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8
9 **BEFORE THE INSURANCE COMMISSIONER**
10 **OF THE STATE OF CALIFORNIA**

11 In the Matter of

12 **ANTHEM BLUE CROSS LIFE**
13 **AND HEALTH INSURANCE**
14 **COMPANY,**

15 Respondent.

CDI File No. NC-2010-00001

OAH No.:

**ORDER TO SHOW CAUSE; STATEMENT
OF CHARGES / ACCUSATION; NOTICE
OF MONETARY PENALTY/NOTICE OF
HEARING**

(California Insurance Code §§ 790.05, 700(c),
704, 790.035)

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17
18 The California Department of Insurance (“Department”) alleges that:

19 **JURISDICTION AND PARTIES**

20 1. From August 2, 1991 to the present, Respondent, ANTHEM BLUE CROSS LIFE &
21 HEALTH INSURANCE COMPANY (“ABC”), has been the holder of a Certificate of Authority
22 issued by the Insurance Commissioner (“Commissioner”) authorizing ABC to transact the
23 business of life and disability insurance in the State of California, pursuant to § 700 et seq. of the
24 California Insurance Code (“Insurance Code”).

25 2. ABC is domiciled in California.

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

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

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

7 6. Insurance Code § 790.03 defines unfair methods of competition and deceptive acts or
8 practices in the business of insurance.

9 7. Insurance Code § 790.03(h) enumerates sixteen (16) claims settlement practices that,
10 when either knowingly committed on a single occasion, or performed with such frequency as to
11 indicate a general business practice, are considered to be unfair claims settlement practices, and
12 are thus prohibited.

13 8. Insurance Code § 790.03(h)(1) prohibits insurers from misrepresenting to claimants
14 pertinent facts or insurance policy provisions relating to any coverages contained in the contract.

15 9. Insurance Code § 790.03(h)(2) prohibits insurers from failing to acknowledge and act
16 reasonably promptly upon communications with respect to claims arising under their insurance
17 policies.

18 10. Insurance Code § 790.03(h)(3) prohibits insurers from failing to adopt and implement
19 reasonable standards for the prompt investigation and processing of claims arising under
20 insurance policies.

21 11. Insurance Code § 790.03(h)(4) requires that insurers affirm or deny coverage of claims
22 within a reasonable time after proof of loss requirements have been completed and submitted by
23 the insured.

24 12. Insurance Code § 790.03(h)(5) requires that insurers exercise good faith to effectuate
25 prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

26 13. Insurance Code § 790.03(h)(13) requires that insurers promptly provide a reasonable
27 explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law,
28 for the denial of a claim or for the offer of a compromise settlement.

1 14. Insurance Code § 880 requires that every insurer conduct its business in this state in its
2 own name.

3 15. Insurance Code § 10123.13(a) requires that “[e]very insurer issuing group or
4 individual policies of health insurance that covers hospital, medical, or surgical expenses,
5 including those telemedicine services covered by the insurer as defined in subdivision (a) of
6 Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of
7 any claim, whether in state or out of state, for those expenses as soon as practical, but no later
8 than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof
9 is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim
10 is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice
11 that a claim is being contested or denied shall identify the portion of the claim that is contested or
12 denied and the specific reasons including for each reason the factual and legal basis known at that
13 time by the insurer for contesting or denying the claim. If the reason is based solely on facts or
14 solely on law, the insurer is required to provide only the factual or the legal basis for its reason for
15 contesting or denying the claim. The insurer shall provide a copy of the notice to each insured
16 who received services pursuant to the claim that was contested or denied and to the insured's
17 health care provider that provided the services at issue. The notice shall advise the provider who
18 submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of
19 payment and the insured that either may seek review by the Department of a claim that the insurer
20 contested or denied, and the notice shall include the address, Internet Web site address, and
21 telephone number of the unit within the Department that performs this review function. The
22 notice to the provider may be included on either the explanation of benefits or remittance advice
23 and shall also contain a statement advising the provider of its right to enter into the dispute
24 resolution process described in Insurance Code § 10123.137. The notice to the insured may also
25 be included on the explanation of benefits.”

26 16. Insurance Code § 10123.13(b) requires that insurers pay 10% interest per annum on
27 uncontested claims not reimbursed by delivery to the claimant's address of record within 30
28 working days after receipt.

1 17. Insurance Code § 10123.13(c) requires that an insurer who has received all of the
2 information necessary to determine payer liability for a contested claim and has not reimbursed a
3 claim determined to be payable within 30 working days of receipt of that information, shall pay
4 interest at a rate of 10 percent per annum beginning with the first calendar day after the 30-
5 working day period.

6 18. Insurance Code § 10169(m) requires that insurers notifying an insured of the
7 disposition of a grievance provide the insured with an approved one-page application and an
8 addressed envelope which the insured may return to initiate an independent medical review. .

9 19. California Code of Regulations (“CCR”), Title 10, Chapter 5, Subchapter 7.5, Article
10 1 contains Fair Claims Settlement Practices Regulations “to promote the good faith, prompt,
11 efficient and equitable settlement of claims.” These regulations delineate certain minimum
12 standards for the settlement of claims which, when violated knowingly on a single occasion or
13 performed with such frequency as to indicate a general business practice, shall constitute an
14 unfair claims settlement practice within the meaning of Insurance Code § 790.03(h). Other acts
15 or practices not specifically delineated in this set of regulations may also be unfair claims
16 settlement practices subject to Insurance Code § 790.03. All licensees are required to have
17 thorough knowledge of such regulations.

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

22 21. CCR, title 10, § 2695.3(b)(2) requires that all insurers record in the file the date the
23 licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every
24 material and relevant document in the file.

25 22. CCR, title 10, § 2695.4(a) requires that all insurers disclose to a first party claimant or
26 beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued
27 by that insurer that may apply to the claim presented by the claimant. When additional benefits
28 might reasonably be payable under an insured's policy upon receipt of additional proofs of claim,

1 the insurer shall immediately communicate this fact to the insured and cooperate with and assist
2 the insured in determining the extent of the insurer's additional liability.

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

7 24. CCR, title 10, § 2695.5(b) requires a licensee receiving any communication from a
8 claimant that reasonably suggests that a response is expected shall immediately, but in no event
9 more than 15 calendar days after receipt of that communication, furnish the claimant with a
10 complete response based on the facts as then known by the licensee.

11 25. CCR, title 10, § 2695.6(a) requires that all insurers adopt and communicate to all their
12 claims agents written standards for the prompt investigation and processing of claims

13 26. CCR, title 10, § 2695.7(b)(3) requires a licensee to include a statement in its claim
14 denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she
15 may have the matter reviewed by the California Department of Insurance, and must include the
16 address and telephone number of the unit of the Department which reviews claims practices.

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

20 28. CCR, title 10, § 2695.7(g) prohibits any insurer from attempting to settle a claim by
21 making a settlement offer that is unreasonably low.

22 29. CCR, title 10, § 2695.11(a)(2)(C) requires an insurer to notify the insured of errors
23 resulting in overpayment within six months or 15 calendar days of discovery.

24 30. CCR, title 10, § 2695.11(b) requires an insurer to include with each claim payment to
25 the claimant and assignee an explanation of benefits which shall include the name of the provider
26 or services covered, dates of service, and a clear explanation of the computation of benefits.

27 31. CCR, title 10, § 2695.11(d) requires that an insurer contesting a claim under Insurance
28 Code § 10123.13 shall subsequently affirm or deny the claim within 30 calendar days from the

1 original notification. In the event an insurer requires additional time to affirm or deny the claim, it
2 shall notify the claimant and assignee in writing. This written notice shall specify any additional
3 information the insurer requires in order to make a determination and shall state any continuing
4 reasons for the insurer's inability to make a determination. This notice shall be given within 30
5 calendar days of the notice (required under Insurance Code § 10123.13) that the claim is being
6 contested and every 30 calendar days thereafter until a determination is made or legal action is
7 served. If the determination cannot be made until some future event occurs, the insurer shall
8 comply with this continuing notice requirement by advising the claimant and assignee of the
9 situation and providing an estimate as to when the determination can be made.

10 32. CCR, title 10, § 2695.11(e) provides that when a policy requires preauthorization of
11 non-emergency medical services, the preauthorization must be given immediately but in no event
12 more than five calendar days after the request for preauthorization. The preauthorization shall be
13 communicated or confirmed in writing to the insured and the medical service provider, and shall
14 explain the scope of the preauthorization and whether the preauthorization is or is not a guarantee
15 of acceptance of the claim. In the event the preauthorization is denied, the reason(s) for the denial
16 shall be communicated in writing to the insured and the medical service provider.

17 33. Insurance Code § 790.035 provides that “any person who engages in any unfair
18 method of competition or any unfair or deceptive act or practice defined in § 790.03 is liable to
19 the state for a civil penalty to be fixed by the Commissioner, not to exceed five thousand dollars
20 (\$5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten
21 thousand dollars (\$10,000) for each act. The Commissioner shall have the discretion to establish
22 what constitutes an act.”

23 34. Insurance Code § 790.08 states that “The powers vested in the Commissioner in this
24 article shall be additional to any other powers to enforce any penalties, fines or forfeitures,
25 denials, suspensions or revocations of licenses or certificates authorized by law with respect to the
26 methods, acts and practices hereby declared to be unfair or deceptive.”

27 **FACTUAL ALLEGATIONS**

28 35. The Department’s Claims Service Bureau (“CSB”) reviewed its files relating to ABC

1 claims closed during the period January 1, 2006 through December 31, 2006. For this review
2 period, any CSB complaint file for ABC containing one or more violations was reviewed to
3 determine whether the denial of claims and claims handling practices conformed to its contractual
4 obligations and applicable state law. This review found a total of 175 violations in the 63 files
5 reviewed.

6 36. CSB reviewed its files relating to ABC claims closed during the period January 1,
7 2007 through December 31, 2007. For this review period, any CSB file for ABC containing one
8 or more violations was reviewed to determine whether ABC's denial of claims and claims
9 handling practices conformed to its contractual obligations and applicable state law. This review
10 found a total of 204 violations in the 78 files reviewed.

11 37. CSB reviewed its files relating to ABC claims closed during the period January 1,
12 2008 through December 31, 2008. For this review period, any CSB file for ABC containing one
13 or more violations was reviewed to determine whether ABC's denial of claims and claims
14 handling practices conformed to its contractual obligations and applicable state law. This review
15 found a total of 172 violations.

16 38. CSB reviewed its files relating to ABC claims closed during the period January 1,
17 2009 through December 31, 2009. For this review period, any CSB file for ABC containing one
18 or more violations was reviewed to determine whether ABC's denial of claims and claims
19 handling practices conformed to its contractual obligations and applicable state law. This review
20 found a total of 166 violations.

21 39. Based on the Department's investigation of consumer and provider complaints
22 received in 2006 - 2009, the Department alleges that ABC has engaged in the following 717
23 unfair or deceptive acts or practices, in violation of Insurance Code § 790.03 or the Fair Claims
24 Settlement Practices Regulations as follows:

25 **Misrepresenting pertinent facts or insurance policy provisions (IC § 790.03(h)(1))**

26 40. On 66 occasions, ABC misrepresented to claimants pertinent facts or insurance policy
27 provisions relating to coverages. In one representative example, on August 11, 2006 ABC sent a
28 letter to the member misrepresenting the correct process by which insured could file a claim.

1 ABC's misrepresentations were only corrected after the Department intervened. (CSB-6204102)

2 **Failure to act reasonably promptly upon communications (IC § 790(h)(2))**

3 41. On three occasions, ABC failed to acknowledge and act promptly upon the
4 correspondence from the insured. In one representative example, ABC failed to respond
5 promptly to correspondence from the insured which clarified that the complainant had coverage
6 during the six month pre-existing period as documented in the ABC letter dated June 24, 2006.
7 (CSB-6167772)

8 **Failure to implement reasonable standards for processing claims (IC § 790(h)(3))**

9 42. On 32 occasions, ABC failed to implement reasonable standards for the prompt
10 processing of claims. In one representative example, ABC reviewed and denied a claim twice
11 before the complainant contacted the Department for assistance. The intervention of the
12 Department prompted further investigation which resulted in the company reversing its position
13 and paying the claim. (CSB-6188005)

14 **Lack of good faith attempt to effectuate prompt, fair and equitable settlement (IC §**
15 **790.03(h)(5))**

16 43. On 15 occasions, ABC failed to make a good faith attempt to effectuate prompt, fair
17 and equitable settlements when liability has become clear. In one representative example, a claim
18 for services rendered August 8, 2005 was denied in error on June 19, 2006. The insured appealed
19 the decision but the same claim was denied again June 27, 2006 and July 28, 2006. After
20 intervention by the Department, the claim was finally paid with interest on August 25, 2006.
21 (CSB-6211612)

22 **Failure to provide reasonable explanation for denial of claim (IC § 790.03(h)(13))**

23 44. On one occasion, ABC failed to promptly explain the basis, in law or facts, of its
24 denial of insured's claim by failing to provide a reasonable explanation of why the treating
25 dentist's professional opinion received less weight in the claim denial decision-making process
26 than did ABC's internal medical reviewer. (CSB-6198934)

27 **Failure to conduct business in its own name (IC § 880)**

28 45. On five occasions, ABC failed to conduct its business under its own name. In one

1 representative example, ABC sent a letter to an insured on March 15, 2009 which did not identify
2 the full legal name of the company which underwrote the insurance. (CSB-6187921)

3 **Failure to reimburse claims within 30 days (IC § 10123.13(a))**

4 46. On 277 occasions, ABC failed to comply with notice and reimbursement requirements
5 of the Insurance Code. In one representative example, on July 5, 2006 ABC received a claim for
6 service provided on June 26, 2006. ABC responded with a letter dated September 11, 2006
7 indicating claims were denied in error and that claims would be reprocessed. The claim was not
8 correctly adjusted and processed until October 3, 2006. There was no interest calculated and
9 paid. The claim file provided fails to include a copy of the Explanation of Benefits for the
10 adjustment payment made on October 3, 2006. (CSB-6217563)

11 **Failure to pay interest on uncontested, unreimbursed claims (IC § 10123.13(b))**

12 47. On 25 occasions, ABC failed to pay interest on unreimbursed claims when required.
13 In one representative example, ABC approved a claim on December 5, 2005; yet the claim was
14 not paid until July 4, 2006. No interest was included in the reimbursement. (CSB-6196396)

15 **Failure to pay interest on contested, unreimbursed claims following**
16 **receipt of dispositive information favorable to insured's claim (IC § 10123.13(c))**

17 48. On six occasions, ABC had the information necessary to dispose of a contested claim
18 in insured's favor and did not reimburse within 30 working days. ABC failed to pay 10% interest
19 from the 31st working day after receipt of information until reimbursement was made. In one
20 representative example, a claim in the amount \$238.00 for service provided on January 8, 2005
21 was received by ABC on January 28, 2005. All necessary information to properly process the
22 claim was received on or before April 29, 2005. The claim was not correctly processed and
23 adjusted until March 20, 2007. Interest was not included with the payment of this claim on
24 March 20, 2007. (CSB-6247019)

25 **Failure to notify insured of right to Independent Medical Review (IC § 10169(m))**

26 49. On two occasions, ABC failed to properly notify an insured of the right to an
27 independent medical review. In one representative example, ABC issued denial letters to an
28 insured on March 5, 2007 and April 19, 2007. Neither letter included notice of the right for an

1 independent medical review (“IMR”) or the Department’s contact information as required by
2 statute. Instead, the insured was provided with information and forms for filing an IMR request
3 with the California Department of Managed Health Care (“DMHC”). The IMR forms were sent
4 by the complainant to the DMHC who then forwarded the IMR request to the Department after
5 determining the correct jurisdiction. (CSB-6256996)

6 **Failure to properly maintain claims files (10 CCR § 2695.3(a))**

7 50. On 18 occasions, ABC failed to maintain claim files in a manner that permitted
8 adequate reconstruction of the claim and the licensee’s action pertaining to the claim. In one
9 representative example, the Department notified ABC that the claim file it sent to the Department
10 was missing pertinent information, specifically a letter to the insured. ABC, in its letter dated
11 July 27, 2007 admitted it was unable to locate a copy of the missing letter. (CSB-6259094)

12 **Failure to maintain a proper claim file log (10 CCR § 2695.3(b)(2))**

13 51. On nine occasions, ABC failed to properly maintain a claim file log. In one
14 representative example, ABC received a claim with a date of service August 2, 2005. The
15 Department was unable to determine by reviewing the file on what date ABC received the
16 insured’s correspondence dated October 7, 2005. (CSB-6165947)

17 **Failure to disclose all relevant coverages and benefits (10 CCR § 2695.4(a))**

18 52. On three occasions, ABC failed to disclose all relevant coverages and benefits
19 until presented with a complaint from the Department rather than initially in response to the
20 claim. In one representative example, documentation in the ABC claim file for service provided
21 on February 2, 2006 indicated that certain file information was not properly disclosed to the
22 insured. (CSB-6166050)

23 **Failure to respond to Department inquiry within 21 calendar days (10 CCR § 2695.5(a))**

24 53. On 143 occasions, ABC failed to respond within 21 calendar days of receipt of a
25 Department inquiry. In one representative example, the Department sent an inquiry letter to ABC
26 dated May 18, 2007 requesting a response and the complete claim file. The Department received
27 an incomplete response on June 11, 2007. The response lacked multiple relevant documents.
28 The Department sent ABC a follow-up request dated July 5, 2007. ABC responded on July 27,

1 2007. (CSB-6258210)

2 **Failure to respond to claimant inquiry within 15 calendar days (10 CCR § 2695.5(b))**

3 54. On 20 occasions, ABC failed to respond to communications from an insured
4 within 15 days. In one representative example, an insured sent letters seeking a response from
5 ABC dated February 14, 2007 and May 9, 2007. ABC did not respond to the claimant's letters.
6 (CSB-6166050)

7 **Failure to adopt written standards and convey to all agents (10 CCR § 2695.6(a))**

8 55. On four occasions, ABC failed to adopt and communicate to all its claims
9 personnel written standards for prompt investigation and processing of claims. In one
10 representative example, ABC admitted in its letter of February 8, 2007, that the instant claim was
11 referred to management for staff training thereby delaying claim processing. (CSB-6235826)

12 **Failure to notify claimant of right of review (10 CCR § 2695.7(b)(3))**

13 56. On 18 occasions, ABC failed to inform claimant whose claim had been denied that
14 review was available through the Department. In one representative example, ABC denied by
15 letter a claim on March 7, 2007 and failed to include the Department's contact information.
16 (CSB-6254882)

17 **Failure to diligently pursue claims handling in a fair manner (10 CCR § 2695.7(d))**

18 57. On 22 occasions, after receiving a claim, ABC did not diligently review the claim
19 or additional information provided by the claimant for the resolution of the claim, paid previously
20 denied claims due to processing errors, and paid previously unpaid/denied claims without
21 explanation months later. In one representative example, for a claim for services provided on
22 December 13, 2006 for which all relevant information had been received by January 19, 2007,
23 ABC continued requesting information through Explanations of Benefits which were sent on
24 February 13, 2007, March 22, 2007 and May 22, 2007. The claim was finally paid on June 26,
25 2007. (CSB-6258728)

26 **Unreasonably low settlement offers (10 CCR § 2695.7(g))**

27 58. On 22 occasions, ABC attempted to settle a claim by making an offer that was
28 unreasonably low. In one representative example, ABC denied claims for services rendered on

1 September 19, 2006, September 26, 2006, November 13, 2006, January 18, 2007, and January 25,
2 2007, due to the claimant's pre-existing condition. Following Department intervention ABC
3 reversed its position citing some sort of inputting error. (CSB-6255983)

4 **Untimely notice of overpayment (10 CCR § 2695.11(a)(2)(C))**

5 59. On one occasion, ABC failed to notify insured of an overpayment within six
6 months or 15 days of discovery. (CSB-6252196)

7 **Failure to explain benefits and payments (10 CCR § 2695.11(b))**

8 60. On one occasion, ABC failed to include a clear and concise explanation of benefits
9 with each claim benefit. In this instance, ABC adjusted its reimbursement for an overpayment
10 without explanation to the insured. (CSB-6146848)

11 **Failure to timely inform insured that claim is being contested (10 CCR § 2695.11(d))**

12 61. On 21 occasions, ABC did not send a letter contesting the claim within the
13 required 30 days or did not provide the required 30 working day status updates. In one
14 representative example, in the letter of July 3, 2006, ABC contested the claim received on
15 December 15, 2005. A 30 day letter (required to be sent by January 14, 2006) was not issued until
16 February 4, 2006. ABC received the requested items on February 13, 2006. A letter contesting
17 the claim (or a 30 day letter that specified the additional information needed) was required by
18 March 6, 2008. A request for additional documentation was not sent until May 2, 2006.
19 Additional 30 day letters were required by March 15, and April 14, 2006 but were not timely sent.
20 ABC received the requested information on May 16, 2006. Pursuant to the regulations ABC had
21 to accept or contest the claim by June 30, 2006. It was not accepted until July 3, 2006. (CSB-
22 696401)

23 **Failure to give timely preauthorization (10 CCR § 2695.11(e))**

24 62. On two occasions, ABC failed to give pre-authorization of non-emergency medical
25 services no later than five calendar days after request. In one representative example, insured's
26 dentist submitted a request for preauthorization for non-emergency services on June 26, 2006.
27 The request was denied on August 4, 2006 and additional information was requested. The
28 provider submitted the requested information on August 14, 2006. The insured called ABC on

1 September 19, 2006 and was told the request would be expedited, but it could take a month.
2 During a telephone conversation with ABC on October 30, 2006, the insured was advised that the
3 request for services had not been processed as promised. ABC processed the request on
4 November 29, 2006 after receipt of the inquiry from the Department. (CSB-6225080)

5 **STATUTORY VIOLATIONS**

6 63. The facts alleged in Paragraphs 35 through 62 demonstrate that ABC has engaged
7 in acts which constitute an unfair method of competition and/or unfair or deceptive acts or
8 practices in this State, in violation of California Insurance Code § 790.03 and/or the Fair Claims
9 Settlement Practices Regulations. ABC's conduct constitutes grounds for the Commissioner to
10 assess a monetary penalty pursuant to Insurance Code § 790.035.

11 64. The facts alleged in Paragraphs 35 through 62 demonstrate that ABC has not
12 carried out its contracts in good faith, and constitute grounds for the Commissioner to suspend
13 ABC's Certificate of Authority pursuant to Insurance Code § 704(b).

14 65. The Department hereby notifies ABC that, based upon the facts alleged herein,
15 ABC is in violation of Insurance Code §§ 700(c), 704(b), 790.03, 10123.13, and 10169, and the
16 Fair Claims Settlement Regulations contained in California Code of Regulations, Title 10,
17 Chapter 5, Subchapter 7.5, commencing with § 2695.1.

18 **DEMAND PURSUANT TO INSURANCE CODE §§ 790.035, 790.05, and 790.08**

19 66. PLEASE TAKE NOTICE that the Insurance Department may, as a result of
20 ABC's actions set forth above, and pursuant to Insurance Code § 790.035, seek monetary
21 penalties up to:

22 a. \$5,000 for each unfair method of competition or any unfair or deceptive act
23 or practice defined in Insurance Code § 790.03 according to proof; or

24 b. \$10,000 for each act set out above that is deemed willful according to
25 proof.

26 67. PLEASE TAKE FURTHER NOTICE that, as a result of the actions of ABC set
27 forth above, and pursuant to Insurance Code § 790.08, demand is hereby made for such other
28 equitable relief, including restitution, as may be necessary to redress ABC's violations of

1 enumerated California statutory law and regulations and for such other and further relief as may
2 be just and proper.

3 **ORDER TO SHOW CAUSE PURSUANT TO INSURANCE CODE §§ 790.03 and 790.05**

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

8 69. THEREFORE, the Department hereby notifies ABC that a hearing shall be held at
9 a time and place to be determined by the Department which shall not be fewer than 30 days after
10 service of the herein Order to Show Cause to determine whether the alleged methods, acts or
11 practices set forth herein should be declared to be unfair or deceptive and whether the
12 Commissioner should issue an Order to pay the penalty imposed by Insurance Code § 790.035
13 and to cease and desist from such acts or practices.

14 WHEREFORE, the Department prays for the following:

15 1. An Order to Cease and Desist against ABC from engaging in unfair methods of
16 competition and unfair and deceptive acts or practices in the business of life and disability
17 insurance in violation of Insurance Code §§ 790.03;

18 2. An Order to Cease and Desist against ABC from engaging in activities in the
19 business of life and disability insurance in violation of Insurance Code §§ 700(c), 704(b),
20 10123.13, and 10169,

21 3. The imposition of monetary penalties as provided by law, pursuant to Insurance
22 Code § 790.035, of up to \$5,000 for each non-willful act of unfair competition or unfair or
23 deceptive practices alleged above that is established, and a penalty of up to \$10,000 for each
24 willful act of unfair competition or unfair or deceptive practices alleged above that is established
25 according to proof;

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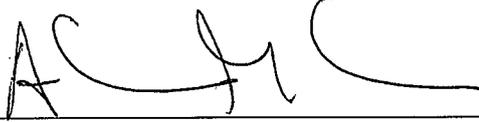
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4. The imposition of such other equitable relief, including restitution, as may be necessary to redress ABC's violations as set forth above; and

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

Dated: February 22, 2010

CALIFORNIA DEPARTMENT OF INSURANCE

By 

Adam M. Cole
General Counsel

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PROOF OF SERVICE
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY
Case No. NC-2010-00001

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 300 Capitol Mall, 17th Floor, Sacramento California 95814. On February 22, 2010, I served the following document(s):

**ORDER TO SHOW CAUSE; STATEMENT OF CHARGES /
ACCUSATION; NOTICE OF MONETARY PENALTY/NOTICE OF
HEARING; NOTICE OF DEFENSE; STATEMENT TO RESPONDENT**

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 Sacramento, 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 Sacramento, 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.

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



Sarian Wyse

SERVICE LIST
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY
Case No. NC-2010-00001

Name/Address

Phone/Fax
Numbers

Method of Service

Jere Keprios
c/o CT Corporation System
818 West Seventh Street, 2nd Floor
Los Angeles, CA 90017

Certified U. S. MAIL
7008 1830 0002 6197 2642

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only, No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

7008 1830 0002 6197 2642

Postage	\$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	\$

Postmark
Here

Sent To Jere Keprios, c/o CT Corp. Sys.
Street, Apt. No.,
or PO Box No. 818 W. Seventh St., 2nd Flr.
City, State, ZIP+4 Los Angeles, CA 90017

PS Form 3800, August 2006 See Reverse for Instructions