REPORT OF TARGETED MARKET CONDUCT EXAMINATION

OF

TIME INSURANCE COMPANY

NAIC# 69477

AS OF

JUNE 30, 2008

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Department of Insurance
State of Arizona
Market Oversight Division
Examinations Section
Telephone: (602) 364-4994
Fax: (602) 364-4998

JANICE K. BREWER
Governor

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
www.azinsurance.gov

CHRISTINA URIAS
Director of Insurance

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

Dear Director Urias:

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:

TIME INSURANCE COMPANY

NAIC # 69477

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; and Sondra Faye Davis, Market Conduct Examiner.

The examination covered the period of July 1, 2005, through June 30, 2008.

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, and Sondra Faye Davis, Market Conduct Examiner, the examination of Time 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 May, 2010.

Vanessa Farias

Notary Public

My Commission Expires 4.21.2012

OFFICIAL SEAL
VANESSA L. FARIAS
NOTARY PUBLIC - State of Arizona
MARICOPA COUNTY
My Comm. Expires April 21, 2012

FOREWORD

This targeted market examination of Time Insurance Company ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent examiners contracting with the Department. A targeted market 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.

During Part 1, the examination consisted of a review of the following components of the Company's major medical health insurance business:

1. The Company conducts a reasonable and timely investigation before denial of claims, and
2. The Company has appropriate procedures in place to identify and correct errors in its claim processing system.

At the conclusion of Part 1, this market conduct examination was expanded (Part 2) to include 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.

This Report of Examination ("Report") includes the findings from both Part 1 and Part 2, along with the standards of review for each.

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. Part 1 of the targeted market conduct examination of the Company covered the period from July 1, 2005 through June 30, 2006 for the lines of business reviewed. Part 2 of the targeted market conduct examination of the Company covered the period from July 1, 2005 through June 30, 2008. 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. This examination was completed by applying tests to each examination standard to determine compliance with the standard. The standards applied during Part 1 of the examination are stated in this Report at page 19. The standards applied during Part 2 of the examination are stated in this Report at page 58.

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 utilized both examination-by-test and examination-by-sample. Examination by test involves 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, examinations by test and by sample were completed as to those populations without the need to utilize computer software.

File sampling was based in part on statistical analysis of raw systems 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, Amy Jo Jones, Director, Market Conduct. 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.

On February 11, 2004, the Company (formerly called Fortis Insurance Company) entered into a Consent Order, Docket No. 04A-026-INS ("the Consent Order'), wherein the Company agreed to cease and desist certain business practices found to have violated Arizona insurance laws.

PART 1: HEALTHCARE DENIED CLAIMS MARKET CONDUCT EXAMINATION

Examination Period July 1, 2005, through June 30, 2006

EXECUTIVE SUMMARY

This examination was completed 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 19, and the examination findings are reported beginning on page 6.

1. The Company failed Standard No. 1 in 22 (12%) of 190 denied claims reviewed in three samples, in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F) by failing to conduct a timely and reasonable investigation of claims before denying claims.
2. The Company failed Standard No. 2 in 49 (18%) of 272 denied claims reviewed in four samples, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a) by failing to provide a reasonable explanation for the denial of claims in sufficient detail to allow members and providers to appeal an adverse decision.
3. The Company failed Standard No.2, in apparent violation of A.R.S. § 20-461(A)(17) by utilizing policy forms containing exclusions for treatment provided by chiropractic physicians.
4. The Company failed Standard No. 2, in apparent violation of A.R.S. § 20-461(A)(1) and A(15) by failing with regard to four Explanation of Benefits (EOB) forms reviewed, to:
   a. Prominently display appeal information; and
   b. Provide proper time frames for appeal.
5. The Company failed Standard No. 3 in apparent violation of A.R.S. § 20-461(A)(1) by failing, on first party claims not paid within 30 days after the receipt of an acceptable proof of loss by the insurer which contained all information necessary for claim adjudication, to pay interest at the legal rate from the date that the claim was received by the insurer.

PROCEDURES PERFORMED

The Examiners reviewed the Company's appeal policies and procedures, claims manuals, training manuals, and responses to interrogatories in preparation for the file reviews to be conducted.

The Examiners reviewed a sample of 56 claims-related requests for reconsideration selected from the Company's appeal log containing a population of 118 appeals. No trends of overturned denials related to similar procedural codes (CPT-4, HCPCS, etc.) or Explanation of Benefits (EOB) messages were noted during the review of files selected from the appeal log.

The Company provided a population of 69,923 claims denied during the examination period. Using CPT codes and EOB codes identified during the review of denied claim populations, the Examiners extracted a subpopulation of 8,094 denied claims in 11 categories based on the reasons given for the denial. During the Phase I review, the Examiners selected 11 random samples totaling 285 files based on the categories of denial codes reasons identified during the claims analysis. Based on the results from the Phase I examination, the Department initiated a Phase II examination of four of the categories of denial reason codes and selected four additional samples totaling 220 denied claims for review. One sample of 55 files was selected from the subpopulation of claims denied as "excluded" and this sample was reviewed under Standards 1 and 2. A second Phase II sample of 55 files was selected from the subpopulation of claims denied as "no maternity benefits" and this sample was reviewed under Standards 1 and 2. A third Phase II sample of 55 files was selected from the subpopulation of claims denied as "not covered" and this sample was reviewed under Standards 1 and 2. A fourth Phase II sample of 55 files was selected from the subpopulation of claims denied for "ambulance services" and this sample was reviewed under Standards 1 and 2. Therefore, a total of 505 files were reviewed during the Phase I and Phase II examinations.

EXAMINATION FINDINGS – FAILED STANDARD 1

Based on the Examiners' review of the Company's denied health care claims and EOB forms, the Company failed to meet the following standard for review with regard to:

1. Claims denied using Reason code 0371;
2. Claims denied using Reason code 0136;
3. Claims denied using Reason codes 0005, 0514, and 0529.

#	STANDARD	Regulatory Authority
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation.	A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F))

Claims Denied Using Reason Codes 0203, 0371, 0378, 0497, 0509, 0510, 0619, 0663 and 0664

Of the 11 categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 82 (3%) files from a subpopulation of 2,906 files denied using one or more of the following 9 reason codes indicating the claim was denied as "not covered" under the policy. The Company failed to meet the standard for claims denied using Reason codes 0203, 0371, 0378, 0497, 0509, 0510, 0619, 0663 and 0664 as follows:

Seven (9%) of 82 claims in this samples were denied using Reason code 0371, which states: "This condition is not covered. Please refer to the special exception rider attached to your policy." These seven claims files failed Standard 1 because the Company failed to conduct a reasonable investigation prior to the denial of claims in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C R20-6-801(F)). Reference PF # 003 and PF # 019.

Subsequent Events

Two claims denied using Reason code 0371 were reprocessed by the Company prior to this examination. This information was provided to the Department by the Examiners.

Claims Denied Using Reason Code 0136

Of the 11 categories of denied claims, the Examiners selected a sample of 26 (100%) from a subpopulation of 26 files denied using Reason code 0136 indicating the claim was denied

for the following reason: "Your policy does not contain a maternity benefit; therefore, no coverage is available for newborn expense." The Company failed to meet the standard for claims denied using Reason codes 0136 as follows:

Eight (31%) of 26 claims denied using Reason code 0136 failed Standard 1 because the Company failed to conduct a reasonable investigation prior to the denial of claims in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C R20-6-801(F). Reference PF # 007. The Company also appears to have violated the Consent Order by using a non-compliant standard for the exclusion of coverage for a newborn.

Subsequent Events

Subsequent to the issuance of Preliminary Findings 007 the Company provided documentation to show that they had reprocessed the eight claims denied using Reason code 0136. This information was provided to the Department by the Examiners.

Claims Denied Using Reason Codes 0005, 0105, 0113, 0120, 0356, 0407, 0422, 0428, 0432, 0498, 0503, 0514, 0521, 0529, 0571 and 0607.

Of the 11 categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 82 (7%) files from a subpopulation of 1,151 files denied using one or more of the following 16 reason codes indicating the claim was denied as "not covered" under the policy. The Company failed to meet the standard for claims denied using Reason codes 0005, 0105, 0113, 0120, 0356, 0407, 0422, 0428, 0432, 0498, 0503, 0514, 0521, 0529, 0571 and 0607 as follows:

Seven (9%) of 82 claims in this sample failed Standard 1 because the Company failed to conduct a reasonable investigation prior to the denial of claims in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C R20-6-801(F)). Reference PF # 017.

- Three of the claims were denied using Reason code 0005 which states: "Benefits are not available for the expense submitted."
- Two of the claims were denied using Reason code 0514 which states: "Eye exams, charges for refractions, eye surgery to correct refractions, glasses, contacts, vision therapy and hearing aids are not covered."

- Two of the claims were denied using Reason code 0529 which states: "Expenses related to the treatment of obesity are not covered."

Subsequent Events

Subsequent to the issuance of Preliminary Findings 017, the Company provided documentation to show that they had reprocessed two of the claims denied using Reason code 0005. One claim denied using Reason code 0005 was reprocessed by the Company prior to this examination. This information was provided to the Department by the Examiners.

Summary of Standard 1 Findings

Denied Reason or CPT-4 Code	Population	Sample	# of Exceptions	Error Ratio	PF Reference
0371	2,906	82	7	9%	003, 019
0136	26	26	8	31%	007
005, 0514, 0529	1,151	82	7	9%	017

Recommendations

Within 90 days of the filed Report, as prescribed by A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), the Company should:

1. Provide documentation that procedures and controls are in place to ensure that the Company conducts timely investigation of claims and does not deny claims without conducting a reasonable investigation;
2. Reprocess the five claim files identified using Preliminary Finding 019 and denied using Reason code 0371, which were denied on the basis that the services were excluded by a Special Exception Rider ("SER") attached to the policy to determine whether these claims were denied inappropriately and without adequate investigation;
3. Perform a self-audit of all claims denied using Reason code 0371 during the three years prior to the date of the Report to determine whether other claims for covered medical conditions which were excluded under SERs have been denied inappropriately and without adequate investigation;
4. Perform a self-audit of all claims denied using Reason code 0136 during the three years prior to the date of the Report to determine whether other claims for

newborn services have been denied inappropriately and without adequate investigation;

5. Perform a self-audit of all claims denied using Reason code 0005 during the three years prior to the date of the Report to determine whether other claims for covered medical conditions have been denied inappropriately and without adequate investigation;
6. Reprocess the two claim files identified in Preliminary Finding 017 and denied using Reason code 0529, where services were denied for treatment of medical conditions other than obesity, to determine whether these claims were denied inappropriately and without adequate investigation;
7. Perform a self-audit of all claims denied using Reason code 0529 during the three years prior to the date of the Report to determine whether other claims denied due to a diagnosis of obesity have been denied inappropriately and without adequate investigation;
8. Reprocess the two claim files identified using Preliminary Finding 017 and denied using Reason code 0514, where services were denied because of an exclusion for refractions, to determine whether these claims were denied inappropriately and without adequate investigation;
9. Perform a self-audit of all claims denied using Reason code 0514 during the three years prior to the date of the Report to determine whether other claims for refractions have been denied inappropriately and without adequate investigation;
10. Pay restitution including interest for any claim identified from the self-audit as having been denied inappropriately; and
11. With each payment of restitution, provide a letter indicating that an audit of claims resulting from an examination by the Arizona Department of Insurance had resulted in the correction of the previous denial.

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of the Company's denied health care claims, policy forms and EOB forms, the Company failed to meet the following standard for review with regard to:

1. Claims denied using Reason code 0497;
2. Claims denied using Reason code 0136;
3. Claims denied using Reason codes 0005, 0113, 0514, 0521, and 0529;
4. One policy form; and
5. Four EOB forms.

#	STANDARD	Regulatory Authority
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision.	A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a)

Claims Denied Using Reason Codes 0203, 0371, 0378, 0497, 0509, 0510, 0619, 0663 and 0664

Of the 11 categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 82 (3%) files from a subpopulation of 2,906 files denied using one or more of the following 9 reason codes indicating the claim was denied as "not covered" under the policy. The Company failed to meet the standard for claims denied using Reason codes 0203, 0371, 0378, 0497, 0509, 0510, 0619, 0663 and 0664 as follows:

Six (7%) of 82 claims in this sample were denied using Reason code 0497, which states: "This is not a covered expense. Please refer to the exclusions section of policy for details." These six claims failed Standard 2 because the Company misrepresented or concealed pertinent facts or policy provisions pertinent to a claim and failed to provide a reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, in apparent violation of A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(G)(1)(a). Reference PF # 002 and PF # 020.

Claims Denied Using Reason Codes 0136

Of the 11 categories of denied claims, the Examiners selected a sample of 26 (100%) from a subpopulation of 26 files denied using Reason code 0136 indicating the claim was denied

for the following reason: "Your policy does not contain a maternity benefit; therefore, no coverage is available for newborn expense." The Company failed to meet the standard for claims denied using Reason codes 0136 as follows:

Eighteen (69%) of 26 claims denied using Reason code 0136 failed Standard 2 because the Company misrepresented or concealed pertinent facts or policy provisions pertinent to a claim and failed to provide a reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, in apparent violation of A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(G)(1)(a). Reference PF # 008 Revised. The Company also appears to have violated the Consent Order by using a non-compliant standard for the exclusion of coverage for a newborn.

Claims Denied Using Reason Codes 0005, 0105, 0113, 0120, 0356, 0407, 0422, 0428, 0432, 0498, 0503, 0514, 0521, 0529, 0571 and 0607

Of the 11 categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 82 (7%) files from a subpopulation of 1,151 files denied using one or more of the following 16 reason codes indicating the claim was denied as "not covered" under the policy. The Company failed to meet the standard for claims denied using Reason codes 0005, 0105, 0113, 0120, 0356, 0407, 0422, 0428, 0432, 0498, 0503, 0514, 0521, 0529, 0571 and 0607 as follows:

Twelve (15%) of 82 claims in this sample failed Standard 2 because the Company misrepresented or concealed pertinent facts or policy provisions pertinent to a claim and failed to provide a reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, in apparent violation of A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(G)(1)(a). Reference PF # 009 and PF # 018.

- Two claims were denied using Reason code 0514 which states: "Eye exams, charges for refractions, eye surgery to correct refractions, glasses, contacts, vision therapy and hearing aids are not covered."
- Eight claims were denied under Reason code 0113 which states "This type of medical supply/equipment is not covered."
- Two claims were denied using Reason code 0529, which states: "Expenses related to the treatment of obesity are not covered."

Policy Forms

As a result of the review of the policy forms utilized by the Company during the examination period the Examiners identified an apparent violation of Standard 2. The Company failed to meet the standard for policy form No. 244 issued in Arizona as follows:

Policy form No. 244 contained an exclusion for services or treatment provided by a chiropractor, which is expressly prohibited by A.R.S. § 20-461(A)(17). By denying claims under a policy exclusion, which is prohibited by statute, the company misstated pertinent Arizona law related to discrimination against chiropractors and has failed to provide a reasonable explanation for the denial of the claim in sufficient detail to allow members and providers to appeal the adverse decision. PF # 002.

EOB Forms

As a result of the review of the EOB forms issued by the Company during the examination period the Examiners identified apparent violations of Standard 2. The Company failed to meet the standard for appeal messages on four EOB forms issued on denied Arizona claims because the forms:

- Failed to prominently display the appeal information in apparent violation of A.R.S. § 20-2533(D);
- Failed to provide appeal procedures, although they indicate procedures are provided, in apparent violation of A.R.S. § 20-2533(D); and
- Provided erroneous information about the time allowed for filing a claim in apparent violation of A.R.S. § 20-2535(A). Reference PF # 013.

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

Summary of Standard 2 Findings

Denied Reason or CPT-4 Codes	Population	Sample	# of Exceptions	Error Ratio	PF Reference
0497	2,906	82	6	7%	002, 020
0136	26	26	18	69%	008
005, 0514, 0113, 0529	1,151	82	25	30%	009, 018
Policy Forms	NA	NA	1	NA	002
EOB Forms	NA	NA	4	NA	013

Recommendations

Within 90 days of the filed Report, as prescribed by A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(D)(1) and (G)(1)(a), the Company should:

1. Provide documentation that procedures and controls are in place to ensure that the Company does not misrepresent or conceal pertinent facts or policy provisions pertinent to a claim and provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision;
2. Reprocess the 13 claim files identified in Preliminary Finding 014 and denied using Reason Code 0020, where services were denied for treatment of newborn expenses, to determine whether these claims were denied inappropriately and without adequate investigation, to comply with A.R.S. § 20-1342(A)(3);
3. Reprocess the 18 claim files identified in Preliminary Finding 008 Revised and denied using Reason Code 0020, where services were denied for the treatment of newborn expenses, to determine whether these claims were denied inappropriately and without adequate investigation, to comply with A.R.S. § 20-1342(A)(3);
4. Perform a self-audit of all claims denied using Reason code 0020 during the three years prior to the date of the Report to determine whether other claims for newborn expense have been denied inappropriately and without adequate investigation, to comply with A.R.S. § 20-1342(A)(3);
5. Provide documentation that the exclusions for newborn children in the absence of maternity benefits have been removed from policy forms 225 and 244 to comply with A.R.S. § 20-1342(A)(3);
6. Provide documentation that the chiropractic exclusion which discriminates against chiropractors and which is prohibited by statute has been removed from policy form 244 to comply with A.R.S. § 20-461(A)(17);
7. Perform a self-audit of all claims denied using Reason code 0497 and policy form 244 during the three years prior to the date of the Report to determine whether other claims for chiropractic services have been denied inappropriately and without adequate investigation, to comply with A.R.S. § 20-461(A)(17);

8. Provide documentation that EOB messages have been modified to prominently display appeal information to comply with A.R.S. § 20-2533(D); and

9. Provide documentation that EOB messages have been modified to provide appeal information when the EOB states that appeal information is provided to comply with A.R.S. § 20-2533(D); and

10. Provide documentation that EOB messages have been modified to Correctly state information about the time allowed for filing a claim to comply with A.R.S. § 20-2535(A).

EXAMINATION FINDINGS – FAILED STANDARD 3

Based on the Examiners' review of the information provided by the Company in response to Attachment B-Interrogatories, the Company failed, with regard to claims paid to insured's, to meet the following standard for review:

#	STANDARD	Regulatory Authority
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims.	A.R.S. § 20-462(A)

The Company failed to meet the standard for claims paid to insured's as follows:

The Company's response to request B.13. stated as follows:

> We currently follow the guidelines below for Arizona.
> Interest and Penalty Requirements
> - 10% per year (This is based on the legal rate, unless a different rate is contracted in writing). The 2004 rate currently is being applied and will be updated as necessary.
> - Interest accrues from the date that payment is due to the date that payment is ultimately made.
> - We are only required to pay interest to the provider in AZ. Therefore, interest will not be paid to the insured if they reside in AZ.

Based on information provided by the Company, the Company failed Standard 3 by failing, on first party claims not paid within 30 days after the receipt of an acceptable proof of loss by the insurer which contained all information necessary for claim adjudication, to have procedures in place to pay interest at the legal rate form the date the claim was received by the insurer. Reference PF # 001

Recommendations

The Examiners recommend that, to comply with A.R.S. § 20-462(A), the Company, within 90 days of the filed Report, should:

1. Provide documentation that the Company has appropriate policies and procedures in place for the payment of interest at the legal rate of 10% per annum on all claims submitted by an insured whenever such claims are paid more than 30 days after receipt of adequate proofs of loss, as prescribed by A.R.S. § 20-462(A);
2. Perform a self-audit of all insured-submitted claims paid during the three years prior to the date of the Report, to determine if interest was paid on claims not paid within 30 days after receipt of adequate proofs of loss;
3. Pay interest at the legal rate of 10% per annum from the date that the claim was received until the date that the claim was paid for any claim identified from the

self-audit as not having been paid within 30 days of receipt of an acceptable proof of loss; and

4. With each payment of interest, provide a letter indicating that an audit of claims following an examination by the Arizona Department of Insurance had resulted in the identification of claims were interest was owed.

SUMMARY OF PART 1 STANDARDS

#	STANDARD FOR REVIEW	PASS	FAIL
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation, per A.R.S. §§ 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).		X
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, per A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801.		X
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims, per A.R.S. § 20-462(A).		X

PART 2: EXPANDED MARKET CONDUCT EXAMINATION

Examination Period July 1, 2005, through June 30 2008

EXECUTIVE SUMMARY

This examination was completed 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 58, and the examination findings are reported beginning on page 25.

1. The Company failed Standard 1 in apparent violation of A.R.S. § 20-444 and R20-6-201 with regard to 86 of 187 advertising pieces reviewed, including print ads, direct sales scripts, and television ads.
2. The Company failed Standard 2 in apparent violation of A.R.S. § 20-448(B) by using advertisements and issuing policies that offer to forego rate increases for new insureds for up to 36 months without offering the same rate structure to existing insureds of the same class and of essentially the same hazard.
3. The Company failed Standard 4 by using policy forms that failed to comply with pertinent Arizona laws, as follows:
    a. Failed to provide the required notice on certificates of coverage for policies issued in states other than Arizona, in apparent violation of A.R.S. § 20-1401.01;
    b. Failed to provide the required newborn coverage on group policy certificate of coverage in apparent violation of A.R.S. § 20-1402(A)(2) and the Consent Order; and
    c. Included subrogation language in group certificates, in apparent violation of the prohibition established by *Allstate Ins. Co. v. Druke*, 118 Ariz. 301, 576 P.2d 489 (1978).
4. The Company failed Standard 6, in apparent violation of A.R.S. § 20-1379(L) because the Company:
    a. Failed to issue certificates of creditable coverage at the time coverage was terminated; or
    b. Issued certificates of creditable coverage that failed to comply with the statutory requirements.

5. The Company failed Standard 6 in apparent violation of A.R.S. § 20-1377(E) by failing to give pre-existing condition credit earned when replacing existing "Assurant" policies.

6. The Company failed Standard 7 in apparent violation of A.R.S. § 20-2323(A) by failing to provide the required disclosure forms to employers and certificate holders.

7. The Company failed Standard 9 in apparent violation of A.R.S. § 20-448.01 and A.A.C. R20-6-1204 by using unapproved disclosure authorization forms, which authorize the release of HIV diagnosis and treatment information, but which fail to provide all of the information required for such a release.

8. The Company failed Standard 10 in apparent violation of A.R.S. §§ 20-2101, *et seq.*, by

   a. Failing to provide a document that satisfies the requirement for a full Notice of Insurance Information Practices document, in apparent violation of A.R.S. § 20-2104(C);

   b. Failing to provide a copy of the Notice of Insurance Information Practices prior to obtaining personal information from a third party, in apparent violation of A.R.S. § 20-2104(B)(1)(b);

   c. Using pre-screening questions to determine eligibility to complete an application without providing a Summary of Rights to individuals not permitted to proceed with the application process, in apparent violation of A.R.S. § 20-2110(A) and (D) and the Consent Order;

   d. Failing to provide the reason(s) for an adverse underwriting decision and a Summary of Rights to individuals who completed an application, in apparent violation of A.R.S. § 20-2110(A) and/or (D) and the Consent Order.

   e. Using disclosure authorization provisions on its applications that failed to comply with the "no more than" 30-month limit prescribed by law, in apparent violation of A.R.S. § 20-2106(7)(a) and the Consent Order.

9. The Company failed Standard 11 with regard to claims handling, by:

a. Failing to adjudicate 45 (51%) of 88 Short Term Medical Denied claims within 30 days of receipt of a clean claim, in apparent violation of A.R.S. § 20-3102(A) and/or (B) and the Consent Order;

b. Failing to refund moneys received by subrogation in a timely manner, in apparent violation of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(G)(3);

c. Failing to pay interest on Short Term Medical Paid claims not paid within 30 days of receipt of a clean claim, in apparent violation of A.R.S. § 20-3102(A);

d. Failing to provide an adequate reason for the denial of a claim in sufficient detail to allow the claimant to prepare a meaningful appeal, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

10. The Company failed Standard 14 with regard to claims handling by:

a. Misclassifying covered benefits as "ineligible charges" in apparent violation of A.R.S. §461(A)(1) and A.A.C. R20-6-801(D)(1);

b. Used letters, forms, claim payment checks, and Explanation of Benefits ("EOB") forms using the name "Assurant Health" and which failed to identify the issuing carrier as Time Insurance Company, in apparent violation of A.R.S. § 20-461(A)(1).

11. The Company failed Standard 16 with regard to appeal handling and notices of appeal rights, as follows:

a. Used group certificate forms that misstated the time period for filing a first level appeal, in apparent violation of A.R.S. §§ 20-2535(A) and/or 20-2536(A);

b. Misstated in notices of denied claims and in letters upholding first level appeals that the second level appeal was the final level of review, in apparent violation of A.R.S. §§ 20-2536(G) and 20-2537;

c. Failed to send acknowledgments to appeals within five business days, in apparent violation of A.R.S. §§ 20-2535(B) or 20-2536(B) and the Consent Order;

d. Failed to resolve the appeal within the time period prescribed by law, in apparent violation of A.R.S. §§ 20-2535(D) or 20-2536(E)(2).

12. The Company failed Standard 17 in apparent violation of A.R.S. § 20-191(A) and (B) because the Company failed to give credit for premium payments as of the date that they were deposited in the United States mail or as of the date of registration or certification as established by the United States mail.

13. The Company failed Standard 18 with regard to 11 (15%) of 73 Individual New Business Rescission files reviewed, in apparent violation of A.R.S. §§ 20-1345 and 20-1346, by:

    a. Rescinding eight policies based on medical history information that was not a part of the application record, and therefore was not certified as true and correct by the applicant; and

    b. Rescinding three policies that were issued based on applications completed by a Company employee via telephone interview without obtaining a signed application and/or Acceptance of Offer and Attestation form and without offering the applicant the opportunity to review and approve the application's contents.

14. The Company passed Standards 3, 5, 8, 12, 13, and 15.

EXAMINATION FINDINGS – FAILED STANDARD 1

Based on the Examiners' review of the Company's individual major medical print advertising, TV media advertising and direct sales scripts, short term medical print advertising and group major medical print advertising, the Company failed to meet the following standard for review:

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

Individual Major Medical Advertising

The Examiners reviewed 136 print advertisements, 15 direct sales scripts and 15 TV media advertisements and found apparent violations of Standard 1 as described below. Based on the Examiners' review of the Company's print and media advertising and direct sales scripts, the Company failed to meet Standard 1 for review with regard to:

1. Print advertising;
2. Direct sales scripts; and
3. TV media advertising.

Print Advertising

The Examiners selected advertising samples during the examination totaling 136 (63%) of 217 individual major medical and short term major medical print advertisements utilized by the Company during the examination period.

The Company utilized 56 advertisements that contained statements:

1. Which were misleading in that they implied that short-term medical insurance is a similar product to COBRA, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(1) and (C)(2).
2. Referenced specific policy benefits but failed to disclose any related exclusions, reductions or limitations, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(7).

3. Referenced specific policy benefits but failed to disclose any exclusion, reduction or limitation applicable to pre-existing conditions, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(9).

4. Which were misleading about the length of time in business and relative position in the insurance industry in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(P).

The Company therefore failed Standard 1 in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(1), (C)(2), (C)(7), (C)(9) and (P) by utilizing print advertisements that referenced specific policy benefits but failed to disclose any exclusion, reduction or limitation applicable to pre-existing conditions and that contained misleading statements in 56 (41%) of 136 advertisements reviewed. See PF # 006-TI.

Direct Sales Scripts

The Examiners selected samples of direct sales scripts during the examination totaling 15 (100%) of 15 individual major medical direct sales scripts utilized by the Company during the examination period.

The Company utilized 11 direct sales scripts that:

1. Failed to identify the source of statistics used in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(F) and contained misleading statements about the time in which claims are paid and the number of claims paid in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(O).

2. Contained unsupported, unsubstantiated and incomplete comparisons with other policies or benefits in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(I).

3. Used a trade name only and failed to identify the name of the insurer issuing the coverage in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(K).

The Company therefore failed Standard 1 in apparent violation of A.R.S. § 20-444(A) and R20-6-201(F), (I), (K), (O) and (P) by utilizing direct sales scripts that contained misleading statements, unsupported, unsubstantiated and incomplete comparisons and that failed to identify the name of the insurer in 11 (73%) of 15 direct sales scripts reviewed. See PF # 008-TI and PF # 021-TI.

The Company failed Standard 1 in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(1), (C)(2) and (I) by utilizing direct sales scripts which made misleading assertions suggesting that individual medical insurance or short term medical insurance are comparable to COBRA benefits in all ways except premiums, in seven (47%) of 15 direct sales scripts reviewed. See PF # 024-TI.

TV Media Advertising

The Examiners selected samples of TV media advertisements during the examination totaling 15 (100%) of 15 individual major medical TV media advertisements utilized by the Company during the examination period.

The Company utilized 13 TV media advertisements that:

1. Used words and phrases to describe policy benefits that did not accurately describe the benefits of the policy and that exaggerated policy benefits in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-201(C)(3).
2. Described specific policy benefits but failed to disclose any related exclusions, reductions or limitations in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-201(C)(7).
3. Described specific policy benefits but failed to disclose any related exclusions, reductions or limitations applicable to a preexisting condition in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-201(C)(9).
4. Contained unsupported, substantiated and incomplete comparisons with other policies or benefits in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(I).
5. Failed to state the name of the actual insurer, to clearly identify the insurer and used a trade name or insurance group designation in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(K).

The Company therefore failed Standard 1 in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(3), (C)(7), (C)(9), (I), (K) and (P) by utilizing direct sales scripts that contained misleading statements, unsupported, unsubstantiated and incomplete comparisons and that failed to identify the name of the insurer in 13 (87%) of 15 direct sales scripts reviewed. See PF # 028-TI.

Group Major Medical Advertising

The Examiners selected samples of print advertisements during the examination totaling 21 (100%) of 21 group major medical print advertisements utilized by the Company during the examination period.

The Company failed Standard 1 in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(7) by utilizing a print advertisement that referenced specific policy benefits such as 100% first dollar coverage, no deductibles and no copays but failed to disclose any related exclusion, reductions or limitations in one (5%) of 21 group print advertisements reviewed. See Preliminary Finding # 014-TI.

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

Summary of Findings – Standard 1 Advertising Review

Type of Advertising	Population	Sample	Exceptions	Error Ratio	PF #
Individual Major Medical - Print	217	136	56	NA	006-TI
Individual Major Medical – Scripts	15	15	11	NA	008-TI, 021-TI
Individual Major Medical – Media	15	15	13	NA	028-TI
Group Major Medical - Print	21	21	1	NA	014-TI
Totals =	**268**	**187**	**81**	**NA**	

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 2

Based on the Examiners' review of individual major medical policies issued by the Company during the examination period, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
2	The Company markets its products in a fair and nondiscriminatory manner to all eligible individuals and/or groups.	A.R.S. § 20-448

The Company failed Standard 2 in apparent violation of A.R.S. § 20-448(B) by utilizing Individual Major Medical direct sales scripts that unfairly discriminated against existing insureds by offering no rate increases for new policies for up to 36 months in 11 of 15 direct sales scripts reviewed. See PF # 009-TI and PF #022-TI.

The Company failed Standard 2 in apparent violation of A.R.S. § 20-448(B) by utilizing TV media advertisements that offered no rate increases to new insureds and thereby unfairly discriminated against existing insureds in eight of 15 TV media advertisements reviewed. See PF # 029-TI.

The Company issued individual medical policies to new Arizona insureds during the examination period that contained a provision that guaranteed that the insured's rate was locked in for a period of 24 or 36 months. This offer was not extended to existing policyholders of the same policy forms, which policyholders are of essentially the same class and/or the same hazard. See PF # 076-TI.

The Company therefore failed Standard 2 in apparent violation of A.R.S. § 20-448(B) by unfairly discriminating against existing insureds of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for a policy or contract of disability insurance.

Summary of Findings – Standard 2 Advertising and Marketing File Review

Type of Advertising	Population	Sample	Exceptions	Error Ratio	PF #
Individual Major Medical – Scripts	15	15	11	NA	009-TI, 022-TI
Individual Major Medical – Media	15	15	8	NA	029-TI
Totals =	**30**	**30**	**19**	**NA**	

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 policy forms, including pertinent applications, policies, rider, endorsements, and other notices in use during the examination period, as well as the examiners' review of samples of New Business, Cancellation, and other underwriting files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
4	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

Certificates for Policies Issued Outside Arizona

The Examiners reviewed 11 group certificate forms provided by the Company in response to the Coordinator's Handbook, Attachment A, question II.B that were issued in a state other than Arizona. The Company failed Standard 4, as follows:

1. The Company failed with regard to four of these group certificate of coverage forms to include the noticed required by A.R.S. § 20-1401.01, which states "Notice: This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully." (See PF #036-TI).
2. The Company failed with regard to five certificates to comply with the mandated newborn coverage of A.R.S. § 20-1402(A)(2) and the Consent Order, as follows (see PF#037-TI):
    a. Four group certificate of coverage forms stated that the premium for the newly born child's coverage must be paid within 31 days of birth or coverage is not effective from the date of birth.
    b. One group certificate of coverage form stated that coverage would only be provided during the first 30 days of life.
3. The Company failed with regard to two group certificate of coverage forms to comply with the prohibition against subrogation established by *Allstate Ins. Co v. Druke*, 118 Ariz. 301, 576 P.2d 489 (1978). These two certificates included a section headed "Recovery Provisions" that provide for subrogation, or

reimbursement of funds paid by other insurers or entities, or recovered during a lawsuit or other proceedings in connection with any such accident or occurrence covered by the certificate. The certificate did not include any language clarifying that this provision does not apply in Arizona. See PF 039-TI.

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

Summary of Findings – Standard 4 Policy Forms Review

Form Number	Out-of-State Notice	Newborn Benefits	Subrogation	PF #
TGM.TRT.AZ (Rev. 04/2006)	X	X	X	036-TI, 037-TI, 039-TI
244.001.AZ		X		037-TI
TIM.CER.AZ	X		X	036-TI, 039-TI
554	X			036-TI
136.001.XX	X			036-TI
C99.100.SIG.AZ		X		037-TI
C99.100.SIG.AZ (Fortis Contract)		X		037-TI
C61.100.SIG.AZ(Fortis Contract)		X		037-TI
Totals =	**4**	**5**	**2**	

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 6

Based on the Examiners' review of the documents, forms, and information provided by the Company in response to the Coordinators Handbook, as well as a review of samples of New Business, Cancellation, and other underwriting files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
6	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

Issuance of Certificates of Creditable Coverage

The Company failed Standard 6 in apparent violation of A.R.S. § 20-1379(L) by failing to provide appropriate certificates of creditable coverage ("CCCs") within 30 days after the termination of coverage as follows:

1. The Company failed to issue CCCs within 30 days to:
   a. Four (13%) policyholders from a sample of 32 Student Select New Business Termination files terminated during the examination period. See PF # 082-TI.
   b. Thirty-four (32%) policyholders from a sample of 105 Short Term Medical New Business Cancellation files terminated during the examination period. See PF # 086-TI.
2. The Company failed to include all of the required information on 11 (10%) CCCs from a sample of 105 Short Term Medical files terminated during the examination period. See PF # 085-TI.

Credit For Prior Coverage

From a sample of 108 Individual Medical New Business files reviewed, the Examiners identified nine policies that were issued to replace existing "Assurant Health Plan" policies. In three (33%) of the nine files, the Company failed to give pre-existing condition credit earned during the period the replaced coverage was in force.

The Company therefore failed Standard 6 in apparent violation of A.R.S. § 20-1377(E) by failing to give credit for preexisting conditions exclusionary periods previously satisfied under the prior coverage. See PF # 113-TI.

Summary of Findings – Standard 6 Underwriting File Review

Sample Description	Population	Sample	Exceptions	Error Ratio	PF #
Student Select New Business Terminated	68	32	4	13%	082-TI
Short Term Medical New Business Canceled	9,329	105	45	43%	085-TI, 086-TI
Individual Medical New Business Replacements	9	9	3	33%	113-TI
Totals =	**9,406**	**146**	**52**	**36%**	

A 36% error ratio does not meet the standard; therefore recommendations are warranted.

EXAMINATION FINDINGS – FAILED STANDARD 7

Based on the Examiners' review of the information provided by the Company in response to Attachment A, Section II(K) of the Coordinator's Handbook and a supplemental request for additional information, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
7	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

In response to a request for copies of disclosure forms provided to employers and certificate holders in compliance with A.R.S. § 20-2323, and a description of how and when this disclosure form is provided, the Company did not provide any information concerning outline of coverage and disclosure forms provided to employers and certificate holders when responding to the Coordinator's Handbook.

The Examiners issued a supplemental request for additional information, and the Company advised that it does not have a record of disclosure forms provided to employers and certificate holders.

The Company has failed Standard No. 7 in apparent violation of A.R.S. § 20-2323(A) because the Company does not have a record of disclosure forms provided to employers and certificate holders. See PF #111-TI.

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

EXAMINATION FINDINGS – FAILED STANDARD 9

Based on the Examiners' review of the Company's policy forms provided in response to Attachment A of the Coordinator's Handbook, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
9	The Company obtains prior written consent, using approved consent forms, before conducting tests for HIV or genetic disorders.	A.R.S. § 20-448.01 and A.A.C. R20-6-1203(C)

The Examiners reviewed three forms titled Notice and Consent Form for AIDS Virus (HIV) Antibody/Antigen Testing, which forms were provided by the Company in response to the Coordinator's Handbook, Attachment A, question II.I. The Department has no record that these forms were submitted to the Director for approval. See PF # 058-TI.

The Examiners reviewed 55 Student Select denied claims provided by the Company in response to Request 069. Fifty-five of the claim files, which involved claims for health insurance benefits, included a medical disclosure authorization form that purports to authorize the release of information regarding the diagnosis and/or treatment for HIV. See PF # 070-TI. The forms do not comply with the notice and disclosure requirements of A.A.C. R20-6-1204 in that they do not:

1. Contain the name and address of the person to whom the information is to be disclosed;
2. State the specific purpose for which disclosure is to be made; and/or
3. Limit the time period for the disclosure to no more than 180 days.

The Examiners reviewed seven Small Group New Business Policies Issued files provided by the Company in response to Request 041-TI. This review included a review of the enrollment forms utilized by the Company to enroll employees during the examination period. One of the medical enrollment forms included a medical disclosure authorization form that purports to authorize the release of information regarding the diagnosis and/or treatment for HIV. The Company failed to include on the notice the address of EMSI, to whom information may be disclosed, in apparent violation of A.R.S. § 20-448.01 and A.A.C. R20-6-1204. (See PF#140-TI)

The Company has therefore failed Standard 9 in apparent violation of A.R.S. § 20-448.01 and A.A.C. R20-6-1203(C), by using HIV disclosure authorization forms that do not meet the prescribed format and which have not been approved by the Director.

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

EXAMINATION FINDINGS – FAILED STANDARD 10

Based on the Examiners' review of the forms, documents, and information provided by the Company in response to the Coordinator's Handbook and supplemental requests for information, as well as New Business, Cancellation/Termination, and Rescission files, the Company failed the following standard for review:

#	STANDARD	Regulatory Authority
10	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 Company was unable to provide the Examiners with a copy of the full Notice of Insurance Information Practices as prescribed by A.R.S. § 20-2104(C). The Company provided only an abbreviated notice allowed by A.R.S. § 20-2104(D). The abbreviated notice must include a notice that a full Notice of Insurance Information Practices will be provided upon request. Therefore the Company failed Standard 10, in apparent violation of A.R.S. § 20-2104(C), by failing to provide a Notice of Insurance Information Practices that complies with the statutory requirements. See PF # 108-TI. A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

The Company failed Standard 10, in apparent violation of A.R.S. § 20-2104(B)(1)(b), by failing to provide proof of policies and procedures for providing a copy of the Notice of Insurance Information Practices prior to obtaining personal information from a third party, as follows:

1. In four of 26 application forms provided for review in response to the Coordinator's Handbook, Attachment A, question II(C). See PF #040-TI. A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.
2. In 37 of 55 Individual Medical New Business Incomplete files reviewed, where information was obtained from Medical Information Bureau ("MIB"). See PF # 119-TI.
3. In 39 of 55 Individual Medical New Business Declined files reviewed, where information was obtained from MIB. See PF # 123-TI.

Eligibility Review – Ineligible to Complete Application

The Company failed Standard 10, in apparent violation of A.R.S. § 20-2110(A) and (D), by using application forms that included at the beginning of the application form packet an Eligibility Review that included several questions that required a "YES" or "NO" response. If any of these questions was answered "YES" the individual was not eligible to complete the application form. This action would be considered an adverse underwriting decision as defined by A.R.S. § 20-2102(1). There is no indication from the wording on the Eligibility Review form or elsewhere in the application packet, or the procedures provided by the Company that the applicant, policyholder or individual proposed for coverage would be provided with the specific reason for the adverse underwriting decision, or advised that the individual could, upon written request, receive the specific reason for the adverse underwriting decision in writing or that the applicant, policyholder or individual proposed for coverage would be provided with a summary of the rights established under subsection B of this section and sections 20-2108 and 20-2109. See PF #042-TI and PF # 159-TI.

In response to these PFs, as well as to a request for additional information (Request #138-TI) the Company stated "The eligibility questions are a screening tool used during the sales process and are intended to assist the agent and prospective customer in determining eligibility to apply for coverage, they are not used for the purposes of underwriting nor are they a part of our filed application."

The declination of insurance coverage is an adverse underwriting decision as defined by A.R.S. § 20-2102(1)(a), and the Eligibility Review establishes a process whereby the producers perform preliminary screening and underwriting in order to decline the coverage on the Company's behalf. Furthermore, the failure of a producer to apply for the coverage requested by an applicant is an adverse underwriting decision as defined by A.R.S. § 20-2102(1)(c).

There is no indication from the Company's response or from the procedures provided by the Company during the examination that the applicant would be provided with the specific reason for the adverse underwriting decision, or advised that the individual could, upon written request, receive the specific reason for the adverse underwriting decision in writing or that the applicant would be provided with a summary of the rights established under subsection B of this section and sections 20-2108 and 20-2109.

The Company has therefore violated Standard 10 in apparent violation of A.R.S. § 20-2110(A) and (D), in 10 of 26 application forms for Individual Medical coverage provided for review in response to the Coordinator's Handbook, Attachment A, question II(C). A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

Adverse Underwriting Decisions on Completed Applications

The Company failed Standard 10, in apparent violation of A.R.S. § 20-2110(A) and (D), by using eight application forms that stated in the non-medical section of the application that 'IF EITHER QUESTION N2 OR N3 IS ANSWERED "YES" MEDICAL COVERAGE CANNOT BE ISSUED.' This action would be considered an adverse underwriting decision as defined by A.R.S. § 20-2102(1). There is no indication from the wording on the application, or the procedures provided by the Company that the applicant, policyholder or individual proposed for coverage would be provided with the specific reason for the adverse underwriting decision, or advised that the individual could, upon written request, receive the specific reason for the adverse underwriting decision in writing or that the applicant, policyholder or individual proposed for coverage would be provided with a summary of the rights established under subsection B of this section and sections 20-2108 and 20-2109. The Company has therefore violated Standard 10 in apparent violation of A.R.S. § 20-2110(A) and (D) and the Consent Order, by failing to provide the specific reason for the adverse underwriting decision and a Summary of Rights in eight of 26 application forms for individual coverage provided for review in response to the Coordinator's Handbook, Attachment A, question II(C). A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified. See PF #041-TI.

The Company failed Standard 10, in apparent violation of A.R.S. § 20-2110(A) and (D), when the Company offered other than standard coverage and a notice was not sent to the applicant, policyholder or individual proposed for coverage that included the specific reason for the adverse underwriting decision, or was the applicant, policyholder or individual proposed for coverage provided with a Summary of the Rights established under subsection B of this section and sections 20-2108 and 20-2109. The Company has therefore violated Standard 10 in apparent violation of A.R.S. § 20-2110(A) and (D) and the Consent Order, by failing to provide the specific reason for the adverse underwriting decision and a Summary of Rights, as follows:

1. In one of 108 Individual Medical New Business Issued files reviewed. See PF # 117-TI.
2. In eight of 55 Individual Medical New Business Incomplete files reviewed. See PF # 121-TI.
3. In one of 55 Short Term Medical New Business Not Taken files reviewed, because the Company declined to offer coverage to the applicant after the agent advised that the applicant had previously been declined for coverage. See PF # 089-TI.

The Company has violated Standard 10 in apparent violation of A.R.S. § 20-2110(A) and the Consent Order, by failing to provide a Summary of Rights with notice of an adverse underwriting decision, as follows:

1. In three of 55 Individual Medical New Business Declined files reviewed. See PF # 125-TI.
2. In 62 of 63 Individual Medical New Business Reformation files reviewed. See PF # 136-TI.
3. One of one reformation file reviewed as part of the sample of Short Term Medical New Business Cancellation files reviewed. See PF #151-TI.
4. In 49 of 49 Individual Medical New Business Rescission files at the time the Company offered to reform the policy, an adverse underwriting decision, and subsequently rescinded the coverage when the reformation was not accepted by the insured. See PF # 156-TI.

Disclosure Authorizations

The Company failed Standard 10, in apparent violation of A.R.S. § 20-2106(7)(a) and the Consent Order by using disclosure authorization provisions on its applications that failed to comply with the "no more than" 30-month limit prescribed by law, as follows:

1. In nine of 26 application forms for Individual Medical coverage provided for review in response to the Coordinator's Handbook, Attachment A, question II(C). A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified. See PF #043-TI.
2. In 50 of 50 Voluntary Mart New Business application files reviewed. See PF #075-TI and PF # 100-TI.

3. In 15 of 108 Individual Medical New Business Issued files reviewed. See PF # 116-TI.
4. In six of 55 Individual Medical New Business Incomplete files reviewed. See PF # 120-TI.
5. In 11 of 55 Individual Medical New Business Declined files reviewed. See PF # 124-TI.

Summary of Findings – Standard 10 Underwriting File Review

Sample Description	Population	Sample	Exceptions	Error Ratio	PF #
IM New Business Incomplete	4,965	55	38	n/a	119-TI, 120-TI, 121-TI
IM New Business Declined	1,412	55	48	n/a	123-TI, 124-TI, 125-TI
IM New Business Issued	12,320	108	15	n/a	116-TI, 117-TI
IM New Business Reformed	63	63	62	n/a	136-TI
IM New Business Rescinded (reformation offered)	49	49	49	n/a	156-TI
STM New Business Canceled/Reformed	1	1	1	n/a	151-TI
SRM New Business Not Taken	365	55	1	n/a	089-TI
VM New Business Issued	640	50	50	n/a	075-TI, 100-TI
Totals =	**19,815**	**436**	**264**	**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 11

Based on the Examiners' review of paid and denied claim samples provided by the Company, as well as a review of the Company's claim handling procedures and forms, the Company failed the following standard for review:

#	STANDARD	Regulatory Authority
11	Claims are handled timely and appropriately in accordance with policy provisions and applicable statutes and rules.	A.R.S. § 20-3102

Time Service for Claims Handling

The Company failed Standard 11, in apparent violation of A.R.S. § 20-3102(A) and (B) and the Consent Order, to adjudicate claims in a timely manner as prescribed by law, as follows:

1. In 44 (80%) of 55 Short Term Medical Denied claims that were denied due to rescission of the policy. See PF # 071-TI.
2. In one (3%) of 33 Short Term Medical Denied claims that were denied under Reason code 0497. See PF # 093-TI.

The Company failed Standard 11, in apparent violation of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(G)(3). The Examiners identified two claims where the Company received a refund of claim monies from a provider, since another carrier paid the claim in full, that were previously paid to the provider by the Company for payment of the claim. The Company failed to promptly pay the claimant the full amount of the refunded claim monies, even though file notes indicated that the Company recognized that it could not subrogate claims in Arizona, crediting these refunded monies to recovery. See PF # 148-TI.

Payment of Interest

The Company failed Standard 11, in apparent violation of A.R.S. § 20-3102(A), by failing to pay interest on provider claims not paid within 30 days after the claim was adjudicated, in four (4%) of 109 Short Term Medical Paid claims reviewed. See PF # 034-TI.

Claim File Number	Days Overdue	Payment Amount	Interest Due
TI-STM-014	38	$292.00	$3.04
TI-STM-027	57	$472.64	$7.38
TI-STM-045	168	$2,260.57	$104.05
TI-STM-063	60	$350.03	$5.75
Totals		**$3,375.24**	**$120.22**

Reasonable Explanation for Denial

The Company failed Standard 11, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a), by failing to provide an adequate reason for the denial of a claim in sufficient detail to allow the claimant to prepare a meaningful appeal. The Examiners reviewed 55 Short-Term Medical Denied claims denied under Reason Codes 0106, 0113, 0302, 0384, 0416 and 0520. Nine (16%) of the files reviewed were denied using Reason Code 0520, which states, "Inpatient/outpatient treatment for this condition is not covered." This denial does not provide the policy provision relied upon for the denial, as required by A.A.C. R20-6-801(G)(1)(a). See PF # 095-TI.

Summary of Findings – Standard 11 Claim File Review

Description	Population	Sample	Exceptions	Error Ratio	PF #
Short Term Medical Paid	17,443	109	4	4%	034-TI
Short Term Medical Denied (Resc)	189	55	44	80%	071-TI
Short Term Medical Denied (0497)	50	33	1	30%	093-TI
Short Term Medical Denied (0520)	893	55	9	16%	095-TI
Subrogated claims	2	2	2	100%	148-TI
Totals =	**18,577**	**254**	**60**	**24%**	

A 24% error ratio does not meet the standard; therefore recommendations are warranted.

EXAMINATION FINDINGS – FAILED STANDARD 14

Based on the Examiners' review of the information provided by the Company in response to Attachment A materials of the Coordinator's Handbook, as well as claim sample file reviews, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
14	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

Misstatement of Benefits

The Company failed Standard 14, in apparent violation of A.R.S. § 20-461(A)(1) and A.A.C. R20-6-801(D)(1), by misstating covered benefits by misclassifying covered "Wellness Benefits" as "Ineligible Charges" in three (5%) of 55 Voluntary Mart Denied claims reviewed. See PF # 030-TI.

Failure to Identify Correct Name of Insurer

The Company failed Standard 14, in apparent violation of A.R.S. § 20-461(A)(1) by failing to identify the correct name of the insurer, as follows:

1. With regard to Voluntary Mart Paid claims, the Company:
   a. Used one form in processing Voluntary Mart Paid claims that used the name Assurant Health and failed to identify the issuing insurer as Time Insurance Company.
   b. Paid benefits using checks identifying the insurer as John Alden Life Insurance Company, rather than Time Insurance Company.

   See PF # 027-TI. A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.
2. With regard to 63 (57%) of 110 Individual Medical Paid Claims files reviewed, used an "Assurant Health" EOB form that failed to otherwise identify the issuing carrier as Time Insurance Company. See PF # 079-TI.
3. With regard to 52 (47%) of 110 Small Group Paid Claims (ACES claim system) files reviewed, used an "Assurant Health" EOB form that failed to otherwise identify the issuing carrier as Time Insurance Company. See PF # 080-TI.

4. With regard to 49 (94%) of 52 Appeal files reviewed, used "Assurant Health" letterheads on correspondences that failed to otherwise identify the issuing carrier as Time Insurance Company. See PF # 031-TI.

Summary of Findings – Standard 14 Claim File Review

Description	Population	Sample	Exceptions	Error Ratio	PF #
VM Denied	1,224	55	3	5%	030-TI
IM Paid	582,615	110	63	57%	079-TI
SG Paid (ACES)	37,552	110	52	47%	080-TI
Appeals	279	52	49	94%	031-TI
Totals =	**621,670**	**327**	**167**	**51%**	

A 51% error ratio does not meet the standard; therefore recommendations are warranted.

EXAMINATION FINDINGS – FAILED STANDARD 16

Based on the Examiners' review of the information provided by the Company in response to Attachment A of the Coordinator's Handbook, as well as sample appeal files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
16	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.*

Notice of Appeal Rights

The Company failed Standard 16, in apparent violation of A.R.S. §§ 20-2535(A) and/or 20-2536(A) by failing to provide correct information concerning the insured's right to appeal a denied claim within two years of the date of denial, as follows:

1. During the forms review, the Examiners reviewed 10 specimens of group certificates issued in Arizona during the examination period and found two forms that misstated the time allowed for appealing a denied claim. See PF #038-TI:
   a. Group certificate form TIM.CER.AZ provides conflicting and confusing information. The form states on Page 68 under the paragraph headed Claim Appeal that "A review must be requested in writing within 180 days following Your receipt of the notice that the claim was denied or reduced." On page 5 of the Arizona Appeal Packet under paragraph headed Level 2 Formal Appeal it states "If we did not provide a Level 1 review of your denied claim, you have 2 years from our first denial notice to request Formal Appeal."
   b. Group certificate form 136.001.XX states on Page 23 under the paragraph headed Claim Appeal that "You must submit a written request to Us at Our office within 90 days of the denial."
2. In 30 (91%) of 33 first-level appeal files reviewed where the Company "upheld" the denial of the claims, the Company used letters advising the insured of the right to file a second-level appeal, but stating that the second level review was the final level of appeal. These letters misstated the statutorily prescribed levels of review and deprived the claimants of information concerning the availability of the right

to an External Independent Review, in apparent violation of A.R.S. §§ 20-2536(G) and 20-2537. See PF # 060-TI.

3. In the sample of Short Term Medical Claims denied due to preexisting conditions, the Examiners identified the use of one form letter stating that the second level review was the final level of appeal, which misstates the prescribed levels of review and deprives the claimant of information concerning the availability of the right to an External Independent Review, in apparent violation of A.R.S. §§ 20-2536(G) and 20-2537. See PF # 96-TI.

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

Time Service for Appeal Handling

The Company failed Standard 16, in apparent violation of A.R.S. §§ 20-2530, *et seq.*, to process appeals in a timely manner as prescribed by law, as follows:

1. The Company failed to acknowledge 15 (29%) of 52 appeal files reviewed within five business days, as follows (see PF #061-TI):
   a. In 11 (23%) of 48 first level appeal files reviewed, the Company failed to acknowledge the request for informal reconsideration within 5 business days of receipt, in apparent violation of A.R.S. § 20-2535(B) and the Consent Order; and
   b. In four (100%) of four second level appeal files reviewed, the Company failed to acknowledge the formal appeal within 5 business days of receipt, in apparent violation of A.R.S. § 20-2536(B).
2. The Company failed to resolve 15 (29%) of 52 appeal files reviewed within the time period prescribed by law, as follows (see PF # 062-TI):
   a. In 12 (25%) of 48 first level appeal files reviewed, the Company failed to resolve the appeal within 30 days of receipt of the appeal, in apparent violation of A.R.S. § 20-2535(D).
   b. In one (25%) of four second level appeals reviewed, the Company failed to resolve the appeal within 60 days of receipt of the appeal, in apparent violation of A.R.S. § 20-2536(E)(2).

Summary of Findings – Standard 16 Appeals File Review

Description	Population	Sample	Exceptions	Error Ratio	PF #
First Level Appeal	252	48	19	40%	060, TI, 061-TI, 062-TI
Second Level Appeal	27	4	4	100%	061-TI, 062-TI
Totals =	**279**	**52**	**23**	**44%**	

A 44% error ratio does not meet the standard; therefore recommendations are warranted.

EXAMINATION FINDINGS – FAILED STANDARD 17

Based on the Examiners' review of the information provided by the Company in response to a request for a description of policies and procedures related to premium payments, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
17	The Company affords adequate grace periods without cancellation of coverage for the receipt of premiums as required by law.	A.R.S. § 20-191

The Company provided a written explanation of how the Company determines the date that premium payments are received by the Company when the premium payments are received through regular United States mail. During the examination period, small group business was administered on the GMS and GRASS processing systems, and premium payments are/were considered received on the date they were received in the lockboxes of US BANK or the date that they were received in the general mailroom of the Company.

The Company has failed Standard No. 17 in apparent violation of A.R.S. § 20-191(A) and (B) with regard to premium payments received through standard United States mail or certified or registered United States mail because the Company had no procedures in place to give credit for premium payments as of the date that they were deposited in the United States mail or as of the date of registration or certification as established by the United States mail. See PF #018-TI.

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 18

Based on the Examiners' review of the information provided by the Company in response to the Coordinator's Handbook as well as the review of policy termination files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
18	The Company does not cancel, non-renew, or rescind 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

Required Renewal Notices

The Company failed Standard 18 in apparent violation of A.R.S. § 20-2309(A) by failing to include in the renewal notice for group coverage any explanation of the extent to which the increase in premium was due to the actual or expected claims experience of the individuals covered under the plan. See PF # 001-TI and PF # 102-TI. A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

Incorporation of Medical History into Policy Application

The Examiners reviewed 73 Individual Medical New Business Rescission application files provided by the Company in response to Request 39-TI. Eight (11%) of the 73 Individual Medical New Business Rescission application files included medical history on the Worksheet Summary but there is no indication, based on the information provided, that the medical history listed on the Worksheet Summary was made part of the application by using an amendment of application form or an Additional Notes form in use by the Company during the examination period.

The Company, based on the applicant's medical history recorded on the Worksheet Summary, had knowledge of the applicant's prior medical history. The application file did not include an amendment of application form or an Additional Notes form that incorporated this known medical history as part of the application.

Since the Company did not incorporate known medical history as part of the application form, and the Company continued to accept the policyholder's premium payments on the contract knowing that the policy contract provided to the policyholder did not include all the medical history known to the Company, the applicant was never given the opportunity to review the application statements that were the basis for issuing the policy contract. Therefore the

Company does not have the right to use the incomplete statements on the application as a basis for rescinding the contract.

The Company therefore has failed Standard No. 18 in apparent violation of A.R.S. §§ 20-1345 and 20-1346 by failing to incorporate known medical history into the application for review by the applicant. See PF # 157-TI.

Electronic Signatures

The Examiners reviewed 73 Individual Medical New Business Rescission application files provided by the Company in response to Request 39-TI. Three of the 73 Individual Medical New Business Rescission application files did not include a paper application form signed by the proposed insured. Company employees completed these applications based on the applicant's responses during telephone interviews. The applicant did not personally complete the application, and therefore had no direct knowledge of the actual content of the information recorded by the Company employee.

The unsigned paper application contains a field for the applicant's agreement that to the best of the applicant's knowledge and belief, that all statements and answers on this enrollment form are complete and true and that the recorded Personal Health History, the enrollment form and any amendments shall be the basis for the offer of coverage.

On the unsigned "Acceptance of Offer and Attestation" form there is a field for the applicant and agent to certify "We, the undersigned proposed insured(s) and agent acknowledge that the proposed insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation on the enrollment form and /or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provision of the contract."

At no time during the telephone interview of the applicant did the Company offer the applicant the opportunity to "read the completed enrollment form." Likewise, at no time did the Company ask the applicant to attest to the statements contained in the application and/or to attest to the understanding that "any fraudulent statement or material misrepresentation on the enrollment form and/or any amendments may result in claim denial or contract rescission." The response relied upon by the Company to effect its "electronic signature" in these cases was to the question of whether the applicant granted permission for the application to be submitted. Therefore, the Company cannot rely upon these electronic signatures, because in these cases they

fail to meet the definition set forth in A.R.S. § 44-7002(8). There is no evidence that the applicant understood that the policy might be rescinded based on information that was written down by a Company employee and which the applicant was offered no opportunity to confirm as accurate or complete.

The Company, therefore, rescinded the policies related to these three applications without establishing that the applicant had made an actual misstatement in the application for insurance coverage.

The Company failed Standard No. 18 in apparent violation of A.R.S. §§ 20-1345 and 20-1346 because it rescinded a health insurance contract on the basis of an application form that was not signed by the applicant or proposed insured. See PF #158-TI.

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

Summary of Findings – Standard 18 Appeals File Review

Description	Population	Sample	Exceptions	Error Ratio	PF #
Individual Medical New Business Rescission	73	73	11	n/a	157-TI, 158-TI
Totals	**73**	**73**	**11**	**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.

RECOMMENDATIONS

Within 120 days of the filed date of this Report, the Company should:

1. Perform a self-audit of all Short Term Medical Paid claims processed during the three years prior to the filed date of this Report;
2. Pay restitution including interest at the legal rate for any claim identified from the self-audit as having been paid more than 30 days after adjudication of a clean claim for which interest was not paid or for which interest was not paid in the correct amount; and
3. With each payment of restitution, provide a letter indicating that an audit of claims resulting from an examination by the Arizona Department of Insurance had resulted in the correction of the previous denial. This letter should be approved by the Department prior to its use.

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:

4. All print advertisements, direct sales scripts, television advertisements, and other forms of advertising and/or marketing materials intended for use and/or distribution in Arizona comply with A.R.S. § 20-444 and A.A.C. R20-201, to ensure that these items:
   a. Do not contain statements that indicate that short-term medical insurance is a low cost alternative to COBRA, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(C)(1) and (C)(2);
   b. Disclose any related exclusions, reductions, or limitations, including but not limited to those applicable to preexisting conditions for any advertisements and/or marketing materials that describe policy benefits, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(C)(7) and (9);
   c. Avoid the use of misleading statements about the time in which claims are paid and/or the number of claims paid, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(F) and (O);
   d. Do not contain unsupported, unsubstantiated, and incomplete comparisons with other companies' policies or benefits, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(I);

e. Identify the name of the insurer issuing the coverage, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(K);

f. Do not indicate that "Assurant Health" has an AM Best Rating, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(P); and

5. The Company markets and issues its individual health insurance products in a manner that does not unfairly discriminate among individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy, to comply with A.R.S. §§ 20-448(B).

6. All policy forms comply with pertinent Arizona laws, and specifically provides evidence that certificates of coverage issued in Arizona:

a. Include the required notice on certificates of coverage for policies issued in states other than Arizona, to comply with A.R.S. § 20-1401.01;

b. Include the correct policy benefits for newborns or newly adopted children to ensure coverage from the date of birth or adoption for 31 days, to comply with A.R.S. § 20-1402(A)(2) and the Consent Order; and

c. Omit or nullify with regard to Arizona certificate holders any policy language concerning subrogation of claims, to comply with *Allstate Ins. Co. v. Druke*, 118 Ariz. 301, 576 P.2d 489 (1978).

7. Company issues certificates of creditable coverage for all applicable terminating policies and that certificates of creditable coverage contain all of the information required, to comply with A.R.S. § 20-1379(L).

8. The Company gives credit for preexisting conditions exclusionary periods previously satisfied when replacing existing "Assurant" policies, to comply with A.R.S. § 20-1377(E).

9. The Company issues disclosure forms to employers and certificate holders, to comply with A.R.S. § 20-2323(A).

10. The Company obtains prior approval for HIV disclosure authorization forms and ensures that all of the information required for such a release is contained on the form, to comply with A.R.S. § 20-448.01 and A.A.C. R20-6-1204.

11. The Company has a full Notice of Insurance Information Practices to be provided upon request by an insured, to comply with A.R.S. § 20-2104(C).

12. The Company provides a copy of the Notice of Insurance Information Practices when it first obtains personal information about an applicant from a third party, to comply with A.R.S. § 20-2104(B)(1)(b).

13. The Company provides a Summary of Rights to individuals not permitted to proceed with the application process because of answers to pre-screening questions, in apparent violation of A.R.S. § 20-2110(A) and (D) and the Consent Order.

14. The Company provides a Summary of Rights and the specific reason(s) why coverage has been declined to all individuals who have completed an application whenever a policy is not issued, to comply with A.R.S. § 20-2110(A) and (D) and the Consent Order.

15. The Company uses disclosure authorization provisions on its applications that comply with the "no more than" 30-month limit prescribed by law, to comply with A.R.S. § 20-2106(7)(a) and the Consent Order.

16. The Company adjudicates claims within 30 days of receipt of a clean claim and pays interest on all claims not paid within 30 days after the date of adjudication, to comply with A.R.S. § 20-3102(A) and (B) and the Consent Order.

17. The Company refunds in a timely manner any and all funds received through the subrogation of a claim, to comply with A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(G).

18. The Company provides an adequate reason for the denial of a claim in sufficient detail to allow the claimant to prepare a meaningful appeal, to comply with A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

19. The Company does not misstate or misclassify covered benefits as "ineligible charges," to comply with A.R.S. § 20-461(A)(1) and A.A.C. R20-6-801(D)(1).

20. The Company properly identifies the correct name of the issuing carrier on all correspondence with insureds, including but not limited to letters, memoranda, payment instruments, and EOBs.

21. The Company provides accurate information in its group certificates regarding the number of days allowed for filing a first level appeal, to comply with A.R.S. §§ 20-2535(A) and/or 20-2536(A).

22. The Company does not misrepresent the availability of all levels of appeals prescribed by Arizona law, to comply with A.R.S. §§ 20-2536(G) and 20-2537.

23. The Company provides a written acknowledgment to first and second level appeals within five business days, to comply with A.R.S. §§ 20-2535(B) or 20-2536(B) and the Consent Order.

24. The Company resolves first level appeals within 30 days of receipt of the appeal, to comply with A.R.S. § 20-2535(D).

25. The Company resolves second-level appeals within 60 days of receipt of the appeal, to comply with A.R.S. § 20-2536(E)(2).

26. The Company has procedures in place to give credit for premium payments as of the date that they were deposited in the United States mail or as of the date of registration or certification as established by the United States mail, to comply with A.R.S. § 20-191(A) and (B).

27. The Company does not rescind individual insurance coverage based on health history information not incorporated as part of the application, to comply with A.R.S. § 20-1346.

28. The Company does not rescind individual insurance coverage based upon unsigned applications or without obtaining a signed Acceptance of Offer and Attestation form, or in the alternative does not apply electronic signatures to applications without disclosing to the applicant the true nature of the electronic signature, to comply with A.R.S. § 20-1346.

SUMMARY OF PART 2 STANDARDS

A. Advertising, Marketing and Sales

#	STANDARD	PASS	FAIL
1	All advertising and sales materials are in compliance with applicable statutes and rules. (A.R.S. §§ 20-442, 20-443, 20-444, and A.A.C. R20-6-201 and R20-6-201.01)		X
2	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
3	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	

B. Underwriting/Portability/Guaranteed Issue

#	STANDARD	PASS	FAIL
4	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)		X
5	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	
6	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
7	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
8	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	
9	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
10	The Company complies with all notice of insurance information and privacy requirements. (A.R.S. §§ 20-2101, *et seq.*)		X

C. Claims Processing

#	STANDARD	PASS	FAIL
11	Claims are handled timely and appropriately in accordance with policy provisions and applicable statutes and rules. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)		X
12	Claim files are adequately documented in order to be able to reconstruct the claim. (A.R.S. § 20-461 and A.A.C. R20-6-801)	X	
13	All claim forms contain an appropriate fraud warning. (A.R.S. § 20-466.03)	X	
14	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

D. Policyholder Services

#	STANDARD	PASS	FAIL
15	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	
16	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

E. Cancellation, Non-Renewals, and Rescissions

#	STANDARD	PASS	FAIL
17	The Company affords adequate grace periods without cancellation of coverage for the receipt of premiums as required by law. (A.R.S. §§ 20-191 and 20-1347)		X
18	The Company does not cancel, non-renew, or rescind 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)		X