STATE OF ARIZONA
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DEPT. OF INSURANCE

REPORT OF TARGETED MARKET CONDUCT EXAMINATION

OF

JOHN ALDEN LIFE INSURANCE COMPANY

NAIC# 65080

AS OF

JUNE 30, 2008

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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:

JOHN ALDEN LIFE INSURANCE COMPANY

NAIC # 65080

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 John Alden Life Insurance Company, hereinafter referred to as the "Company" was performed at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss the findings set forth in this Report. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

Sandra Lewis

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

Subscribed and sworn to before me this 28th day of June, 2010.

Amanda A. Neff

Notary Public

My Commission Expires June 1, 2011

OFFICIAL SEAL
AMANDA A. NEFF
NOTARY PUBLIC - State of Arizona
PINAL COUNTY
My Comm. Expires June 1, 2011

FOREWORD

This targeted market examination of John Alden Life 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 29. The standards applied during Part 2 of the examination are stated in this Report at page 61.

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 May 24, 2000 the Company entered into a Consent Order, Docket No. 00A-085-INS ("Consent Order 2000"), and on February 5, 2003, the Company entered into a Consent Order, Docket No. 03A-023-INS ("Consent Order 2003") 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 29, and the examination findings are reported beginning on page 9.

BEST Claims Processing System

1. The Company failed Standard No. 1 in 10 (12%) of 84 files reviewed in two of 11 BEST denied claim 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 53 (22%) of 245 files reviewed in four of 11 BEST denied claim samples, in apparent violation of A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(D)(1) and (G)(1)(a) by misrepresenting or concealing pertinent facts or policy provisions pertinent to a claim, and by failing to provide a reasonable explanation for the denial of claims in sufficient detail to allow members and providers to appeal the 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 one Explanation of Benefits (EOB) form reviewed, to prominently display appeal information.

ACES Claims Processing System

5. The Company failed Standard No. 1 in 14 (11%) of 133 files reviewed in three of 10 ACES denied claim 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.
6. The Company failed Standard No. 2 in 16 (18%) of 90 files reviewed in three of 10 ACES denied claim samples, in apparent violation of A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(D)(1) and (G)(1)(a) by misrepresenting or concealing pertinent facts or policy provisions pertinent to a claim, and by failing to provide a reasonable

explanation for the denial of claims in sufficient detail to allow members and providers to appeal the adverse decision.

7. 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.

8. The Company failed Standard No. 2, in apparent violation of A.R.S. § 20-461(A)(1) and (A)(15) by failing:

   a. With regard to three EOB forms reviewed, to prominently display appeal information; and

   b. With regard to one EOB form reviewed, to correctly state the name of the insurer.

All Claim Systems

9. The Company failed Standard No. 3 in apparent violation of A.R.S. § 20-461(A)(1) and Consent Order 2000 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.

BEST Claims Processing System

The Examiners reviewed a sample of 46 claims-related requests for reconsideration selected from the Company's appeal log containing a population of 262 appeals. From these appeals, the Examiners noted certain trends of overturned denials related to similar procedural codes (CPT-4, HCPCS, etc.), as well as certain apparent trends related to overturned denials carrying the same EOB codes. From the review of the 46 files, the Examiners identified one CPT-4 code (A-0429) and one EOB message (F030) that appeared to be most commonly overturned on appeals. The Examiners used this information, along with an analysis of denied

claims, to extract a segmented population of denied claims that appeared to indicate a failure to adequately investigate claims prior to their denial.

The Company provided a population of 31,026 claims denied during the examination period. Using CPT codes and EOB codes identified during the review of appeals and denied claim populations, the Examiners extracted a subpopulation of 2,809 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 277 files based on the categories of denial codes reasons identified during the claims analysis. Three of the files did not meet the sample criteria and therefore only 274 files were actually reviewed. Based on the results under 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 217 denied claims for review. One sample of 55 files was selected from the subpopulation of claims denied as "experimental" "elective" or "routine" 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 "not covered" and this sample was reviewed under Standards 1 and 2. A third Phase II sample of 53 files was selected from the subpopulation of claims denied as "no pregnancy benefits" 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 as "work-related" and this sample was reviewed under Standards 1 and 2. Four of the files failed to meet the sample criteria and therefore 214 files were actually reviewed. Therefore, a total of 488 files were reviewed during the Phase I and Phase II examinations.

ACES Claims Processing System

The Examiners reviewed a sample of 16 claims-related requests for reconsideration selected from the Company's appeal log containing a population of 34 appeals. From these appeals, the Examiners noted certain trends of overturned denials related to similar procedural codes (CPT-4, HCPCS, etc.), as well as certain apparent trends related to overturned denials carrying the same EOB codes. From the review of the 16 files, the Examiners identified two EOB messages (0371 and 0832) that appeared to be most commonly overturned on appeals. The examiners used this information, along with an analysis of denied claims, to extract a segmented population of denied claims that appeared to indicate a failure to adequately investigate claims prior to their denial.

The Company provided a population of 10,161 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 1,525 denied claims in 10 categories based on the reasons given for the denial. During the Phase I review, the Examiners selected 10 random samples totaling 227 files based on the categories of denial codes reasons identified during the claims analysis. Two of the files did not meet the sample criteria and therefore only 225 files were actually reviewed. Based on the results under the Phase I examination, the Department initiated a Phase II examination of two of the categories of denial reason codes and selected two additional samples totaling 71 denied claims for review. One 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 second Phase II sample of 16 files was selected from the subpopulation of claims denied as "preexisting conditions" and this sample was reviewed under Standards 1 and 2. Two of the files did not meet the sample criteria and therefore only 69 files were actually reviewed. Therefore, a total of 294 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 appeals and denied claims, the Company failed to meet the following standard for review:

#	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)

The Examiners reviewed 11 claim samples from the BEST claims processing system and 10 samples from the ACES claims processing system and found apparent violations of Standard 1 as described below:

BEST Claims Processing System

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 under Reason code F023; and
2. Claims denied under CPT-4 code 59514.

Claims Denied Under Reason Codes F023.

Of the 11 categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 80 (29%) files from a subpopulation of 272 files denied using one or more of the following two reason codes indicating the claim was denied as "work-related" under the policy. The Company failed to meet the standard for the sample of claims denied under Reason code F023 as follows:

Seven (9%) of 80 claims denied using Reason code F023, which states: "Charges for work-related illnesses or injuries are not covered by your plan," 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 and PF #021.

Subsequent Events

Subsequent to the issuance of Preliminary Findings 007 and 021, the Company provided documentation to show that they had reprocessed one of the claims denied under Reason code

F023. Five claims denied under Reason code F023 were reprocessed by the Company prior to this examination. This information was provided to the Department by the Examiners.

Claims Denied Under CPT-4 Code 59514

Of the 11 categories of denied claims, the Examiners selected a sample during Phase I of four (100%) from a subpopulation of four files denied under CPT-4 code 59514 (Cesarean delivery only including postpartum care). The Company failed to meet the standard for claims denied under CPT-4 code 59514 as follows:

Three (75%) of four claims denied under CPT-4 code 59514 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 # 008.

Subsequent Events

Subsequent to the issuance of Preliminary Finding 008, the Company provided documentation to show that they had reprocessed each of the three claims denied under CPT-4 code 59514. This information was provided to the Department by the Examiners.

Summary of Standard 1 Findings (BEST System)

Denied Reason or CPT-4 Code	Population	Sample	# of Exceptions	Error Ratio	PF Reference
E050, E196, F030	102	82	24	29%	002, 024
E203, F123	279	77	8	10%	005, 022
E181, F023	272	80	7	9%	007, 021
59514	4	4	3	75%	008

Standard 1 Recommendations – BEST System

Within 90 days of the filed date of this Report, 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 to comply with A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F);
2. Reprocess claim WR-071 identified under #021 which was denied under Reason code F023 to determine whether the claim was denied inappropriately and without adequate investigation due to the fact that the treated condition was work-related when services were also provided for a condition that was not work-related;
3. Perform a self-audit of all claims denied under Reason code F023 during the three years prior to the date of the Report to determine whether other claims denied under Reason Code F023 have been denied inappropriately and without adequate investigation due to the fact that the treated condition was work-related when services were also provided for a condition that was not work-related;
4. Perform a self-audit of all claims denied under CPT-4 code 59515 during the three years prior to the date of the Report to determine whether other claims for cesarean sections denied under CPT-4 code 59515 have been denied inappropriately and without adequate investigation due to the fact that they were non-covered elective cesarean sections when in fact the cesarean sections were not elective and as such were covered complications of pregnancy;
5. Pay restitution including interest for any claim identified from the self-audits as having been denied inappropriately; and

6. 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.

ACES Claims Processing System

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 under Reason code 0953;
2. Claims denied under Reason codes 0005 and 0106; and
3. Claims denied under Reason code 0832.

Claims Denied Under Reason Codes 0009, 0912, 0925 and 0953

Of the 10 categories of denied claims, the Examiners selected samples during Phase I totaling 10 (100%) files from a subpopulation of 10 files denied using one or more of the following four reason codes indicating the claim was "adjusted" or "reprocessed" under the policy. The Company failed to meet the standard for the sample of claims denied under Reason codes 0009, 0912, 0925 and 0953 as follows:

Two (20%) of 10 claims reprocessed using Reason code 0953, which states "This expense is being reprocessed," 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 # 010.

Subsequent Events

Two claims reprocessed under Reason code 0953 were reprocessed by the Company prior to this examination. This information was provided to the Department by the Examiners.

Claims Denied Under Reason Codes 0005, 0106, 0107, 0113, 0120, 0302, 0384, 0422, 0497, 0510, 0529 and 0607

Of the 10 categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 80 (29%) files from a subpopulation of 274 files denied using one or more of the following 12 reason codes indicating the claim was denied as "not covered" under the policy. The Company failed to meet the standard for claims denied under Reason codes 0005, 0106, 0107, 0113, 0120, 0302, 0384, 0422, 0497, 0510, 0529 and 0607 as follows:

Five (6%) of 80 claims in this sample were denied using Reason codes 0005 and 0106. These five claims 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 # 014 Revised.

- Three of the claims were denied under Reason code 0005 which states: "Benefits are not available for the expense submitted."
- Two of the claims were denied under Reason code 0106 which states: "Your policy provides coverage for treatment of an illness or injury. The diagnosis provided for the services rendered represents a routine service and therefore is not covered."

Subsequent Events

Subsequent to the issuance of Preliminary Finding 014 Revised, the Company provided documentation to show that they had reprocessed one of the claims denied under Reason code 0005. Two claims denied under Reason code 0005 were reprocessed by the Company prior to this examination. This information was provided to the Department by the Examiners.

Claims Denied Under Reason Code 0832

Of the 10 categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 43 (100%) files from a subpopulation of 43 files denied using Reason code 0832 indicating the claim was denied for the following reason: "Based on our investigation we have determined this is a preexisting condition, therefore, benefits are not available." The Company failed to meet the standard for claims denied under Reason code 0832 as follows:

Seven (16%) of 43 claims denied under Reason code 0832 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 # 016 Revised.

Subsequent Events

Subsequent to the issuance of Preliminary Finding 016 Revised, the Company provided documentation to show that they had reprocessed seven of the claims denied under Reason code 0832. This information was provided to the Department by the Examiners.

Summary of Standard 1 Findings (ACES Claims Processing System)

Denied Reason Code	Population	Sample	# of Exceptions	Error Ratio	PF Reference
0009, 0912, 0925, 0953	10	10	2	20%	010
0005, 0106, 0107, 0113, 0120, 0302, 0384, 0422, 0497, 0510, 0529, 0607	274	80	5	6%	014 Revised
0832	43	43	7	16%	016 Revised

Standard 1 Recommendations – ACES System

Within 90 days of the filed date of this Report, 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 to comply with A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F);
2. Reprocess claims A-NC-027 and A-NC-073 identified under Preliminary Finding #014 Revised and denied under Reason code 0106 to determine if these claims were denied inappropriately and without adequate investigation as "not covered" routine services when the services were actually provided for covered medical conditions;
3. Perform a self-audit of all claims denied under Reason Codes Reason codes 0005, 0106, 0107, 0113, 0120, 0302, 0384, 0422, 0497, 0510, 0529 and 0607 during the three years prior to the date of the Report to determine whether other claims denied under these Reason codes have been denied inappropriately and without adequate investigation due to the fact that the denied services were not routine but were provided for covered medical conditions;
4. Perform a self-audit of all claims denied under Reason code 0832 during the three years prior to the date of the Report to determine whether other claims denied under Reason code 0842 have been denied inappropriately and without adequate investigation due to the fact that the Company denied claims on the basis that the diagnosis indicated a preexisting condition when the denied diagnoses represented medical conditions which had been determined not to be preexisting;

5. Pay restitution including interest for any claim identified from the self-audits as having been denied inappropriately; and
6. 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 appeals and denied claims, the Company failed to meet the following standard for review:

#	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)

The Examiners reviewed 11 claim samples from the BEST claims processing system and 10 samples from the ACES claims processing system and found apparent violations of Standard 2 as described below:

BEST Claims Processing System

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 under Reason codes E050, E196 and F030;
2. Claims denied under Reason codes E087, E294, E490, F049, and S157;
3. Claims denied under Reason code E203;
4. Claims denied under CPT-4 code 59514;
5. One policy form; and
6. One EOB form.

Claims Denied Under Reason Codes E050, E196 and F030

Of the 11 categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 82 (80%) files from a subpopulation of 102 files denied using one or more of the following three reason codes indicating the claim was denied as "experimental," "elective," or "routine" under the policy. The Company failed to meet the standard for claims denied under Reason codes E050, E196 and F030 as follows:

Twenty-eight (34%) of 82 claims in this sample were denied using Reason codes E050, E196, and F030 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 # 025.

- Three of the claims were denied using Reason code E050 which states: "Your medical plan does not cover services, treatments or supplies considered to be unsafe, experimental or investigational."
- Six of the claims were denied under using Reason code E196 which states: "Elective procedures are not covered by your plan."
- Nineteen of the claims were denied using Reason Code F030 which states: "Routine and/or elective procedures are not covered by your plan."

Claims Denied Under Reason Codes E087, E294, E449, E490, F049, F092, F308, S157 and S457

Of the 11 categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 82 (13%) files from a subpopulation of 619 files denied using one or more of the following nine reason codes indicating the claim was denied as "not covered" under the policy. The Company failed to meet the standard for this sample of claims denied under Reason codes E087, E294, E449, E490, F049, F092, F308, S157 and S457 as follows:

Twenty-two (27%) of 82 claims in this sample were denied under Reason codes E087, E294, E490, F049, and S157. These claims failed Standard 2 because the Company 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)(15) and A.A.C. R20-6-801(G)(1)(a). Reference PF # 004 and PF # 028.

- Five claims were denied using Reason code E087 which states: "Charges for this condition are not covered under your certificate."
- Two claims were denied under using Reason code E294 which states: "Inpatient/outpatient treatment of this condition is not covered."
- Three claims were denied using Reason code E490 which states: "These services are not covered under your contract."
- Five claims were denied using Reason code F049 which states: "This charge is not covered under your certificate."

- Seven claims were denied using Reason code S157 which states: "These charges are not covered under the certificate.

Claims Denied Under CPT-4 Code 59414

Of the 11 categories of denied claims, the Examiners selected a sample during Phase I of four (100%) from a subpopulation of four files denied under CPT-4 code 59514 (Cesarean delivery only including postpartum care). The Company failed to meet the standard for this sample of claims denied under CPT-4 code 59514 as follows:

Three (75%) of four claims denied under CPT-4 code 59514 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(D)(1) and (G)(1)(a). Reference PF # 009.

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 J4000 issued in Arizona as follows:

Policy for J4000 contained a limitation of 50 visits per year for outpatient therapy, except for services provided by chiropractors, which are limited to 20 outpatient visits per year. This discrimination against services or treatment provided by a chiropractor is expressly prohibited under A.R.S. § 20-461(A)(17), as well as by state law in Illinois where the master policy was issued. By denying claims under a policy limitation that 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 # 026.

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 one EOB form issued on denied Arizona claims because the form failed to prominently display the appeal information in apparent violation of A.R.S. § 20-2533(D). Reference PF # 019.

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 (BEST Claims Processing System)

Denied Reason or CPT-4 Codes	Population	Sample	# of Exceptions	Error Ratio	PF Reference
E050, E196, F030	102	82	28	34%	025
E087, E294, E449, E490, F049, F092, F308, S157, S457	619	82	22	27%	004,028
E203, E123	279	77	8	10%	006,023
59414	4	4	3	75%	009
Policy Forms	NA	NA	1	NA	026
EOB Forms	NA	NA	1	NA	019

Standard 2 Recommendations – BEST System

Within 90 days of the filed date of this Report, 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 to comply with A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(D)(1) and (G)(1)(a);
2. Provide documentation that the outpatient therapy limitation which discriminates against chiropractors and which is prohibited by statute has been removed from policy form J4000 to comply with A.R.S. § 20-461(A)(17).
3. Perform a self-audit of all claims where chiropractic services were denied under policy form J4000 during the three years prior to the date of the Report to determine whether claims for chiropractic services have been denied inappropriately due to a policy limitation for chiropractic services that discriminates against chiropractors and is prohibited under A.R.S. § 20-461(A)(17).
4. Provide documentation that EOB messages have been modified to prominently display appeal information to comply with A.R.S. § 20-2533(D);

5. Pay restitution including interest for any claim identified from the self-audits as having been denied inappropriately; and

6. 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.

ACES Claims Processing System

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 under Reason codes 0009, 0912, 0925, 0953;
2. Claims denied under Reason codes 0005;
3. One policy form; and
4. Three EOB forms.

Claims Denied Under Reason Codes 0009, 0912, 0925 and 0953

Of the 10 categories of denied claims, the Examiners selected samples during Phase I totaling 10 (100%) files from a subpopulation of 10 files denied using one or more of the following four reason codes indicating the claim was "adjusted" or "reprocessed" under the policy. The Company failed to meet the standard for this sample of claims denied using Reason codes 0009, 0912, 0925 and 0953 as follows:

Two (20%) of 10 claims reprocessed using Reason codes 0009, 0912, 0925 and 0953 failed Standard 2 because the Company 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)(15) and A.A.C. R20-6-801(G)(1)(a). Reference PF # 011.

Claims Denied Under Reason Codes 0005, 0106, 0107, 0113, 0120, 0302, 0384, 0422, 0497, 0510, 0529 and 0607

Of the 10 categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 80 (29%) files from a subpopulation of 274 files denied using one or more of the following 12 reason codes indicating the claim was denied as "not covered" under the policy.

The Company failed to meet the standard for this sample of claims denied using Reason codes 0005, 0106, 0107, 0113, 0120, 0302, 0384, 0422, 0497, 0510, 0529 and 0607 as follows:

Fourteen (18%) of 80 claims in this sample were denied using Reason code 0005, which states: "Benefits are not available for the expense submitted." The Company failed Standard 2 because with regard to these claims, because it 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)(15) and A.A.C. R20-6-801(G)(1)(a). Reference PF # 015 and PF # 029.

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 380.S01.AZ issued in Arizona as follows:

Policy for 380.S01.AZ contained an exclusion for services or treatment provided by a chiropractor which is expressly prohibited under 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 # 027.

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 EOB forms issued on denied Arizona claims because:

- Three forms failed to prominently display the appeal information in apparent violation of A.R.S. § 20-2533(D); and
- One form misstated the name of the insurer in apparent violation of A.R.S. § 20-461(A)(1). Reference PF # 020.

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 (ACES Claims Processing System)

Denied Reason Codes	Population	Sample	# of Exceptions	Error Ratio	PF Reference
0009, 0912, 0925, 0953	10	10	2	20%	011
0005, 0106, 0107, 0113, 0120, 0302, 0384, 0422, 0497, 0510, 0529, 0607	274	80	15	19%	015, 029
0832	43	43	6	14%	018
Policy Forms	NA	NA	1	NA	027
EOB Forms	NA	NA	5	NA	020

Standard 2 Recommendations – ACES System

Within 90 days of the filed date of this Report, 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 to comply with A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(D)(1) and (G)(1)(a);
2. Provide documentation that the chiropractic exclusion which discriminates against chiropractors and which is prohibited by statute has been removed from policy form 380.S01.AZ to comply with A.R.S. § 20-461(A)(17).
3. Perform a self-audit of all claims where chiropractic services were denied under policy form 380.S01.AZ during the three years prior to the date of the Report to determine whether claims for chiropractic services have been denied inappropriately due to a policy exclusion for chiropractic services which discriminates against chiropractors and is prohibited under A.R.S. § 20-461(A)(17).
4. Provide documentation that EOB messages have been modified to prominently display appeal information to comply with A.R.S. § 20-2533(D);
5. Provide documentation that EOB messages have been modified to display the correct name of the insurer to comply with A.R.S. § 20-461(A)(1);

6. Pay restitution including interest for any claim identified from the self-audits as having been denied inappropriately; and

7. 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 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 in apparent violation of A.R.S. § 20-461(A) and Consent Order 2000 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 that were paid during the three years prior to the date of the Report, to determine if interest was paid on those 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 61, and the examination findings are reported beginning on page 35.

10. The Company failed Standard 1 in apparent violation of A.R.S. § 20-444 and R20-6-201 with regard to 78 of 198 advertising pieces reviewed, including print ads and direct sales scripts.

11. The Company failed Standard 2 in apparent violation of A.R.S. § 20-448(B) by

    a. 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.

    b. Providing discounted premiums to some, but not all, applicants whose applications were received outside the prescribed "offer" period for the discount.

12. 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

    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).

13. The Company failed Standard 6, in apparent violation of A.R.S. § 20-157(A) because the Company failed to provide documents it had archived concerning the declination of small group coverage, when requested to do so by the Examiners in the course of the examination.

14. 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.

15. The Company failed Standard 9 in apparent violation of A.R.S. § 20-448.01 and A.A.C. R20-6-1203(C) and 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.

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

    a. 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);

    b. 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);

    c. 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 (D), Consent Order 2000, and Consent Order 2003.

    d. 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 Consent Order 2003.

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

    a. Failing to acknowledge two (20%) of 10 Short Term Medical Paid claims submitted directly by the Insured within 10 working days, in apparent violation of A.R.S. § 20-461(A)(2), A.A.C. R20-6-801(E)(1) and Consent Order 2000.

b. Failing to adjudicate 10 (11%) of 89 Short Term Medical Paid claims, received from providers, within 30 days of receipt of a clean claim, in apparent violation of A.R.S. § 20-3102(A) and/or (B);

c. Failing to adjudicate six (5%) of 110 Small Group Paid claims, received from providers, within 30 days of receipt of a clean claim, in apparent violation of A.R.S. § 20-3102(A) and/or (B);

d. Failing to pay interest on Small Group Paid claims not paid within 30 days of receipt of a clean claim, in apparent violation of A.R.S. § 20-3102(A).

18. The Company failed Standard 14 with regard to claims handling by using letterheads for claims-related correspondence, which displayed the name "Assurant Health," and which failed to identify the issuing carrier as John Alden Life Insurance Company, in apparent violation of A.R.S. § 20-461(A)(1).

19. 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. 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 Consent Order 2003;

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

20. 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.

21. The Company failed Standard 18, in apparent violation of A.R.S. § 20-2309(A), Consent Order 2000, and Consent Order 2003, by failing to include in the group renewal notice an explanation of the extent to which claims experience of the individuals covered by the plan would affect premium increases.

22. 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/Short Term Medical Advertising

The Examiners reviewed 136 print advertisements and seven direct sales scripts and found apparent violations of Standard 1 as described below.

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 31 advertisements that contained statements:

1. 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).
2. 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).
3. Which were misleading about the length of time the Company has been 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)(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. See PF # 007-JA.

Direct Sales Scripts

The Examiners selected samples of direct sales scripts during the examination totaling seven individual major medical direct sales scripts utilized by the Company during the examination period.

The Company utilized three 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).

The Company utilized two direct sales scripts that:

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).
4. Contained misleading statements regarding the length of time the company has been in business and misleading statements regarding the company's brand approval 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(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. See PF # 011-JA.

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 seven direct sales scripts (Picasso 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 of 15 direct sales scripts reviewed. See PF # 025-JA.

Group Major Medical ("GMM") Advertising

The Examiners selected samples of print advertisements during the examination totaling 55 (100%) of 55 GMM print advertisements utilized by the Company during the examination period. The Examiners found that the Company used:

1. Eighteen GMM print advertisements referenced specific policy benefits as indicated above 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 R20-6-201(C)(9). See PF #015-JA.
2. Fourteen GMM print advertisements referenced listed specific policy benefits such as Physician Services, Preventive Care Services, Prescription Drug Benefit, Hospital Services, Lab and x-ray, Maternity Coverage and Dental Insurance but failed to disclose any related exclusion, reductions or limitations, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(7). See PF #015-JA.
3. One GMM print ad targeted to small groups that stated it is the Company's "practice" not to cancel small groups due to claims experience, implying other companies may not share this practice, thereby misstating pertinent Arizona law in apparent violation of A.R.S. § 20-444(A) and A.A.C R20-6-201(C)(1) and (C)(11). See PF # 016-JA.
4. Six GMM print advertisements that used words or phases or statements that may mislead or deceive purchasers, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(2). See PF # 016-JA.
5. Twenty-one GMM print advertisements that used vague and ambiguous promises concerning prompt and accurate claims payments, in apparent violation of Standard 1, A.R.S. § 20-444(A) and A.A.C. R20-6-201(O). See PF # 016-JA.
6. Thirty-three GMM Print advertisements that contained false statements about the length of time the Company has been in business, using express statements such as "more than 110 years," and "since 1892," where neither of these statements is accurate for this Company, in apparent violation of Standard 1, A.R.S. § 20-444(A) and A.A.C. R20-6-201(P). See PF #016-JA.

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	31	NA	007-JA
Individual Major Medical – Scripts	15	15	7	NA	011-JA, 025-JA
Group Major Medical - Print	55	55	44	NA	015-JA, 016-JA
Totals =	**279**	**198**	**78**	**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 applicants/policyholders for up to 36 months in three of seven direct sales scripts reviewed. See PF # 012-JA.

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 # 077-JA.

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.

From August 1, 2005, through August 4, 2006, the Company offered a $10 discount for all new applications where the applicant agreed to receive the policy and the Notice of Privacy Practices via the Internet for its Short Term Medical ("STM") coverage. The Examiners reviewed 110 STM policy applications from the examination period (July 1, 2005 through June 30, 2008) and found that 59 applications reviewed were dated outside the "offer" period. Of these, the Examiners identified three applications that were received and policies were issued prior to the offer period, and two applications that were received and policies were issued after the offer period where the applicants were awarded the $10 discount. Other applications received either before or after the offer period did not receive the offer or the discount. See PF # 153-JA.

The Company therefore failed Standard 2 in apparent violation of A.R.S. § 20-448(B) by unfairly discriminating in favor of certain applicants by providing a $10 discount not offered to other applicants from the same time periods.

Summary of Findings – Standard 2 Advertising and Marketing File Review

Type of Advertising	Population	Sample	Exceptions	Error Ratio	PF #
Individual Major Medical – Scripts	7	7	3	NA	012-JA, 077-JA
STM file review	5,068	110	5	NA	053-JA

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 procedure manuals, 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

Procedure Manuals

The Examiners reviewed the Small Group Procedure Manual provided by the Company in response to the Coordinator's Handbook, Attachment A, question II.E. The Small Group Procedure Manual states on page 7, Adding Newborns, adoption or placement dated April 27, 2006 that

> Insurance for a newborn or adopted child will become effective on the child's date of birth, adoption or placement, without any review of health history, provided we receive an enrollment request with (sic) the first 31 days (60 days in ID, WA, WI, 90 in AR) of birth, adoption or placement.

(Emphasis added). See PF # 046-JA. As noted below, the certificates of coverage issues in Arizona during the examination period further support the validity of this finding. The Company therefore failed Standard 4 in apparent violation of A.R.S. § 20-1402(A)(2).

Certificates for Policies Issued Outside Arizona

The Examiners reviewed five group certificate forms, including three association 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 three group certificate of coverage forms to include the notice 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 #047-JA.

2. The Company failed with regard to two certificates to comply with the mandated newborn coverage of A.R.S. § 20-1402(A)(2), as follows (see PF # 048-JA):
   a. One group certificate of coverage form 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 # 050-JA.

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 #
JGM.TRT.AZ (Rev. 04/2006) Medical Coverage	X	X	X	047-JA, 048-JA, 050-JA
390.001.AZ Medical Certificate	X			047-JA
Form J-4000-CC (AZ)	X			047-JA
JIM.CER.AZ Medical Certificate	X			047-JA
380.001.AZ Medical Certificate	X	X	X	047-JA, 048-JA, 050-JA
Totals =	**5**	**1**	**1**	

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

The Examiners requested 29 of 29 Small Group New Business Declined files. Company failed to produce 25 of the 29 files requested. The Company states the group was declined for not meeting the small group eligibility requirements, but the Examiners were unable to confirm this assertion. The Examiners were also unable to establish compliance with Consent Order 2003, page 13, lines 11 – 12, regarding failure to offer coverage to eligible small groups.

The Company failed Standard 6 in apparent violation of A.R.S. § 20-157(A), by failing to provide the records requested by the Examiners for review during the course of the examination. See PF # 098-JA. The Company agreed with this PF, stating:

> The group was submitted in 2005 and closed on 11/2/05 as the group was not eligible (this information was obtained from our system notes). The file is likely in archives, however, we are unable to locate the file. A copy of our system notes is provided that indicates the group was closed for not meeting eligibility requirements.

(Emphasis added).

Summary of Findings – Standard 6 Underwriting File Review

Sample Description	Population	Sample	Exceptions	Error Ratio	PF #
Small group New Business Declined	29	29	25	N/A	098-JA

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 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. Data supplied by the Company indicates that the Company issued policies with effective dates during the examination period (July 1, 2005, through June 30, 2008) to 302 Arizona small groups, and issued 1,715 small group certificates during that time.

The Examiners confirmed through the review of 28 of 37 small groups identified during the review of the Small Group Not Issued sample that the Company does not provide the mandated disclosure form.

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 #110-JA and 134-JA.

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

Summary of Findings – Standard 7 Underwriting File Review

Type of Advertising	Population	Sample	Exceptions	Error Ratio	PF #
SG Not Issued	37	28	28	NA	110-JA, 134-JA

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 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) and R20-6-1204.

The Examiners reviewed two 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 # 059-JA.

The Examiners reviewed 55 Small Group New Business Not Issued files provided by the Company in response to Request 082-JA. Fifty-five of the New Business files included a medical disclosure authorization form that purports to authorize the release of information regarding the diagnosis and/or treatment for HIV. See PF # 146-JA. 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 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 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 in three of 26 application forms provided for review in response to the Coordinator's Handbook, Attachment A, question II(C). See PF #051-JA.

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

Eligibility Review – Ineligible to Complete Application

The Company failed Standard 10, in apparent violation of A.R.S. § 20-2110(A) and (D) and Consent Order 2000, 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 #053-JA.

In response to this PF, 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) and Consent Order 2000, in eight 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) and Consent Order 2000, by using seven 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), Consent Order 2000, and Consent Order 2003, by failing to provide the specific reason for the adverse underwriting decision or 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 #052-JA.

The Company failed Standard 10, in apparent violation of A.R.S. § 20-2110(A) and (B), 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 (B), Consent Order 2000, and Consent Order 2003, by failing to provide the specific reason for the adverse underwriting decision or a Summary of Rights in three of 55 Short Term Medical New Business Issued files reviewed. See PF # 078-JA.

The Company has violated Standard 10 in apparent violation of A.R.S. § 20-2110(A), Consent Order 2000, and Consent Order 2003, by failing to provide a Summary of Rights with notice of an adverse underwriting decision in six of six Individual Medical New Business Reformation files reviewed. See PF # 138-JA.

Disclosure Authorizations

The Company failed Standard 10, in apparent violation of A.R.S. § 20-2106(7)(a) and Consent Order 2003 by using disclosure authorization provisions on its applications that failed to comply with the "no more than" 30-month limit prescribed by law in 18 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 #054-JA.

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

Claims Received from the Insured

The Examiners reviewed ten Short Term Medical Paid claims that were submitted to the Company by the Insured. The Company failed Standard 11, in apparent violations of A.R.S. § 20-461(A)(2), A.A.C. R20-6-801(E)(1), and Consent Order 2000 by failing to acknowledge two (20%) of these claims within 10 working days. See PF # 128-JA.

Claims received from a Provider

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

1. In 10 (11%) of 89 Short Term Medical Paid claims received from providers, which claims were not adjudicated within 30 days of receipt of a clean claim. See PF # 129-JA.
2. In six (5%) of 110 Small Group Paid claims that were not adjudicated within 30 days of receipt of a clean claim. See PF # 074-JA.

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 adjudicated and paid within the time permitted after receipt of a clean claim, in four (4%) of 110 Small Group Paid claims reviewed. See PF # 073-JA.

Claim File Number	Days Overdue	Payment Amount	Interest Due
JA-SGP-002	414	$1,297.20	$147.13
JA-SGP-064	7	$46.00	$0.09
JA-SGP-090	240	$178.96	$11.77
JA-SGP-100	16	$36.75	$0.16
Totals		**$1,558.91**	**$159.15**

The Examiners found one Small Group Paid claim that was cited for more than one of the violations described above. In the following table "Exceptions" refers to the number of files rather than to the number of violations.

Summary of Findings – Standard 11 Claim File Review

Description	Population	Sample	Exceptions	Error Ratio	PF #
Short Term Medical Paid	6,751	99	12	12%	128-JA, 129-JA
Small Group Paid	239,050	110	12	11%	073-JA, 074-JA
Totals =	**245,801**	**209**	**24**	**11%**	

An 11% 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

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. With regard to 16 (100%) of 16 Appeal files reviewed, used "Assurant Health" letterheads on correspondences that failed to otherwise identify the issuing carrier as John Alden Life Insurance Company. See PF # 032-JA.

Summary of Findings – Standard 14 Claim File Review

Description	Population	Sample	Exceptions	Error Ratio	PF #
IM Appeals	16	16	16	N/A	032-JA

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 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 five 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. Both forms (Form Number JGM.TRT.AZ (Rev. 04/2006) Medical Coverage and Form Number JIM.CER.AZ Medical Certificate) state 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." See PF #049-JA.

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 Examiners reviewed 46 Small Group Appeals and 16 Individual Medical Appeals, for a total of 62 appeals reviewed. Of these, 58 were first-level appeals and four were second-level appeals. 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 appeals within five business days, as follows (see PF # 063-JA):

a. In seven (12%) of 58 first-level appeal files reviewed, the Company failed to acknowledge the appeal within 5 business days of receipt, in apparent violation of A.R.S. § 20-2535(B) and Consent Order 2003; and

b. In one (25%) of four second-level appeal files reviewed, the Company failed to acknowledge the appeal within 5 business days of receipt, in apparent violation of A.R.S. § 20-2536(B) and Consent Order 2003.

2. The Company failed to resolve five (9%) of 58 first-level appeal files reviewed within 30 days of receipt of the appeal, in apparent violation of A.R.S. § 20-2535(D). See PF # 064-JA.

The Examiners found one first-level appeal that was cited for more than one of the violations described above. In the following table "Exceptions" refers to the number of files rather than to the number of violations.

Summary of Findings – Standard 16 Appeals File Review

Description	Population	Sample	Exceptions	Error Ratio	PF #
First-level Appeal	58	58	11	19%	063-JA, 064-JA
Second-level Appeal	4	4	1	25%	063-JA
Totals =	**62**	**62**	**12**	**19%**	

A 19% 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 processing system, 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 #019-JA.

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), Consent Order 2000, and Consent Order 2003 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 # 002-JA.

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

RECOMMENDATIONS

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

1. Perform a self-audit of all policies lapsed during the previous three years to determine whether any claims were denied inappropriately because the Company failed to credit premium payments based on the date premiums were mailed.
2. Pay restitution including interest at the legal rate for any claim identified from the self-audit as having paid without more than 30 days after receipt of a clean claim for which interest was not paid or 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. R20-6-201(C)(2) and 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 use the aggregate number of years in business of the Company and its sister carriers to indicate the time the Company has been in business or its relative position in the insurance industry, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(P).

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 provide 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

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. The Company produces the 25 missing Small Group Business Declined files requested by the Examiners pursuant to Request Number 081-JA dated July 27, 2009, to comply with A.R.S. § 20-157(A) and Consent Order 2003.

8. The Company has procedures in place to locate and provide archived documents to the Department and its Examiners in a timely manner when requested to do so, to comply with A.R.S. § 20-157(A).

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. R20-6-1203(C) and R20-6-1204.

11. 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).

12. 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).

13. 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), Consent Order 2000, and Consent Order 2003.

14. 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 Consent Order 2003.

15. The Company acknowledges claims submitted directly by the Insured within 10 working days, to comply with A.R.S. § 20-461(A)(2), A.A.C. R20-6-801(E)(1) and Consent Order 2000.

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/or (B).

17. The Company pays interest on all claims not adjudicated and paid within the times permitted for clean claims, to comply with A.R.S. § 20-3102(A) and/or (B).

18. The Company properly identifies the correct name of the issuing carrier on all claims-related correspondence with insureds, including but not limited to letters, memoranda, payment instruments, and EOBs, to comply with A.R.S. § 20-461(A).

19. 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).

20. 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 Consent Order 2003.

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

22. 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).

23. The Company provides, at least sixty days before the date of expiration of a health benefits plan, a written notice to the employer of the terms for renewal of the plan, including an explanation of the extent to which any increase in premiums is due to actual or expected claims experience of the individuals covered under the employer's health benefits plan contract, to comply with A.R.S. § 20-2309(A), Consent Order 2000, and Consent Order 2003.

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