STATE OF ARIZONA
Department of Insurance and Financial Institutions
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**Department of Insurance and Financial Institutions**

**State of Arizona**

*Market Regulation and Consumer Services Division*

**REPORT OF TARGET MARKET CONDUCT EXAMINATION**

**OF**

**FREEDOM LIFE INSURANCE COMPANY OF AMERICA**

**NAIC #62324**

**AS OF**

**DECEMBER 31, 2017**

**NAIC MATS # AZ-AILORM-3**

**AZ Exam # 21885**

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**Douglas A. Ducey, Governor**
**Evan G. Daniels, Director**

The Honorable Evan G. Daniels
Director
Arizona Department of Insurance & Financial Institutions
100 N. 15th Ave, Suite 261
Phoenix, Arizona 85007-2624

Director Daniels:

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

**Freedom Life Insurance Company of America NAIC CoCode 62324**

The examination was conducted by James C. Williams, CPA, CFE, CIE, MCM, Examination Supervisor; Marlys A. Rulon, CPA, CFE, CIE, Examiner-in-Charge; Sara J. Schumacher, CPA, CFE, CIE, MCM, CPCU, Market Conduct Senior Examiner; James Menck, CPA, CFE, CFE (Fraud), MCM, Market Conduct Examiner, and Emilie Brady, CFE, AIE, MCM, Market Conduct Examiner.

The examination covered the period of July 1, 2015 through December 31, 2017.

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

Sincerely yours,

Maria G. Ailor, AIE, AMCM
Assistant Director

# FOREWORD

This target market conduct examination report of Freedom Life Insurance Company of America (herein referred to as the “Company”), was prepared by independent examiners contracting with the Department in conjunction with employees of the Arizona Department of Insurance and Financial Institutions (“Department”). The purpose of a target market conduct examination is to review business practices of insurers licensed to conduct the business of insurance in the state of Arizona to determine compliance with State and Federal insurance laws. 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 product developed in the production of this report, are the sole property of the Department per A.R.S. § 20-158(F).

The examination of the Company consisted of a review of the following business operations for the Company’s accident and health insurance lines of business:

A. Operations and Management

B. Advertising, Marketing and Sales

C. Producer Licensing

D. Forms

E. Underwriting/Portability/Guaranteed Issue

F. Claims Processing

G. Affordable Care Act

Some unlawful practices may not have been discovered if such practices occurred outside the scope of the examination and were not preliminarily identified as an area of concern. However, failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department. If findings outside the scope of these areas were discovered in the course of the examination, they are included in the report.

# SCOPE AND METHODOLOGY

The examination of the Company followed the standards and procedures established by the Department and the National Association of Insurance Commissioners (NAIC) as outlined in the Market Regulation Handbook. The target market conduct examination of the Company covered the period of July 1, 2015 through December 31, 2017. The purpose of the examination was to determine the Company's compliance with State of Arizona and Federal insurance laws. The examination was completed by testing each of the Company’s business operations in accordance with NAIC Market Regulation Handbook standards, where applicable. Each of the standards applied during the examination is outlined in this report.

The Examiners utilized both examination by test and examination by sample methodologies. Examination by test involved review of all records within the population, while examination by sample involved the review of a systematically selected number of records from within the population. Tests applied to sample data resulted in an exception ratio, the percentage of files reviewed that were in error, which was used to determine 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". Some standards, such as those in the areas of procedures and forms, are considered not met if any exception is identified. For these standards, no exception ratio was given.

Administration of accident and health insurance is generally regulated by the insurance laws of each applicable state as overseen by the state's insurance department. However, the body of federal laws and regulations related to the Patient Protection and Affordable Care Act (PPACA or ACA) also apply to many health insurance products, particularly major medical health insurance plans.

# HISTORY OF THE COMPANY

The Company is a stock life insurance company originally organized under the laws of Mississippi on March 28, 1956, operating under the name of American Liberty Life Insurance Company. The Company changed its name to Freedom Life Insurance Company of America on August 2, 1983. The Company was redomesticated to Texas on March 24, 1999. The Company currently remains domiciled in the state of Texas, with its statutory home office, including the primary location of its books and records, located at 300 Burnett Street, Suite 200, Fort Worth, TX 76102-2734. The Company is a wholly owned subsidiary of USHEALTH Group, Inc. (USHEALTH). The Department admitted the Company as a Life and Disability insurer in the state of Arizona on June 15, 1981.

The Company is licensed in 35 states and primarily issues individual and group accident and health insurance policies. USHEALTH Advisors, LLC, an affiliate of the Company, is the principal sales and marketing channel for its products.

# EXAMINATION OVERVIEW

## Examination Background

The Department commenced a targeted market conduct examination of the Company as a result of the following concerns:

- Consumer complaints filed with the Department against the Company were directly or indirectly related to point-of-sale representations and disclosures. Specifically, consumers did not understand the limitations and exclusions of the limited benefit policies they purchased. Complaints demonstrated a general trend of consumers believing they had purchased major medical health insurance or something comparable to major medical health insurance.

- Despite the fact that the Company had an approved guaranteed issue ACA-compliant major medical insurance plan (ACA-compliant plan), evidence indicated that the Company was not making this plan available to individuals who were seeking major medical insurance coverage.

## Examination Objectives

The examination had the following objectives:

- Determine if the Company's sales and marketing practices complied with all applicable statutes, rules and regulations, with an emphasis on point-of-sale interactions between Agents and consumers;
- Determine if the Company was complying with applicable statutes, rules, and regulations related to its guaranteed issue ACA-compliant plan;
- Determine if the Company's marketing materials complied with all applicable statutes, rules, and regulations, with an emphasis on whether or not they contained all necessary disclosures related to the Company's limited benefit policies;
- Determine if the Company's claims settlement practices complied with all applicable statutes, rules and regulations; and
- Determine the nature of the Company's relationship with the Associations and the Associations' role in the Company's insurance operations to ensure compliance with all applicable statutes, rules, and regulations.

## Executive Summary

At the outset of the examination, the Department conducted a "Secret Shopper" call to study the sales and marketing practices of the Company. Specifically, the Department sought to learn how the Company offered and sold its guaranteed issue ACA-compliant plan. During the 2017 call, an agent advised the secret shopper that the Company did not have an ACA-compliant plan and referred the secret shopper to the marketplace for coverage options. The Department shared the recordings of the Secret Shopper call with the Company during the on-site management interviews.

Additionally, the following trends were identified in the consumer complaints filed with the Department against the Company during the examination review period: (1) consumers believed they purchased coverage that was comparable to or a substitute for major medical health insurance, although more affordable, and (2) consumers learned that their coverage was not comparable to major medical health insurance when they submitted a claim to the Company and it was denied under one of the limitations and exclusions of their limited benefit policy. As a result of these complaint trends, the Department decided to conduct consumer interviews to collect additional information on the Company's sales and marketing practices. In order to protect the confidentiality of the

consumers, the Department has chosen not to include the information collected during the consumer interviews as evidence in any of the examination findings.

Throughout the course of the examination, Preliminary Findings (PF) were issued to the Company for review and response. The Company provided lengthy rebuttals to each finding, totaling more than 500 pages of written objections alone and more than 3,000 pages when including all exhibits and attachments. The Examiners reviewed and considered any new information or evidence provided by the Company prior to the drafting of the Report of Examination. Below is a summary of the examination findings. The detailed findings, including the failed standards and citations, are included in the Factual Findings section.

During the period under review, the Examiners determined that the Company engaged in misrepresentations and misleading, deceptive, and unfair sales, marketing, and business acts and practices. Specifically, the Examiners concluded unlawful conduct occurred relating to the Company's limited benefit policies, including the PremierChoice, SecureAccess, and PremierMed products. The Company (1) designed these products and its marketing materials in a manner that falsely suggested its limited benefit policies were comparable to or a substitute for a major medical insurance plan; (2) trained its agents to market these products as a more affordable option when compared to a major medical plan, while failing to adequately train agents on the significant differences in coverage between its limited benefit policies and a major medical plan; and (3) failed to demonstrate it had sufficient oversight and control of its sales force to make accurate representations to consumers about the Company's insurance products, which contributed to and exacerbated the prevalence of misleading, deceptive, and unfair sales and marketing conduct.

A summary of the specific facts that support these conclusions are outline below:

- The Company bundled multiple limited benefit policies including accident-only and specified-disease policies with accompanying riders in a manner that suggested the policies' coverage was comparable to or a substitute for major medical insurance plans by:
    - Presenting the products in a single brochure;
    - Combing policy benefits and statistics in a singular image or table;
    - Failing to list the limitations and exclusion in close enough proximity to the benefits to provide appropriate context;
    - Using terminology commonly associated with major medical insurance plans ("Head to Toe", "PPO", and "provider network");
    - Including the names of some major medical carriers ("CIGNA"); and
    - Excluding language that would have identified that the policies were limited benefit ("Limited Benefit" and "Supplemental").

- Included with the bundled limited benefit products was a rider that gave consumers the right to purchase a Short Term Limited Duration (STLD) policy at a later date without additional underwriting. The Company referred to the process of obtaining such policy as "Upgrading" in its marketing materials and policy documents when in fact the consumer would actually be purchasing an entirely separate standalone policy with its own separate benefits, limitations and exclusions, and premiums. Advertising

and agent statements suggested this rider was specifically designed to market the Company's bundled limited benefit policies as a substitute for major medical insurance by allowing the consumer to purchase additional coverage, or "upgrade," only when needed by using phrases such as "Access More Coverage… But Only When You Need It" and "Why buy it until you need it?"[1]

- The Company failed to advise consumers that they were required to join an Association, pay an initiation fee, and pay monthly dues in order to purchase the Company's limited benefit policies. The Company's brochures did not disclose the requirement to join the Association nor the costs associated with the Association. Further, the Association brochures, which were supposed to be presented in conjunction with the Company's brochures, were not filed with the Department as required.
- The Company's agent training did not adequately educate agents on the limitations and exclusions of the Company's limited benefit policies. Nor did the training educate agents how to determine the suitability of its products. As previously stated, during interviews with the Examiners, the Company's agents were unable to provide basic information on the limitations and exclusions of the Company's limited benefit policies. As part of the examination, the Examiners interviewed 7 Arizona-licensed agents, resident and non-resident, who were contracted with the Company during the examination review period. All 7 agents were subpoenaed and interviewed under oath with counsel present. During these interviews, most of the agents could not describe the basic limitations and exclusions of the Company's limited benefit policies even when they were offered the product brochures for reference. To protect their confidentiality, the names of the agents interviewed are not included in this report. However, the Examiners provided the Company with a summary of the information collected during the interviews.
- In the Company's verification call (V-call) process, the Company used the term "excepted" benefits to describe the fact that these policies did not constitute Minimum Essential Coverage under the ACA, rather than using plain language or common terminology understood by the average consumer. Further, the Company failed to follow its V-call procedure as follows: (1) the Company failed to verify with the consumer that they were informed of the requirement to join an Association and pay Association dues in order to purchase the Company's limited benefit policies, and (2) when the consumer had a question, the Company failed to transfer the consumer back to the agent as was the Company's reported procedure.
- The Company failed to demonstrate that it had sufficient oversight and control of its sales force. Specifically, the Company had no written procedures for agent oversight nor were the Company's management or agents able to identify a specific Department or individual responsible for agent monitoring and oversight. Further, the Company had no mechanism for monitoring and responding to trends in consumer complaints related to agent conduct or sales and marketing issues. In failing to establish sufficient oversight and control of its sales force, the Company created an environment that allowed unlawful conduct—specifically in the omissions and misrepresentations commonly made to consumers about the Company's insurance products—to proliferate without correction.

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[1] Quotes taken from the PowerPoint sales presentation (PPT-Sales-PC-PM-ANC-1115) provided by the Company in response to Information Request (IR) 27A.

# FACTUAL FINDINGS

## Operations and Management

The Examiners reviewed the following information as part of the testing of the Operations and Management standards:

- All 85 responses to the requests for information from the Company; and
- All 45 vendor agreements including amendments plus 6 Association agreements.

The Examiners maintained an information request log and noted that the Company provided timely responses to all 70 Information Requests (IR) and to all 15 Preliminary Findings (PF).

The Company submitted 45 agreements or amendments executed with 27 vendors for services such as information systems, preferred provider network, pharmacy benefit management, case management, administrative services, etc., along with a listing of the summarized terms of each agreement. The Examiners reviewed all the agreements provided and tested the completeness and accuracy of the Company's listing by reviewing the documentation for 7 vendors. These 7 vendors had 7 agreements plus 6 related amendments. No exceptions were noted in the accuracy of the agreement terms summarized in the listing. However, the Examiners concluded that the listing was incomplete because it did not include the 7 agreements for the Associations used by the Company during the examination review period.

The Examiners went back and specifically requested the written agreements for the 7 Associations with which the Company did business, as well as information on the business activities of the Associations. However, the Company was only able to provide 6 written agreements, because the agreement for 1 of the associations was with USHEALTH rather than the Company.

**The following Operations and Management Standard was met:**

| # | Standard | Regulatory Authority |
|---|---|---|
| A-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)<br>A.A.C. R20-6-801(C) |
| A-2 | Contracts between the Company and other entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, general agents, associations, third-party administrators and management agreements must comply with applicable licensing requirements, statutes, rules and regulations. | A.R.S. § 20-485.01(A) |

## Advertising, Marketing and Sales

The Examiners reviewed the following information as part of the testing of the Advertising, Marketing and Sales standards:

- The Examiners conducted a forms analysis by comparing the list of advertisements submitted by the Company with the list of advertisements filed with the Department;
- The Company with the list of advertisements filed with the Department;
- The Examiners reviewed the advertising used by the 7 Associations through which the Company sold its limited benefit policies;
- The Examiners reviewed the 9 “secret shopper” call recordings provided by the Department;
- The Examiners conducted interviews with 7 agents who were employed with the Company during the examination review period. During the interviews, 1 of the agents provided to the Examiners a PowerPoint presentation that had not been submitted or filed by the Company;
- The content, language, and format of sales and marketing brochures the Company used during the examination review period. The Examiners selected a sample of 16 of the 118 sales and marketing documents submitted by the Company, 12 of which were original documents and 4 of which were a revised version of 1 of the originals;
- One hundred and fourteen policies for 66 policyholders including applications, V-calls and other correspondence and information related to the underwriting file;
- Nineteen applications that the Company denied or were withdrawn including the application, V-calls, and other correspondence and information related to the underwriting file;
- Files for 7 of the 11 consumers who inquired about the Company’s ACA-compliant plan during 2017 including correspondence and other materials of which 1 resulted in an issued ACA-compliant policy;
- Arizona agent licensing information for 72 policies;
- Agent training materials related to the Company’s ACA-compliant plan for 2015, 2016 and 2017, along with the listing of agents in attendance and/or training test scores;
- The Company’s website;
- The Business Plan Enrollment Projections for the Company;
- The Company’s commission schedule;
- The Company’s response to IRs 9, 14, 14A, 14B, 14C, 16, 22, 25, 27, 27A, and 27B including all exhibits and attachments; and
- The Company’s response to PFs 3, 5, 7, 9, 11, 14, and 15 including all attachments and exhibits.

**The following Advertising, Marketing and Sales Standards failed:**

| # | Standard | Regulatory Authority |
|---|---|---|
| B-3 | All advertising and sales materials comply with applicable statutes and rules. | A.R.S. §§ 20-442, 20-443(A)(1), 20-443(A)(4), 20-444(A), 20-1110(E), and 20-1137(A)<br>A.A.C. R20-6-201(C)(1), R20-6-201(C)(2), R20-6-201(C)(3), R20-6-201(C)(5), R20-6-201(C)(8), R20-6-201(C)(9), R20-6-201(D), R20-6-201(F), R20-6-201(H)(1), R20-6-201(H)(2), and R20-6-201.01(A) |
| B-4 | The Company markets its products in a fair and nondiscriminatory manner to all eligible individuals and/or groups. | A.R.S. §§ 20-1379(A) and 20-1379(B)<br>45 CFR[2] 147.104(a) and 147.104(e) |
| B-5 | Marketing and sales practices are in compliance with the requirement to make approved, individual plans available and to accept every individual that applies for coverage. | A.R.S. §§ 20-1379(A) and 20-1379(B)<br>45 CFR 147.104(a) and 147.104(e) |

**Failure to File Advertising Materials (Association Brochures) – Finding No. 11[3]**

The Company utilized 5 marketing brochures for the American Business Coalition Association during the examination review period that were not filed with the Department before use which represents 5 violations of A.R.S. § 20-1110(E).

**Use of Misleading Marketing Materials – Finding No. 7**

The Examiners reviewed a sample of 16 of the Company's sales and marketing materials and determined 85 violations of Arizona law related the use of misleading or inaccurate information and the omission of important information. Violations included using statistical information not specific to the plan to make representations about the plan, failing to include limitations and exclusions in a conspicuous manner, making exaggerated statements about product coverages, failing to include information on limitations related to pre-existing conditions, failing to disclose waiting periods, omitting key terms that would accurately describe the policies ("Limited Benefit" and "Supplemental") and including terms typically associated with major medical insurance coverage ("PPO" and "provider network").

[2] Code of Federal Regulations

[3] Findings are numbered in the report in accordance with the Preliminary Findings (PFs) as issued to the Company, not in sequential order for ease of response by the Company

All 85 violations noted by the Examiners are broken down by legal provision as follows:

- 40 violations of A.A.C. R-20-6-201(C)(1);
- 1 violation of A.A.C. R-20-6-201(C)(3);
- 20 violations of A.A.C. R-20-6-201(C)(5);
- 5 violations of A.A.C. R-20-6-201(C)(8);
- 5 violations of A.A.C. R-20-6-201(C)(9);
- 9 violations of A.A.C. R-20-6-201(D); and
- 1 violation of A.A.C. R-20-6-201(F).

**Bundling Various Limited Benefit Products – Finding No. 9**

The Examiners concluded that the Company advertised and sold bundled limited benefit insurance policies in a manner that led consumers to believe the plans were major medical health insurance or could be a substitute for major medical health insurance in violation of A.R.S. § 20-1137(A) and A.R.S. § 20-442. During the review period:

- The Company combined the agent training and certification test for its bundled limited benefit policies;
- Agents were paid a single commission for the bundled limited benefit policies;
- The consumer completed 1 application form for the bundled limited benefit policies;
- The Company performed 1 V-call for the bundled limited benefit policies;
- The Company's marketing materials, including sales brochures and the website, present the bundled limited benefit policies under a single name, comingled product benefits, utilized terms commonly associated with major medical health insurance ("Head to Toe", "PPO", and "provider network"), and omitted key terms that would have identified the products as supplemental and limited benefit ("Limited Benefit" and "Supplemental");
- The Company could not provide any documentary evidence that it presented the consumer with the separate cost of each policy and rider as part of the sales process;
- The Company sold, as a rider, the right to purchase separate coverage under its STLD plan, PremierMed, at a later date. The Company marketed this STLD rider in a misleading manner by calling the process for invoking the right to purchase the STLD plan "upgrading" and by allowing its corporate staff to sell this product to consumers thereby implying it was an added benefit of the consumer's accident and specified disease policies rather than a separate standalone policy. Advertising and agent statements suggested this rider was specifically designed to market the Company's bundled limited benefit policies as a substitute for major medical insurance, which is specifically prohibited under Arizona law, by allowing the consumer to purchase additional coverage, or "upgrade", only when needed by using phrases such as "Access More Coverage… But Only When You Need It" and "Why buy it until you need it?" Further, the Company reported that it only sold the STLD rider to individuals who did not have major medical insurance when the Company's sales data indicated this rider was sold to nearly 100

percent of consumers. In other words, the Company knowingly sold its limited benefit policies to individuals without major medical health insurance despite the fact that these products are intended to supplement, not replace, a major medical insurance plan.

**Misrepresentations; and Misleading, Deceptive and Unfair Acts and Practices – Finding No. 15**

During the period under review, the Company engaged in misrepresentations and misleading, deceptive, and unfair sales, marketing, and business acts and practices. Specifically, the Examiners concluded unlawful conduct occurred relating to the Company's limited benefit policies, including the PremierChoice, SecureAccess, and PremierMed products.

The Company bundled and marketed its limited benefit insurance policies in a manner that indicated they were comparable to or a substitute for a major medical insurance plan. The Company presented these products in a single brochure under a single name, commingled product benefits, and reported combined statistical information on the products. The marketing materials also used terminology commonly associated with major medical insurance plans ("Head to Toe", "PPO", and "provider network") and even included the names of some major medical carriers ("CIGNA"), while omitting key terms that would have identified the products as limited benefit ("Limited Benefit" and "Supplemental"). Further, the disclosures that the products were not Minimum Essential Coverage included legal technical language not commonly understood by consumers ("excepted benefits"). Agent training for the limited benefit policies was also bundled together in a manner that suggested they were a single product. The Company contends that, although the names and benefits for the limited benefit policies are presented together, by using the word "plans" in the plural in the marketing materials and agent training they are not bundling their products.

The Company sold, as a rider, the onetime right to purchase additional coverage under its STLD plan, PremierMed. The Company marketed the STLD rider in a misleading manner by calling the process for invoking the right to purchase the STLD plan the "upgrade" process and by allowing its unlicensed corporate staff to sell this product to consumers, thereby implying it was an added benefit of the consumer's accident and specified disease policies rather than a separate standalone policy with its own benefits, limitations and exclusions, and premiums. Advertising and agent statements suggested this rider was specifically designed to market the Company's bundled limited benefit policies as a substitute for major medical insurance by allowing the consumer to purchase additional coverage, or "upgrade", by using phrases such as "Buy More Coverage, if you need it, without additional underwriting." Also, the Company reported that it only sold the STLD rider to individuals who did not have major medical insurance while the Company's sales data indicated this rider was sold to nearly 100 percent of customers. The Company knowingly sold its limited benefit policies to individuals without major medical health insurance despite the fact that these products are intended to supplement, not replace, a major medical insurance plan. Further, the combined cost of the PremierMed deductible and the catch-up premium required to buy PremierMed

benefits meant that it was only to the member's advantage to enroll in the PremierMed policy if they had at least $15,600 in medical expenses. At the time the rider was sold, the Company did not disclose to insureds that there were limited circumstances under which the future purchase of the PremierMed product would be financially beneficial. The Company thus misrepresented the value of the rider to insureds at the time of purchase in violation of A.R.S. § 20-443. This is evidenced by the fact that the PremierMed rider was sold to 99.9% of individuals who purchased Premier Choice, but only executed by 2.1% of individuals.

The marketing materials did not delineate the separate product costs or deductibles and the Company could not provide any documentary evidence that they had disclosed the separate costs of the individual policies to the consumer, even in instances where the consumer specifically inquired about the separate product costs. By presenting a single bundled cost for the limited benefit policies, the Company further gave the impression that the products were comparable to or a substitute for a major medical insurance plan.

The Company failed to inform consumers of the limitations and exclusions of its limited benefits policies. Consumer complaint trends show that consumers were unaware of the limitations and exclusions of the limited benefit policies they purchased. Further, during interviews with the Examiners, the agents were unable to answer basic questions concerning the limitations and exclusions of the Company's limited benefit policies. Also, the Company's product brochures summarized the benefits without adequately communicating the limitations and exclusions associated with the covered service.

The Company failed to advise consumers that they were required to join an Association, which included paying an initiation fee and monthly dues, in order to have access to the Company's limited benefit insurance policies. The product brochures did not disclose the requirement to join the Association or to pay monthly Association dues. Additionally, the Association brochures that were supposed to be presented during the sales processes in conjunction with the product brochures were not filed with the Department in violation of Arizona law. Finally, the Company failed to include language related to the Association in its V-call even though it was in the V-call script.

The Company's agent training did not adequately educate agents about the limitations and exclusions of the Company's limited benefit policies, nor did the training educate agents on how to determine which products were suitable for a consumer. As previously stated, during interviews with the Examiners, agents were unable to provide basic information about the limitations and exclusions of the Company's limited benefit policies. These facts suggest that the Company trained its agents to sell its bundled limited benefit policies based on the consumer's budget, not based on coverage suitability.

The Company failed to make available to consumers its guaranteed issue ACA-compliant major medical health insurance plan, which was approved for sale in the applicable market. In 2015, 2016, and 2017, the Company erected multiple impediments for consumers to access its guaranteed issue ACA-compliant plan, including failing to inform all of its Arizona licensed captive sales agents of the availability of this product. In so restricting the avenues through which an individual could identify the Company's ACA-compliant plan as available for enrollment, and effectuate enrollment in that product, the Company failed to comply with the guaranteed availability requirements. The few ACA-compliant policies that the Company did sell (only 7 policies over a three-year period)

were issued to consumers who were already insured by the Company under one of its limited benefit policies, and the notes from the underwriting file clearly indicate the Company offered this product to the customer as another "upgrade" option in lieu of a STLD plan due to a major accident or illness.

The Company implemented a V-call process regarding the Company's limited benefit policies that was misleading, deceptive, and unfair. The Company used the term "excepted benefits" in V-call disclosures because these policies are not considered Minimum Essential Coverage under the ACA, rather than using plain language or commonly used terminology. Further, the Company failed to follow its own V-call procedure as follows: (1) the individuals performing the calls failed to confirm with consumers whether they understood that they were required to join an association and pay association membership dues as part of their enrollment in the limited benefit policies; and (2) when consumers had a question, the individuals performing the calls did not answer the question nor did they transfer the consumer back to the agent as was the reported procedure.

The Company failed to demonstrate that it had sufficient oversight and control of its sales force, which allowed for significant and uncorrected misrepresentations to be made to consumers. Specifically, the Company had no written procedures for agent monitoring and oversight nor was the Company's management or agents able to identify a specific Department or individual responsible for agent monitoring and oversight. Further, the Company failed to demonstrate that it had sufficient oversight and controls in place to identify trends in consumer complaints, including issues related to product suitability, product misrepresentation, agent misconduct, and agent training, and to take corrective action as needed. In failing to establish sufficient oversight and control of its sales force, the Company contributed to and exacerbated the prevalence of misleading, deceptive, and unfair sales and marketing conduct.

**Availability of Guaranteed Issue ACA-compliant Health Insurance Plan – Finding No. 4**

The Company did not comply with the requirement to make available to any individual in the State its ACA-compliant plan as was approved for sale in the applicable market as required by 45 CFR 147.104(A), 45 CFR 147.104(E), A.R.S. § 20-1379(A) and A.R.S. § 20-1379(B). The Examiners determined from the "secret shopper" calls conducted by the Department and the agent interviews completed by the Examiners that the Company failed to inform its sales force that it had an ACA-compliant plan available. This resulted in consumers who were seeking such a product being sold non ACA-compliant products or being turned away all together. Further, all of the ACA- compliant policies issued by the Company during the examination review period were to consumers who were already insured under one of the Company's limited benefit policies, and notes in the policy file indicate the plan was sold as another "upgrade" option similar to the Company's STLD plan.

## Producer Licensing

The Examiners reviewed the following information as part of the testing of the Producer Licensing standards:

- Agent training materials including 16 training modules and accompanying tests covering the Company's products, the training modules and accompanying tests covering the company overview and marketing compliance, and training modules without tests covering open enrollment and the CIGNA PPO Network;
- Twenty-seven Arizona agent licensing files;
- The Producer Licensing listing submitted by the Company (Att C Itm 4 – Producer Licensing_v3);
- The agent licensing list provided by the Department for all agents licensed during the examination review period;
- The new business data population for the examination review period submitted by the Company (Att C Itm 1 – New Business Issued v2) and the list of consumers who inquired about the Company's ACA-compliant plan during 2017;
- One hundred and fourteen policies for 66 policyholders including applications, V-calls, and other correspondence and information related to the underwriting file;
- Files for 7 of the 11 consumers who inquired about the Company's ACA-compliant plan during 2017, 1 of which resulted in an issued ACA-compliant 2018 policy, including correspondence and other materials;
- The Company's response to IRs 9, 10, 16, 18, 18A, 18B, 21, 25, 26, 26A, 26B, 27, 27A, and 27B including all exhibits and attachments; and
- The Company's response to PFs 3, 4, 14, and 15 including exhibits and attachments.

**The following Producer Licensing standards were met:**

| # | Standard | Regulatory Authority |
|---|---|---|
| B-6 | The Company's internal producer training materials are in compliance with applicable statutes, rules and regulations. | A.R.S. § 20-441, *et seq*. |
| B-7 | The regulated entity's records of licensed producers agree with the insurance department records. | A.R.S. § 20-282, *et seq*. |

**The following Producer Licensing Standard failed:**

| # | Standard | Regulatory Authority |
|---|---|---|
| B-8 | Producers writing business for the Company to Arizona insureds are properly licensed in the State of Arizona. | A.R.S. § 20-282 |

**Sales of Policies by Unlicensed Agents – Finding No. 3**

The Company sold its STLD and ACA-compliant plans using unlicensed corporate staff in violation of A.R.S. § 20-282. Nine of the 72 policies and applications tested by the Examiners were for STLD or ACA-compliant plans, all of which were sold by an unlicensed corporate staff person.

## Forms

The Examiners reviewed the following information as part of the testing of the Forms standards:

- Seventy-five policies and/or applications for 32 policyholders, which included all 7 of the ACA-compliant plan applications from the examination review period;
- The listing of policy forms provided by the Company (Att. A, VI.C. Forms Spreadsheet) and the 71 related forms provided by the Company;
- The listing of forms the Company filed through SERFF;
- The Company's response to IRs 19, 19A and 28 including exhibits and attachments; and
- The Company's response to PF 2 including exhibits and attachments.

Policy forms were not reviewed as part of the examination, therefore no determination was made as to the compliance of the forms with State and/or Federal law.

**The following Forms Standard was met:**

| # | Standard | Regulatory Authority |
|---|---|---|
| C-11 | Individual insurance policy forms provided to the insured contain a 10-day free look provision, which is prominently displayed on the first page of the policy. Company is honoring the free look provision. | A.A.C. R20-6-501 |

**The following Forms Standards failed:**

| # | Standard | Regulatory Authority |
|---|---|---|
| C-9 | Policy forms, including but not limited to contracts, certificates, applications, riders and endorsements, comply with pertinent laws and regulations. | A.R.S. § 20-2533(C) |
| C-10 | The Company is issuing the policy and application forms as approved by the Department and in accordance with filed rates. | A.R.S. § 20-1110(A) |

**Failure to Provide Health Care Appeals Information Packet at the Time Coverage was Initiated – Finding No. 2**

The Company was unable to provide evidence that it complied with A.R.S. § 20-2533(C) to provide the Arizona Health Care Appeals Process Information Packet at the time coverage was initiated.

The Examiners tested 32 applications submitted during the examination review period that resulted in a total of 75 Arizona policies issued. The Examiners determined 59 instances in which the Company did not provide the Health Care Appeals Process Information Packet.

The Examiner also tested the policies associated with 109 denied claims, which, after removing duplicates from policies already tested, resulted in an additional 39 policies. Among these 39 policies, the Examiners determined 32 instances in which the Company did not provide the Health Care Appeals Process Information Packet, for a total of 91 exceptions.

The Examiners determined that the exceptions occurred for the following products:

- PremierChoice Specified Disease/Sickness Plan (form number SDUP2PY-2014-C-FLIC)
- PremierChoice Accident Plan (form number ACCUP2PY-2014-C-FLIC)
- Accident Protector (form number GACC-2010-C-FLIC)
- Income Protector (form number ACCDIS-2011-C-FLIC)
- Accident Only Blanket Association Group (form number BLKACCUP2-2014-P-FLIC)
- Blanket Association Group Policy (form number BACC-2012-P-FLIC)
- Specified Disease Blanket Association Group (form number BLKSDUP2-2014-P-FLIC)
- Critical Illness Blanket Association Group (form number BLKTCRTIL-P-AZ-FLIC)

| Population New Business (policy types listed above) | Sample | # of Exceptions | Error Rate to Sample |
|---|---|---|---|
| 27,913 | 114 | 91 | 80% |

This represents 91 violations of A.R.S. § 20-2533(C), which is an error rate of 80%."

**Failure to Use Filed and Approved Form (ACA-compliant Health Insurance Plan Application) – Finding No. 6**

The Company did not use the ACA-compliant plan application form as filed and approved by the Department which is a violation of A.R.S. § 20-1110(A).

The Examiners reviewed all 7 ACA-compliant plan applications completed during the examination review period and concluded that none were completed using the filed and approved application form. Further, all 7 application forms included questions related to medical history and health information. While these questions were not completed in any of the applications, the Company's failure to utilize the correct application form indicates that the Company did not establish clear processes related to its ACA-compliant plan.

| Population | Sample | # of Exceptions | Error Rate to Sample |
|---|---|---|---|
| 7 | 7 | 7 | 100% |

## Underwriting/Portability/Guaranteed Issue

The Examiners reviewed the following information as part of the testing of Underwriting/Portability/Guaranteed Issue Standards:

- Seventy-five policies and/or applications for 32 policyholders, which included all 7 of the ACA-compliant plan applications from the examination review period;
- The listing of policy forms provided by the Company (Att. A, VI.C. Forms Spreadsheet) and the 71 related forms provided by the Company;
- The Company's response to IRs 7, 10, 12, 18, 18A, 18B, 21, 26, and 32 including all exhibits and attachments; and
- The Company's response to PFs 2, 3, 4, 8, 14, and 15 including all exhibits and attachments.

As part of the testing of the Underwriting/Portability/Guaranteed Issue standards, the Examiners reviewed the policies, disclosures, applications and related underwriting materials for 32 policyholders and/or applicants and found no issues related to the standards listed below. The information provided by the Company also included commissions, forms, and disclosure materials related to HIV, Genetic Testing, HIPAA, Privacy and other related topics.

**The following Underwriting/Portability/Guaranteed Issue Standards were met:**

| # | Standard | Regulatory Authority |
|---|---|---|
| D-14 | The Company uses appropriate consent and/or release forms regarding the testing for or disclosure of HIV-related or genetic testing information. | A.R.S. §§ 20-448.01, 20-448.02, and A.A.C. R20-6-1201, *et seq.* |
| D-15 | The Company complies with all notice of insurance information and privacy requirements. | A.R.S. § 20-2101, *et seq*. |
| D-16 | The Company does not permit illegal rebating, commission-cutting or inducements. | A.R.S. §§ 20-449 and 20-452 |

**The following Underwriting/Portability/Guaranteed Issue Standards failed:**

| # | Standard | Regulatory Authority |
|---|---|---|
| D-12 | The Company issues coverage to all eligible groups and individuals. | A.R.S. §§ 20-1379(A), 20-1379(B), 45 CFR 147.104(A) and 147.104(E) |

**Availability of Guaranteed Issue ACA-compliant Health Insurance Plan – Finding No. 4**

The Company did not comply with the requirement to make available to any individual in the State its ACA-compliant plan as approved for sale in the applicable market as required by 45 CFR 147.104(A), 45 CFR 147.104(E), A.R.S. § 20-1379(A) and A.R.S. § 20-1379(B). It was determined from the "secret shopper" calls conducted by the

Department and the agent interviews completed by the Examiners that the Company failed to inform its sales force that it had an ACA-compliant plan available. This resulted in consumers who were seeking such a product being sold non ACA-compliant products or being turned away all together. Further, all of the ACA-compliant policies issued by the Company during the examination review period were issued to customers who were already insured by the Company under one of its limited benefit policies, and notes in the policy file indicate the plan was sold as an "upgrade" similar to the Company's STLD plan.

## Claims Processing

While on-site at the Company's headquarters in Fort Worth, Texas, the Examiners met with and interviewed various members of management, as noted in the Appendix, to obtain an overview of the claims process, walkthrough the claims systems, obtain information on claims internal controls, and test a sample of denied claims. Although management personnel were present to assist, the Examiners were not able to complete claims testing on-site due to the lack of documentation in the Company's claims system.

The Examiners reviewed the following information as part of the testing of the Claims Processing standards:

- One hundred and forty five denied claims comprised of a sample of 105 denied claims from the denied claim population provided by the Company (Att C Itm 3 – Claims – Denied, Closed wo Pay v2) and all 40 denied claims for the Company's ACA-compliant policies from the examination review period. As part of testing, the Examiners reviewed the policy, explanation of benefits letter, call logs, supporting documentation related to the claim determination, interest calculation on any claims not paid timely, and other materials as appropriate to determine if a claim file was adjudicated in compliance with Arizona Revised Statutes and Arizona Administrative Code;
- The Company's response to all IRs including exhibits and attachments;
- The Company's response to examination interrogatories;
- Interviews with the Company's management; and
- The Company's response to all PFs including exhibits and attachments.

**The following Claim Processing Standard was met:**

| # | Standard | Regulatory Authority |
|---|---|---|
| E-19 | All claim forms contain an appropriate fraud warning. | A.R.S. § 20-466.03 |

**The following Claim Standards failed:**

| # | Standard | Regulatory Authority |
|---|---|---|
| E-17 | The Company handles claims timely and appropriately, and in accordance with policy provisions and applicable statutes and rules. | A.R.S. §§ 20-461(A)(3), 20-462(A), 20-1342(A)(3), 20-2533(D), and 20-3102(A) |

| # | Standard | Regulatory Authority |
|---|---|---|
| E-18 | The Company adequately documents claim files to contain all notes and work papers in such detail as necessary to reconstruct the claim. | A.R.S. § 20-461(A)(3), A.A.C. R20-6-801(C), and R20-6-801(G)(2) |
| E-20 | 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)(3), A.A.C. R20-6-801(C), and R20-6-801(G)(2) |

**Failure to Provide Notification of Appeal Rights at the Time of Claim Denial – Finding No. 1**

The Company did not provide the "Notice of Appeals Rights" on the explanation of benefits form (EOB) nor did the Company notify the claimant of their right to appeal in any other form for 99 out of the 109 denied claims from the testing population. This represents 99 violations of A.R.S. § 20-2533(D), which is an error rate of 90.8%.

| Population Denied Claims | Sample | # of Exceptions | Error Rate to Sample |
|---|---|---|---|
| 63,964 | 109 | 99 | 90.8% |

**Failure to Extend Coverage to a Newly Born Child – Finding No. 8**

The Company did not extend policy benefits to a newly born child within the 31 day period from birth as required per A.R.S. § 20-1342(A)(3). As a result, the Company failed to pay the claim for a newly born child representing 1 violation of the statute.

**Failure to Correctly Process ACA-compliant Health Insurance Plan Claims– Finding No. 10**

The Examiners tested all 40 denied claims for the Company's ACA-compliant plan for the examination review period. The Examiners concluded the Company incorrectly processed 5 of the 40 denied claims, which represents 5 violations of A.R.S. § 20-461(A)(3), for failing to adopt and implement reasonable standards for the prompt investigation of claims, which is an error rate of 12.5%.

Further, when the Company reprocessed the claims identified above to pay them in accordance with the terms of the policy, the Company failed to correctly pay interest on these claims. The late payments for these 5 claims and the subsequent incorrectly paid interest represents 1 violation of A.R.S. § 20-462(A), timely payment of claims to a consumer, and 4 violations of A.R.S. § 20-3102(A), timely payment of health care providers' claims.

| Population Denied ACA-compliant Plan Claims | Sample | # of Exceptions | Error Rate to Sample |
|---|---|---|---|
| 40 | 40 | 5 | 12.5% |

## Affordable Care Act

The Examiners reviewed the following information as part of the testing of the Affordable Care Act (ACA) standards:

- The new business data population for the examination review period submitted by the Company (Att C Itm 1 – New Business Issued v2) and the applications not taken or declined for the examination review period submitted by the Company (Att C Itm 2 – Applications Declined – Not Taken v2);
- All ACA-compliant policies written during the examination review period with the following effective dates:
  - 2015 - 3 policies
  - 2016 - 3 policies
  - 2017 - 1 policy
  - 2018 - 1 policy;
- Nineteen applications that were either denied or withdrawn including the V-calls and other correspondence and information related to the underwriting file;
- All of the ACA-compliant policies issued during the examination review period including the applications, V-calls and other correspondence and information related to the underwriting file;
- Files for 7 of the 11 consumers who inquired about the Company's ACA-compliant plan during 2017 including correspondence and other materials of which 1 resulted in an issued ACA-compliant policy;
- The Arizona agent licensing information for all agents associated with the ACA-compliant plan applications completed during the examination review period;
- The total population of denied claims for the ACA-compliant plan policies from the examination review period. As part of the review, the Examiners reviewed the issued policy, the explanation of benefits letter, documentation to verify the claim appeared to be appropriately denied, the interest calculation on any claims not paid timely and other materials as appropriate to determine whether a claim file was adjudicated in compliance with Arizona law;
- The Company's response to IRs 8, 8A through 8G, 12, 15, 19, 19A, 20, 32, 35, and 36 including all exhibits and attachments;
- The Company's response to PF 4 including exhibits and attachments;
- The Company's response to examination interrogatories;
- Information gathered during the interviews with the Company's management;
- Information gathered during the "secret shopper" call conducted by the Department;
- Information gathered by the Examiners during the 7 agent interviews;
- Agent training materials related to the Company's ACA-compliant plan for 2015, 2016, and 2017, including the training attendance information and/or test scores;
- The Company's website;
- The Company's Business Plan Enrollment Projections; and
- The Company's commission schedule.

The Examiners did not review any brochures or other sales materials related to the Company's ACA-compliant plan, other than the Company's website, because the Company did not produce any marketing materials for this product during the examination review period.

**The following Affordable Care Act Standards were met:**

| # | Standard | Regulatory Authority |
|---|---|---|
| F-21 | Extension of Dependent Coverage to Age 26<br>A group health plan, or a health carrier offering group or individual health insurance coverage, that makes available dependent coverage of children shall make such coverage available for children until attainment of 26 years of age. A health carrier must make child-only plans available. | PHSA[4] §2714,<br>45 CFR 147.120 and 147.150 |
| F-23 | Guaranteed Renewability of Coverage<br>A health carrier offering individual market health insurance coverage shall renew or continue in force the coverage, at the option of the policyholder, subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). | PHSA §2703 and<br>45 CFR 147.106 |
| F-24 | Prohibition On Preexisting Condition Exclusions<br>A health carrier may not deny coverage to applicants/proposed insureds or insured, based on any preexisting condition exclusion or preexisting condition limitation. | PHSA §2704 and §1255, and<br>45 CFR 147.108 |
| F-25 | Summary Of Benefits And Coverage (SBC) And Uniform Glossary<br>The appearance, language, form and content of a summary of benefits and coverage (SBC) and uniform glossary issued by a health carrier shall be in compliance with final regulations issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). | PHSA §2715 |
| F-26 | Summary Of Benefits And Coverage (SBC) And Uniform Glossary<br>A health carrier shall timely deliver content-compliant summaries of benefits and coverages (SBC) in compliance with final regulations issued by the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). | 45 CFR 147.200 |

[4] Public Health Services Act

**The following Affordable Care Act Standards failed:**

| # | Standard | Regulatory Authority |
|---|---|---|
| F-22 | Guaranteed Availability of Coverage (Individual Market)<br>A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any individual who: (1) applies for the plan; (2) agrees to make the required premium payments; and (3) meets other reasonable conditions consistent with federal and state law. | A.R.S. §§ 20-1379(A) and 20-1379(B), 45 CFR 147.104(A), and 147.104(E) |

**Availability of Guaranteed Issue ACA-compliant Health Insurance Plan – Finding No. 4**

The Company did not comply with the requirement to make available to any individual in the State its ACA-compliant plan as approved for sale in the applicable market as required by 45 CFR 147.104(A), 45 CFR 147.104(E), A.R.S. § 20-1379(A) and A.R.S. § 20-1379(B). As determined during the "secret shopper" call conducted by the Department and the agent interviews completed by the Examiners, the Company failed to inform its sales force that it had an ACA-compliant plan available which resulted in consumers who were seeking such a product being turned away. Further, all of the ACA-compliant policies issued by the Company during the examination review period were issued to consumers that were already insured by the Company under one of its limited benefit policies and notes in the policy file indicate the plan was sold as an "upgrade" similar to the Company's STLD plan.

## SUMMARY OF STANDARDS AND FINDINGS

### A. Operations and Management

| # | STANDARD | PASS | FAIL | FINDING |
|---|---|---|---|---|
| 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 | | None |
| 2 | Contracts between the Company and other entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, general agents, associations, third-party administrators and management agreements must comply with applicable licensing requirements, statutes, rules and regulations. (A.R.S. § 20-485 and A.A.C. R20-6-201.01(A)) | X | | None |

### B. Advertising, Marketing, and Sales

| # | STANDARD | PASS | FAIL | FINDING |
|---|---|---|---|---|
| 3 | All advertising and sales materials comply 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) | | X | 7, 9, 11, 15 |
| 4 | The Company markets its products in a fair and nondiscriminatory manner to all eligible individuals and/or groups. (A.R.S. §§ 20-1378, 20-1379, 20-2304, 20-2307, 20-2313, 20-2324; 45 CFR 147.104, 147.106, 147.120, and 147.150; Regulatory Bulletin 2015-03) | | X | 4 |
| 5 | Marketing and sales practices are in compliance with the requirement to make approved, individual plans available and to accept every individual that applies for coverage. (45 CFR 147.104) | | X | 4 |
| 6 | The Company's internal producer training materials are in compliance with applicable statutes, rules and regulations. (A.R.S. § 20-441, *et seq*.) | X | | None |
| 7 | The regulated entity's records of licensed producers agree with the insurance department records. | X | | None |
| 8 | Producers writing business for the Company to Arizona insureds are properly licensed in the State of Arizona. (A.R.S. §§ 20-282, 20-286, 20-287) | | X | 3 |

### C. Forms

| # | STANDARD | PASS | FAIL | FINDING |
|---|---|---|---|---|
| 9 | Policy forms, including but not limited to contracts, certificates, applications, riders, and endorsements, comply with pertinent laws and regulations. (A.R.S. § 20-1342, *et seq*., 45 CFR 147.150, 144.102) | | X | 2 |
| 10 | Company is issuing the policy and application forms as approved by the Department and in accordance with filed rates. (A.R.S. § 20-1110) | | X | 6 |

| # | STANDARD | PASS | FAIL | FINDING |
|---|---|---|---|---|
| **11** | Individual insurance policy forms provided to the insured contain a 10-day free look provision, which is prominently displayed on the first page of the policy. Company is honoring the free look provision. (A.A.C. R20-6-501) | X | | None |

**D. Underwriting/Portability/Guaranteed Issue**

| # | STANDARD | PASS | FAIL | FINDING |
|---|---|---|---|---|
| **12** | The Company issues coverage to all eligible groups and individuals. (A.R.S. §§ 20-2304, 20-2307, 20-2313, 20-2324, 45 CFR 147.104) | | X | 4 |
| **14** | The Company uses appropriate consent and/or release forms regarding the testing for or disclosure of HIV-related or genetic testing information. (A.R.S. §§ 20-448.01, 20-448.02, and A.A.C. R20-6-1201, *et seq.)* | X | | None |
| **15** | The Company complies with all notice of insurance information and privacy requirements. (A.R.S. § 20-2101, *et seq*.) | X | | None |
| **16** | The Company does not permit illegal rebating, commission-cutting or inducements. (A.R.S. §§ 20-449, 20-452) | X | | None |

**E. Claims Processing**

| # | STANDARD | PASS | FAIL | FINDING |
|---|---|---|---|---|
| **17** | The Company handles claims timely and appropriately, and in accordance with policy provisions and applicable statutes and rules. (A.R.S. §§ 20-448, 20-461, 20-462, 20-2803, and 20-3102, A.A.C. R20-6-801, and 45 CFR 147.138) | | X | 1, 8, 10 |
| **18** | The Company adequately documents claim files to contain all notes and work papers in such detail as necessary to reconstruct the claim. (A.R.S. § 20-461 and A.A.C. R20-6-801) | X | | None |
| **19** | All claim forms contain an appropriate fraud warning. (A.R.S. § 20-466.03) | X | | None |
| **20** | 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 and A.A.C. R20-6-801) | X | | None |

**F. Affordable Care Act (ACA) Related Standards**

| # | STANDARD | PASS | FAIL | FINDING |
|---|---|---|---|---|
| **21** | **Extension of Dependent Coverage to Age 26** A group health plan, or a health carrier offering group or individual health insurance coverage, that makes available dependent coverage of children shall make such coverage available for children until attainment of 26 years of age. A health carrier must make child-only plans available. (PHSA §2714, 45 CFR 147.120, 147.150) | X | | None |

| # | STANDARD | PASS | FAIL | FINDING |
|---|---|---|---|---|
| **22** | **Guaranteed Availability of Coverage (Individual Market)**<br>A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with federal and state law. (PHSA §2702, and 45 CFR 155.410(e), 147.104, and 155.420) | | X | 4 |
| **23** | **Guaranteed Renewability of Coverage**<br>A health carrier offering individual market health insurance coverage shall renew or continue in force the coverage, at the option of the policyholder, subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (PHSA §2703 and 45 CFR 147.106) | X | | None |
| **24** | **Prohibition On Preexisting Condition Exclusions**<br>A health carrier may not deny coverage to applicants/proposed insureds or insured, based on any preexisting condition exclusion or preexisting condition limitation. (PHSA §2704 and §1255, and 45 CFR 147.108) | X | | None |
| **25** | **Summary Of Benefits And Coverage (SBC) And Uniform Glossary**<br>The appearance, language, form and content of a summary of benefits and coverage (SBC) and uniform glossary issued by a health carrier shall be in compliance with final regulations issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (PHSA §2715) | X | | None |
| **26** | **Summary Of Benefits And Coverage (SBC) And Uniform Glossary**<br>A health carrier shall timely deliver content-compliant summaries of benefits and coverages (SBC) in compliance with final regulations issued by the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (45 CFR 147.200) | X | | None |

# APPENDIX

The examiners met with the following Company management personnel for the Management Interviews:

1. James L. Jackson, Vice President/Association General Counsel, March 19-23, 2018
2. Erica Gibbs, Attorney, Legal Department, March 19, 2018
3. Shelley Kuhleman, Assistant Vice President, Product Development, March 19, 2018
4. Karla McCombs, Senior Director of Marketing and Sales Compliance, March 19, 2018
5. Joey Hembree, Manager, New Business, March 19, 2018
6. John Stone, Assistant Vice President and Association Chief Underwriter, March 19, 2018
7. Suzanne Turley, Claims Review Unit Supervisor, March 19, 2018
8. Dana Bailey, Customer Service Manager, March 20, 2018
9. Ronnie Rahe, Consumer Affairs Assistant Vice President, March 20, 2018
10. Bill Shelton, Vice President-Marketing, March 20, 2018
11. Cynthia E. Smith, Licensing Manager, March 20, 2018
12. Randy Albaugh, USHEALTH Advisors, LLC, Training and Development, March 20, 2018
13. Wynonne Hamer, Manager, Agency Compensation, March 20, 2018
14. Joan Turner, Forms Review, March 19, 2018
15. Leigh (Cole) Stern, Claims Manager, March 20, 2018
16. Dean Whaley, Vice President of Analysis, March 23, 2018

The following management personnel assisted the Examiners with testing:

1. Erica Gibbs, Attorney, Legal Department
2. Joan Lee (Turner), Vice President, Consumer Affairs
3. Leigh (Cole) Stern, Claims Manager
4. Joey Hembree, Manager, New Business