REPORT OF TARGETED EXAMINATION

OF

LIFE INSURANCE COMPANY OF NORTH AMERICA

NAIC# 65498

AS OF

December 31, 2010

TABLE OF CONTENTS

Department of Insurance
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GERMAINE L. MARKS
Director of Insurance

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

Dear Director Marks:

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

LIFE INSURANCE COMPANY OF NORTH AMERICA

NAIC # 65498

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

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

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

Sincerely yours,

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

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, Sandra Lewis, CIE, MCM, being first duly sworn state that I am a duly appointed Market Conduct Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of James R. Dargavel, CIE, MCM, Senior Market Conduct Examiner and Data Specialist, Mel Mohs, CIE, Senior Market Conduct Examiner, Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner, Sondra Faye Davis, Market Conduct Examiner, and John Kilroy, Market Conduct Examiner, the examination of Life Insurance Company of North America, hereinafter referred to as the "Company" was performed in part at the offices of CIGNA Healthcare at 25500 North Norterra Parkway, Phoenix, Arizona 85085, and in part at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss the findings set forth in this Report. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

Sandra Lewis

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

Subscribed and sworn to before me this 12th day of November, 2013.

Notary Public

My Commission Expires 04/21/2014

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

FOREWORD

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

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

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

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

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The targeted market conduct examination of the Company covered the period from January 1, 2008, through December 31, 2010, for the lines of business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. The Examiners completed this examination by applying tests to each examination standard to determine compliance with the standard. The standards applied during the examination are stated in this Report at page 15.

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

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

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

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

EXECUTIVE SUMMARY

The Examiners completed this examination by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report beginning at page 15 and the examination findings are reported beginning on page 4.

1. The Company failed Standard No. 3, in apparent violation of A.R.S. § 20-448(B), by unfairly discriminating among individuals of essentially the same hazard, in the benefits payable or in the application of the terms or conditions of a cancer policy resulting from a cancer diagnosis made during the waiting period.
2. The Company failed Standard No. 16, as follows:
    a. By failing to accept or deny 108 (20%) of 550 Insured claims within 15 working days of receipt of acceptable proofs of loss, in apparent violation of A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a).
    b. By failing to adjudicate 69 (20%) of 340 Provider claims within 30 days of receipt of a clean claim, in apparent violation of A.R.S. § 20-3102(A).
    c. By failing to provide a reasonable explanation for the denials of:
        i. Nine (9%) of 100 Insured and Provider claims, in apparent violation of A.R.S. § 20-461(A)(15), and
        ii. Eight (15%) of 53 Insured claims in apparent violation of A.A.C. R20-6-801(G)(1)(a).
    d. By failing to pay the correct interest in the amount of $66.93 on 12 (11%) of 107 Insured claims in apparent violation of A.R.S. § 20-462(A).
    e. By failing to pay the correct interest in the amount of $204.82 on 62 (27%) of 227 Provider claims, in apparent violation of A.R.S. § 20-3102(A).
5. The Company failed Standard No. 20, by failing to respond in a timely manner to pertinent claims correspondences with regard to nine (7%) of 137 complaints, in apparent violation of A.R.S. § 20-461(A)(2) and A.A.C. R20-6-801(E)(3).
6. The Company passed Standards 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 21, 22, 23 and 24.

EXAMINATION FINDINGS – FAILED STANDARD 3

Based on the Examiners' review of the Company's administration of cancer claims, the Company failed to meet the following standard for review:

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

The Company provided Group Cancer Policy LIT-104002 in response to the Coordinator's Handbook and in conjunction with the claims review for its Cancer policies. The Exclusions and Limitations Section of Policy LIT-104002 states that no benefits will be paid, and any premium collected will be refunded, if cancer is diagnosed during the policy's 60-day waiting period. The policy makes no exception depending on the type of cancer or for any other reason. The policy also provides a $30.00 benefit for a cancer screening test and a $30.00 benefit for a diagnostic test, payable once per year.

The Examiners reviewed 55 denied Cancer policy claims produced in response to Request 061, and identified one claim where benefits were denied because cancer had been diagnosed within 60 days of the coverage effective date, but the Company failed to rescind the policy and refund the premiums in accordance with the policy provision. The Examiners therefore used the data supplied by the Company to identify all claims denied because of a cancer diagnosis during the 60-day waiting period. The Examiners identified five such claims during the examination period, including the one previously reviewed, and requested copies of the other four claims.

With regard to three of the five reviewed cancer claims where cancer was diagnosed within 60 days of the effective date of the policy, the Company failed to rescind the policy in accordance with the policy provision. With regard to the remaining two claims, the Company rescinded the policy and refunded the premiums. In one case the Company paid the benefit for the cancer screening and diagnostic test that resulted in the cancer diagnosis during the waiting period; the company did not pay this benefit to the other four policyholders. Two of the policies remained in force at the time of the Examiners' file review.

The Company has not met Standard No. 3 and appears to be in violation of A.R.S. § 20-448(B) with regard to the claims listed on the following table, because it unfairly discriminated among individuals of essentially the same hazard, in the benefits payable or in the application of

the terms or conditions of the contract regarding a cancer diagnosis during the waiting period. See PF # 019.

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

Summary of Administration of Cancer Policies
Where Cancer Was Diagnosed during the 60-Day Waiting Period

REQ NO.	ADOI FILE NO.	DISPOSITION OF CLAIM AND CANCER POLICY
061	L-08-AGIACA-D-002	Claim denied February 13, 2008; No rescission action commenced; Policy lapsed effective April 2008 for nonpayment of premiums
125	L-AGIACA R29-D-001	Claim denied March 30, 2009; Policy rescinded and premiums refunded
125	L-AGIACA R29-D-002	Claim denied March 25, 2010; No rescission action commences and policy still in force at the time of the examination in 2012.
125	L-AGIACA R29-D-003	Claim denied August 4, 2010; Policy rescinded and premiums refunded.
125	L-AGIACA R29-D-004	Claim denied September 10, 2008, but screening and diagnostic benefit ($30) paid; Policy still in force at the time of the examination in 2012.

EXAMINATION FINDINGS – FAILED STANDARD 16

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

#	STANDARD	Regulatory Authority
16	Claims are handled timely and appropriately in accordance with policy provisions and applicable statutes and rules.	A.R.S. §§ 20-461, 20-462, 20-1215, 20-3102, and A.A.C. R20-6-801

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

Time Service for Paying or Denying Claims

Insured Claim Processing

The Examiners reviewed Insured claims to determine the timeliness of the acceptance or denial of the claim. The Examiners found that the Company failed Standard 16 by failing to accept or deny Insured claims within 15 working days of receipt of properly executed proofs of loss, in apparent violation of A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a), as follows:

1. The Examiners reviewed 155 PCI Accident Paid claims provided by the Company in response to REQ067, REQ068 and REQ069. The Company paid 44 of the 155 claims directly to the Insured. The Company failed to notify the Insured of the acceptance of and/or failed to pay 10 (23%) of the 44 claims within 15 working days of receipt of acceptable proof of loss. Two of the 10 claims were paid in 2008, and eight of the 10 claims were paid in 2010. See PF # 002.
2. The Examiners reviewed 163 PCI Accident Denied claims files provided by the Company in response to Requests 070, 071 and 072, for the years 2008, 2009 and 2010 respectively. The Company denied 19 of the 163 reviewed claims that had been submitted by and were payable to the Insured. With regard to 8 (42%) of 19 Insured claims, the Company failed to notify the Insured of the denial of the claim within 15 working days of receipt of the properly executed proofs of loss. All eight of the cited claims were denied in 2008. See PF # 005.

3. The Examiners reviewed 165 AGIA Cancer Paid claims provided by the Company in response to Requests 060, 046 and 047, for the years 2008, 2009 and 2010 respectively. All of the claims reviewed were paid directly to the Insured. The Company failed to pay 19 (12%) of 165 Insured claims within 15 working days of receipt of the properly executed proofs of loss. Fifteen of the 19 claims were paid in 2008; two of the 19 claims were paid in 2009; and two of the 19 claims were paid in 2010. See PF # 007.

4. The Examiners reviewed 164 AGIA Cancer Denied claims files provided by the Company in response to Requests 061, 048 and 049, for the years 2008, 2009 and 2010 respectively. All 164 of the denied claims were payable to the Insured. With regard to 15 (9%) of 164 Insured claims, the Company failed to notify the Insured of the denial of the claim within 15 working days of receipt of the properly executed proofs of loss. Nine of the 15 claims were denied in 2008; five of the 15 claims were denied in 2009; and one of the 15 claims was denied in 2010. See PF # 009.

5. The Examiners reviewed 75 AGIA Life-Accident Paid claims provided by the Company in response to Requests 064, 054 and 055, for the years 2008, 2009 and 2010 respectively. The Company paid 36 of the 75 claims directly to the Insured. The Company failed to pay nine (25%) of 36 Insured claims within 15 working days of receipt of the properly executed proofs of loss. One of the nine claims was paid in 2008; one claim was paid in 2009; and seven claims were paid in 2010. See PF # 010 and PF # 015.

6. The Examiners reviewed 67 AGIA Life-Accident Denied Claims files provided by the Company in response to Requests 065, 056 and 057, for the years 2008, 2009 and 2010 respectively. The Company denied 42 of the 67 reviewed claims that had been submitted by and were payable to the Insured. With regard to 19 (45%) of 42 Insured claims, the Company failed to notify the Insured of the denial of the claim within 15 working days of receipt of the properly executed proofs of loss. Eighteen of the 19 claims were denied in 2008, and one of the 19 claims was denied in 2010. See PF # 017.

7. The Examiners reviewed 143 Health Special Risks Accident Paid claims files provided by the Company in response to Requests 078, 079 and 080, for the years 2008, 2009 and 2010 respectively. The Company paid 27 of the 143 claims directly to the Insured. The Company failed to pay eight (30%) of 27 Insured claims within 15 working days of receipt of the properly executed proofs of loss. Two of the eight claims were paid in

2008; three of the eight claims were paid in 2009; and three of the eight claims were paid in 2010. See PF # 012.

8. The Examiners reviewed 100 Health Special Risks Accident Denied claims files provided by the Company in response to Requests 081, 082 and 083, for the years 2008, 2009 and 2010 respectively. The Company denied 53 of the 100 reviewed claims that had been submitted by and were payable to the Insured. With regard to 20 (38%) of 53 Insured claims, the Company failed to notify the Insured of the denial of the claim within 15 working days of receipt of the properly executed proofs of loss. Thirteen of the 20 claims were paid in 2008; two of the 20 claims were paid in 2009; and five of the 20 claims were paid in 2010. See PF # 022.

Summary of Findings – Acceptance or Denial of Insured Claims

Description	Population	Sample Size	Insured Claims Reviewed	Exceptions	Error Ratio	PF #
PCI Accident Paid	619	155	44	10	23%	002
PCI Accident Denied	3,225	163	19	8	42%	005
AGIA Cancer Paid	5,195	165	165	19	12%	007
AGIA Cancer Denied	2,873	164	164	15	9%	009
AGIA Life-Accident Paid	97	75	36	9	25%	010, 015
Life-Accident Denied	68	67	42	19	45%	017
Health Special Risks Accident Paid	693	143	27	8	30%	012
Health Special Risks Accident Denied	150	100	53	20	38%	022
Totals	**12,920**	**1,036**	**550**	**108**	**20%**	

A 20% error ratio does not meet the standard; therefore recommendations are warranted.

Provider Claim Processing

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

1. The Examiners reviewed 155 PCI Accident Paid claims provided by the Company in response to REQ067, REQ068 and REQ069. The Company paid 111 of the 155 claims to the Provider. The Company processed or reprocessed 20 (18%) of the 111 Provider claims more than 30 days after receipt of a clean claim. Three claims were paid in 2008, and 17 were paid in 2010. See PF # 004.

2. The Examiners reviewed 163 PCI Accident Denied Claims files provided by the Company in response to Requests 070, 071 and 072, for the years 2008, 2009 and 2010

respectively. One hundred forty-four of the 163 claims reviewed were Provider claims. The Company failed to adjudicate 24 (17%) of 144 Provider claims within 30 days of receipt of the clean claim. Three claims were denied in 2008, and 21 claims were denied in 2010. See PF # 006.

3. The Examiners reviewed 75 AGIA Life-Accident Paid Claims files provided by the Company in response to Requests 064, 054 and 055, for the years 2008, 2009 and 2010 respectively. Thirty-nine of the 75 claims reviewed were Provider claims. The Company processed or reprocessed 18 (46%) of the 39 Provider claims more than 30 days after receipt of a clean claim. All 18 claims were paid in 2008. See PF # 016.

4. The Examiners reviewed 100 HSR Accident Denied Claims files provided by the Company in response to Requests 081, 082 and 083, for the years 2008, 2009 and 2010 respectively. Forty-seven of the 100 claims reviewed were Provider claims. The Company failed to adjudicate seven (15%) of 47 Provider claims within 30 days of receipt of the clean claim. Five claims were denied in 2008, and two claims were denied in 2010. See PF # 023.

Summary of Findings – Adjudication of Provider Claims

Description	Population	Sample Size	Provider Claims Reviewed	Exceptions	Error Ratio	PF #
PCI Accident Paid	619	155	111	20	18%	004
PCI Accident Paid	3,225	163	144	24	17%	006
AGIA Life-Accident Paid	97	75	39	18	46%	016
HSR Accident Denied	150	100	47	7	15%	023
Totals	**4,091**	**493**	**340**	**69**	**20%**	

A 20% error ratio does not meet the standard; therefore recommendations are warranted.

Reasons for Denial of Claims

During the Examiners' review of samples of denied claims provided by the Company, the Examiners reviewed the EOBs sent to both the insured and the provider to determine the reasons for the denial of the claims. The Examiners found that the Company failed Standard 16 by failing to provide a reasonable explanation for the denial and to reference the specific policy provision, condition or exclusion relied upon, in apparent violation of A.R.S. § 20-461(A)(15), as follows:

1. The Examiners reviewed 100 HSR Accident Denied claims provided by the Company in response to Requests 081, 082 and 083, for the years 2008, 2009 and 2010 respectively. The Company denied 53 of the 100 reviewed claims that had been submitted by and were payable to the Insured. With regard to eight (15%) of 53 Insured claims, the Company failed to provide, in written form on the EOB, the specific reason for the denial of the

claim. The claims were also found to be in apparent violation of A.A.C. R20-6-801(G)(1)(a). See PF # 020.

2. The Examiners reviewed 100 HSR Accident Denied claims provided by the Company in response to Requests 081, 082 and 083, for the years 2008, 2009 and 2010 respectively. The Company denied 47 of the 100 reviewed claims that had been submitted by and were payable to the Provider. With regard to one (2%) of 47 Provider claims, the Company failed to provide, in written form on the EOB, the specific reason for the denial of the claim. The claims were also found to be in apparent violation of A.A.C. R20-6-801(G)(1)(a). See PF # 020.

Summary of Findings – Reasons for Claims Denials

Description	Population	Sample Size	Exceptions	Error Ratio	PF #
HSR Accident Denied (Insured claims)	150	53	8	15%	020
HSR Accident Denied (Provider claims)		47	1	2%	021
Totals	**150**	**100**	**9**	**9%**	

A 9% error ratio does not meet the standard; therefore recommendations are warranted.

Payment of Interest

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

Claims Submitted by or Paid Directly to the Insured

The Examiners found that the Company failed Standard 16 by failing to pay interest or by failing to pay the correct amount of interest on claims submitted by the insured for claims that were not paid within 30 days of receipt of acceptable proofs of loss, in apparent violation of A.R.S. § 20-462(A), as follows:

1. The Examiners reviewed a sample of 155 PCI Accident Paid claims provided by the Company in response to Requests 067, 068 and 069, for the years 2008, 2009 and 2010 respectively. The Company paid 44 of the 155 reviewed claims directly to the insured. The Company failed to pay interest at the legal rate on seven (16.0%) of 44 Insured claims that were paid more than 30 calendar days after receipt of properly executed proofs of loss, and the amount of interest due is $2.82. One of the seven claims was paid in 2008, and six claims were paid in 2010. See PF # 003. The single largest amount of interest on any one claim was $1.07.

2. The Examiners reviewed 75 AGIA Life-Accident Paid claims provided by the Company in response to Requests 064, 054 and 055, for the years 2008, 2009 and 2010 respectively. The Company paid 36 of the 75 claims directly to the Insured. The Company failed to pay interest at the legal rate on three (8%) of 36 Insured claims that were paid more than 30 calendar days after receipt of properly executed proofs of loss, and the amount of interest due is $50.12. All three of the 36 claims were paid in 2010. See PF # 011.

Subsequent Events

As a result of this examination, the Company paid interest on the three claims in the amount of $50.12, and provided proof that these payments were made to each of the Insureds on March 8, 2013.

3. The Examiners reviewed 143 Health Special Risks Accident Paid Claims files provided by the Company in response to Requests 078, 079 and 080, for the years 2008, 2009 and 2010 respectively. The Company paid 27 of the 143 claims directly to the Insured. The Company failed to pay interest at the legal rate on six (22%) of 27 Insured claims that were paid more than 30 calendar days after receipt of properly executed proofs of loss, and the amount of interest due is $13.99. Two of the six claims were paid in 2008; one of the six claims was paid in 2009; and three of the six claims were paid in 2010. See PF # 013.

Summary of Findings – Interest Payments on Insured Claims

Description	Population	Sample Size	Insured Claims Reviewed	Exceptions	Error Ratio	Interest Due	PF #
PCI Accident Paid	619	155	44	7	16%	$ 2.82	003
AGIA Life-Accident Paid	97	75	36	3	8%	50.12	011
Health Special Risks Accident Paid	693	143	27	6	22%	13.99	013
Totals	**1,409**	**373**	**107**	**16**	**15%**	**$ 66.93**	

A 15% error ratio does not meet the standard; therefore recommendations are warranted.

The following sample *passed* Standard 16 with comment:

The Examiners reviewed a sample of 165 AGIA-HIP Paid claims files provided by the Company in response to Request 058, 042 and 043, for the years 2008, 2009 and 2010 respectively. All of the 165 reviewed claims were paid directly to the Insured. The Company failed to pay one (1%) of 165 Insured claims within 30 days after receipt of properly executed

proofs of loss, and the amount of interest due is $36.48. See PF # 001. Although this single claim does not meet the 5% threshold for this examination, it is reported herein because of the amount of restitution owed.

Subsequent Events

As a result of this examination, the Company paid interest on this claim in the amount of $36.48, and provided proof that this payment was made to the Insured on March 27, 2012.

Claims Submitted by or Paid Directly to the Provider

The Examiners found that the Company failed Standard 16 by failing to pay interest or by failing to pay the correct amount of interest on claims submitted by the provider, in apparent violation of A.R.S. § 20-3102(A), as follows:

1. The Examiners reviewed 164 PCI Accident Paid claims provided by the Company in response to REQ067, REQ068 and REQ069. The Company paid 111 of the 155 claims to the Provider. Regarding 11 (10%) of the 110 Insured claims, the Company failed to pay interest at the legal rate on claims not paid within 30 days of the required adjudication date, and the amount of interest due is $128.07. One claim was paid in 2008, and 10 claims were paid in 2010. See PF # 004.
2. The Examiners reviewed 143 Health Special Risks Accident Paid Claims files provided by the Company in response to Requests 078, 079 and 080, for the years 2008, 2009 and 2010 respectively. One hundred sixteen of the 143 claims reviewed were Provider claims. The Company processed or reprocessed 41 (35%) of the 116 Provider claims more than 30 days after receipt of a clean claim, and with regard to 26 (22%) of the 116 provider claims, the Company failed to pay interest at the legal rate on claims not paid within 30 days of the required adjudication date, and the amount of interest due is $76.75. Fifteen of the 41 claims were paid in 2008; nine of the 41 claims were paid in 2009; and 17 of the 41 claims were paid in 2010. See PF # 014.

Summary of Findings – Interest Payments on Provider Claims

Description	Population	Sample Size	Provider Claims Reviewed	Exceptions	Error Ratio	Interest Due	PF #
PCI Accident Paid	619	155	111	11	10%	$128.07	004
Health Special Risks Accident Paid	693	143	116	41	35%	76.75	014
Totals	**1,312**	**298**	**227**	**62**	**27%**	**$204.82**	

A 27% error ratio does not meet the standard; therefore recommendations are warranted.

EXAMINATION FINDINGS – FAILED STANDARD 20

Based on the Examiners' review of sample complaints handled by the Company during the examination period, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
20	The Company takes adequate steps to finalize and dispose of the complaints in accordance with policy provisions and applicable statutes and rules.	A.R.S. § 20-461, A.A.C. R20-6-801

The Examiners requested three samples consisting of 137 Complaints and Complaint-related Appeals using Requests 002, 003 and 004, for the complaints initiated in years 2008, 2009 and 2010 respectively. The Company provided, and the Examiners reviewed, 136 complaints and complaint-related appeals in response to these requests.

The Company failed to appropriately reply to nine pertinent communications from seven (5%) of 136 claimants within 10 working days of receipt of the communication. See PF # 024.

The Company has not met Standard No. 20 and appears to be in violation of A.R.S. § 20-461(A)(2) and A.A.C. R20-6-801(E)(3) with regard to the complaints listed on the following table, because it failed to appropriately reply to pertinent communications from claimants within 10 working days of receipt.

REQ No.	ADOI No.	Date of Communication	Date of Response	No. Work Days
002	L-08COMP-017	12/10/08	03/09/09	61
002	L-08COMP-018	12/01/08	12/16/08	11
003	L-09COMP-020	12/21/09	01/12/10	14
003	L-09COMP-020	03/23/10	04/14/10	16
003	L-09COMP-022	03/23/10	06/22/10	64
003	L-09COMP-024	10/14/09	11/11/09	20
003	L-09COMP-027	02/17/09	03/10/09	15
003	L-09COMP-033	03/31/09	05/06/09	26
003	L-09COMP-033	10/06/09	12/16/09	50

Summary of Findings – Response to Claims Communications

Description	Population	Sample Size	Exceptions	Error Ratio
REQ002 – 2008 Complaints	40	40	2	5%
REQ003 – 2009 Complaints	47	47	7	15%
REQ004 – 2010 Complaints	50	50	0	0%
Totals	**137**	**137**	**9**	**7%**

A 7% error ratio does not meet the standard; therefore recommendations are warranted.

RECOMMENDATIONS

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

1. The Company administers its Cancer policies in accordance with policy language and in a non-discriminatory manner, to comply with A.R.S. § 20-448(B).
2. The Company identifies the insured associated with ADOI File Number L-08-AGIACA-D-002, and refunds all premiums collected under this policy in accordance with the Cancer policy provision that any premium collected will be refunded if cancer is diagnosed during the policy's 60-day waiting period.
3. The Company accepts or denies Insured claims within 15 working days of receipt of acceptable proofs of loss, to comply with A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a).
4. The Company adjudicates all provider claims within 30 days of receipt of a clean claim, to comply with A.R.S. § 20-3102(A).
5. The Company provides a reasonable explanation for the denial of a claim, to comply with A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).
6. The Company pays interest at the legal rate from the date of receipt of the claim for all Insured claims not paid within 30 days of receipt of acceptable proofs of loss, to comply with A.R.S. § 20-462(A).
7. The Company pays interest at the legal rate from the date the claim should have been paid on all clean Provider claims not paid within 30 days of the adjudication date, or within 60 days of receipt of the clean claim, which is sooner, to comply with A.R.S. § 20-3102.
8. The Company responds to all pertinent claims correspondence within 10 working days, to comply with A.R.S. § 20-461(A)(2) and A.A.C. R20-6-801(E)(3).

SUMMARY OF STANDARDS

A. Operations and Management

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

B. Advertising, Marketing, and Sales

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

C. Policy Forms

#	STANDARD	PASS	FAIL
7	Policy forms, including but not limited to contracts, certificates, applications, riders, and endorsements, comply with pertinent Arizona laws and/or the laws of the state where the policy was issued. (A.R.S. §§ 20-1205, 20-1342, *et al.*, including but not limited to A.R.S. § 20-1401.01)	X	
8	Individual insurance policy forms, except those for which no renewal is provided, contain a 10-day free look provision, which is prominently displayed on the first page of the policy. (A.A.C. R20-6-501)	X	
9	**(Annuity only)** Company applications and policy/contract forms contain notices the right to request information regarding benefit and contract provisions and the right to return the contract for a refund of premium as prescribed by law. A.R.S. § 20-1233(A), (B) & (C)	X	
10	**(Annuity Only)** Company provides disclosure documents, buyer's guides and annual report to contract owners as prescribed by law. A.R.S. § 20-1242.02.	X	

D. Underwriting/Portability/Guaranteed Issue

#	STANDARD	PASS	FAIL
11	The Company issues coverage to all eligible groups and individuals. (A.R.S. §§ 20-1378, 20-1379, 20-2304, 20-2307, 20-2313, 20-2324)	X	
12	The Company provides approved disclosure of information forms to all group employers prior to executing a contract for coverage under a health care plan. (A.R.S. § 20-2323)	X	
13	The Company does not impose exclusions or limitations for preexisting conditions except as permitted by law. (A.R.S. §§ 20-1379, 20-2308, 20-2310, 20-2321)	X	
14	The Company obtains prior written consent, using approved consent forms, before conducting tests for HIV or genetic disorders. (A.R.S. §§ 20-448.01, 20-448.02, and A.A.C. R20-6-1203)	X	
15	The Company complies with all notice of insurance information and privacy requirements. (A.R.S. §§ 20-2101, *et seq.*)	X	

E. Claims Processing

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

F. Policyholder Services

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

G. Cancellation, Non-Renewals, and Rescissions

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

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

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

I. Replacements (Life and Annuity)

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