REPORT OF TARGETED EXAMINATION

OF

AETNA LIFE INSURANCE COMPANY

NAIC# 60054

AS OF

December 31, 2009

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Department of Insurance
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GERMAINE L. MARKS
Director of Insurance

Honorable Germaine Marks
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Marks:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, a targeted examination has been made of the market affairs of:

AETNA LIFE INSURANCE COMPANY

NAIC # 60054

The above examination was conducted by Sandra Lewis, CIE, MCM, Examiner-in-Charge; James R. Dargavel, CIE, MCM, Senior Market Conduct Examiner and Data Specialist; Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner; Sondra Faye Davis, Market Conduct Examiner; and John Kilroy, Market Conduct Examiner.

The examination covered the period of January 1, 2009, through December 31, 2009.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Helene I. Tomme

Helene I. Tomme, CPCU, CIE
Market Examinations Supervisor
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, Sandra Lewis, CIE, MCM, being first duly sworn state that I am a duly appointed Market Conduct Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of James R. Dargavel, CIE, MCM, Senior Market Conduct Examiner and Data Specialist, Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner, Sondra Faye Davis, Market Conduct Examiner, and John Kilroy, Market Conduct Examiner, the examination of Aetna Life Insurance Company, hereinafter referred to as the "Company" was performed at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss the findings set forth in this Report. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

Sandra Lewis

Sandra Lewis, CIE, MCM
Market Conduct Examiner-in-Charge

Subscribed and sworn to before me this 17th day of September, 2012.

Notary Public

My Commission Expires March 25, 2013

OFFICIAL SEAL
MICHELLE ANN GUEVARA
NOTARY PUBLIC - State of Arizona
MARICOPA COUNTY
My Comm. Expires March 25, 2013

FOREWORD

This targeted market conduct examination of the Aetna Life Insurance Company ("the Company"), was prepared by employees of the Arizona Department of Insurance ("the Department") as well as independent examiners contracting with the Department. A targeted market conduct examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the State of Arizona. The Examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158, and 20-159. The findings in this report, including all work products developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of all aspects of the Company's operations in Arizona, including but not limited to: Advertising, Sales and Marketing, Underwriting, Forms, Claims, Appeals and Grievances, Policyholder Services, and Terminations.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The targeted market conduct examination of the Company covered the period from January 1, 2009, through December 31, 2009, for the lines of business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. The Examiners completed this examination by applying tests to each examination standard to determine compliance with the standard. The standards applied during the examination are stated in this Report at page 43.

In accordance with Department procedures, the Examiners completed a Preliminary Finding ("PF") on those policies, claims, complaints, and/or procedures not in apparent compliance with Arizona law. The PF forms were submitted for review and comment to the

Company representative designated by Company management as being knowledgeable about the files. For each PF, the Company was requested to agree, disagree, or otherwise justify the Company's noted action.

The Examiners used both examination-by-test and examination-by-sample. Examination-by-test involves the review of all records within the population, while examination-by-sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, the Examiners completed examinations-by-test and examinations-by-sample as to those populations without the need to use computer software.

The Examiners based their file sampling on a review of Appeal, New Business, and Claims data provided by the Company. Samples were randomly or systematically selected by using ACL (formerly "Audit Command Language") software and computer data files provided by the Company's Representative, Lucinda Casillas, Regulatory Compliance Director. Samples were tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data resulted in an exception ratio, which determined whether or not a standard was met. If the exception ratio found in the sample was, generally, less than 5%, the standard was considered as "met". A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXECUTIVE SUMMARY

The Examiners completed this examination by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report beginning at page 43, and the examination findings are reported beginning on page 8.

1. The Company failed Standard No. 2, as follows:
    a. With regard to 24 individual medical print ads, failing to file the ads with the Department prior to their use, in apparent violation of A.R.S. § 20-1110(E).
    b. With regard to 23 specific advertising pieces reviewed because the Company failed to identify policy exclusions and limitations for specific benefits referenced in the advertising, including exclusions for preexisting conditions, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(7) and (C)(9).
    c. With regard to two individual medical advertising pieces reviewed because the Company used misleading statements comparing the coverage to COBRA, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(1) and (C)(2).
    d. With regard to 13 specific advertising pieces reviewed because the Company used unsupported and undocumented statements regarding the Company's relative position in the insurance industry, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(P).
    e. With regard to one Student Health advertising print ad reviewed because the Company failed to identify the source of the statistic used in the advertising, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(F) and (O).
    f. With regard to one Student Health "testimonial" video ad that implied that preexisting chronic conditions are covered, despite policy exclusions and limitations for preexisting conditions, in apparent violation of A.R.S. §§ 20-443(A)(1) and 20-444(A), and A.A.C. R20-6-201(C)(1), (C)(2) and (C)(10).

g. With regard to 13 Student Health Brochures because the Company provided inaccurate, incorrect and misleading descriptions of benefits when compared to the master group policies, in apparent violation of A.R.S. §§ 20-443 and 20-444, and A.A.C. R20-6-201(C)(1) and (C)(2).

h. With regard to one Student Health print ad that contained an exclusion for chiropractic care, in apparent violation of A.R.S. §§ 20-443(A)(1), 20-444(A), and 20-461(A)(17).

2. The Company failed Standard No. 4, in apparent violation of A.R.S. § 20-2304(C), by failing to provide the required notice to small group employers in a form that meets the standards established by the statute.

3. The Company failed Standard No. 5, as follows:

a. With regard to three master group policies issued to Arizona universities, certificates of which were issued to Arizona residents, by applying chiropractic exclusions and limitations, in apparent violation of A.R.S. § 20-461(A)(17).

b. With regard to one Individual Medical policy, failing to express the entire money or other consideration for the coverage, in apparent violation of A.R.S. § 20-1342(A)(1).

c. With regard to 12 Student Health Brochures, failing to include in certificates of coverage in summary form all of the essential features of the coverage, in apparent violation of A.R.S. § 20-1402(A)(2).

d. By issuing one policy form that asserts the right of the Company to subrogate claims, in apparent violation of *Allstate vs. Druke*, 118 Ariz. 301, 576 P.2d 489 (1978).

e. With regard to four applications for Individual Medical insurance, using disclosure authorizations that were not limited to 30 months, for the purpose of collecting information in connection with an application for an insurance policy, in apparent violation of A.R.S. § 20-2106(7)(a).

f. With regard to a disclosure authorization form used in conjunction with the processing of health insurance claims, failing to meet the requirements of A.R.S. § 20-2106(3), (5), (6), (8), and (9).

g. With regard to 70 employer certificates and 163 employee certificates issued under extraterritorial policies, failing to include on the certificates of insurance the required notice, in apparent violation of A.R.S. § 20-1401.01.

4. The Company failed Standard No. 8, in apparent violation of A.R.S. § 20-2323(A) by failing to provide disclosure forms to employer groups that included the required content in a form prescribed by the Director.

5. The Company failed Standard No. 12, as follows:

   a. With regard to three Individual Medical policies, failing to provide the applicant with the Notice of Insurance Information Practices at the time personal information was requested during the underwriting process from a party other than the applicant, in apparent violation of A.R.S. § 20-2104(B)(1)(b).

   b. With regard to 48 Individual Medical policies, failing to provide a Summary of Rights to applicants at the time the adverse underwriting decision was communicated, in apparent violation of A.R.S. § 20-2110(A).

6. The Company failed Standard No. 13, as follows:

   a. By failing to acknowledge 27 (77%) of 35 Insured claims within 10 working days of receipt of the claim, in apparent violation of A.R.S. § 20-461(A)(2) and A.A.C. R20-6-801(E)(1).

   b. By failing to accept or deny nine (39%) of 23 Insured claims within 15 days of receipt of acceptable proofs of loss, in apparent violation of A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a).

   c. By failing to adjudicate 67 (19%) of 344 Provider claims within 30 days of receipt of a clean claim, in apparent violation of A.R.S. § 20-3102(A).

   d. By failing to provide a reasonable explanation for the denials of 109 (26%) of 422 claims, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

   e. By failing to pay or deny benefits in accordance with policy provisions on 67 (17%) of 398 claims, in apparent violation of A.R.S. § 20-461(A) and A.A.C. R20-6-801(D)(1).

f. By attempting to settle eight (7%) of 107 claims for amounts less than a reasonable person would expect by reference to written or printed advertising material, in apparent violation of A.R.S. § 20-461(A)(9).

g. By failing to pay nine (10%) of 92 claims in accordance with a state mandate concerning newborn benefits, in apparent violation of A.R.S. § 20-1404(E).

h. By failing to perform a reasonable investigation before denying 12 (63%) of 19 Insured claims, in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).

i. By failing to perform a reasonable investigation of 63 (17%) of 361 Provider claims, in apparent violation of A.R.S. §§ 20-461(A)(3) and (4) and 20-3102(B), and A.A.C. R20-6-801(F).

j. By failing to pay the correct interest on three (60%) of five Insured claims in apparent violation of A.R.S. § 20-462(A).

k. By failing to pay the correct interest on 59 (39%) of 152 Provider claims, in apparent violation of A.R.S. § 20-3102(A);

7. The Company failed Standard No. 18, as follows:

a. By misstating Arizona appeals rights in numerous documents, in apparent violation of A.R.S. §§ 20-2530, *et seq.*

b. By failing to allow a treating provider's appeal on behalf of a member, in apparent violation of A.R.S. § 20-2535(A), as defined by A.R.S. § 20-2530(1).

c. Failing to provide the criteria used and clinical reasons for an appeal decision, in apparent violation of A.R.S. § 20-2536(E)(2).

d. Failing to provide the notice at the conclusion of a formal appeal of the right to proceed to an external independent review, in apparent violation of A.R.S. § 20-2536(G).

8. The Company failed Standard No. 20, by failing to provide renewing employer groups with an explanation of the extent to which premium increases at renewal were due to the actual or expected claims experience of the individuals covered by the health benefits plan, in apparent violation of A.R.S. § 20-2309(A).

9. The Company passed Standards 1, 3, 6, 7, 9, 10, 11, 14, 15, 16, 17, 19, 21, 22, 23 and 24.

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of advertising used by the Company during the examination period, as provided by the Company in response to the Coordinator's Handbook and subsequent requests for additional information ("REQs") by the Examiners, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
2	All advertising and sales materials are in compliance with applicable statutes and rules.	A.R.S. §§ 20-442, 20-443, 20-444, 20-1137, and A.A.C. R20-6-201, R20-6-201.01, and R20-6-202.

The Examiners reviewed 266 individual pieces of advertising provided by the Company for review during the examination. The following table indicates the nature of the ads (print, video, or electronic) and the lines of business for which the advertising applied:

Lines of Business	Print Ads	Video Ads	Web Ads	Total Reviewed
Individual Medical	61	0	1	62
Group Medical Coverage	73	0	0	73
AARP Individual Medical	34	0	4	38
Student Health Individual	28	5	0	33
Student Health Brochures[1]	13	0	0	13
SRC Limited Medical	20	0	0	20
Web Sites at Aetna.com	n/a	n/a	27	27
Total Reviewed	**229**	**5**	**32**	**266**

The Examiners found that the Company failed Standard 2 and issued findings setting forth various apparent violations of pertinent Arizona statutes and rules:

Filing Advertising with the Department

During the examination period, the Company used 24 individual medical print ads that it had failed to file with the Department prior to their use, in apparent violation of A.R.S. § 20-1110(E). See PF # 126.

[1] The Company provided the 13 Student Health brochures referenced above to students at the beginning of each academic year or term as a presale description of the coverage offered through the specific schools. The Company offers this coverage to the students of seven Arizona schools, and provided copies to the Examiners of two brochures (based on academic years) for each of six schools and one brochure for the seventh school. The students are instructed to retain the brochure as their evidence of coverage and summary of benefits if they opt to purchase the coverage. The brochure, therefore, serves as both a marketing tool and as the student's "certificate of insurance" if coverage is ultimately purchased. For this reason, the Examiners reviewed the brochures as advertising and marketing pieces, and also as policy forms.

Advertising That Referenced Specific Policy Benefits

During the examination period, the Company used advertising items that referenced specific policy benefits. In the review of these items, the Examiners found that the Company failed to identify policy exclusions and limitations for specific benefits referenced, including exclusions and limitations for preexisting conditions, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(7) and (C9), as follows:

1. Eleven individual medical print ads. See PFs # 002 and 052.
2. Five group health print ads. See PF # 087.
3. One AARP web ad. See PF # 128.
4. Four Student Health print ads. See PF # 085.
5. Two SRC plan sponsored print ads. See PF # 084.

Misleading Content

During the examination period, the Company used two individual medical print ads that contained incomplete and misleading comparisons between Individual Medical insurance and COBRA coverage, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(1) and (C)(2). See PF # 052.

During the examination period the Company used advertising items that contained unsupported and undocumented statements regarding the Company's relative position in the insurance industry, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(P), as follows:

1. Six individual medical print ads. See PF # 052.
2. Five group health print ads. See PF # 087.
3. One Student Health print ad. See PF #094.
4. One SRC plan sponsored print ad. See PF # 084.

Subsequent Events:

In July 2012, at the completion of the examination review, the Company filed two revised RFP documents with the Department. These documents provide supporting evidence of the claims made by the company concerning initiatives, achievements, awards and recognition of the Company's industry position with regard to student health coverage. The RFPs direct the prospective applicant to a web page containing this supporting documentation.

During the examination period the Company used one Student Health print ad that contained statistics related to the timeliness of claims processing. The Company failed to identify the source of or applicable time period for the statistics used in the advertising, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(F) and (O). See PF # 003.

During the examination period, the Company used one misleading Student Health "testimonial" video ad that implied that preexisting chronic conditions such as asthma are covered without exclusion or limitation, despite the exclusions and limitations for preexisting conditions contained the Student Health medical policy, in apparent violation of A.R.S. §§ 20-443(A)(1) and 20-444(A), and A.A.C. R20-6-201(C)(1), (C)(2) and (C)(10). See PF # 123.

During the examination period, the Company used 13 Student Health Brochures that provided inaccurate, incomplete, and misleading descriptions of benefits when compared to the Master Group Policies issued to the corresponding Arizona schools, in apparent violations of A.R.S. §§ 20-443(A)(1) and 20-444(A), and A.A.C. R20-6-201(C)(1) and (C)(2). See PF #024. The violations in the Student Brochures can be summarized as including, but not limited to:

1. Misstating the deductibles, copays, and/or coinsurance as compared to those out-of-pocket costs listed in the Master Group Policies.
2. Failing to include all benefits available under the Master Group Policies, such as durable medical equipment, surgical benefits, pre-admission testing, maternity expenses, home health benefits, to name only a few.
3. Including benefits in the Brochures that are not provided in the Master Group Policies, such as "$1,000 expense for injury resulting from the play or practice of intercollegiate sports," to name one example.
4. Failing to identify in the Brochures all policy exclusions and limitations set forth in the Master Group Policies.
5. Including exclusions and limitations in the Brochures that are not listed in the Master Group Policies.
6. Failing to define terms within the Brochures using the same language and meaning as those used in the Master Group Policies.
7. Failing to provide the specific issue date and/or termination date for the coverage.

   - and/or -
8. Identifying deductible waivers in the Brochures where no such waivers are provided in the Master Group Policies.

During the examination period the Company used one Student Health print ad that contained exclusions for chiropractic care, in apparent violation of A.R.S. §§ 20-443(A)(1), 20-444(A), and 20-461(A)(17). See PF # 086.

Subsequent Events:

With regard to the exclusion for chiropractic services, the Company mailed a notice on June 17, 2011, to members enrolled in the pertinent plan for school year 2010–2011, notifying the enrollees that benefits were available for chiropractic services. In addition, the Company made the required changes to the school's Student Brochure for school year 2011-2012.

Several advertisements were cited by the Examiners for more than one of the violations described above. In the following table "Exceptions" refers to the number of forms cited rather than to the number of violations.

Summary of Findings – Standard 2 Advertising Review

Type of Advertising	No. of Items Reviewed	Exceptions	Error Ratio	PF #
Individual Heath - Print	61	26	n/a	002, 052, 126
Group Health – Print	73	10	n/a	087
AARP – Web	5	1	n/a	128
Student Health – Print	28	10	n/a	003, 085, 086, 094
Student Health – Video	5	1	n/a	123
Student Health – Brochures	13	13	n/a	024
SRC Lines – Print	20	5	n/a	084
Totals =	**205**	**66**	n/a	

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified; therefore recommendations are warranted.

EXAMINATION FINDINGS – FAILED STANDARD 4

Based on the Examiners' review of the Company's group new business policy forms submitted pursuant to Attachment A of the Coordinator's Handbook, as well as materials provided by the Company in response to the Examiners' REQs, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
4	The Company discloses information concerning the provisions of coverage, the benefits and the premiums available to small group employers as part of sales materials for its small group employers.	A.R.S. § 20-2304

The Company provided several documents to the Examiners in response to requests for the notice to small group employers required by A.R.S. § 20-2304(C). The Examiners reviewed all of the documents provided and concluded that the Company failed Standard No. 4, in apparent violation of A.R.S. § 20-2304(C), by failing to provide the required notice to small group employers in a form that meets all of the content standards established by the statute, and as detailed beginning at page 3 of Circular Letter 97-7. See PFs #020 and #053.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 5

Based on the Examiners' review of the Company's policy forms provided by the Company in response to the Coordinator's Handbook, as well as policies provided for purposes of claims review and documents supplied in responses to the Examiners' REQs, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
5	Policy forms, including but not limited to contracts, certificates, applications, riders, and endorsements, comply with pertinent Arizona laws and/or the laws of the state where the policy was issued.	A.R.S. §§ 20-1342, *et al.*, including but not limited to A.R.S. § 20-1401.01; 20-2301, *et seq.*, and A.A.C. R20-6-1205.

Chiropractic Benefits Exclusions

The Company failed to meet Standard 5 of this examination, in apparent violation of A.R.S. § 20-461(A)(17), by issuing policies and their certificates that discriminate as to the benefits available for treatment by chiropractors. See PFs # 011, # 119, and # 125. The Company failed this standard as follows:

1. During the examination period the Company issued Blanket Student Accident and Health Policy, form GR-96134 ED 6-02, certificates of which were issued to Arizona residents. This form states under exclusion 85 that: "Expenses incurred for chiropractic care" are excluded from coverage.
2. During the examination period the Company issued Blanket Student Accident and Health Policy, form GR-96134 ED 8-06, which was issued to three Arizona universities, and form GR-96134 ED. 3-98, which was issued to one Arizona university, and the certificates of which were issued to Arizona residents. Both of these policy forms impose an annual limit on the number of visits to a chiropractor, but impose no such limit for outpatient treatment of the same conditions by other types of physicians.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

Subsequent Events

After receiving PF # 011, the Company voluntarily identified 129 Student Health chiropractic claims received from August 1, 2009, through July 31, 2010. The Company completed the reprocessing of 114 of the 129 claims and paid additional benefits on 35 claims. The Company determined that the remaining 15 of 129 claims had been processed and paid when they were originally received or had been reprocessed and paid prior to the commencement of this examination, and the Company did not reprocess those 15 claims. The Company has paid additional benefits of $4,524.17, plus interest in the amount of $135.81, for total restitution of $4,659.98 on 35 claims. [EXAMINERS' NOTE: The Examiners computed the required interest on the 35 paid claims and found that the Company had underpaid interest on 34 claims and overpaid interest on one claim, as discussed in more detail under Standard 13 of this Report.]

The Company also supplied copies of revised student health policies for the 2011-2012 academic year showing that the policy exclusions had been deleted.

Format of the Policy

During the examination period, the Company used application form GR-67466-42 (6/07), which was included in and made part of the issued policies. This application form contained the following language in bold letters on page 6: "Any rate adjustment made in accordance with the underwriting process will automatically be charged to your account. Please be advised that such rate adjustment may result in an increase of 25% to 50% of the standard premium."

The Company failed Standard 5 with regard to one Individual Medical In Force file (A-INBIF-089) reviewed, where the insured's application was taken on form GR-67466-42 (6/07), because the policy was issued with a rate increase on the husband totaling 100% of standard premium. The applied 100% rate increase exceeds the 25% to 50% rate increase that is identified in application form GR-67466-42 (6/07). Therefore, the Company failed to issue a policy that expressed the entire money and other considerations for the policy, in apparent violation of A.R.S. § 20-1342(A)(1). See PF # 101.

Subsequent Events

At the conclusion of the review phase of the examination, the Company provided copies of revised application forms [Form # GR-68388-2 (5-12) and Form # GR-67466-42 (5-12)] showing that rates may be adjusted up to 100% of the standard premium based on underwriting.

During the examination period, the Company used 13 Student Health brochures, which as previously noted, served as both marketing tools and certificates of coverage. The Examiners found that 12 of the brochures did not contain all related exclusions, reductions, and limitations that were contained in the master group policies issued to the respective Arizona schools. Therefore the Company failed Standard 5 by using certificates of coverage for group insurance that failed to set forth in summary form a statement of the essential features of the insurance coverage of the group member to whom benefits are payable, in apparent violation of A.R.S. § 20-1402(A)(2). See PF # 116.

During the examination period the Company issued one policy form GR-11697, ED. 10/03 Rev 06/06, which includes a section titled "Third Party Liability and Right of Recovery", that provides for subrogation, or reimbursement of funds paid by other insurers or entities, or payments made by a third party tortfeasor or any insurance company on behalf of a third party tortfeasor. The Company has failed Standard 5, in apparent violation of *Allstate vs. Druke*, 118 Ariz. 301, 576 P.2d 489 (1978). See PF # 078.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

Disclosure Authorization

The Examiners reviewed three Association Group Individual (DE Trust) application forms and one Association Group Individual AARP plan application form provided by the Company in response to the Coordinator's Handbook, Attachment A, question 7.A. The Examiners also reviewed 53 Individual Medical New Business Cancellation sample files provided by the Company in response to REQ063. During the examination period, the Company used four different application forms for its Association Group individual coverage issued through trust arrangements:

Form GR-67466-42 (6/07)
Form GR-68388-2 (8/07)
Form GR-67466-42 (2/09)
Form GR-67466-10 (5/06)

Each of the four application forms contains a disclosure authorization stating: "This authorization will remain valid for the term of the coverage and for so long thereafter as allowed by law." The Company failed Standard 5, in apparent violation of A.R.S. § 20-2106(7)(a) by

using a disclosure authorization for the purpose of collecting information in connection with an application for an insurance policy that was not limited to 30 months. See PFs # 009 and # 113.

Subsequent Events

At the conclusion of the review phase of the examination, the Company provided a copy of revised application Form # GR-67466-42 (5-12) showing that the disclosure authorization shall be valid for 30 months. The Company asserts it will bring all application forms into compliance no later than first quarter 2013.

The Examiners reviewed 63 Large Group Medical Claims denied because of preexisting conditions. The Company provided these claims to the Examiners in response to REQ041. In each of the claim files reviewed, the Examiners found a document used for the purpose of obtaining medical information from persons other than the insured. The document did not include a form number for reference herein. See PF # 060. The Company failed Standard 5 by using a disclosure authorization form in conjunction with the processing of health insurance claims that:

1. Did not specify the types of persons authorized to disclose information about the insured, in apparent violation of A.R.S. § 20-2106(3).
2. Did not name the insurance institution or insurance producer and identified by generic reference representatives of the insurance institution to whom the individual is authorizing information to be disclosed, in an apparent violation of A.R.S. § 20-2106(5).
3. Did not specify the purpose for which the information is collected, in an apparent violation of A.R.S. § 20-2106(6).
4. Did not specify the length of time that the authorization remains valid, in apparent violation of A.R.S. § 20-2106(8).
5. Did not advise the individual or a person authorized to act on behalf of the individual that the individual or the individual's authorized representative is entitled to receive a copy of the authorization form, in apparent violation of A.R.S. § 20-2106(9).

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

Extraterritorial Policies

The Examiners reviewed 292 certificates of coverage in the review of Large Group denied claims. The Examiners identified 70 employer certificates of coverage and 163 employee certificates of coverage that were provided to Arizona employers and/or residents under policies situsued in states other than Arizona. The Company failed Standard 5, in apparent violation of A.R.S. § 20-1401.01 by failing to include on the certificates of insurance the required notice "Notice: This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully." See PFs # 105 and # 118.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 8

Based on the Examiners' review of samples of the Company's new business files, as well as policy forms provided in response to the Coordinator's Handbook and/or the Examiners' REQs, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
8	The Company provides approved disclosure of information forms to all group employers prior to executing a contract for coverage under a health care plan.	(A.R.S. § 20-2323)

The Examiners reviewed 48 Large Group Medical in-force new business files. Twenty of the files did not include copies of the disclosure form required by A.R.S. § 20-2323(A). The 28 remaining files contained the disclosure forms used by the Company during the examination period, but these forms did not include all of the prescribed content of the statute as illustrated by Circular Letter 97-7.

The Examiners reviewed 62 Small Group Medical in-force files and found no evidence in any of the files of the disclosures required by A.R.S. § 20-2323(A).

The Examiners requested copies of the disclosure forms used in conjunction with the Company's Small Group Medical new business (REQ100). In response to this request, the Company provided a document entitled "Health Care Insurer Appeal Information Packet." Upon further inquiry by the Examiners, the Company responded, among other things, that certain items of information required by the statute are included in the policy or contract.

The Director's prescribed form for the disclosure is outlined in detail in Circular Letter 97-7, which describes the purpose of the disclosure forms as follows:

> The disclosures to be made by accountable health plans will permit employers considering the purchase or renewal of a health benefits plan to evaluate the contents of competing health benefit plans through the evaluation of standardized forms.

Including the required information in the policy or contract defeats that purpose. The Company failed Standard No. 8, in apparent violation of A.R.S. § 20-2323(A) by failing to provide disclosure forms to employer groups in a form that meets the requirements for content established by the statute "in a form that is prescribed by the Director." See PFs # 013, # 015, # 022, and # 054.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 12

Based on the Examiners' review of the Company's selected samples of new business and in-force policy files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
12	The Company complies with all notice of insurance information and privacy requirements.	A.R.S. §§ 20-2101, *et seq.*

Notice of Insurance Information Practices

The Examiners reviewed 93 Individual Medical New Business in-force policy files. The Examiners found that in three of the reviewed files, the Company requested medical records during the underwriting process. In each of the three cases, the Company failed Standard 12 by failing to provide a "Notice of Insurance Information Practices" to the applicants at the time the Company requested personal information from a source other than the applicant, in apparent violation of A.R.S. § 20-2104(B)(1)(b). See PF # 102.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

Summary of Rights

The Examiners reviewed 93 Individual Medical New Business in-force policy files. The Examiners found that in 28 of the reviewed files, the Company made an adverse underwriting decision as defined by A.R.S. § 20-2102(1). In each of the 28 cases, the Company failed Standard 12 by failing to provide a Summary of Rights established by A.R.S. §§ 20-2108 and 20-2109 at the time the Company communicated the adverse underwriting decision, in apparent violation of A.R.S. § 20-2110(A). See PF # 103.

The Examiners reviewed 53 Individual Medical New Business cancellation policy files. The Examiners found that in 20 of the reviewed files, the Company made an adverse underwriting decision as defined by A.R.S. § 20-2102(1). In each of the 20 cases, the Company failed Standard 12 by failing to provide a Summary of Rights established by A.R.S. §§ 20-2108 and 20-2109 at the time the Company communicated the adverse underwriting decision, in apparent violation of A.R.S. § 20-2110(A). See PF # 115.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 13

Based on the Examiners' review of selected sample claim files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
13	Claims are handled timely and appropriately in accordance with policy provisions and applicable statutes and rules.	A.R.S. §§ 20-461, 20-462, and 20-1215, and A.A.C. R20-6-801

During the Examiners' review of samples of paid and denied health care claims, the Examiners distinguished those claims that were submitted by or paid directly to the insured ("Insured claims") from those that had been submitted by and paid directly to the provider ("Provider claims"), in order for the Examiners to apply the appropriate governing statutes and rules, where different, to each type of claim.

Time Service for Acknowledging Insured Claims

The Examiners reviewed Insured claims to determine the timeliness of the acknowledgment of the claim. The Examiners found that the Company failed Standard 13 by failing to acknowledge claims within 10 working days, in apparent violation of A.R.S. § 20-461(A)(2) and A.A.C. R20-6-801(E)(1), as follows:

1. The Examiners reviewed 53 Individual Medical claims denied for a specified list of reason codes, provided by the Company in response to REQ016. Eight claims were Insured claims. The Company failed to acknowledge three (38%) of the eight Individual Medical denied Insured claims within 10 working days. See PF # 073.
2. The Examiners reviewed 24 Student Health claims that had been denied as not medically necessary, provided by the Company in response to REQ088. Eleven claims were Insured claims. The Company failed to acknowledge 11 (100%) of the 11 Student Health denied Insured claims within 10 working days. See PF # 041.
3. The Examiners reviewed 55 Vision paid claims, provided by the Company in response to REQ021. Four claims were Insured claims. The Company failed to acknowledge three (75%) of the four paid Insured claims within 10 working days. See PF # 017.

4. The Examiners reviewed 48 denied Vision claims, provided by the Company in response to REQ022. Twelve claims were Insured claims. The Company failed to acknowledge 10 (83%) of the 12 denied Insured claims within 10 working days. See PF # 008.

Subsequent Events

At the conclusion of the review phase of the examination, the Company provided a copy of a form letter in use as of April 2012 whereby the Company acknowledges receipt of a claim payable to the insured.

Summary of Findings – Acknowledgment of Insured Claims

Description	Population	Sample Size	Insured Claims Reviewed	Exceptions	Error Ratio	PF #
Individual Medical Denied SR	135	53	8	3	38%	073
Student Health Denied NMN	25	24	11	11	100%	041
Vision Paid	1,708	55	4	3	75%	017
Vision Denied	48	48	12	10	83%	008
Totals	**1,916**	**180**	**35**	**27**	**77%**	

A 77% error ratio does not meet the standard; therefore recommendations are warranted.

Time Service for Paying or Denying Claims

Insured Claim Processing

The Examiners reviewed Insured claims to determine the timeliness of the acceptance or denial of the claim. The Examiners found that the Company failed Standard 13 by failing to accept or deny Insured claims within 15 working days of receipt of properly executed proofs of loss, in apparent violation of A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a), as follows:

1. The Examiners reviewed 53 Individual Medical claims denied using various reason codes, provided by the Company in response to REQ016. Eight claims were Insured claims. The Company failed to advise the Insured within 15 working days from receipt of acceptable proofs of loss of the denial of two (25%) of the eight Insured claims reviewed. See PF # 074.
2. The Examiners reviewed 24 Student Health Medical claims denied as not medically necessary, provided by the Company in response to REQ088. Eleven claims were Insured claims. The Company failed to advise the Insured within 15 working days from receipt of acceptable proofs of loss of the denial of four (36%) of the 11 Insured claims reviewed. See PF # 042.

3. The Examiners reviewed 55 Vision paid claims, provided by the Company in response to REQ021. Four claims were Insured claims. The Company failed to advise the Insured within 15 working days from receipt of acceptable proofs of loss of the acceptance of three (75%) of the four Insured claims reviewed. See PF # 018.

Summary of Findings – Acceptance or Denial of Insured Claims

Description	Population	Sample Size	Insured Claims Reviewed	Exceptions	Error Ratio	PF #
Individual Medical Denied	135	53	8	2	25%	074
Student Health Denied NMN	25	24	11	4	36%	042
Vision Paid	1,708	55	4	3	75%	018
Totals	**1,868**	**132**	**23**	**9**	**39%**	

A 39% error ratio does not meet the standard; therefore recommendations are warranted.

Provider Claim Processing

The Examiners reviewed Provider claims to determine the timeliness of the adjudication, payment and/or denial of the claim. The Examiners found that the Company failed Standard 13 by failing to adjudicate Provider claims within 30 days from receipt of the clean claim, in apparent violation of A.R.S. § 20-3102(A), as follows:

1. The Examiners reviewed 57 Large Group Medical claims that were denied because of preexisting conditions, provided by the Company in response to REQ041. Fifty-seven of the 57 claims reviewed were Provider claims. The Company failed to advise the insured and provider within thirty days after the Company received the clean claim of the decision to deny 13 (23%) of 57 Provider claims reviewed. See PF # 061.
2. The Examiners reviewed 107 Student Health paid claims, provided by the Company in response to REQ085. One hundred six of the 107 claims reviewed were Provider claims. The Company failed to adjudicate 14 (13%) of 106 Provider claims within 30 days of receipt of the clean claim. See PF # 089.
3. The Examiners reviewed 24 Student Health Medical claims denied as not medically necessary, provided by the Company in response to REQ088. Thirteen of the 24 claims reviewed were Provider claims. The Company failed to advise the insured and provider within thirty days after the Company received the clean claim of the decision to deny one (8%) of 13 Provider claims reviewed. See PF # 040.
4. The Examiners reviewed 26 Student Health BIAC denied claims, provided by the Company in response to REQ091. All 26 claims reviewed were Provider claims. The Company failed to advise the insured and provider within thirty days after the Company

received the clean claim of the decision to deny nine (35%) of 26 Provider claims reviewed. See PF # 100.

5. The Examiners reviewed 45 Student Health EBN denied claims, provided by the Company in response to REQ086. All 45 claims reviewed were Provider claims. The Company failed to advise the insured and provider within thirty days after the Company received the clean claim of the decision to deny five (11%) of 45 Provider claims reviewed. See PF # 106.

6. The Examiners reviewed 47 Student Health NCNN denied claims, provided by the Company in response to REQ087. Forty-six of the claims reviewed were Provider claims. The Company failed to advise the insured and provider within thirty days after the Company received the clean claim of the decision to deny four (9%) of 46 Provider claims reviewed. See PF # 107.

7. The Examiners reviewed 52 Student Health Dental denied claims provided by the Company in response to REQ094. Fifty-one of the 52 claims reviewed were Provider claims. The Company failed to advise the insured and provider within thirty days after the Company received the clean claim of the decision to deny 21 (41%) of 51 Provider claims reviewed. See PF # 035.

Subsequent Events

At the conclusion of the review phase of the examination, the Company provided copies of internal monitoring system put in place to identify workflow issues, as well as to identify performance issues by specific claims examiners.

Summary of Findings – Adjudication of Provider Claims

Description	Population	Sample Size	Provider Claims Reviewed	Exceptions	Error Ratio	PF #
Large Group PX denied	63	57	57	13	23%	061
Student Health Paid	56,154	107	106	14	13%	089
Student Health NMN denied	25	24	13	1	8%	40
Student Health BIAC denied	33	26	26	9	35%	100
Student Health EBN denied	199	45	45	5	11%	106
Student Health NCNN denied	383	47	46	4	9%	107
Student Health Dental denied	52	52	51	21	41%	035
Totals	**56,909**	**358**	**344**	**67**	**19%**	

A 19% error ratio does not meet the standard; therefore recommendations are warranted.

Reasons for Denial of Claims

During the Examiners' review of samples of denied claims provided by the Company, the Examiners reviewed the EOBs sent to both the insured and the provider to determine the reasons for the denial of the claims. The Examiners found that the Company failed Standard 13 by failing to provide a reasonable explanation for the denial and to reference the specific policy provision, condition or exclusion relied upon, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a), as follows:

1. The Examiners reviewed 54 Small Group Medical claims denied as not medically necessary, provided by the Company in response to REQ027. The Company denied three (6%) of the 54 claims reviewed using a Reason Code that states, "This statement includes a denied expense. Please call the number located on the Member I.D. card for an explanation." See PF # 071.
2. The Examiners reviewed 55 denied Small Group Medical claims denied because of preexisting conditions and 55 Small Group Medical claims denied because of other specific reason codes, provided by the Company in response to REQ024 and REQ025 respectively. The Company used EOB reason codes that provided multiple and alternative reasons for the denial of benefits, and therefore failed to provide a reasonable explanation for the denials, in 8 (7%) of the 110 claims reviewed. See PF # 012.
3. The Examiners reviewed 100 Small Group Medical claims denied using a free-form text denial message, provided by the Company in response to REQ026. The Company denied seven (7%) of the 100 claims reviewed using a Reason Code that states, "Your plan benefits do not cover all services. The service noted above is not covered. Please read your plan booklet for details." See PF # 070.
4. The Examiners reviewed 55 Large Group claims denied referencing the plan booklet, provided by the Company in response to REQ038. The Company used EOB reason codes that provided multiple and alternative reasons for the denial of benefits, and therefore failed to provide a reasonable explanation for the denials, in 41 (75%) of the 55 claims reviewed. See PF # 019.
5. The Examiners reviewed 55 SRC claims denied as "not covered," provided by the Company in response to REQ080. The Company used EOB reason codes that stated merely that the claim is not covered without specifying the policy provision, condition or exclusion relied upon in 33 (60%) of the 55 claims reviewed. The term "not covered" is

merely another way of saying, "denied," and therefore the Company failed to provide a reasonable explanation for the denials. See PF # 026.

6. The Examiners reviewed 48 denied Vision claims, provided by the Company in response to REQ022. The Company used EOB reason codes that provided multiple and alternative reasons for the denial of benefits, and therefore failed to provide a reasonable explanation for the denial, in 17 (35%) of the 48 claims reviewed. See PFs # 005, # 006 and # 007.

Summary of Findings – Reasons for Claims Denials

Description	Population	Sample Size	Exceptions	Error Ratio	PF #
Small Group Medical NMN denied	135	54	3	6%	071
Small Group Medical PX/SR denied	770	110	8	7%	012
Small Group Medical Blank denied	11,752	100	7	7%	070
Large Group PB denied	394	55	41	75%	019
SRC NC denied	220	55	33	60%	026
Vision Non-duplicate denied	48	48	17	35%	005, 006, 007
Totals	**13,319**	**422**	**109**	**26%**	

A 26% error ratio does not meet the standard; therefore recommendations are warranted.

Benefits Paid or Denied Inconsistently With Policy Provisions

During the Examiners' review of samples of claims provided by the Company, the Examiners reviewed the EOBs sent to both the insured and the provider to determine the reasons for the denial of the claims. The Examiners compared the benefits paid or denied with the pertinent policy provisions governing the claim. The Examiners found that the Company failed Standard 13 by denying claims, or in the alternative underpaying claims, inconsistently with pertinent policy provisions. The Company therefore misrepresented pertinent facts or insurance policy provisions relating to coverages at issue, in apparent violation of A.R.S. § 20-461(A)(1) and A.A.C. R20-6-801(D)(1), as follows:

1. The Examiners reviewed 55 Individual Medical claims denied using a free-form text denial message, provided by the Company in response to REQ034. The Company paid three (5%) of the 55 claims reviewed, but applied a copayment that was excessive based on the policy language, resulting in the underpayment of the claims. See PF # 088.

2. The Examiners reviewed 100 Small Group Medical claims denied using a free-form text denial message, provided by the Company in response to REQ026. The Company paid nine (9%) of the 100 claims reviewed, but applied a copayment in excess of the copayment provision in the policy, resulting in the underpayment of the claims. See PF # 069.

3. The Examiners reviewed 57 Large Group Medical claims denied due to preexisting conditions, provided by the Company in response to REQ041. The Company investigated 37 claims in this sample by sending to the treating provider a form requesting information about prior treatment. The form asked the provider for a "yes" or "no" response. The form deviated from the policy language and requirements in two ways: (1) by using a longer "look back" period than that provided for in the policy for determining preexisting conditions, and (2) by listing all conditions on the claim in the aggregate. The format of the document thereby required the provider to respond "yes" or "no" if any of the conditions had been treated by the provider, without determining which of the multiple conditions listed had been treated and/or whether any had not been treated during the time period. The Company proceeded to use a "yes" response on the form submitted by the provider to deny benefits for all conditions itemized on the claim as "preexisting." The Company denied 34 (60%) of the 57 claims due to preexisting conditions where some or all of the medical conditions on the claim may not have been preexisting. Four claims were denied solely by using a "look back" period that exceeded the policy language. Thirty claims were denied in their entirety as preexisting using a provider's "yes" response that may have applied to only one of the multiple conditions so listed. See PF # 057.

4. The Examiners reviewed 55 Large Group Medical claims denied as not medically necessary, provided by the Company in response to REQ040. The Company denied nine (16%) of the 55 claims reviewed, citing a determination that the services were not medically necessary. See PF # 067. The Examiners requested additional information about these files, and found that the Company failed to:

   a. Provide a copy of a Clinical Claim Review relative to the denied claims or which supported the claim denial.

   b. Provide a copy of a Clinical Claim Review that supported the denial of claims for the specific insured who received the services that were billed.

   c. Provide a concurrent Clinical Claim Review for the most recent dates of service and/or that reviewed all injuries and illnesses treated as indicated by the ICD-9 codes. In one case, the Company relied on an outdated review (more than four months old), thereby effectively imposing an indefinite exclusion of benefits for conditions with the same or similar diagnosis codes.

d. Pay one claim where the Clinical Claim Review had, in fact, approved the medical necessity of treatment on that date of service.

5. The Examiners reviewed 107 Student Health paid claims, provided by the Company in response to REQ085. As previous noted, the Company used the Student Brochures as both a marketing tool and as the certificate of insurance for this line of business. The Student Brochures contained numerous inconsistencies when compared to the master group contracts issued to the various schools through which the Company offers this coverage. The Company failed to pay benefits in accordance with the Student Brochures as provided to the students as their evidence of coverage with regard to nine (8%) of 107 claims reviewed. See PF # 091.

6. Eight (7%) of the 107 claims described in Item #5 above were underpaid according to the terms of the Student Brochure, in apparent violation of A.R.S. § 20-461(A)(9). See PF # 092.

7. The Examiners reviewed 24 Student Health Medical claims denied as not medically necessary, provided by the Company in response to REQ088. The Company denied three (13%) of the 24 claims reviewed, despite policy language indicating that benefits were available under the terms of coverage. See PF # 043.

Subsequent Events

At the conclusion of the review phase of the examination, the Company provided documentation showing that it has reprocessed eight claims included in PF # 043, #091, and #092 listed above. For these eight claims, the Company paid additional benefits of $1,225.12, plus accrued interest of $67.47, for total restitution of $1,292.59.

Summary of Findings – Benefits Inconsistent With Policy

Description	Population	Sample Size	Exceptions	Error Ratio	PF #
Individual Medical Blank denied	1,721	55	3	5%	034
Small Group Blank denied	11,752	100	9	9%	069
Large Group Medical PX denied	63	57	34	60%	057
Large Group Medical NMN denied	460	55	9	16%	067
Student Health Medical paid	56,154	107	9	8%	091,092
Student Health Medical NMN denied	25	24	3	13%	043
Totals	**70,175**	**398**	**67**	**17%**	

A 17% error ratio does not meet the standard; therefore recommendations are warranted.

Benefits Denied Inconsistently With an Arizona Mandate

The Examiners reviewed 45 Student Health Medical EBN and 47 Student Health NCNN denied claims, provided by the Company in response to REQ086 and REQ87 respectively. The Company denied nine claims for routine newborn services because the child was not enrolled in the coverage. The Company failed Standard 13 by improperly denying nine (10%) of 92, in apparent violation of A.R.S. § 20-1404(E). See PFs #098 and # 109.

Subsequent Events

The Company agreed with these findings. Prior to the completion of the examination file review, the Company provided documentation to the Examiners showing that it had reprocessed and paid the nine claims for newborn services. The Company made benefits payments in the amount of $397.45, plus interest in the amount of $85.40, for total restitution payments of $482.85.

Summary of Findings – Benefits Inconsistent With State Mandate

Description	Population	Sample Size	Exceptions	Error Ratio	PF #
Student Health NC denied	582	92	9	10%	098, 109

A 10% error ratio does not meet the standard; therefore recommendations are warranted.

Investigation of Claims

Insured Claims Processing

During the Examiners' review of samples of denied claims provided by the Company, the Examiners reviewed the EOBs for Insured claims sent to both the insured and the provider, as well as the claim processing notes, to determine whether the Company appeared to have performed a reasonable investigation, where necessary, before denying claims. The Examiners found that the Company failed Standard 13 by denying claims that may have been payable under the policy terms had a reasonable investigation been performed prior to denying the claim, in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), as follows:

1. The Examiners reviewed 53 Individual Medical claims denied for a specified list of reason codes, provided by the Company in response to REQ016. Eight claims were Insured claims. The Company failed to perform a reasonable investigation before denying eight (100%) of eight Insured claims reviewed, as follows. See PF # 080.
   a. The Company denied five claims for wart removal under the exclusion for cosmetic procedures without performing a reasonable investigation to determine

whether there was a medical reason, such as severe pain or bleeding, requiring the removal.

b. The Company uses internal documents Clinical Policy Bulletins ("CPBs") to evaluate to applicability of benefits to various medical conditions and diagnoses. The Company supplied copies of the CPBs to the Examiners for use in reviewing the denied claims samples. Some of these CPBs included medical criteria under which policy benefits would be payable. The Company denied three Insured claims reviewed without performing a reasonable investigation to determine whether the patient met the medical criteria established by the CPBs prior to denying the claims.

2. The Examiners reviewed 24 Student Health Medical claims denied as not medically necessary, provided by the Company in response to REQ088. Eleven of the 24 claims were Insured claims. The Company denied four (36%) of the 11 Insured claims reviewed without performing a reasonable investigation prior to denying the claims. See PF # 044.

Subsequent Events

On April 25, 2012, at the conclusion of the examination review, the Company conducted in-house training of examiners regarding durable medical equipment benefits to ensure accuracy of pending decisions by claims examiners.

Summary of Findings – Investigation of Insured Claims

Description	Population	Sample Size	Insured Claims Reviewed	Exceptions	Error Ratio	PF #
Individual Medical SR denied	135	53	8	8	100%	080
Student Health NMN denied	25	24	11	4	36%	044
Totals	**160**	**77**	**19**	**12**	**63%**	

A 63% error ratio does not meet the standard; therefore recommendations are warranted.

Provider Claims Processing

During the Examiners' review of samples of denied claims provided by the Company, the Examiners reviewed the EOBs sent to both the insured and the provider, as well as the claim processing notes, to determine the Company's procedures for handling incomplete claims. The Company failed Standard 13 by failing to make a written request for additional information within 30 days from the date of receipt of a claim that is not a "clean claim," in apparent violation of A.R.S. § 20-3102(B), as follows:

1. The Examiners reviewed 24 Student Health Medical claims denied as not medically necessary, provided by the Company in response to REQ088. Thirteen of the 24 claims reviewed were Provider claims. The Company failed to make a written request for additional information within thirty days of the dates the Company received one (8%) of 13 Provider claims that was not a "clean claim." See PF # 040.
2. The Examiners reviewed 11 Student Health paid Dental claims provided by the Company in response to REQ093. Ten of the 11 claims reviewed were Provider claims. The Company failed to make a written request for additional information within thirty days of the dates the Company received two (20%) of 10 Provider claims that were not "clean claims." See PF # 037.
3. The Examiners reviewed 52 Student Health denied Dental claims provided by the Company in response to REQ094. Fifty-one of the 52 claims reviewed were Provider claims. The Company failed to make a written request for additional information within thirty days of the dates the Company received 21 (41%) of 51 Provider claims that were not "clean claims." See PF # 036.

Subsequent Events

At the conclusion of the review phase of the examination, the Company provided copies of internal monitoring system put in place to identify workflow issues, as well as to identify performance issues by specific claims examiners.

In addition to the foregoing, the Company failed Standard 13 by failing to perform a reasonable investigation before denying a claim, in apparent violation of A.R.S. § 20-461(A)(3) and (4), as follows:

4. The Company uses its CPBs to evaluate the applicability of benefits to various medical conditions and diagnoses. The Company supplied copies of the CPBs to the Examiners for use in reviewing the denied claims samples. Some of these CPB included medical criteria under which benefits would be payable. The Company failed to perform a reasonable investigation to determine whether the patient met the medical criteria established by the CPBs prior to denying the claims, as follows:
    a. The Company denied 20 (44%) of the 45 Individual Medical denied Provider claims, provided by the Company in response to REQ014. See PF # 075.
    b. The Company denied five (17%) of the 30 Individual Medical denied Provider claims, provided by the Company in response to REQ017. See PF # 093.

c. The Company denied one (2%) of the 54 Small Group Medical MN denied Provider claims, provided by the Company in response to REQ027. See PF # 120.

5. The Examiners reviewed 57 Large Group Medical claims denied due to preexisting conditions, provided by the Company in response to REQ041. Fifty-seven of the 57 claims reviewed were Provider claims. The Company denied six (11%) of the 57 Provider claims reviewed without performing a reasonable investigation prior to denying the claims as "preexisting conditions." In the case of four of these claims for the same individual, the Company appears to have used the health history of another person covered under the policy to determine the preexisting condition. See PF # 058.

6. The Examiners reviewed 55 Large Group Medical claims denied as not medically necessary, provided by the Company in response to REQ040. All 55 claims were Provider claims. The Company denied four (7%) of 55 claims reviewed relying on the performance of a "Clinical Claims Review." The Company did not provide the Examiners with a copy of the clinical review for one of the claims. The documentation supplied for the remaining three claims relied upon a previous claims review that was performed four months prior to the new dates of service, thereby rubber-stamping the denial without performing a concurrent investigation of the new claims. See PF # 068.

7. The Examiners reviewed 47 Student Health NCNN denied claims, provided by the Company in response to REQ087. Forty-six of the claims reviewed were Provider claims. The Company failed to perform a reasonable investigation of three (7%) of 46 Provider claims prior to denying the claims. See PF # 122.

Summary of Findings – Investigation of Provider Claims

Description	Population	Sample Size	Provider Claims Reviewed	Exceptions	Error Ratio	PF #
Individual Medical EXP denied	45	45	45	20	44%	075
Individual Medical SNA denied	31	31	30	5	17%	093
Small Group Medical NMN denied	436	54	54	1	2%	120
Large Group Medical PX denied	63	57	57	6	11%	058
Large Group Medical NMN denied	460	55	55	4	7%	068
Student Health Denied NMN denied	25	24	13	1	8%	040
Student Health Medical NCNN denied	383	47	46	3	7%	122
Student Health Dental paid	11	11	10	2	20%	037
Student Health Dental denied	52	52	51	21	41%	036
Totals	**1,506**	**376**	**361**	**63**	**17%**	

An 17% error ratio does not meet the standard; therefore recommendations are warranted.

Payment of Interest

During the Examiners' review of samples of paid claims provided by the Company, the Examiners reviewed the timeliness of claims, and where appropriate, the payment of interest at the legal rate in accordance relevant laws governing provider-paid or insured-paid claims.

Claims Submitted by or Paid Directly to the Insured

The Examiners found that the Company failed Standard 13 by failing to pay interest or by failing to pay the correct amount of interest on claims submitted by the insured for claims that were not paid within 30 days of receipt of acceptable proofs of loss, in apparent violation of A.R.S. § 20-462(A), as follows:

1. The Examiners reviewed 11 Student Health paid Dental claims provided by the Company in response to REQ093. One of the 11 claims reviewed was an Insured claim. The Company took 59 days to pay this claim after receipt of acceptable proofs of loss, but failed to pay interest on the late claim with regard to one (100%) on one Insured claim file reviewed. See PF # 038.

   Subsequent Events

   On March 31, 2012, the Company paid the interest indicated in PF # 038 in the amount of $7.78.

2. The Examiners reviewed 55 paid Vision claims, provided by the Company in response to REQ021. Four of the 55 claims were Insured claims. The Company failed pay two (50%) of the four claims and failed to pay interest on either of the two claims. See PF # 016.

Summary of Findings – Interest Payments on Insured Claims

Description	Population	Sample Size	Insured Claims Reviewed	Exceptions	Error Ratio	PF #
Student Health Dental paid	11	11	1	1	100%	038
Vision paid	1,708	55	4	2	50%	016
Totals	**1,719**	**66**	**5**	**3**	**60%**	

A 60% error ratio does not meet the standard; therefore recommendations are warranted.

Claims Submitted by or Paid Directly to the Provider

The Examiners found that the Company failed Standard 13 by failing to pay interest or by filing to pay the correct amount of interest on claims submitted by the provider, in apparent violation of A.R.S. § 20-3102(A), as follows:

1. During the examination, the Company identified 129 chiropractic claims submitted between August 1, 2009, and July 31, 2010, under a Student Health policy that excluded chiropractic services in apparent violation of Arizona law.[2] As a result of the Examiners' findings:

   a. The Company voluntarily reprocessed 114 Student Health claims for chiropractic benefits and paid additional benefits for 35 claims to providers. The Company failed to pay the correct interest on 35 (27%) of the 129 previously denied chiropractic claims. See PF # 033.

   b. The Company determined that 15 of the chiropractic claims submitted during the time period were previously paid at the time the original claim was received or reprocessed and paid at a later date prior to the commencement of this examination. The Company provided documentation to the Examiners that it had paid benefits to providers on 14 of the 15 claims, and that interest had been paid on all 14 claims. The Company failed to pay the correct interest on 14 (11%) of the 129 previously denied chiropractic claims. See PF # 033.

Subsequent Events

At the conclusion of the examination review, the Company paid the interest related to 44 of the 49 claims cited above in the amount of $310.87. In addition, on two of these claims, the Company paid additional benefits in the amount of $53.54, for total restitution of $364.41.

2. The Examiners reviewed 24 Student Health Medical claims denied as not medically necessary, provided by the Company in response to REQ088. Thirteen of the 24 claims reviewed were Provider claims. At the completion of the appeal process, the Company reprocessed and paid two claims that had been denied in error. The Company failed to pay the correct interest on two (15%) of 13 Provider claims reviewed. See PF # 047.

Subsequent Events

At the conclusion of the examination review, the Company paid the interest related to two claims cited above, for total interest restitution of $1.72.

3. The Examiners reviewed 11 Student Health Dental paid claims provided by the Company in response to REQ093. Ten of the 11 Student Health paid dental claims were Provider claims. The Company failed to pay the correct interest on claims, as follows:

[2] The Examiners issued PF # 011, which is discussed in detail under Standard 5 of this Report.

a. The Company underpaid the interest on seven (70.0%) of 10 Provider claims reviewed. See PF # 034

b. The Company overpaid the interest on one (10.0%) of 10 Provider claims reviewed. See PF # 034.

Subsequent Events

At the conclusion of the examination review, the Company paid the interest related to seven claims cited above, for total interest restitution of $43.18.

Summary of Findings – Interest Payments on Provider Claims

Description	Population	Sample Size	Provider Claims Reviewed	Exceptions	Error Ratio	PF #
Student Health Chiropractic denied	129	129	129	49	38%	033
Student Health Medical NMN denied	25	24	13	2	15%	047
Student Health Dental denied	11	11	10	8	80%	034
Totals	**165**	**165**	**152**	**59**	**39%**	

A 39% error ratio does not meet the standard; therefore recommendations are warranted.

EXAMINATION FINDINGS – FAILED STANDARD 18

Based on the Examiners' review of the Company's appeals handling procedures, as well as selected samples of appeal files and documents used by the Company to advise the member and the member's treating provider of the member's rights of appeal, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
18	**(Health Insurance Only).** The Company provides timely appeals from denied claims and/or denied services and provides appropriate and timely acknowledgments, responses, and notices throughout the appeal process.	A.R.S. §§ 20-2530, *et seq.*

Appeal Rights Notices

The Examiners reviewed various documents used by the Company during the issuance of policies and claims processing for notifying the member and the member's treating provider of the right to appeal a denied claim. The Company failed Standard 18 as follows:

1. The Examiners reviewed certain plan documents provided by the Company in response to the Coordinator's Handbook and for use with reviewing samples of appeals and claims processed during the examination period. The Company issued and distributed to members the following plan documents that appear to supersede the Appeal Information Packet required by A.R.S. § 20-2533(C). In some cases the Company provides several documents to each member that contain contradictory and inconsistent information about the member's appeal rights. The Examiners identified the following nonconforming plan documents:
   a. Form # GR-9N-Appeals 01-01-01 (Dental insurance and AARP medical insurance). See PF # 025, # 027 and # 055.
   b. Form # GR-9N-GM Appeals 01-01 01 (Group Retiree Booklet-Certificates). See PF # 029.
   c. Form # GR-9N-Appeals 01-01-01AZ) for Group Policy No. GP-123456 (SRC). See PF # 031.
   d. Forms # GR-11698-1- Ed. 9/05 and #GR-11698-dental Ed. 2/08. (Dental – DE Trust). See PF # 028.
   e. Forms # GR-11697-R Ed. 03/08 and # GR-11697-LME Ed. 03/06 (Individual – DE Trust). See PF # 030.

f. Form # GR-9N-Appeals 01/06/01, Form ERISA - Trust (Health), Form Gen Fund form DE-F, Rev1_06.12.07 See PF # 055.

g. 13 Student Health Brochures. See PF # 032.

The plan documents enumerated above contain some or all of the following examples of misstatements of appeal rights. The list is not exhaustive of the noncomplying language found in these documents, but represents the most frequently identified misstatements:

a. Requiring the first-level appeal to be in writing, which is inconsistent with A.R.S. §20-2535(A).

b. Stating that there are two levels of appeal (some documents state that there may be only one level of appeal), which is inconsistent with A.R.S. § 20-2533(B).

c. Limiting the time period for filing a first-level appeal to 180 days, which is inconsistent with A.R.S. §§ 20-2535(A) and 20-2536(A).

d. Misstating the time period for resolving an expedited medical review as 36 hours, which is inconsistent with A.R.S. § 20-2534(B).

e. Establishing criteria, including the money value of the claim, to qualify for a formal appeal, which is inconsistent with A.R.S. § 20-2536(A).

f. Establishing criteria for an expedited appeal, including who may file, and misstating the time period for resolution, which is inconsistent with A.R.S. § 20-2537(K).

g. Establishing criteria, including the money value of the claim, to qualify and misstating the procedures for an external independent review, which is inconsistent with A.R.S. § 20-2537(C).

Subsequent Events

At the conclusion of the examination review, the Company revised its Appeal Information Packet and student health brochures to correct the misstatements regarding appeal rights. [EXAMINERS' NOTE: The corrective action documents supplied by the Company at the conclusion of the examination are silent as to whether these revisions have been filed with the Department for approval, as required by A.R.S. § 20-2533(C). Such filings should occur through the Department's normal procedures and submission of these documents to the Market Oversight Division does not constitute compliance with this requirement.]

2. The Examiners reviewed claim samples provided by the Company for various lines of business. Within the claim files, the Examiners identified 14 separate EOB forms and four claim denial letters used by the Company during the examination period in the processing of claims:

EOB Form Number	EOB Form Number
AZ DD202 (06-07)	M-TRA-AZ-Key-***
AZ-AGB-***	M-TRA-AZ-Nat-***
AZ-Key***	M-TRA-AZ-Nat-*** (Spanish)
AZ-Sma-***	M-TRA-AZ-Sma-***
M-CHI-AZ-CHI-***	P2438021007
M-TRA-AZ-***-Alb	P2438021008
M-TRA-AZ-CT-Nat-***	Version Date: 3/25/05 AZ

The Company also used claim denial letters that did not contain a form number for reference herein. The denial letters and the EOB forms enumerated above contain notices of the student's appeal rights. These forms include misstatements related to the right to appeal a denied claim decision as prescribed by Arizona law. See PFs # 032, #039, and # 072. Misstatements of appeal rights in the forms include, but are not limited to:

a. Requiring the first-level appeal to be in writing, which is inconsistent with A.R.S. §20-2535(A).

b. Stating that there are two levels of appeal, which is inconsistent with A.R.S. § 20-2533(B).

c. Limiting the time period for filing a first-level appeal to 180 days, which is inconsistent with A.R.S. §§ 20-2535(A) and 20-2536(A).

d. Indicating that a plan may afford only a single appeal, which is inconsistent with A.R.S. § 20-2533(A).

e. A statement that the final determination for a first-level appeal will be sent within 60 days, which is inconsistent with A.R.S. § 20-2535(D).

f. A statement that "A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative," which is inconsistent with A.R.S. § 20-2535(D).

3. The Examiners reviewed claim samples provided by the Company for various lines of business. Within the claim files, the Examiners identified 16 plan documents used by the Company during the examination period that instructed the member to file an appeal with a state (other than Arizona) rather than filing the appeal with the Company, which is inconsistent with A.R.S. § 20-2533(F). See PF # 056.

ADOI FILE NO.	PLAN NO.	WHERE TO FILE AN APPEAL FOR AN ADVERSE BENEFIT DETERMINATION
A-SGMD-PX-024	SG-16	Maryland Insurance Commissioner
A-SGMD-SR-010	SG-41	File a complaint or appeal with the Office of the Insurance Commissioner
A-SGMD-SR-011	SG-16	Maryland Insurance Commissioner.
A-LGMCD-SR-031	870600	New York State Department of Insurance
A-LGMCD-SR-033	621337	New Jersey Department of Banking & Insurance
A-LGMCD-SR-043	803202	Texas Department of Insurance
A-LGMCD-PB-013	299132	U. S. State's Department of Insurance
A-LGMCD-PB-023	814031	New York State Department of Insurance
A-LGMCD-PB-044	658720	Nevada Office for Consumer Health Assistance
SRC-DC-NACE-021	382250	Texas Department of Insurance
SRC-DC-NACE-052	500212	Maryland Insurance Commissioner
SRC-DC-PX-011	500212	Maryland Insurance Commissioner
SRC-DC-PX-016	801365	Missouri Department of Insurance
SRC-DC-PX-025	384006	Department of Insurance, Columbus, Ohio
SRC-DC-NB-020	500212	Maryland Insurance Commissioner
SRC-DC-NB-034	800126	Department of Insurance, Columbus, Ohio

4. The Examiners reviewed appeal samples provided by the Company for various lines of business. Within the appeal files, the Examiners identified three separate forms used by the Company during the examination period in the processing of appeals:

ADOI File Number	Description
A-A-BL-016	Attachment to acknowledgment letter
A-A-PP-006	Attachment (Form Gen F)
A-A-PP-043	Attachment DE-F – Rev1_06.12.07

The plan documents enumerated above contain some or all of the following examples of misstatements of appeal rights. These forms include misstatements related to the right to appeal a denied claim decision as prescribed by Arizona law. See PF # 055. Misstatements of appeal rights in enumerated forms include, but are not limited to:

a. Stating that there are two levels of appeal, which is inconsistent with A.R.S. § 20-2533(B).

b. Limiting the time period for filing a first-level appeal to 180 days, which is inconsistent with A.R.S. §§ 20-2535(A) and 20-2536(A).

c. Failing to provide the required notice of the right to proceed to an external independent review at the end of the appeal process, which is inconsistent with A.R.S. §§ 20-2535(F) and 20-2536(G).

The Company has failed Standard 18 in apparent violation of A.R.S. § 20-2533(C), as well as numerous provisions of A.R.S. §§ 20-2530, *et seq.*, by issuing and distributing notices of appeal rights that are inconsistent the Company's approved Appeal Information Packet and that misstate numerous provisions of Arizona appeal laws.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

Appeal Procedures

The Examiners reviewed the Company appeal procedures, Appeal Information Packet, and various samples of claim and appeal files to determine whether the Company complies with A.R.S. §§ 20-2530, *et seq*. The Company failed Standard 18 as follows:

Failing to Allow a Member's Appeal by the Treating Provider

The Examiners reviewed a sample of 24 Student Health claims that were denied as not medically necessary. Four of the claims were for the same insured and received from the same treating provider for dates of service from July 1, 2008, through December 22, 2008. The denial of these claims shifted the burden for the cost of treatment onto the member, not the provider. On April 6, 2010, the Company received an appeal from the treating provider for reconsideration of these denied claims. The Company responded as follows:

> **"Subject: Too Late to Appeal**
> **We did not receive your review request within the allowed time frame.** We are writing in response to your request for a review of our payment decision for the claims reference above. According to state mandates, a claim payment decision review request must be filed within 1 year of the initial claim decision."

The Company disregarded that this was an appeal of a denied claim for which the member became financially responsible and held the provider to the timeframes established in its provider grievance process, per A.R.S. § 20-3102(F). The provider grievance process is intended for the settlement of disputes affecting the provider's burden for treatment costs: "A health care insurer shall establish an internal system for resolving payment disputes and other contractual

grievances with health care providers." Nothing in A.R.S. § 20-3102(F) supersedes the right of a treating provider to appeal a denied claim on behalf of member in accordance with A.R.S. § 20-2530(1):

> 20-2530. Definitions
> For the purposes of this article:
> 1. "Member" means a person who is covered under a health care plan provided by a health care insurer **or that person's treating provider,** parent, legal guardian, surrogate who is authorized to make health care decisions for that person by a power of attorney, a court order or the provisions of section 36-3231, or agent who is an adult and who has the authority to make health care treatment decisions for that person pursuant to a health care power of attorney.

(Emphasis added). A member has two years from the date the claim is denied to file a request for an informal reconsideration. The Company has failed Standard 18, in apparent violation of A.R.S. § 20-2535(A) by failing to allow a member's appeal by a treating provider where the appeal was timely filed within two years of the dates the claims were denied. See PF # 050.

Criteria Used and Clinical Reasons for Upholding the Denial

The Examiners reviewed various denied claim samples provided by the Company during the examination. In appeal documents located within the claim file ADOI File No. A-IMD-SR-021, the Company failed to provide the criteria used and the clinical reasons for upholding the denial of the claim, in apparent violation of A.R.S. § 20-2536(E)(2). See PF # 082.

Subsequent Events

Based upon the Examiners request in Request #175-CLM, the Company provided documentation to show that file A-IMD-SR-021 was reprocessed and a benefit in the amount of $23.91 was applied to the deductible.

Notice of Next Level of Appeal

The Examiners reviewed various denied claim samples provided by the Company during the examination. In appeal documents located within the claim files, the Company failed at the conclusion of the formal appeal, where the Company upheld the denial of the claim, to use a form that advises the member of the right to proceed to an external independent review, in apparent violation of A.R.S. § 20-2536(G).

ADOI File Number	See PF #
A-LGMCD-EL-010	066
A-LGMCD-EL-039	066
A-IMD-SR-021	082

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 20

Based on the Examiners' review of the Company's renewal and cancellation policies and procedures, forms, and selected samples of renewed/in-force as well as canceled/nonrenewed policy files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
20	The Company does not cancel or non-renew coverage except as allowed by law.	(A.R.S. §§ 20-448, 20-1342, 20-1346, 20-1347, 20-1378, 20-1380, 20-1402, 20-1404, 20-1411, 20-2110, 20-2309, 20-2321)

The Examiners' reviewed selected samples of renewed/in-force policy files provided by the Company. The Examiners found that the Company failed Standard 20 by failing at the time of renewing employer group coverage to provide an explanation of the extent to which any increase in premiums is due to actual or expected claims experience of the individuals covered under the employer's health benefits plan, in apparent violation of A.R.S. § 20-2309(A), as follows:

1. Three groups from the sample of 55 Small Group in-force new business files provided by the Company in response to REQ056. See PF # 021.
2. Five groups from the sample of 12 Large Group Medical cancellation files provided by the Company in response to REQ054. See PF # 049.
3. Fourteen groups from the sample of 32 Large Group terminated files provided by the Company in response to REQ066. See PF # 112.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

RECOMMENDATIONS

Within 90 days of the filed date of this Report, the Company should provide documentation that procedures and controls are in place to ensure that:

1. The Company files all health insurance advertising with the Department prior to its use, to comply with A.R.S. § 20-1110(E).
2. All advertisements and marketing materials that describe policy benefits disclose any related exclusions reductions of limitations, including exclusions and limitations for preexisting conditions, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(C)(7) and (9).
3. Advertising and marketing materials do not indicate that individual medical insurance is a low cost alternative to COBRA without providing a complete and accurate comparison of the advantages and disadvantages of each, to comply with A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(1) and (C)(2).
4. All advertising claims regarding the Company's relative position in the insurance industry are supported and documented, to comply with A.R.S. § 20-444(A) and A.A.C. R20-6-201(P).
5. All statistical information used in advertising and marketing materials refers to the source of the statistical information and provides points of reference to enable the consumer to evaluate the impact of the statistics, to comply with A.R.S. § 20-444(A) and A.A.C R20-6-201(F) and (O).
6. All advertising and marketing materials, including testimonials, accurately represent the policy benefits, exclusions and limitations, to comply with A.R.S. §§ 20-443(A)(1) and 20-444(A) and A.A.C. R20-6-201(C)(1), (C)(2) and (C)(10).
7. The Company provides the required notices to group employers in a form that meets the standards established by the statute, to comply with A.R.S. §§ 20-2304(C) and 20-2323(A).
8. All policies provide benefits for chiropractors to be the same as those for other physicians treating the same conditions, to comply with A.R.S. § 20-461(A)(17).
9. All Individual Medical policies express the entire money or other consideration for the coverage to comply with A.R.S. § 20-1342(A)(1).
10. All group certificates of insurance provide in summary form all of the essential features of the coverage, to comply with A.R.S. § 20-1402(A)(2).

11. All policy forms issued in Arizona clearly indicate that claims will not be subrogated, to comply with *Allstate vs. Druke*, 118 Ariz. 301, 576 P.2d 489 (1978).

12. All disclosure authorization forms used for the purpose of collecting information in connection with an application for insurance are limited in effect to no longer than 30 months, to comply with A.R.S. § 20-2106(7)(a).

13. All disclosure authorization forms used in conjunction with the processing of health insurance claims comply with the content requirements of A.R.S. § 20-2106.

14. All employer group certificates of insurance issued under extraterritorial policies include the required notice, to comply with A.R.S. § 20-1401.01.

15. The Company provides a Notice of Insurance Information Practices to the applicant/insured at the time personal information is requested from sources other than the applicant, to comply with A.R.S. § 20-2104(B)(1)(b).

16. The Company provides a Summary of Rights at the time of an adverse underwriting decision, to comply with A.R.S. § 20-2110(A).

17. The Company acknowledges all claims submitted directly by insureds within 10 working days of receipt of the claims, to comply with A.R.S. § 20-461(A)(2) and A.A.C. R20-6-801(E)(1).

18. The Company accepts or denies Insured claims within 15 working days of receipt of acceptable proofs of loss, to comply with A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a).

19. The Company adjudicates all provider claims within 30 days of receipt of a clean claim, to comply with A.R.S. § 20-3102(A).

20. The Company provides a reasonable explanation for the denial of a claim, to comply with A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

21. The Company pays and denies benefits in accordance with the terms of the policy, the certificate of insurance, and all marketing items related to the coverage, to comply with A.R.S. § 20-461(A)(1) and (9) and A.A.C. R20-6-801(D)(1).

22. The Company performs an adequate investigation of claims prior to denying the claim, to comply with A.R.S. §§ 20-461(A)(3) and (4) and 20-3102(B), and A.A.C. R20-6-801(F).

23. The Company pays interest at the legal rate from the date of receipt of the claim for all Insured claims not paid within 30 days of receipt of acceptable proofs of loss, to comply with A.R.S. § 20-462(A).

24. The Company pays interest at the legal rate from the date the claim should have been paid on all clean Provider claims not paid within 30 days of the adjudication date, or within 60 days of receipt of the clean claim, which is sooner, to comply with A.R.S. § 20-3102.

25. All policy forms, including amendments and riders, EOB forms, advertising forms, and/or correspondence provide an appropriate notice of the right to appeal a denied claim, to comply with A.R.S. § 20-2533(D).

26. The Company allows appeals on behalf of the member by the treating provider, to comply with A.R.S. § 20-2535(A), as defined by A.R.S. § 20-2530(1).

27. The Company provides the criteria used and clinical reasons for all appeal decisions to comply with A.R.S. §§ 20-2535(E) and 20-2536(E).

28. The Company provides the notice of the next level of review and the right to proceed to an external independent review at the conclusion of all appeals where the claim denial is upheld, to comply with A.R.S. §§ 20-2535(F) and 20-2536(G).

29. The Company provides renewing employer groups with an explanation as to the extent to which premium increases at renewal are due to actual or expected claims experience of the individuals covered under the health benefits plan, to comply with A.R.S. § 20-2309(A).

SUMMARY OF STANDARDS

A. Operations and Management

#	STANDARD	PASS	FAIL
1	Company maintains adequate records and produces records in a timely manner as required by the Examiners for the completion of the market conduct examination. (A.R.S. § 20-157 and A.A.C. R20-6-801)	X	

B. Advertising, Marketing, and Sales

#	STANDARD	PASS	FAIL
2	All advertising and sales materials are in compliance with applicable statutes and rules. (A.R.S. §§ 20-442, 20-443, 20-444, 20-1137, and A.A.C. R20-6-201, R20-6-201.01, and R20-6-202)		X
3	The Company markets its products in a fair and nondiscriminatory manner to all eligible individuals and/or groups. (A.R.S. §§ 20-448, 20-2313)	X	
4	The Company discloses information concerning the provisions of coverage, the benefits and the premiums available to small group employers as part of sales materials for its small group employers. (A.R.S. § 20-2304)		X

C. Policy Forms

#	STANDARD	PASS	FAIL
5	Policy forms, including but not limited to contracts, certificates, applications, riders, and endorsements, comply with pertinent Arizona laws and/or the laws of the state where the policy was issued. (A.R.S. §§ 20-1342, *et al.*, including but not limited to A.R.S. § 20-1401.01; 20-2301, *et seq.*, and A.A.C. R20-6-1205)		X
6	Individual insurance policy forms, except those for which no renewal is provided, contain a 10-day free look provision, which is prominently displayed on the first page of the policy. (A.A.C. R20-6-501)	X	

D. Underwriting/Portability/Guaranteed Issue

#	STANDARD	PASS	FAIL
7	The Company issues coverage to all eligible groups and individuals. (A.R.S. §§ 20-1378, 20-1379, 20-2304, 20-2307, 20-2313, 20-2324)	X	
8	The Company provides approved disclosure of information forms to all group employers prior to executing a contract for coverage under a health care plan. (A.R.S. § 20-2323)		X
9	The Company does not impose exclusions or limitations for preexisting conditions except as permitted by law. (A.R.S. §§ 20-1379, 20-2308, 20-2310, 20-2321)	X	
10	The Company obtains prior written consent, using approved consent forms, before conducting tests for HIV or genetic disorders. (A.R.S. §§ 20-448.01, 20-448.02, and A.A.C. R20-6-1203)	X	
11	The Company does not disclose HIV-related information without first obtaining a written release executed by the individual or his/her designated representative. (A.R.S. § 20-448.01 and A.A.C. R20-6-1204)	X	
12	The Company complies with all notice of insurance information and privacy requirements. (A.R.S. §§ 20-2102, *et seq.*)		X

E. Claims Processing

#	STANDARD	PASS	FAIL
13	Claims are handled timely and appropriately in accordance with policy provisions and applicable statutes and rules. (A.R.S. §§ 20-461, 20-462, and 20-1215, and A.A.C. R20-6-801)		X
14	Claim files are adequately documented in order to be able to reconstruct pertinent events of the claim. (A.R.S. § 20-157(A) and A.A.C. R20-6-801)	X	
15	All claim forms contain an appropriate fraud warning. (A.R.S. § 20-466.03)	X	
16	The Company provides accurate benefits information to claimants and does not misstate pertinent provisions of the policy or Arizona law. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	

F. Policyholder Services

#	STANDARD	PASS	FAIL
17	The Company takes adequate steps to finalize and dispose of the complaints in accordance with policy provisions and applicable statutes and rules. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
18	**(Health Insurance Only).** The Company provides timely appeals from denied claims and/or denied services and provides appropriate and timely acknowledgments, responses, and notices throughout the appeal process. (A.R.S. §§ 20-2530, *et seq.*)		X

G. Cancellation, Non-Renewals, and Rescissions

#	STANDARD	PASS	FAIL
19	The Company affords adequate grace periods without cancellation of coverage for the receipt of premiums as required by law. (A.R.S. §§ 20-191, 20-1203, and 20-1347)	X	
20	The Company does not cancel, non-renew, or rescind coverage except as allowed by law (A.R.S. §§ 20-448, 20-1204, 20-1213, 20-1342, 20-1346, 20-1347, 20-1378, 20-1380, 20-1402, 20-1404, 20-1411, 20-2110, 20-2309, 20-2321)		X
21	**(Life Insurance)** The Company's contracts and applications contain appropriate notices concerning the right to return the policy/contract for a full refund of premiums. A.R.S. § 20-1233(A), (B), and (C).	X	
22	**(Life Insurance)** Company handling of requests for refunds using the "Free Look" option, or the 30 day option if the application involved replacement of existing coverage are in compliance with applicable statutes, rules and regulations. A.R.S. §§ 20-1233(A) & (B), 20-1241.05(E) and 20-1241.07(B)	X	

H. Nonforfeiture, Dividends, Loans

#	STANDARD	PASS	FAIL
23	**(Life Insurance)** The Company complies with pertinent Arizona law regarding nonforfeiture, dividends and/or policy loans. (A.R.S. §§ 20-1207 through 20-1212, and 20-1231 through 20-1232)	X	

I. Replacements

#	STANDARD	PASS	FAIL
24	**(Life Insurance)** Company internal policies and procedure, forms and materials regarding replacement of existing coverage are in compliance with applicable statutes, rules and regulations. A.R.S. §§ 20-1241, *et seq.*	X	