REPORT OF TARGETED EXAMINATION

OF

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

NAIC# 62308

AS OF

December 31, 2010

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GERMAINE L. MARKS
Director of Insurance

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

Dear Director Marks:

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

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

NAIC # 62308

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; Mel Mohs, CIE, Senior Market Conduct Examiner, Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner; Sondra Faye Davis, Market Conduct Examiner; and John Kilroy, Market Conduct Examiner.

The examination covered the period of January 1, 2008, through December 31, 2010.

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, Mel Mohs, CIE, Senior Market Conduct Examiner, Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner, Sondra Faye Davis, Market Conduct Examiner, and John Kilroy, Market Conduct Examiner, the examination of Connecticut General Life Insurance Company, hereinafter referred to as the "Company" was performed in part at the offices of CIGNA Healthcare at 25500 North Norterra Parkway, Phoenix, Arizona 85085, and in part 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 12th day of November, 2013.

Notary Public

My Commission Expires 04/21/2014

Neil Fender
Notary Public
Maricopa County, Arizona
My Comm. Expires 04-21-14

FOREWORD

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

On October 24, 2001, the Company entered into a Consent Order, Docket No. 01A-244-INS ("the 2001 Consent Order"), at the conclusion of which the Company agreed to implement certain Corrective Action Plans to prevent repeat violations of A.R.S. §§ 20-461, 20-2535 and 20-2536. On November 16, 2004, the Company entered into a Consent Order, Docket No. 04A-175-INS ("the 2004 Consent Order"), wherein the Company agreed to cease and desist certain business practices found to have violated Arizona insurance laws. On September 30, 2008, the Company entered into a Consent Order, Docket No. 08A-156-INS ("the 2008 Consent Order"), at the conclusion of which the Company agreed to implement certain Corrective Action Plans to prevent repeat violations of A.R.S. §§ 20-2533 through 20-2536, as well as A.R.S. § 20-3102.

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

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

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

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The targeted market conduct examination of the Company covered the period from

January 1, 2008, through December 31, 2010, for the lines of business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. The Examiners completed this examination by applying tests to each examination standard to determine compliance with the standard. A summary of the standards applied during the examination begins at page 38 of this Report.

In accordance with Department procedures, the Examiners completed a Preliminary Finding ("PF") on those policies, claims, complaints, and/or procedures not in apparent compliance with Arizona law. The PF forms were submitted for review and comment to the Company representative designated by Company management as being knowledgeable about the files. For each PF, the Company was requested to agree, disagree, or otherwise justify the Company's noted action.

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

The Examiners based their file sampling on a review of Appeal, New Business, and Claims data provided by the Company. Samples were randomly or systematically selected by using ACL (formerly "Audit Command Language") software and computer data files provided by the Company's Representative, A.J. Charman III, Manager, 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/or the use of policy forms was not met if any exception was identified.

EXECUTIVE SUMMARY

The Examiners completed this examination by applying tests to each examination standard to determine compliance with the standard. A summary of the standards applied during the examination begins at page 38, and the examination findings are reported beginning on page 7.

1. The Company failed Standard 2 by:
   a. Failing to file 166 advertisements related to its various group and individual lines of business with the Department prior to their use, in apparent violation of A.R.S. § 20-1110(E).
   b. Failing to maintain four of 202 advertising pieces, along with notations and supporting documents, for at least three years from the date of dissemination, in apparent violation of A.A.C. R20-6-201.01(C).
   c. Disseminating advertising in various formats that include a description of benefits but do not include the relevant exclusions, reductions or limitations, including those for preexisting conditions, in apparent violation of A.R.S. § 20-444(A) and A.A.C R20-6-201(C)(7) and (C)(9).
   d. Including policy exclusions, reductions, and limitations in fine print and separately located from the description of benefits, in apparent violation of A.R.S. § 20-444(A) and A.A.C R20-6-201(D).
   e. Disseminating advertising in various formats that tend to mislead or deceive the prospective insured by making unsupported and undocumented assertions regarding the policy benefits, claims handling, and/or regarding the Company's relative position in the insurance industry, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(2), (C)(3), (I), and (O).
   f. Using "testimonial" advertising without being able to produce the name of the author or the full text of the testimonial, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(E)(1).
2. The Company failed Standard No. 3, in apparent violation of A.R.S. § 20-448(B), by unfairly discriminating among individuals of essentially the same hazard, in the benefits payable or in the application of the terms or conditions by failing to

offer Individual medical insurance to persons who are not 64½ years old or younger as of the effective date of coverage.

3. The Company failed Standard 7, as follows:

   a. By issuing renewal letters to employers that failed to include an explanation of the extent to which any increase in premium was due to the actual or expected experience of the individuals covered under the plan, in apparent violation of A.R.S. § 20-2309(A) and the 2004 Consent Order.

   b. By using seven application forms for the purpose of collecting information in connection with the application for insurance coverage that failed to limit the disclosure authorization for this information to not more than 30 months, in apparent violation of A.R.S. § 20-2106(7)(a) and the 2004 Consent Order.

   c. By using one application form for coverage other than health insurance containing a disclosure authorization for information collected in connection with claims for benefits that does not limit the effectiveness of the disclosure authorization to the duration of the claim, in apparent violation of A.R.S. § 20-2106(8)(b).

4. The Company failed Standard 15, as follows:

   a. By failing to provide for the delivery of the Notice of Insurance Information Practices at least annually, in apparent violation of A.R.S. § 20-2104(B)(2).

   b. By using letters to notify proposed insureds for Individual insurance coverage of an adverse underwriting decision, which letters did not allow 90 days to request additional information and/or appeal the adverse underwriting decision, in apparent violation of A.R.S. § 20-2110(B).

   c. By using letters to notify proposed insureds for Individual insurance coverage of adverse underwriting decisions that did not include a Summary of Rights as prescribed by A.R.S. §§ 20-2108 and 20-2109, in apparent violation of A.R.S. § 20-2110(A).

5. The Company failed Standard No. 16, as follows:

a. By misrepresenting and/or failing to fully disclose benefits payable under the policy in 91 (14%) of 650 claim files reviewed, in apparent violation of A.R.S. § 20-461(A)(1) and A.A.C. R20-6-801(D)(1).

b. By failing to perform a timely and reasonable investigation prior to denying 47 (27%) of 173 claim files reviewed, in apparent violation of A.R.S. §§ 20-461(A)(3) and (4) and 20-3102(B), A.A.C. R20-6-801(F), and the 2008 Consent Order.

c. By failing to adjudicate Provider claims within 30 days of receipt of a clean claim in 92 (16%) of 569 claim files reviewed, in apparent violation of A.R.S. §§ 20-461(A)(5) and 20-3102(A).

d. By failing promptly to provide a reasonable explanation of the basis in the insurance policy relative to the facts or applicable law for denial of a claim in 177 (28%) of 643 claim files reviewed, in apparent violation of A.R.S. §20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

6. The Company passed Standard 16 "With Comment" with regard to eight claim samples reviewed by failing to pay or underpaying interest on nine claims for a total amount of $72.24.

7. The Company failed Standard No. 21, as follows:

a. By failing to use an acknowledgment letter for an Expedited Medical Review that indicated the correct time frame for reaching a determination, in apparent violation of A.R.S. § 20-2534(B).

b. By using EOBs and other documents for the denial of claims that gave incorrect information concerning the time frame for filing a first level appeal, in apparent violation of A.R.S. § 20-2533(D).

c. By failing with regard to denied claims to provide a notice to the member of the right to appeal the decision, in apparent violation of A.R.S. § 20-2533(D).

d. By failing at the conclusion of an Informal Reconsideration to advise the member of the right to proceed after the formal review to an external independent review, in apparent violation of A.R.S. § 20-2535(F), the 2001 Consent Order, and the 2004 Consent Order.

e. By failing at the conclusion of a Formal Appeal to advise the member of the right to proceed to an external independent review, in apparent violation of A.R.S. § 20-2536(G) and the 2001 Consent Order.

f. By failing to provide the criteria used and clinical reasons for the determination after a Formal Appeal, in apparent violation of A.R.S. § 20-2536(E)(2), the 2001 Consent Order, and the 2008 Consent Order.

g. By failing to forward two (22%) of nine requests for External Independent Review to the Department within five business days, in apparent violation of A.R.S. § 20-2537(C).

8. The Company passed Standards 1, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 17, 18, 19, 20, 22, 23, 24, 25, 26, and 27.

EXAMINATION FINDINGS – FAILED STANDARD 2

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

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

The Examiners reviewed advertising items produced by the Company in response to the ADVERTISING/MARKETING/SALES section of Attachment A of the Coordinator's Handbook. During the course of the examination, the Examiners also identified and requested 202 additional pieces of advertising in print format that had been filed with the Department but had not been included in the Company's response to the Coordinator's Handbook document request. The Examiners issued REQ388 for this purpose. The Company provided 198 of the 202 ads requested.

Not all of the advertising pieces produced by the Company met the criteria for review based on the scope of the examination. The following table indicates the nature of the ads (print, video, audio, etc.) and the number of ads reviewed by the Examiners:

Request	Type of Ad	Ads Produced	Ads Reviewed
Attachment A, ADV/MKT/Sales sec. A	Print media	11	9
Attachment A, ADV/MKT/Sales sec. B	TV ads	0	0
Attachment A, ADV/MKT/Sales sec. C	Radio	0	0
Attachment A, ADV/MKT/Sales sec. D	Direct Mail, Web,	280	244
Attachment A ADV/MKT/Sales sec. E	Producer-prepared	0	0
Attachment A, ADV/MKT/Sales sec. H	New Business	166	166
Attachment A, ADV/MKT/Sales sec. I	§20-2304 Disclosures	1	1
REQ388 (202 ads requested)	Print	198	198
Totals		**656**	**618**

Upon completion of their review of the 618 advertising, sales, and marketing items produced by the Company, the Examiners found that the Company failed Standard 2 with regard to the following:

Filing Advertising with the Department

During the examination period, the Company used 166 advertisements related to its various group and individual lines of business that it had failed to file with the Department prior to use, in apparent violation of A.R.S. § 20-1110(E). See PF # 168.

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

Maintaining Advertising, Notations, and Supporting Documentation

During the examination, the Examiners identified 202 pieces of advertising filed by the Company with the Department during the examination period, but not produced in response to the document request of Attachment A of the Coordinator's Handbook. The Examiners issued REQ388, requesting that the Company produce the 202 filed advertisements. The Company was unable to produce copies of four of these requested ads. The Examiners found that the Company failed to maintain the advertisements, notations, and supporting documentation for at least three years from the date of first dissemination, in apparent violation of A.A.C. R20-6-201.01(C). See PF # 213.

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

Advertising That Referenced Specific Policy Benefits

During the examination period, the Company used advertising items that referenced specific policy benefits, such as coverage for primary care and specialist office visits, emergency care, surgery, hospitalization, urgent care, preventive care, prescription drugs, and other health care services.

The Examiners found that the Company failed to identify and/or failed to prominently display under a conspicuous caption the policy exclusions, reductions, and limitations, including those for preexisting conditions, for specific benefits referenced, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(7) and (C)(9), by using the following:

- Thirty-six of 253 print ads produced in response to Attachment A, sections A through E, of the Coordinator's Handbook. See PF # 016.
- One of one web advertisement produced in response to Attachment A of the Coordinator's Handbook. See PF # 016.

- One of one Individual Medical new business proposal produced in response to Attachment A of the Coordinator's Handbook. See PF # 019.
- Versions of "movie clip" videos for Voluntary Limited Benefits Plans that describe benefits available from Limited Benefits Plans but failed to disclose any related exclusions, reductions and limitation, including exclusions, reductions and limitations applicable to preexisting conditions. See PF # 031.
- Eight of 198 print ads produced in response to REQ388. See PF # 210.

In addition to the findings listed above, the Examiners found that the Company failed to identify policy exclusions and limitations for specific benefits referenced, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(7), for an additional two of 253 print ads produced in response to Attachment A, sections A through E of the Coordinator's Handbook. See PF # 016.

The Examiners found that the Company failed to list the exclusions, reductions, and limitations related to preexisting conditions within the "Exclusions and Limitations" sections of six of 198 ads produced in response to REQ388. Instead, these exclusions, reductions, or limitations regarding preexisting conditions were listed in fine print in a separate location of the ad. The Company failed this Standard by failing to include the required disclosures in a conspicuous location and in close proximity to the statements to which the information relates, or under a prominent caption, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(D). See PF # 211 and # 219.

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

Misleading Content

During the examination period, the Company used advertisements that tended to mislead or deceive purchasers, exaggerate benefits, and/or failed to accurately describe benefits, in apparent violation of A.R.S. § 20-444(A), and A.A.C. R20-6-201(C)(2) and (C)(3), by using the following:

- Versions of "movie clip" videos for Voluntary Limited Benefits Plans that used print captions and a narrator to make the statement "CIGNA took care of all of my claims." See PF # 031.

- Two print ads that contained the statement "Complete Health Coverage for as low as $79.00 per month," where the term "Complete Health Coverage" is undefined and therefore exaggerates benefits. See PF # 212.

In support of its use of the video ads stating "CIGNA took care of all of my claims," (immediately above, Bullet 1), the Company asserted that the statement was based on a customer testimonial, but the Company was unable to provide the name of the author or a copy of the full testimonial in support of that assertion, in apparent violation of A.R.S. § 20-444(A), and A.A.C. R20-6-201(E)(1).

During the examination period the Company used advertising items that contained unsupported and undocumented statements regarding the Company's relative position in the insurance industry, by using the following:

- One group medical ad, which used the term "industry-leading customer service" without citing the source for this claim, in apparent violation of A.R.S. § 20-444(A) and A.A.C R20-6-201(I). See PF # 001.
- Versions of "movie clip" videos for Voluntary Limited Benefits Plans that stated "In fact we surpass the industry standard, turning around claims in an average of six days," in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(I) and (O). See PF # 031.
- A document entitled "Individual & Family Plans Sales Centers Communications and Messaging," which instructed producers to advise prospective insureds that the Company was ranked #1 among health insurers nationwide for paying claims promptly and accurately, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(I) and (O). See PF # 038.

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

EXAMINATION FINDINGS – FAILED STANDARD 3

Based on the Examiners' review of the Company's eligibility requirements for Individual medical insurance, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
3	The Company markets its products in a fair and nondiscriminatory manner to all eligible individuals and/or groups.	A.R.S. §§ 20-448, 20-2313

The Examiners reviewed 253 advertisements requested in Requests A through E of Attachment A in the Coordinator's Handbook. Three of the forms applied to individual medical advertising and contained the statement "Eligible applicants must be age 64½ or younger on the assigned effective date."

The Company did not provide actuarial support for the premise that a person who is age 64 years and six months old is not essentially of the same class and essentially the same hazard as a person whose age is 64 years or 64 years and five months. The Company failed Standard 3 and appears to be in violation of A.R.S. § 20-448(B) by unfairly discriminating in the eligibility requirements for its Individual medical insurance coverage. See PF # 018.

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

EXAMINATION FINDINGS – FAILED STANDARD 7

Based on the Examiners' review of the Company's sample policy forms provided by the Company in response to Attachment A, Underwriting/Portability/Guaranteed Issue section, Items A through C, of the Coordinator's Handbook, as well as the policy forms provided by the Company during the Examiners' review of claims, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
7	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. §§ 20-1205, 20-1342, *et al.*, including but not limited to A.R.S. § 20-1401.01

Renewal Notices

The Examiners reviewed two form letters provided in response to the Attachment A Materials Review request and used to notify employers of renewal terms. The renewal letters failed to include an explanation of the extent to which any increase in premium was due to the actual or expected claims experience of the individuals covered under the plan. The Company did not meet Standard No. 7 and appears to be in violation of A.R.S. § 20-2309(A) and the 2004 Consent Order. See PF # 021.

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

Disclosure Authorization

The Examiners reviewed application forms and enrollment change forms for each policy issued during the examination period. The Company provided these forms in response to Items A through C of the UNDERWRITING/PORTABILITY/GUARANTEED ISSUE section of Attachment A of the Coordinator's Handbook.

The Examiners found that the Company failed Standard 7 in apparent violation of A.R.S. § 20-2106(7)(a) and the 2004 Consent Order by using forms for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement or a request for change in policy benefits that failed to limit the disclosure authorization to 30 months. See PF # 036. The findings included the following types of forms:

- Two dental enrollment forms

- Two dental and Vision enrollment forms
- Three medical enrollment/change of coverage forms.

The Examiners reviewed one application form for enrolling individuals in Group Term Life, Group Universal Life, Accident Coverage and Short-Term Disability Coverage. The form contained an authorization for disclosures in connection with claims for benefits under the insurance policy. The form limited the disclosure authorization to 30 months, rather than to the duration of the claim, in apparent violation of A.R.S. § 20-2106(8)(b). See PF # 025.

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

EXAMINATION FINDINGS – FAILED STANDARD 15

Based on the Examiners' review of the Company's sample policy forms, underwriting manuals and procedures provided by the Company in response to Attachment A of the Coordinator's Handbook, as well as documents supplied by the Company in response to the Examiners' requests for additional information, the Company failed to meet the following standard for review:

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

Notice of Privacy Practices

The Examiners reviewed three Notice of Privacy Practices forms provided in response to the Attachment A Materials Review request of the Coordinator's Handbook. The Examiners found that the Company did not provide the Notice of Privacy Practices, in the case of a policy renewal, at least annually during the continuation of the relationship with the policyholder. The Company failed Standard No. 15 in apparent violation of A.R.S. § 20-2104(B)(2), because the Company's procedures state that it provides the following Notice of Privacy Practices forms only once every three years. See PF # 004.

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

Notice of Appeal of an Adverse Underwriting Decision

The Examiners reviewed seven form letters used by the Company to notify a proposed insured of an adverse underwriting decision. The Company provided these forms in response to the Attachment A Materials Review request of the Coordinator's Handbook. Three of the seven letters were intended for use with the Company's Individual insurance plans.

The Examiners found that by using two of these form letters, one for declining insurance and one for rating up the premiums, the Company allowed only 30 days for the proposed insured to request additional information and/or appeal the adverse underwriting decision. The Company failed Standard No. 15 in apparent violation of A.R.S. § 20-2110(B), because the Company used notices of adverse underwriting decisions that failed to allow 90 days to request additional information and/or appeal the adverse underwriting decision. See PF # 005.

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

Summary of Rights

The Examiners reviewed two form letters used by the Company to notify applicants for Individual insurance coverage of an adverse underwriting decision. The Company failed Standard 15 by failing to provide a Summary of Rights established by A.R.S. §§ 20-2108 and 20-2109 at the time the Company communicated the adverse underwriting decision, in apparent violation of A.R.S. § 20-2110(A). See PF # 028.

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

EXAMINATION FINDINGS – FAILED STANDARD 16

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

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

The Company provided claims data in response to Attachment C of the Coordinator's Handbook. The Examiners used ACL software to analyze the data and select random and/or stratified random samples of claims using ACL's random number generator feature.

Based on the way the Company maintains its claims records, the Company was unable to provide a single record for each claim number. The Company stores claims data by claim line, with each claim number having up to 485 lines. To identify individual claims by claim number, the Examiners extracted all records labeled as Line #1 or Line #2. From this, the Examiners were better able to distinguish paid claims from denied claims. Finally, the Examiners limited the data to one record for each claim number to reduce having duplicates of the same claim number being selected during the random sampling.

Claims may be processed in one of two ways. The Company auto-adjudicates some claims using computer systems without intervention by a claims representative. Manually adjudicated claims involve action by a claims representative at some stage of the processing of the claim.

The Company uses two separate claim systems: Proclaim and PMHS. During the examination period, Arizona claims were processed in any one of the Company's 12 internal claims offices, and each office uses both the Proclaim and the PMHS systems. The Examiners concluded that either claims system would auto-adjudicate claims uniformly, regardless of which claims office handled the claim. Those claims that were manually adjudicated by a claims representative might result in different outcomes depending on the claims office. As a result, the Examiners selected one Proclaim and one PMHS "paid" and one Proclaim and one PMHS "denied" claim sample for each line of business. The files for each "auto-adjudicated" sample were drawn from all 12 claims offices combined. The Examiners reviewed all sample claims provided, except those that fell outside the scope of the examination, and applied the pertinent statutes and rules to each claim, regardless of name of the sample.

For manually adjudicated claims, the Examiners selected stratified random samples, with a representative number of claim files from each of the three years of the examination period, for "paid" or "denied" claims from each of the 12 claims offices and for each line of business processed by that claims office.

In addition to its own internal claims systems, the Company used various TPAs during the examination period to process claims for specific lines of business, including but not limited to specific benefits or ancillary services such as chiropractic, vision and dental benefits. The Examiners used the same methodology as described above for randomly selecting claims for review, by line of business, from each of these TPAs.

Because of the three-year examination period, the number of claims centers (i.e., Company claims offices and/or TPAs) used by the Company during the examination period, the number of lines of business processed by each claims center, and the need to review paid and denied claims separately, the Examiners requested and reviewed 200 claim samples, consisting of a total of 10,887 files. The Examiners wish to express their appreciation for the courtesy and professionalism of the Company and TPA staff who participated in the production of these files for review.

At the conclusion of the examination, the Examiners reviewed the preliminary findings issued for each claims center to determine whether the findings for any individual claim center rose to the level of a business practice, as established by the Department. Violation rates of less than 5% or consisting of a single incident within the sample were found to have passed Standard 16, and those preliminary findings were ultimately withdrawn and have not been included in this report. Violation rates of 5% or more are included, as follows:

Misrepresentation of Policy Benefits

The Examiners reviewed Insured claims to determine that claims are paid fairly and in accordance with policy provisions. The Examiners reviewed policy documents, including the master policies as well as the evidence of coverage and summary of benefits provided to the insured.

The Company failed Standard 16 in apparent violation of A.R.S. § 20-461(A)(1) and A.A.C. R20-6-801(D)(1) by failing to accurately apply benefits as described in the policy documents, and thereby misrepresenting the benefits payable under the policy, as follows:

1. The Examiners reviewed 100 PMHS Large Group Denied claims processed by the Claim Office #17, provided by the Company in response to REQ321. The Examiners' found in

nine (9%) of 100 files reviewed that the claims were denied on the basis that the member had not selected a PCP. A thorough review of the certificate of coverage revealed no exclusionary language based on the failure of the Insured to select a PCP. See PF # 214.

2. The Examiners reviewed 54 PMHS Large Group Medical Paid claims processed by Claim Office #22 and provided by the Company in response to REQ299. The Examiners' found in three (6%) of 54 files (see table below) reviewed that the claims were improperly denied and the denials misrepresented pertinent facts or insurance policy provisions relating to coverages at issue. Each of these files was improperly denied under the Reason code that states, "SERVICES PROVIDED BY A NON-PARTICIPATING PROVIDER ARE NOT COVERED SINCE THE MEMBER'S PLAN HAS NO OUT-OF-NETWORK BENEFITS, MEMBER RESPONSIBLE". Each of these claims was later adjusted and paid based on an appeal or a phone call from the provider indicating that the provider was a participating provider. See PF # 132.

3. The Examiners reviewed 110 Chiropractic Paid claims processed by the third party administrator ASHN in 2009 and 2010, and provided by the Company in response to REQ061 and REQ063. The Examiners' found that in 20 (18%) of the 110 files reviewed the Company denied claims on the basis that the provider had failed to obtain a PCP referral for chiropractic care. This denial resulted in the insured being liable for the billed services. However, none of the policies under which these claims were processed required a PCP referral. See PF # 077.

4. The Examiners reviewed 107 Chiropractic Denied claims processed by the third party administrator ASHN in 2009 and 2010, and provided by the Company in response to REQ062 and REQ064. The copay described in the policy documents was greater than that applied to 19 (18%) of the 107 files reviewed. The Company applied a lower copayment to these 19 claims, resulting in an overpayment of policy benefits to the providers involved. See PF # 073.

5. The Examiners reviewed 159 Paid claims processed by the third party administrator CBH-Net, provided by the Company in response to REQ142, REQ144, and REQ146. The copay described in the policy documents was greater than that applied to 26 (16%) of the 159 files reviewed, the Company applied a lower copayment to the claim, resulting in an overpayment of policy benefits to the providers involved. See PFs # 066 and # 082.

The Company processed 12 of the claims in 2008, one claim in 2009, and 13 claims in 2010.

6. The Examiners reviewed 55 Denied claims processed by the third party administrator CBH-Net in 2010, provided by the Company in response to REQ147. The copay described in the policy documents was greater than that applied to nine (16%) of the 55 files reviewed. The Company applied a lower copayment to these nine claims, resulting in an overpayment of policy benefits to the providers involved. See PF # 065.

7. The Examiners reviewed 55 Large Group Voluntary Emergency Room Paid claims provided by the Company in response to REQ317. In three (5%) of the 55 files reviewed, the Company paid benefits under a discounted fee schedule for network providers, but indicated that the Insured was responsible for the discounted amount. See PF # 155.

Subsequent Events

As a result of these findings, the Company voluntarily instituted refresher training for claims personnel and issued new claim procedures designed to prevent the issuance of EOBs that indicate that the patient is liable for billed services when there is no patient liability due to the Network Agreement between the Company and the Provider.

8. The Examiners reviewed 10 Voluntary "Other" Denied claims provided by the Company in response to REQ206. In two (20%) of the 10 files reviewed, the Company failed to apply policy benefits as described by the policy instruments, resulting in inappropriate denial of the claims. See PF # 090. The benefits were misrepresented as follows:

   a. One claim was denied using a reason code stating "MUST BE ON PLAN 9 MONTHS TO BE ELIGIBLE" and "PRE-EXISTING CONDITIONS ARE NOT COVERED" when there were no applicable policy provisions to support this denial.

   b. One claim was denied using a reason code stating "PRE-EXISTING CONDITIONS ARE NOT COVERED;" however, the Insured had been continuously insured since 2005, and her 12-month Pre-Existing Condition Limitation was no longer applicable.

Subsequent Events

At the conclusion of the examination the Company provided documentation showing that the claims listed cited in PF # 090 had been reprocessed and paid. The Company paid benefits on the first claim listed above in the amount of of $2,750.00 plus interest in the

amount of $1,283.21. The Company paid benefits on the second claim in the amount of $160.71 plus interest in the amount of $56.41. The Company paid $4,250.33 in total restitution on these claims.

Summary of Findings – Misrepresentation of Policy Benefits

Sample Description	Claim Office	Population	Sample Size	Insured Claims Reviewed	Exceptions	Error Ratio	PF #
PMHS LG Medical Denied	#17	12,099	110	100	9	9%	214
PMHS LG Medical Paid	#22	1,690	55	54	3	6%	132
Chiropractic Paid 2009-10	ASHN	217	110	110	20	18%	077
Chiropractic Denied 2009-10	ASHN	454	110	107	19	18%	073
CBH Paid	CBH-Net	4,895	165	159	26	16%	066/082
2010 CBH Denied	CBH-Net	85	55	55	9	16%	065
Voluntary LG ER Paid	VOL	1,269	55	55	3	5%	155
Voluntary Other Denied	VOL	10	10	10	2	20%	090
Total		**20,719**	**670**	**650**	**91**	**14%**	

A 14% error ratio does not meet the standard; therefore recommendations are warranted.

Timely and Reasonable Investigation of Claims

The Examiners reviewed claims to determine that, where needed, incomplete claims are promptly investigated. The Examiners reviewed claim samples along with policy documents and summaries of benefits.

The Company failed Standard 16 in apparent violation of A.R.S. §§ 20-461(A)(3) and (4) and 20-3102(B), A.A.C. R20-6-801(F), and the 2008 Consent Order by failing to investigate Provider claims promptly, as follows:

1. The Examiners reviewed 100 PMHS Large Group Denied claims processed by Claim Office #17, provided by the Company in response to REQ321. The Examiners identified six (6%) of the 100 claims where the Company failed to perform a reasonable investigation before denying benefits on the basis that the Insured had not selected a primary care physician ("PCP"). In two of the six claims, the services involved a self-referral allowed under the policy, and therefore no PCP was required. In the remaining four claims, the services were provided by the Insured's PCP, and therefore a PCP had been selected. See PF # 220.
2. The Examiners reviewed 107 Voluntary Denied claims provided by the Company in response to REQ177. The Examiners identified 18 (17%) of the 107 claims where the Company failed to conduct a reasonable investigation prior to denying the claims. The Company's stated practice with regard to these claims was not to "pend" the claim until an investigation could be completed, but rather to close the claim and issue an EOB

indicating nonpayment of the claim, in most cases, prior to requesting additional information needed to process the claim. In effect, the Company denied claims at this point. The Company states that it does not "reopen" the claim and send any further notice of denial if the requested information is not received. This is further evidence that the Company denied the claim at the time the initial EOB was issued, without having first conducted a reasonable investigation. See PF # 052.

3. The Examiners reviewed 110 Voluntary Paid Claims provided by the Company in response to REQ176. The Examiners identified 18 files from this sample that were actually denied claims, in whole or in part. From this subset of 18 files, the Examiners identified two (11%) of the 18 files where the Company imposed a financial penalty (partial denial) for the misuse of emergency services. The Company failed Standard 16 by partially denying these emergency services claims while failing to request medical records or to perform any other reasonable investigation into the presentation symptoms of the patient at the time care was sought. See PF # 080.

4. As a result of the review of the two claims cited in Item 3 above, the Examiners requested and reviewed 55 additional Emergency Services Paid claims processed by Combined Claims Offices, and provided by the Company in response to REQ317. The Examiners identified 39 (71%) of the 55 claims where the Company applied the policies' financial penalties, which constitute a partial claim denial, based on the ultimate diagnosis without requesting medical records or conducting any type of investigation to ascertain the severity of the presenting symptoms. See PF # 165.

A.R.S. § 20-2801(3) defines "emergency services" as follows:

> 20-2801. Definitions
> In this chapter, unless the context otherwise requires:
> * * *
> 3. "Emergency services" means health care services that are provided to an enrollee in a licensed hospital emergency facility by a provider after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:
> (a) Serious jeopardy to the patient's health.
> (b) Serious impairment to bodily functions.
> (c) Serious dysfunction of any bodily organ or part.

(Emphasis added). The Examiners confirmed that the two policies under which these claims were processed provide for a financial penalty to the Insured for the misuse of the

emergency room services. In addition, the Examiners confirmed that the policies include the following definitions of "emergency care":

> [1] Emergency Care means medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain that is severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following: 1. The patient's health would be placed in serious jeopardy; 2. Bodily function would be seriously impaired; 3. There would be serious dysfunction of a bodily organ or part.
>
> And/or
>
> [2] Emergency Care means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, Sickness or Injury is of such a nature that failure to get immediate medical care could result in: 1. Placing the patient's health in serious jeopardy; 2. Serious impairment of bodily functions; 3. Serious dysfunction of any bodily organ or part; 4. Serious disfigurement; or 5. In the case of a pregnant woman, serious jeopardy to the health of a fetus.

According to all three of these definitions, proper use of the emergency room depends on the severity of the patient's symptoms and a reasonable concern for serious potential outcomes rather than on the ultimate diagnosis.

Summary of Findings – Timely and Reasonable Investigation of Claims

Sample Description	Claim Center	Population	Sample Size	Insured Claims Reviewed	Exceptions	Error Ratio	PF #
PMHS LG Denied	17	12,099	110	100	6	6%	220
Voluntary Denied	VOL	44,159	110	107	18	17%	052
Voluntary Paid	VOL	46,281	110	18	2	11%	080
Emergency Paid	CO	1,269	55	55	39	71%	165
Total		**103,808**	**385**	**280**	**65**	**23%**	

A 23% error ratio does not meet the standard; therefore recommendations are warranted.

Time Service for Adjudicating, Paying and/or Denying Claims

Provider Claim Processing

The Examiners reviewed Provider claims to determine the timeliness of the adjudication, payment and/or denial of the claim. The Examiners found that the Company failed Standard 16 by failing to adjudicate Provider claims within 30 days from receipt of the clean claim, in apparent violation of A.R.S. §§ 20-461(A)(5) and 20-3102(A), as follows:

1. The Examiners reviewed 50 manually adjudicated Proclaim Large Group Paid claims processed by Combined Other Claims Offices ("CO") and provided by the Company in response to REQ037. The Company paid all 50 of the 50 claims to the Provider. The Company failed to adjudicate five (10%) of the 50 Provider claims within 30 days after receipt of a clean claim. All five claims were paid in 2008. See PF # 016.
2. The Examiners reviewed 150 manually adjudicated Proclaim Large Group Paid claims processed by Claims Office #19 and provided by the Company in response to REQ035, REQ051, and REQ083. The Company paid all 150 of the 150 claims to the Provider. The Company failed to adjudicate 13 (9%) of the 150 Provider claims within 30 days after receipt of a clean claim. Four claims were paid in 2008, seven claims were paid in 2009, and two claims were paid in 2010. See PF # 012 and PF # 023.
3. The Examiners reviewed 98 manually adjudicated Proclaim Large Group Paid claims processed by Claims Office #36 and provided by the Company in response to REQ053 and REQ085. The Company paid all 98 of the 98 claims to the Provider. The Company failed to adjudicate 44 (45%) of the 98 Provider claims within 30 days after receipt of a clean claim. Nineteen claims were paid in 2009, and 25 were paid in 2010. See PF # 029.
4. The Examiners reviewed 150 Proclaim Small Group Paid claims processed by Claim Office #65 and provided by the Company in response to REQ108, REQ120, and REQ130. The Company paid all 150 claims to the Provider. The Company failed to adjudicate eight (5%) of the 150 claims within 30 days of receipt of a clean claim. The Company processed six of the claims in 2008, one claim in 2009, and one claim in 2010. See PF # 103.
5. The Examiners reviewed 55 manually adjudicated Proclaim Individual Medical Paid claims processed by Claim Office #68 and provided by the Company in response to REQ214. The Company paid 22 of the 55 claims to the Provider. The Company failed

to adjudicate two (9%) of the 22 claims within 30 days of receipt of a clean claim. One claim was processed in 2008, and one in 2010. See PF # 071.

6. The Examiners reviewed 110 manually adjudicated Proclaim Individual Medical Denied claims processed by Claims Office #86 and provided by the Company in response to REQ297. The Company paid all 110 of the 110 claims to the Provider. The Company failed to adjudicate seven (6%) of the 110 Provider claims more than 30 days after receipt of a clean claim. All seven claims were paid in 2010. See PF # 177.

Summary of Findings – Adjudication of Provider Claims

Description	Claim Office	Population	Sample Size	Provider Claims Reviewed	Exceptions	Error Ratio	PF #
Proclaim LG Paid	CO	318	50	50	5	10%	016
Proclaim LG Paid	19	73,620	150	150	13	9%	012/023
Proclaim LG Paid	36	417	98	98	44	45%	029
Proclaim SG Paid	65	4,799	150	150	8	5%	103
Proclaim Indiv. Medical Paid	68	231	55	22	2	9%	071
Proclaim Indiv. Med. Paid	86	10,062	110	110	7	6%	177
Totals		**89,447**	**613**	**580**	**79**	**14%**	

A 14% error ratio does not meet the standard; therefore recommendations are warranted.

Reasons for Denial of Claims

During the Examiners' review of samples of denied claims provided by the Company, the Examiners reviewed the EOBs sent to both the insured and the provider to determine the reasons for the denial of the claims. The Examiners found that the Company failed Standard 16 by failing promptly to provide a reasonable explanation of the basis in the insurance policy relative to the facts or applicable law for denial of a claim, in apparent violation of A.R.S. §20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a), as follows:

1. The Examiners reviewed 72 PMHS Large Group Denied claims processed by Claim Office #17 and provided by the Company in response to REQ321. The Company failed to provide a specific reason for the denial based on applicable policy provisions in 24 (33%) of the 72 claim files reviewed by:
    a. Denying two of the 72 claims using a reason code that stated "NOT COVERED BY YOUR PLAN. REFER TO PLAN DOCUMENT," thereby failing to provide the specific policy provision relied upon, and
    b. By failing to provide an EOB or other written notification to the member at the time 22 of the 72 claims were denied, thereby failing to provide, in writing, the specific reason for the denial of the claim. See PF # 188.
2. The Examiners reviewed 110 Proclaim Small Group Denied claims processed by Claim Office #86 and provided by the Company in response to REQ288. The Company denied nine (8%) of the 110 reviewed claims using a Reason Code that stated "FOR FUTURE EXPANSION." The Reason Code fails to provide a specific reason for the denial and/or to include the specific policy provision relied upon. See PF # 197.
3. The Examiners reviewed 107 Chiropractic Denied claims processed in 2009 and 2010 by third party administrator ASHN and provided by the Company in response to REQ062 and REQ064. The Company failed with regard to 19 (18%) of the 107 files reviewed to provide an EOB or other written notification to the member at the time the claim was denied, and therefore failed to provide, in writing, the specific reason for the denial of the claim. See PF # 075.
4. The Examiners reviewed 81 BOON 2008 Paid claims provided by the Company in response to REQ134. The Company failed to provide a specific reason for the denial based on applicable policy provisions in nine (11%) of the 81 claims reviewed by:

a. Denying two of the 81 claims using a Reason Code that stated: "This service is listed as an exclusion under the terms of your plan and therefore not covered," where no such exclusion was stated in the policy, and

b. By calculating surgery benefits on seven surgical claims based on an undisclosed schedule and formula known only to the Company, thereby making it impossible for the Insured to determine or estimate the surgical benefit payable under the policy. See PF # 079.

5. The Examiners reviewed 53 CBH-Net Denied claims processed by the third party administrator CBH-Net in 2008 and provided by the Company in response to REQ143. The Company failed with regard to 36 (68%) of the 53 claims reviewed to provide an EOB or other written notification to the member at the time the claim was denied, and therefore failed to provide, in writing, the specific reason for the denial of the claim. See PF # 062.

6. The Examiners reviewed 42 Vision Denied claims processed by the third party administrator VSP and provided by the Company in response to REQ225 and REQ341. The Company failed with regard to all 42 (100%) of the 42 files reviewed to provide an EOB or other written notification to the member at the time the claim was denied, and therefore failed to provide, in writing, the specific reason for the denial of the claim. See PF # 137.

7. The Examiners reviewed 110 Voluntary Paid claims provided by the Company in response to REQ176. The Examiners noted that 18 claims included in the sample were actually denied claims. The Company denied four (22%) of the 18 denied claims using a Reason Code that stated "NOT COVERED BY YOUR PLAN. REFER TO PLAN DOCUMENT." The Reason Code fails to provide a specific reason for the denial and/or to include the specific policy provision relied upon. See PF # 047.

8. The Examiners reviewed 55 Voluntary Dental Paid and 50 Voluntary Dental Denied claims provided by the Company in response to REQ203 and REQ204 respectively, for the years 2008, 2009 and 2010 inclusive. At least 11 of the claims included in the "Paid" sample were actually denied. Therefore, for purposes of the Examiners' findings, the two samples were combined. The Company denied five of the 105 reviewed claims with a reason code reading "EXCEEDS FREQUENCY LIMITS REFER TO FEE SCHEDULE." Twenty-five of the claims reviewed were denied using a reason code

reading "THIS DENTAL CODE IS NOT ON THE FEE SCHEDULE." The Explanations of Benefits ("EOBs") for these claims did not indicate the dental codes for the services denied. Without that information, the consumer could not refer to the schedule of benefits to determine whether the claim may have been denied in error. With regard to 30 (29%) of 105 Insured claims, the Company failed to provide, in written form on the EOB, the specific reason for the denial of the claim. See PF # 083.

9. The Examiners reviewed 55 Large Group Voluntary Emergency Room Denied claims provided by the Company in response to REQ317. The Company denied four (7%) of the 55 reviewed claims using a Reason Code that stated "NOT COVERED BY YOUR PLAN. REFER TO PLAN DOCUMENT." The Reason Code fails to provide a specific reason for the denial and/or to include the specific policy provision relied upon. See PF # 156.

Summary of Findings – Reasons for the Denial of Claims

Description	Claim Office	Population	Sample Size	Claims Reviewed	Exceptions	Error Ratio	PF #
PMHS LG Denied	#17	12,099	110	72	24	33%	188
Proclaim SG Denied	#86	8,680	110	110	9	8%	197
Chiropractor Denied 2009-2010	ASHN	454	110	107	19	18%	075
BOON Paid – 2008	BOON	5,806	110	81	9	11%	079
CBH-Net Denied – 2008	CBH	578	55	53	36	68%	062
Vision Denied	VSP	1,911	50	42	42	100%	137
Voluntary Paid	VOL	46,281	110	18	4	22%	047
Voluntary Dental Paid & Denied	VOL	3,789	105	105	30	29%	083
Voluntary LG ER claims	VOL	1,269	55	55	4	7%	156
Totals		**80,867**	**815**	**643**	**177**	**28%**	

A 28% error ratio does not meet the standard; therefore recommendations are warranted.

Samples That Passed Standard 16 With Comment

The Department has established a benchmark of 5% for compliance with the review standards for market conduct examinations, except in the area of policies and procedures and/or forms review. Although the following samples met the established benchmark, they are included in this Report because of unpaid or underpaid interest of more than one dollar per each claim noted, for which restitution may be required:

The following samples passed Standard 16, but failed to pay or underpaid interest on claims payable directly to the Provider, in apparent violation of A.R.S. § 20-3102(A):

1. The Company failed to pay interest in the amount of $2.56 on one (1%) paid claim processed by Claim Office #19 from a sample of 110 Proclaim Large Group Denied claims provided by the Company in response to REQ243. See PF # 143.
2. The Company failed to pay interest in the amount of $9.64 on three (3%) paid claims processed by Claim Office #19 from a sample of 109 PMHS Large Group Paid claim provided by the Company in response to REQ289. See PF # 130.
3. The Company failed to pay interest in the amount of $10.95 on one paid claim processed by Claim Office #65 from a sample of 110 Proclaim Large Group Denied claims provided by the Company in response to REQ249. See PF # 148.
4. The Company failed to pay interest in the amount of $1.07 on one paid claim processed by Claim Office #65 from a sample of 55 PMHS Large Group Paid claims provided by the Company in response to REQ301. See PF # 130.
5. The Company failed to pay interest in the amount of $2.23 on one paid claim processed by Claim Office #68 from a sample of 108 PMHS Large Group Paid claims provided by the Company in response to REQ302. See PF # 130.
6. The Company failed to pay interest in the amount of $14.98 on one paid claim processed by Claim Office #86 from a sample of 150 Proclaim Small Group Paid claims provided by the Company in response to REQ112, REQ124, and REQ133. See PF # 113.
7. The Company failed to pay interest in the amount of $14.44 on one paid claim processed by third party administrator BOON from a sample of 55 Medical Denied claims provided by the Company in response to REQ135 and REQ316. See PF # 118.
8. The Company failed to pay interest in the amount of $16.37 on one paid claim processed by Claim office #82 from a sample of 100 Proclaim Small Group Paid claims provided by the Company in response to REQ111 and REQ123. See PF # 118.

Summary of Findings – Passed With Comment

Description	Claim Office	Population	Sample Size	Claims Reviewed	Exceptions	Interest Due	PF #
Proclaim LG Denied	#19	40,214	110	110	1	$ 2.56	143
PMHS LG Paid	#19	6,628	110	109	3	$ 9.64	130
Proclaim LG Denied	#65	6,303	110	110	1	$ 10.95	148
PMHS LG Paid	#65	71	55	55	1	$ 1.07	130
PMHS LG Paid	#68	7,321	110	108	1	$ 2.23	130
Proclaim SG Paid	#86	13,549	150	150	1	$ 14.98	113
BOON Paid	BOON	3,378	55	55	1	$ 14.44	118
Proclaim SG Paid	#82	2,385	100	100	1	$16.37	118
Totals		**79,849**	**800**	**797**	**10**	**$72.24**	

Restitution may be owed on these nine claims; therefore recommendations are warranted.

EXAMINATION FINDINGS – FAILED STANDARD 21

Based on the Examiners' review of the Company's policy forms, claim forms, sample claims, the Appeal Information Packet, appeal policies and procedures, and sample appeals handled by the Company during the examination period, the Company failed to meet the following standard for review:

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

Notice of Appeal Rights

Acknowledgment Letter

The Examiners reviewed eight Expedited Medical Review files provided by the Company in response to REQ013. The Company failed Standard 21, in apparent violation of A.R.S. § 20-2534(B) by using one acknowledgment letter that notified the member that the Company had 15 business days to make a determination. See PF # 053.

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

Inadequate Notice of Right to Informal Reconsideration

The Examiners reviewed various EOBs and other documents used by the Company and its TPAs during claims processing for notifying the member and the member's treating provider of the right to appeal a denied claim. The Company failed Standard 21 in apparent violation of A.R.S. § 20-2533(D) as follows:

1. The Examiners reviewed samples of appeals processed by the Company during the examination period. The Company has failed Standard 21, in apparent violation of A.R.S. § 20-2533(D) by failing to provide the notice of the right to appeal a denied claim to the member at the time of the denial. In notifying the member of the denial, the Company used:
   a. A letter from the Starbridge plan requiring appeals to be submitted "no more than fifteen months after the service was provided." See PF # 084.

b. A letter from the CIGNA Voluntary plan requiring appeals to be submitted "no more than one year after the service was rendered." See PF # 084.

c. A letter advising the member, at the conclusion of a first-level appeal, to submit a complaint to the Maryland Insurance Commissioner. See PF # 086.

2. The Examiners reviewed claim samples provided by the Company for various lines of business. Within the claim files, the Examiners identified numerous EOB forms and claim denial letters used by the Company during the examination period in the processing of claims. The forms and other documents contain notices advising the member that an appeal from a denied claim must be in writing and must be filed within 180 days from the date of the denial. The Company has failed Standard 21, in apparent violation of A.R.S. § 20-2533(D) by failing to advise members that a first-level appeal from a denied claim may be filed orally or in writing within two years of the date of the denial, as prescribed by A.R.S. § 20-2535(A) or in writing within two years of the date of the denial as prescribed by A.R.S. § 20-2536(A). See PFs # 013, 014, 015, 022, 035, 040, 045, 084, 088, 122, 131, and 217.

3. The Examiners reviewed 72 PMHS Large Group denied claims that had been manually adjudicated by Claims Office #17 provided by the Company in response to REQ321. The Examiners identified 22 (31%) of the 72 denied claim files reviewed where the Company failed, at the time of issuing a denial, to issue an EOB or other notice notifying the members of the member's right to appeal. See PF # 187.

4. The Examiners reviewed 53 denied medical claims adjudicated by third party administrator CBH-Net during 2008. The Company provided these claims in response to REQ143. The Examiners identified 36 (68%) of the 53 sample claims where the Company failed to issue an EOB or other notice at the time of the denial to the member concerning the member's right to appeal the denial. See PF # 061.

5. The Examiners reviewed 107 denied chiropractic claims adjudicated by third party administrator ASHN during 2009 and 2010. The Company provided these claims in response to REQ062 and REQ064. The Examiners identified 107 (100%) of the 107 sample claims where the Company failed to issue an EOB or other notice at the time of the denial to the member concerning the member's right to appeal the denial. See PF # 074.

6. The Examiners reviewed 42 denied Vision claims adjudicated by the Company during the examination period. The Company provided these claims in response to REQ225 and REQ341. The Examiners identified 42 (100%) of the 42 sample claims where the Company failed to issue an EOB or other notice at the time of the denial to the member concerning the member's right to appeal the denial. See PF # 136.

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

Determination Letters Upholding a Claim Denial

The Examiners reviewed a sample of one Voluntary medical appeal from a denied claim from 2008, provided by the Company in response to REQ164. The provider submitted this appeal on behalf of the member. The Company upheld the denial based on policy benefit limits, but included the following statement in the decision letter:

> "The plan has a time limit of 180 days from the receipt of your Explanation of Benefits to request an appeal. The time limit for filing an appeal on this claim has passed. Please contact our Customer Service Department at *800) 308-5948 for answers to any additional questions you may have."

The Company disregarded that this was an appeal of a denied claim for which the member became financially responsible and appears to have held the provider to the timeframes established in its provider grievance process, per A.R.S. § 20-3102(F). The provider grievance process is intended for the settlement of disputes affecting the provider's financial burden for treatment costs: "A health care insurer shall establish an internal system for resolving payment disputes and other contractual grievances with health care providers." Nothing in A.R.S. § 20-3102(F) supersedes the right of a treating provider to appeal a denied claim on behalf of a member in accordance with A.R.S. § 20-2530(1):

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

(Emphasis added). The Company's Appeal Information Packet, as approved by the Department, affords members an informal reconsideration as prescribed by A.R.S. § 20-2535. A member has two years from the date the claim is denied to file a request for an informal

reconsideration. The Company has failed Standard 21, in apparent violation of A.R.S. § 20-2535(F), the 2001 Consent Order, and the 2004 Consent Order by failing to advise the member of the right to proceed after the formal appeal to an external independent review. See PF # 084.

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

The Examiners reviewed various appeal samples provided by the Company during the examination. The Examiners identified decision letters in some files where Company:

1. Failed at the conclusion of the first level appeal, where the Company upheld the denial of the claim, to use a form that advises the member of the right to proceed after the formal appeal to an external independent review, in apparent violation of A.R.S. § 20-2535(F), the 2001 Consent Order, and the 2004 Consent Order. See PFs # 086 and 087.
2. Failed at the conclusion of the second level appeal, where the Company upheld the denial of the claim, to use a form that advises the member of the right to proceed to an external independent review, in apparent violation of A.R.S. § 20-2536(G) and the 2001 Consent Order. See PFs # 087 and 092-Amended.

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

Criteria Used and Clinical Reasons for Upholding the Denial

The Examiners reviewed various appeal samples provided by the Company during the examination. The Examiners identified decision letters in some files where the Company failed to provide the criteria used and the clinical reasons for upholding the denial of the claim, in apparent violation of A.R.S. § 20-2536(E)(2), the 2001 Consent Order, and the 2008 Consent Order. See PF # 086.

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

Appeal Procedures and Timeliness

The Examiners reviewed the Company appeal procedures, Appeal Information Packet, and various samples of claim and appeal files to determine whether the Company complies with A.R.S. §§ 20-2530, *et seq*. The Company failed Standard 21 as follows:

External Independent Reviews

The Examiners reviewed nine External Independent Review files provided by the Company in response to REQ014. The Examiners identified two (22%) of the nine files where the Company failed to forward the request to the Department within five business days. The Company has failed Standard 21, in apparent violation of A.R.S. § 20-2537(C). See PF # 054. The Company processed one of the External Independent Reviews in 2009 and one in 2010.

Summary of Findings – Appeal Procedures and Timeliness

Description	Population	Sample Size	Exceptions	Error Ratio	PF #
External Independent Review	9	9	2	22%	054
Totals	**9**	**9**	**2**	**22%**	

A 22% error ratio does not meet the standard; therefore recommendations are warranted.

RECOMMENDATIONS

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

1. The Company files all health insurance advertising with the Department prior to its use, to comply with A.R.S. § 20-1110(E).
2. The Company maintains advertising, along with notations and supporting documents, for at least three years from the date of dissemination, to comply with A.A.C. R20-6-201.01(C).
3. The Company includes the relevant exclusions, reductions or limitations in a conspicuous location and in close proximity to the description of benefits in its advertising, to comply with A.R.S. § 20-444(A) and A.A.C R20-6-201(C)(7), (C)(9), and (D).
4. The Company does not make unsupported and undocumented assertions regarding the policy benefits, claims handling, and/or regarding the Company's relative position in the insurance industry, to comply with A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(2), (C)(3), (I), and (O).
5. The Company does not use "testimonial" advertising without being able to produce the name of the author or the full text of the testimonial, to comply with A.R.S. § 20-444(A) and A.A.C. R20-6-201(E)(1).
6. The Company offers Individual insurance to persons between the ages of 64½ and 65 under the same terms and conditions as other applicants in the same class and essentially the same hazard, to comply with A.R.S. § 20-448(B).
7. The Company uses renewal letters to employers that include an explanation of the extent to which any increase in premium is due to the actual or expected experience of the individuals covered under the plan, to comply with A.R.S. § 20-2309(A).
8. The Company uses forms for the purpose of collecting information in connection with an application for insurance coverage that limits disclosure authorizations to not more than 30 months, to comply with A.R.S. § 20-2106(7)(a).
9. The Company uses forms for the purpose of collecting information in connection with a claim for insurance benefits for other than health insurance that limit

disclosure authorizations to the duration of the claims, to comply with A.R.S. § 20-2106(8)(b).

10. The Company provides policyholders with a Notice of Insurance Information Practices at least annually, to comply with A.R.S. § 20-2104(B)(2).

11. The Company allows prospective insureds 90 days in which to request additional information or appeal an adverse underwriting decision, to comply with A.R.S. § 20-2110(B).

12. The Company includes with all notices of an adverse underwriting decision a Summary of Rights that meets the requirements of A.R.S. §§ 20-2108 and 20-2109, to comply with A.R.S. § 20-2110(A).

13. The Company fully discloses benefits payable under the policy, to comply with A.R.S. § 20-461(A)(1) and A.A.C. R20-6-801(D)(1).

14. The Company performs a timely and reasonable investigation prior to denying claims, to comply with A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).

15. The Company adjudicates Provider claims within 30 days of receipt of a clean claim, to comply with A.R.S. §§ 20-461(A)(5) and 20-3102(A).

16. The Company promptly provides a reasonable explanation of the basis in the insurance policy relative to the facts or applicable law for denial of a claim, to comply with A.R.S. §20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

17. The Company uses an acknowledgment letter for an Expedited Medical Review that indicated the correct time frame for reaching a determination, to comply with A.R.S. § 20-2534(B).

18. The Company uses EOBs and other documents for the denial of claims that give the correct information concerning the time frame for filing a first level appeal, to comply with A.R.S. § 20-2533(D).

19. The Company provides a notice to the member of the right to appeal a denied claim decision, to comply with A.R.S. § 20-2533(D).

20. The Company advises the member at the conclusion of an Informal Reconsideration of the right to proceed after the formal review to an external independent review, to comply with A.R.S. § 20-2535(F).

21. The Company advises the member at the conclusion of a Formal Appeal of the right to proceed to an external independent review, to comply with A.R.S. § 20-2536(G).

22. The Company provides the criteria used and clinical reasons for the determination after a Formal Appeal, to comply with A.R.S. § 20-2536(E)(2).

23. The Company forwards requests for External Independent Review to the Department within five business days, to comply with A.R.S. § 20-2537(C).

SUMMARY OF STANDARDS

A. Operations and Management

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

B . Advertising, Marketing, and Sales

#	STANDARD	PASS	FAIL
2	All advertising and sales materials are in compliance with applicable statutes and rules. (A.R.S. §§ 20-442, 20-443, 20-444, 20-1137, and A.A.C. R20-6-201, R20-6-201.01, and R20-6-202)		X
3	The Company markets its products in a fair and nondiscriminatory manner to all eligible individuals and/or groups. (A.R.S. §§ 20-448, 20-2313)		X
4	The Company discloses information concerning the provisions of coverage, the benefits and the premiums available to small group employers as part of sales materials for its small group employers. (A.R.S. § 20-2304)	X	
5	**(Annuity only)** Company applications and policy/contract forms contain notices the right to request information regarding benefit and contract provisions and the right to return the contract for a refund of premium as prescribed by law. A.R.S. § 20-1233(A), (B) & (C)	X	
6	**(Annuity Only)** Company provides disclosure documents, buyer's guides and annual report to contract owners as prescribed by law. A.R.S. § 20-1242.02.	X	

C. Forms

#	STANDARD	PASS	FAIL
7	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. §§ 20-1205, 20-1342, *et al.*, including but not limited to A.R.S. § 20-1401.01)		X
8	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	
9	**(Annuity only)** Company applications and policy/contract forms contain notices the right to request information regarding benefit and contract provisions and the right to return the contract for a refund of premium as prescribed by law. A.R.S. § 20-1233(A), (B) & (C)	X	
10	**(Annuity Only)** Company provides disclosure documents, buyer's guides and annual report to contract owners as prescribed by law. A.R.S. § 20-1242.02.	X	

D. Underwriting/Portability/Guaranteed Issue

#	STANDARD	PASS	FAIL
11	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	
12	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	
13	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	
14	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	
15	The Company complies with all notice of insurance information and privacy requirements. (A.R.S. §§ 20-2101, *et seq.*)		X

E. Claims Processing

#	STANDARD	PASS	FAIL
16	Claims are handled timely and appropriately in accordance with policy provisions and applicable statutes and rules. (A.R.S. §§ 20-461, 20-462, and 20-1215, and A.A.C. R20-6-801)		X
17	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	
18	All claim forms contain an appropriate fraud warning. (A.R.S. § 20-466.03)	X	
19	The Company provides accurate benefits information to claimants and does not misstate pertinent provisions of the policy or Arizona law. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	

F. Policyholder Services

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

G. Cancellation, Non-Renewals, and Rescissions

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

H. Nonforfeiture, Dividends, Loans (Life and Annuity)

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

I. Replacements (Life and Annuity)

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