsistent with each other regarding the handling of three of the rescissions.

BSL based its underwriting approval upon receipt of a clean application and on the applicant's previous BSL claims history. BSL did not obtain statements or medical records from the members when it was aware that the applicants had not fully disclosed their medical histories.

Additionally, two of the individual's prior BSL coverage had not been in effect for over two years. Again, with the knowledge that these individuals had not provided a complete medical history on their applications, BSL made no attempt to investigate the medical history for the period of time from the previous coverage with BSL to the time the incomplete applications were received.

With the knowledge that the applicants had not provided true and accurate medical histories, BSL failed to complete medical underwriting before affording coverage.

This is an unresolved issue that may require further administrative action.

9(b). In three of the seven instances, Parts 4, 5, 6 and 7 of the BSL application require an applicant to disclose his/her medical history. If an applicant answers yes to one or more of the first 24 questions in Part 4, completion of Part 5 is required. Part 5 states, "If you answered "YES" to any of questions 1-24 in PART 4, give details below." The applicant is then required to provide BSL with the name of the patient; diagnosis and treatment; date the condition began; date the condition ended; answer yes or no if the condition still exists; the present status; dates hospitalized or emergency room visited, if applicable; and the name, address and phone number of all physicians and medical groups for each condition listed in Part 4.

> **9(b)(I).** In the first instance, the applicant checked yes to a medical question in part 4 of the application which requires part 5 to be completed. On Part 5, the applicant disclosed that the condition still exists "sometimes". The applicant did not provide the "Present Status" for the condition disclosed as is required by BSL's pending application guideline. In Part 6, the applicant did not provide an answer to the "Frequency". Prior to approving this individual for coverage, BSL did not contact the applicant to obtain responses to information missing on the application. Coverage was afforded with an incomplete application.

Summary of Company Response to 9(b)(I): BSL disagrees. Completion of Part 5 is not required or necessary; rather, it is critical that the applicants disclose their conditions and provide complete information regarding the conditions. The lack of a response on the application does not automatically raise a question for underwriting purposes. It depends entirely on the condition at issue. For part 6, this has no impact on the underwriting of this application, and this information was not required in order to underwrite the application. Underwriting knew that the medication listed by the applicant is a prescription medication used daily to offset the disclosed condition. This was supported by the type of exam noted by the applicant, and the diagnosis. The applicant also noted in Part 7 a yearly exam with "normal" findings about 45 days before signing this application. "No medical records were required based on the condition disclosed by the applicant. The Department has noted in several referrals its belief that medical records are required in order for Blue Shield Life to complete medical underwriting of an application. This is not accurate – either to underwriting in general or specific to Blue Shield Life underwriting practices. Requesting medical records or additional information from the applicant depends on the condition disclosed by the applicant. In this case, the condition disclosed was mild migraines and this does not require medical record review. Underwriting's review of this application was consistent with its guidelines."

The Department's Response to the Company Response to 9(b)(I): BSL's guideline for Part 5 of the application states, "The following information is located in part 5 of the IFP application. Only fields [...] marked with an asterisk (*) can be obtained over the telephone – all others must be obtained in writing (fax or email), initialed and dated by the applicant." The member did not answer the question "present status" and BSL did not follow its own guideline prior to affording coverage by obtaining a statement from the applicant for the unanswered question. It is unclear how BSL determined that no medical records were required based on the condition disclosed by the applicant, when according to BSL's own guidelines the condition disclosed warranted further review at the time of underwriting. There is no documentation in the underwriting file as to how BSL, with only an application was able to evaluate the disclosed condition without obtaining additional medical information from the applicant or the applicant's physician. Another BSL guideline provides that an Attending Physician Statement can be requested for additional information or clarification on symptoms such as headache.

Prior to affording coverage, BSL failed to obtain a completed application by means of an adequate investigation as required by its own procedures.

This is an unresolved issue that may require further administrative action.

9(b)(II). In the second instance, in Part 5 of the application, the applicant listed two conditions. For the first condition listed, the applicant did not provide the diagnosis/condition that led to a surgery. The BSL application requests a response to "Diagnosis and Treatment".

For the second condition, the applicant provided information about treatment that occurred 11 ½ months prior to submitting the application and stated that the condition no longer existed. The applicant then listed the second condition again in Part 7 of the application. In Part 7, the applicant provided that five months prior to signing the application, she was treated for and referred to another physician for the same condition that she reported in Part 5 of the application that no longer existed.

Summary of Company Response to 9(b)(II): BSL disagrees. For the first condition listed, in response to the question, "diagnosis and treatment," the applicant provided what surgery was performed. Therefore, the response to this question was provided by the applicant. In the response to the question, "does the condition still exist?" the applicant responded "no." Therefore, the response to this question was provided by the applicant.

For the second condition listed, there is no conflict of information in this application. The applicant reported in Part 5 that treatment was received in 2003 and that the condition did not still exist and the present status was "good". The applicant then reported a follow-up visit to a general practitioner and present status as "good". There was no new referral or continuing care reported.

The Department's Response to the Company Response to 9(b)(II): For the first condition, the applicant disclosed that at the age of 38, she had a hysterectomy but did not provide, as requested in Part 5 of the application, what medical condition she had that required her to have a hysterectomy at the age of 38. BSL guidelines require that at the time of application if the member does not provide the diagnosis in Part 5, that the required information must be obtained in writing, initialed and dated by the applicant. There is no documentation that BSL followed its own guideline to resolve the missing information on the application.

For the second condition, BSL has interpreted that the treatment reported in Part 7 does not conflict with the same condition reported in Part 5. Part 7 discloses that the member was seen six months prior to her effective date when she was referred by her general practitioner due to stress. If an applicant provides under Part 7, "present status", that they have had a physician's visit within the last 4 years, BSL's guideline is to obtain medical information in writing regarding the condition disclosed

At the time of application, BSL failed to resolve inconsistent statements made on the application or to obtain information its own guidelines require prior to affording coverage.

This is an unresolved issue that may require further administrative action.

9(b)(III). In one of the seven instances, at the time of underwriting, the applicant disclosed a condition on the application. The disclosed condition at the time of application was not listed in the BSL underwriting guide utilized to assess the

rating of an individual for coverage. The applicant was afforded coverage under Tier 1 without the medical condition being reviewed. The file does not document that BSL completed its underwriting requirement at the time coverage was afforded.

Summary of Company Response to 9(b)(III): Because only the most common medical conditions (approximately 1000) are listed in the Milliman guidelines, not every medical condition is included. When confronted with an unlisted condition, the underwriter has several options for the assessing the risk of the condition. The underwriter can (i) request additional information to determine an etiology for the actual debit rating, (ii) cross-reference the condition with similar conditions described in medical dictionaries or texts, (iii) review the matter with underwriting peers, or (iv) request assistance from the medical director in assigning a rate appropriate to the condition.

The Department's referral asked what procedures are in place to evaluate a condition that is disclosed by an application but is not listed in the Milliman guide. BSL fully disclosed those procedures in its response. The referral did not ask which option available under those procedures was followed in this instance. However, in this instance, the underwriter did not consider the hyperhydrosis condition or assign points because the condition is curable with treatment, the application stated that the condition had been cured, and the condition had been cured for over two years.

The Department's Response to the Company Response to 9(b)(III):
BSL has not provided which option the BSL underwriter utilized to review the condition not listed in its underwriting guideline. At the time coverage was afforded, there is no documentation that BSL assessed its risk before issuing coverage.

This is an unresolved issue that may require further administrative action.

10. **In three instances, the Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined.** The first instance pertains to an individual rescission file. BSL had rescinded coverage, and denied the members appeal. At a later date, BSL overturned the rescission and reinstated coverage, pursuant to administrative review. A copy of the administrative review was not provided after a request.

The second instance pertains to a general issue. BSL indicated that it followed its "Underwriting policy and procedure for the review of applications with prior Blue Shield coverage history" but the Company did not provide a copy of the referenced procedures.

The final instance pertains to a general issue. BSL did not provide a copy of its Plan Transfer Matrix used during the period of June 1, 2004 through December 14, 2004. The matrix is used to determine if the member's request to change plans will or will not be

subjected to underwriting.

The Department alleges these acts are in violation of CIC §734.

Summary of Company Response to 10: In regard to the first instance, the complete file was provided to the Department. BSL reinstated coverage due to an administrative review that would not and could not be maintained in the member's file. The administrative review was a review of the agent's entire book of business with Blue Shield, which is a confidential contractual issue between the agent and Blue Shield and would not be appropriate for reference in other business files, including member files. Blue Shield initiated the review of the agent's book of business because of a concern that the agent was submitting applications that he completed and/or was not including all medical details. Action was taken with the agent. Upon Blue Shield's subsequent review of the agent's book of business, coverage was reinstated.

In the second instance, the initial underwriter's review includes a review of prior claims history as documented in the LDIU screen.

In the final instance, BSL did not retain a copy of the plan transfer matrix for the period of June 1, 2004 through December 14, 2004, but has provided copies of all subsequent version of the matrices.

The Department's Response to the Company Response to 10:

These are unresolved issues that may require further administrative action.

LIFE

11. **In three instances, the Company failed to return premium.** At the time of claims settlement the Company failed to return premium to beneficiaries. The Department alleges these acts are in violation of CIC §481.

Summary of Company Response: The Company agrees. Refresher training was completed at the end of April 2006. The Company issued interest payments to the three claimant's totaling $164.60. In July 2006, the Company completed a survey of claims for the years of 2004 through 2006. An additional $15,104.24 was paid to the claimants as a result of the survey.