REPORT OF TARGETED EXAMINATION

OF

MUTUAL OF OMAHA INSURANCE COMPANY

NAIC# 71412

AS OF

JUNE 30, 2006

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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:

MUTUAL OF OMAHA INSURANCE COMPANY

NAIC # 71412

The above examination was conducted by Sandra Lewis, CIE, Examiner-in-Charge, and Jerry Paugh, AIE, Senior Market Examiner.

The examination covered the period of July 1, 2005, through June 30, 2006.

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

Sincerely yours,

Paul J. Hogan, JD, FLMI, ALHC, CIE
Market Oversight Administrator
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, Sandra Lewis, CIE, being first duly sworn state that I am a duly appointed Market Examinations Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of Jerry Paugh, AIE, Senior Market Examiner, the examination of Mutual of Omaha 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, CIE
Market Examinations Examiner-in-Charge

Subscribed and sworn to before me this 23 day of August, 2007

Notary Public

My Commission Expires 11-19-07

OFFICIAL SEAL
JANICE PAULK
NOTARY PUBLIC-ARIZONA
MARICOPA COUNTY
My Comm. Expires Nov. 19, 2007

FOREWORD

This targeted market examination of Mutual of Omaha 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.

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.

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

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

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The targeted market examination of the Company covered the period from July 1, 2005 through June 30, 2006 for the line of business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. This examination was completed by applying tests to each examination standard to determine

compliance with the standard. The standards applied during the examination are stated in this Report at page 6.

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.

Denied claim file sampling was based on a review of denied claims overturned after a request for reconsideration made by or on behalf of the insured, and in part on statistical analysis of raw claims data. Denied claims samples were randomly or systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company's Representative, Pamela Bishop, Regulatory Issues Manager. Samples were tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data resulted in an exception ratio, which determined whether or not a standard was met. If the exception ratio found in the sample was, generally, less than 5%, the standard was considered as "met." A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXECUTIVE SUMMARY

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 6, and the examination findings are reported beginning on page 4.

1. The Company failed Standard No. 2, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a) by failing to provide a reasonable

explanation for the denial of claims in sufficient detail to allow members and providers to appeal an adverse decision. Sixty-four (94%) of 68 files reviewed for claims denied under Reason codes ZNA, YOF and YMV failed Standard No. 2.

2. The Company passed Standard No. 1 and Standard No. 3.

PROCEDURES PERFORMED

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

The Company provided appeal logs indicating it had processed four appeals from denied claims during the examination period. The Examiners selected all of the four appeals for review. No trends of overturned denials related to similar procedural codes (CPT-4, HCPCS, etc.) or EOB messages were noted during the review of the files selected from the appeal log.

The Company provided a population of 1,941 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 273 denied claims from which they selected a stratified random sample of 73 denied claims for review.

Subsequent to the Phase I denied claim review, the Department initiated a Phase II examination and selected an additional sample of 41 denied claim files which were denied under Reason codes ZNA, YOF and YMV for review. This brought the total number of reviewed files to 114.

As a result of the review of the 114 denied claims, the Examiners identified the following findings.

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of the Company's denied health care claims, the Company failed with regard to claims denied under Reason codes ZNA, YOF and YMV 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)(5) and A.A.C. R20-6-801(G)(1)(a)

The Company failed to meet the standard for claims denied under Reason codes ZNA, YOF and YMV as follows:

The sub-population of 273 denied claims included a population of 68 denied claims which were denied under Reason codes ZNA, YOF and YMV. Reason Code ZNA states: "This service is specifically excluded by the plan. Please refer to the plans General Exclusions and Limitations." Reason Code YOF states: "According to the General Exclusions and Limitations, services for this diagnosis are not covered under the plan." Reason code YMV states: "According to the Medical Necessity Definition and the information submitted, services rendered were not medically necessary."

The Examiners reviewed the total population of 68 (100%) of 68 files denied under Reason codes ZNA, YOF and YMV. Of the 68 files reviewed, 64 were denied under Reason code ZNA or Reason code YOF. The "General Exclusions and Limitations" section of the policy failed to contain any exclusion which was applicable to the diagnosis or service provided in any of the 64 files reviewed. Since the diagnoses or services were not specifically excluded in the "General Exclusions and Limitations" section of the policy, as stated in Reason codes ZNA and YOF, neither Reason Code ZNA nor Reason Code YOF provided a reasonable explanation for the denial of the claim in sufficient detail to allow members and providers to appeal the decision.

Sixty-four of 68 (94%) claims denied under Reason code ZNA, YOF and YMV failed Standard 2 because the Company failed to provide a reasonable explanation for the denial of the claims 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 # 005.

Recommendation

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 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 as prescribed by A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

SUMMARY OF 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	