REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

AETNA LIFE INSURANCE COMPANY

AS OF JUNE 30, 2010

COPY

Conducted from April 20, 2011

Through

February 11, 2014

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 06-6033492
NAIC: 60054

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

I, Bryan Wachter, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of Aetna Life Insurance Company as of June 30, 2010, conducted at the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2015-00132 finalizing the Report.

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IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Bureau at the City of Richmond, Virginia, this 15th day of September, 2015.

Bryan Wachter
Examiner in Charge

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I. SCOPE OF EXAMINATION

A Target Market Conduct Examination of Aetna Life Insurance Company (hereinafter referred to as ALIC) was conducted under the authority of various sections of the Code of Virginia (hereinafter referred to as "the Code") and regulations found in the Virginia Administrative Code (hereinafter referred to as "VAC") including, but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1317.1, 38.2-1809, 38.2-3407.15 C, and 38.2-5808 B of the Code, as well as 14 VAC 5-40-60 B and 14 VAC 5-90-170 A.

A previous Market Analysis inquiry covering the period of January 1, 2003, through December 31, 2004, was concluded on September 7, 2007. As a result of this inquiry, ALIC made a monetary settlement offer which was accepted by the State Corporation Commission on May 15, 2008, in Case No. INS-2007-00279.

The current examination revealed violations that were also noted in the previous inquiry. Although ALIC had agreed after the previous inquiry to change its practices to comply with the Code and regulations, the current examination revealed a number of instances where ALIC had not done so. In the examiners' opinion, therefore, ALIC in some instances knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

The period of time covered for the current examination, generally, was January 1, 2010, through June 30, 2010. The on-site examination was conducted at ALIC's Blue Bell, Pennsylvania office from June 6, 2011, through June 9, 2011, and from June 19, 2011, through June 22, 2011, and at ALIC's Medford, Massachusetts office from April 8, 2013, through April 11, 2013, and completed at the office of the State

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Corporation Commission's Bureau of Insurance on February 11, 2014. The violations cited and the comments included in this Report are the opinions of the examiners. The examiners may not have discovered every unacceptable or non-compliant activity in which the company is engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

The purpose of the examination was to determine whether ALIC was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code. Compliance with the following regulations was considered in this examination process:

14 VAC 5-40-10 et seq.	Rules Governing Life Insurance and Annuity Marketing Practices;
14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance;
14 VAC 5-110-10 et seq.	Rules and Regulations for Simplified and Readable Accident and Sickness Insurance Policies;
14 VAC 5-130-10 et seq.	Rules Governing the Filing of Rates for Individual and Certain Group Accident and Sickness Insurance Policy Forms;
14 VAC 5-140-10 et seq.	Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act;
14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS);
14 VAC 5-215-10 et seq.	Rules Governing Independent External Review of Final Adverse Utilization Review Decisions; and

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14 VAC 5-400-10 et seq.	Rules Governing Unfair Claim Settlement Practices.

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIPs)
- Ethics & Fairness in Carrier Business Practices
- Advertising/Marketing Communications
- Policy and Other Forms
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act
- Notice of Premium Increases
- Complaints
- Claim Practices
- Independent External Review of Adverse Utilization Review Decisions

Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to ALIC during the course of the examination.

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Delays in the Examination Process

ALIC's failure to provide timely and complete responses to requests and Review Sheets significantly delayed the completion of this exam. Examples of these issues are discussed in the following paragraphs.

The Coordinator's Handbook for the examination identifies the population data that the company has been requested to provide and includes a certification section for each data request that a company representative must sign and attest to a date that the correct requested data will be provided to the examiners. These certifications specifically state that "The failure to provide correct populations to the examiners by the date specified could result in the imposition of a monetary penalty when the examination

is finalized." The examiners explained the data requests and the certifications during the preliminary meeting with ALIC on November 16, 2010. Although an email from ALIC on December 9, 2010, indicated that some certifications were being sent under separate cover, and despite the examiners inquiring about the certifications again on February 2, 2011, and February 23, 2011, the certifications were never sent to the examiners. In addition, ALIC submitted numerous corrected populations to the examiners after the initial populations had already been provided. After the examiners had performed the first on-site claims review, ALIC determined that the initial claims populations did not include any claims from coverage that had been renewed. Once the examiners received the new populations, the examiners had to select new samples and perform a separate claims review.

The Coordinator's Handbook also states that the company is expected to respond to Review Sheets within 3 working days of receipt. The examiners sent a letter to ALIC on January 23, 2013, that listed 31 Review Sheets and requests that ALIC had failed to respond to in a timely fashion. Of the 31 items, 20 had been outstanding for 16 weeks or longer at that time. One of these items, Review Sheet CL01B, was originally sent to ALIC on July 1, 2011. ALIC did not respond until August 9, 2011. The examiners responded on September 30, 2011, and requested a copy of all contracts and/or agreements linking a provider to ALIC. ALIC did not respond until over 18 months later on April 5, 2013, and ALIC's response was incomplete. The examiners sent another response on August 29, 2013, and requested any other contracts linking the provider to ALIC. On September 11, 2013, ALIC provided a copy of the remaining contract.

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II. COMPANY HISTORY

Aetna Life Insurance Company (ALIC) was incorporated in Connecticut in June, 1853. ALIC was a publicly held corporation until 1967, when all of the outstanding shares of its stock were acquired by Aetna Life and Casualty Company (AL&C) in a share exchange. In 1996, AL&C changed its name to Aetna Services, Inc. (ASI) and became a wholly owned subsidiary of Aetna Inc., a Connecticut corporation (Old Aetna). On October 31, 2000, ASI merged into Old Aetna, and on November 3, 2000, ALIC became a wholly-owned subsidiary of Aetna U. S. Healthcare Inc., a Pennsylvania corporation (New Aetna), which was a wholly owned subsidiary of Old Aetna at such time. On December 13, 2000, Old Aetna sold its financial services and international businesses and simultaneously spun-off New Aetna to its shareholders. On the same date, New Aetna was renamed Aetna Inc. Shares of New Aetna are traded on the New York Stock Exchange.

ALIC's service area includes the following counties and cities: Albemarle, Alexandria City, Amelia, Arlington, Buckingham, Caroline, Charles City, Charlotte, Charlottesville City, Chesterfield, Clarke, Colonial Heights City, Culpeper, Cumberland, Dinwiddie, Fairfax, Fairfax City, Falls Church City, Fauquier, Fluvanna, Frederick, Fredericksburg City, Goochland, Hanover, Harrisonburg City, Henrico, Hopewell City, King George, King William, Loudoun, Lunenburg, Manassas City, Manassas Park City, New Kent, Nelson, Nottoway, Orange, Petersburg City, Powhatan, Prince Edward, Prince George, Prince William, Richmond City, Shenandoah, Spotsylvania, Stafford, Warren, Westmoreland, and Winchester City.

As of December 31, 2010, ALIC's annual statement reported net admitted assets totaling $21,237,425,146, life insurance premiums and annuity considerations in Virginia totaling $64,636,416, and direct accident and health insurance premiums in Virginia totaling $349,187,689.

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III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

Section 38.2-5801 of the Code prohibits the operation of an MCHIP unless the health carrier is licensed as provided in this title. Section 38.2-5802 of the Code sets forth the requirements for the establishment of an MCHIP, including the necessary filings with the Commission and the State Health Commissioner.

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES

Section 38.2-5803 A of the Code requires that the following be provided to covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers.
2. A description of the service area or areas within which the MCHIP shall provide health care services.
3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure, if complaints may be resolved through a specific arbitration agreement.
4. Notice that the MCHIP is subject to regulation in Virginia by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.
5. A prominent notice stating, "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided, which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance."

The review revealed that ALIC was in substantial compliance.

COMPLAINT SYSTEM

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner. Of the total population of 83 appeals and 35 medical

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and dental complaints received during the examination time frame, the examiners reviewed a sample of 30 appeals and a sample of 18 medical and dental complaints. In addition, the examiners selected a sample of 11 from the total population of 22 student health appeals received during the examination time frame.

As discussed in Review Sheet MC01, ALIC failed to obtain approval by the Commission for its complaint system, in violation of § 38.2-5804 A of the Code. ALIC disagreed, indicating that the complaint system had been sent with the annual complaint report. However, the complaint system must be filed for approval with the office of the Managed Care Ombudsman. Previously, when an affiliate of ALIC had filed its complaint system for approval, the office of the Managed Care Ombudsman inquired as to whether a complaint system was going to be filed for ALIC. Neither the affiliate, nor ALIC, responded to this inquiry. ALIC only provided the complaint system as a required attachment to an annual complaint report; therefore, ALIC failed to obtain approval by the Commission for its complaint system.

Since ALIC did not have an approved complaint system, the examiners reviewed the sample complaints to determine if they were handled in accordance with the complaint procedures explained in the policies and certificates and provided with its annual complaint report. As discussed in the next 2 following paragraphs, the review revealed 3 instances in which ALIC failed to maintain its complaint system, in violation of § 38.2-5804 A of the Code.

TIMELINESS

ALIC's complaint and appeal procedures indicate that for post-service appeals, the appeal will be resolved and a resolution letter sent within 30 calendar days from the

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date/time the appeal is received by ALIC or its designee. As discussed in Review Sheet MC03-B, the review revealed that ALIC did not send a resolution letter that was responsive to the appeal until 51 days after the appeal was received. ALIC agreed with the examiners' observations.

HANDLING

ALIC's complaint and appeal procedures indicate that the body of the resolution letter must contain the title of each reviewer. As discussed in Review Sheets MC01-B and MC04-B, the review revealed that in two instances the body of the resolution letter failed to include the title of each of the reviewers. ALIC agreed with the examiners' observations.

PROVIDER CONTRACTS

The examiners reviewed a sample of 37 contracts from a total population of 28,340 provider contracts in force during the examination time frame.

Section 38.2-5805 B of the Code states that every contract with a provider of health care services enabling an MCHIP to provide health care services shall be in writing. ALIC contracted with an intermediary, EyeMed Vision Care LLC (EyeMed), to process vision claims and negotiate contracts with vision providers. In 2 instances, ALIC indicated that a participating vision provider did not have a direct written agreement with EyeMed. An example is discussed in Review Sheet EF03J. ALIC is in violation of § 38.2-5805 B of the Code in both instances.

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IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 of the Code requires that every provider contract entered into by a carrier shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services.

PROVIDER CONTRACTS

The examiners reviewed a sample of 37 contracts from a total population of 28,340 provider contracts in force during the examination time frame. The provider contracts were reviewed to determine if they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

Professional and Facility

The examiners reviewed a sample of 18 professional and 6 facility contracts from a total population of 23,854 professional and 441 facility provider contracts in force during the examination time frame. The review revealed 5 instances in which ALIC's provider contracts failed to contain 1 or more of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations, and corresponding Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 4	3	EF01
§ 38.2-3407.15 B 7	3	EF01
§ 38.2-3407.15 B 9	5	EF02
§ 38.2-3407.15 B 10	3	EF05
§ 38.2-3407.15 B 11	2	EF08

Section 38.2-3407.15 B 9 of the Code states that no amendment to any provider contract shall be effective as to the provider, unless the provider has been provided with

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the applicable portion of the proposed amendment at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract. As reflected in the chart above, the review revealed 5 instances in which the sample professional and facility contracts contained language that conflicted with the notification requirements set forth in § 38.2-3407.15 B 9 of the Code. An example is discussed in Review Sheet EF02, Section 10 of the Regulatory Compliance Addendum in the provider contract states, "No amendment to the Agreement shall be effective unless Provider has been provided with the applicable portion of the proposed amendment and has failed to notify Company within fifteen (15) business days of receipt of the amendment of the Provider's intention to terminate the Agreement in accordance with the terms thereof." This language conflicts with the requirement that the provider be provided with the applicable portion of the proposed amendment at least 60 calendar days before the effective date, and that the provider has 30 calendar days from receipt of the documentation to notify the carrier of the provider's intention to terminate the provider contract. Therefore, ALIC is in violation of § 38.2-3407.15 B 9 of the Code. ALIC disagreed with the examiners observations, but it has not commented specifically about this language.

Beech Street

The examiners reviewed 1 contract that was negotiated with a provider through an intermediary organization identified as Beech Street. As discussed in Review Sheet EF01-B, the review revealed that the provider contract failed to contain all 11 provisions

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required by § 38.2-3407.15 B of the Code. ALIC failed to respond to the examiners' observations.

Pharmacy and Dental

The examiners reviewed a sample of 4 pharmacy and 4 dental provider contracts from a total population of 1,537 pharmacy and 1,255 dental provider contracts in force during the examination time frame. The review revealed that ALIC was in substantial compliance.

Vision

The examiners reviewed a sample of 4 from a total population of 1,253 contracts that were negotiated with vision providers through the intermediary EyeMed and were in force during the examination time frame. The review revealed 2 instances in which ALIC's provider contracts failed to contain 1 or more of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations, and corresponding Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 4	2	EF01J
§ 38.2-3407.15 B 7	1	EF02J
§ 38.2-3407.15 B 8	2	EF01J
§ 38.2-3407.15 B 9	1	EF02J
§ 38.2-3407.15 B 11	2	EF01J

An example is discussed in Review Sheet EF02J in which the provider agreement failed to contain a fee schedule and failed to contain the provisions set forth in §§ 38.2-3407.15 B 4, 38.2-3407.15 B 7, 38.2-3407.15 B 9 and 38.2-3407.15 B 11 of the Code. ALIC disagreed and provided a new Virginia Amendment to the contract. The examiners asked for confirmation that the Virginia Amendment submitted to the

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examiners with ALIC's review sheet response was, in fact, in effect during the examination timeframe. ALIC responded that it had "confirmed with EyeMed that the Virginia Amendments attached to the original contracts sent are the ones that were in effect during the scope of the exam." Therefore, ALIC confirmed that the original contract provided to the examiners is the entire contract that was in effect during the examination time frame, and ALIC is in violation of §§ 38.2-3407.15 B 4, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9 and 38.2-3407.15 B 11 of the Code.

SUMMARY

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 of the Code. The failure of ALIC to amend its provider contracts to comply with § 38.2-3407.15 of the Code occurred with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15 of the Code.

PROVIDER CLAIMS

Section 38.2-510 A 15 of the Code prohibits, as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain provisions requiring the carrier to adhere to and comply with sections 1 through 11 of these subsections in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

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A sample of 143 out of a total population of 280 claims processed under the 37 sample provider contracts was reviewed for compliance with the minimum fair business standards in the processing and payment of claims.

Section 38.2-3407.15 B 3 of the Code requires that any interest due on a claim under § 38.2-3407.1 of the Code shall be paid at the time the claim is paid or within 60 days thereafter. Section 38.2-3407.1 of the Code requires interest to be paid on claim proceeds at the legal rate of interest from the date of 15 working days from the receipt of the proof of loss to the date of claim payment. The review revealed 1 instance in which ALIC failed to pay interest as required by this section, in violation of § 38.2-3407.15 B 3 of the Code. This violation is discussed in Review Sheet EFCL02-B in which a claim received on 1/14/2010 was not paid until 2/19/2010, and Aetna failed to pay interest as required. Although ALIC agreed that the insurance was effective on 1/1/2010, ALIC disagreed with the violation, stating:

> The Plan was effective on 1/1/10; however, due to the late receipt of the paperwork from the Plan Sponsor, the Plan was not set-up on our systems when the sample claim was received on 1/14/10. The Company completed plan set-up and testing on 2/12/10 and the sample claim was paid on 2/19/10. The Company respectfully disagrees that interest is due on this claim.

The examiners acknowledge ALIC's comments regarding its time-frame for system set-up; however, ALIC's internal system issues do not exempt ALIC from complying with the requirements of § 38.2-3407.15 B 3 of the Code.

Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be

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calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis. The review of the sample claims revealed that ALIC underpaid the fee schedule amount specified for the health care service provided in 4 instances, in violation of § 38.2-3407.15 B 8 of the Code. These violations are discussed in Review Sheet EFCL01-B. ALIC disagreed with the examiners' observations and provided a contract with a physician group signed in 2003. The examiners would note that the 2003 contract included with ALIC's response contained no evidence that the provider who submitted the claims was a participating physician with that particular group, and the direct contract between ALIC and that provider was signed on 2/4/2009 and appeared to still be in effect on the dates of service.

ALIC's failure to perform the required provider contract provisions did not occur with such frequency as to indicate a general business practice.

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V. ADVERTISING/MARKETING COMMUNICATIONS

A review was conducted of Aetna Life's advertisements/marketing communications to determine compliance with the Unfair Trade Practices Act, specifically §§ 38.2-502, 38.2-503, and 38.2-504 of the Code, as well as 14 VAC 5-40-10 et seq., Rules Governing Life Insurance and Annuity Marketing Practices and 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement/marketing communication has actually misled or deceived any individual to whom the advertisement was presented. An advertisement/marketing communication may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed (14 VAC 5-90-50), or that a marketing communication has the capacity or tendency to mislead or deceive from the overall impression that the marketing communication may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed (14 VAC 5-40-40 A).

14 VAC 5-40-60 B and 14 VAC 5-90-170 A require each insurer to maintain at its home or principal office a complete file of all advertising/marketing communications with a notation indicating the manner and extent of distribution and the form number of any policy referred to in the advertisement/marketing communication.

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The review revealed 1 violation of 14 VAC 5-40-60 B. As discussed in Review Sheet AD01, ALIC failed to indicate the manner and extent of distribution of the marketing communication files selected for review. ALIC agreed with the examiners' observations.

The examiners reviewed the entire population of 8 life and annuity marketing communications, the entire population of 4 stop loss advertisements, a sample of 15 from a population of 56 advertisements relating to individual health insurance certificates issued under an out-of-state group health insurance policy, and a sample of 8 from a population of 55 student health advertisements used in the Commonwealth of Virginia during the examination time frame. In the aggregate, there were 18 violations, which are discussed in the following paragraphs.

14 VAC 5-90-55 A requires that an invitation to inquire shall contain a provision in the following or substantially similar form: "This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [write] your insurance agent or the company [whichever is applicable]."

The review revealed 4 violations of this section which are discussed in Review Sheets AD01SL, AD02SL, AD03SL, and AD04SL. An example is discussed in Review Sheet AD01SL in which the advertisement failed to contain the required provision. ALIC agreed with the examiners' observations.

14 VAC 5-90-50 B states that advertisements shall be truthful and not misleading in fact or by implication. 14 VAC 5-90-130 A states that the name of the actual insurer,

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the form number or numbers of the policies advertised, and the form number of any application shall be stated on all invitations to contract.

The review revealed 7 violations of each of these sections. As discussed in Review Sheet AD01B-SH, ALIC sent brochures that contained incorrect and misleading statements and failed to contain the policy form number of the student health insurance coverage being advertised. ALIC disagreed, stating:

> The brochures are educational and informational materials sent to students who are covered under student health plans. The brochures set forth the benefits each student health plan covers and provide information about how the plans are administered. The brochures do not contain any materials relating to increasing, decreasing, terminating or expanding coverage. For the reasons stated, the brochures are excluded from the definition of "advertisement" in Chapter 90 of the Virginia Administrative Code....

The examiners do not concur. ALIC had previously indicated that the brochures, along with an application, are provided to all students, not just those students that elect to purchase the coverage offered. Therefore, the brochures are being utilized as advertisements and must comply with 14 VAC 5-90-10 et seq.

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SUMMARY

ALIC violated 14 VAC 5-40-60 B, 14 VAC 5-90-50 B, 14 VAC 5-90-55 A, and 14 VAC 5-90-130 A, placing it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

VI. POLICY AND OTHER FORMS

Although a formal review of policy forms was not performed, the examiners reviewed the policy forms contained in the sample underwriting and claims files to determine if ALIC complied with various statutory, regulatory, and administrative requirements governing the filing and approval of forms.

Section 38.2-316 of the Code sets forth the filing and approval requirements for forms and rates that are to be issued or issued for delivery in Virginia.

14 VAC 5-100-40 2 states that where forms are submitted as replacements, revisions or modifications of previously approved forms, such must be clearly indicated in the letter of transmittal which shall set forth the exact changes that are intended.

14 VAC 5-100-50 1 states that the form number must appear on each form submitted in the lower left-hand corner of the first page.

14 VAC 5-100-50 3 states that a form must be submitted in the final form in which it is to be marketed or issued, sufficiently completed in "John Doe" fashion to indicate how it is intended to be used, if formal approval is sought.

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EXPLANATIONS OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer file its EOBs with the Commission for approval.

As discussed in Review Sheet PF11B, the review revealed that the EOBs sent to ALIC's insureds regarding vision claims processed by ALIC's vision intermediary EyeMed were not filed for approval as required, placing ALIC in violation of this section in 9 instances (and in each instance that the unfiled, altered form was used). ALIC disagreed and initially responded by providing an approved form that had a different

form number than the issued form. ALIC responded further by providing an approved form with the same form number as the issued form, but the approved form differed from the issued form.

As discussed in Review Sheet PF09B, the review revealed that ALIC failed to file the form EXPLANATION OF PAYMENT (no form number) used for prescription drug claims, placing ALIC in violation of this section in each instance that the form was used. ALIC agreed with the examiners' observations.

APPLICATION/ENROLLMENT FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application forms prior to use. As discussed in Review Sheet PF02B, the review revealed that, in 5 instances, ALIC used an application form, GR-66109 (12-98) LIFE/AD&D, that was not filed with and approved by the Commission. As discussed in Review Sheets PF04B and PF06B, the review revealed that, in 8 instances, ALIC used an application form, EMPLOYER APPLICATION GR-23-7 (7/05), that was not filed with and approved by the Commission. As discussed in Review Sheet PF07B, the review revealed that, in 4 instances, ALIC used an application form, GR-65169-2 ED 4-83 Virginia, that was not filed with and approved by the Commission. In the aggregate, there were 17 violations of §§ 38.2-316 B and 38.2-316 C 1 of the Code associated with the use of non-approved application/enrollment forms. ALIC agreed with the examiners' observations regarding Review Sheets PF02B, PF04B and PF06B. ALIC's response to Review Sheet PF07B failed to directly address the examiners' observations.

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OTHER POLICY FORMS

Sections 38.2-316 A and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of policy forms prior to use.

Life Insurance

The review revealed that 2 life insurance policy forms, AETNA LIFE INSURANCE and LIFE INSURANCE CONVERSION POLICY, had not been filed with and approved by the Commission. Both forms had originally been filed and approved under a specific form number and then issued using a different form number and with significant alterations. As discussed in Review Sheet PF01B, although it was similar to the filed and approved policy form number L-70040, the policy issued in 21 instances was policy form number L-70040-90 (10/98) AIFS, which was not filed with and approved by the Commission, in violation of §§ 38.2-316 A and 38.2-316 C 1 of the Code. As discussed in Review Sheet PF03B, although it was somewhat similar to the filed and approved policy form number GR-86515, the policy issued in 7 instances was policy form number GR-86515 Ed. 5/08, which was not filed with and approved by the Commission, in violation of §§ 38.2 316 A and 38.2-316 C 1 of the Code. ALIC agreed with the examiners' observations in both instances.

Accident and Sickness

ALIC's Certificates of Coverage (COCs) consist of a compilation of riders which explain the specific benefits of the coverage provided. The review revealed that, while some of the individual pages of the COCs are riders that have been filed and approved, certain pages of the COCs including the table of contents have not been filed with or approved by the Commission. Review Sheets PF05B and PF10B discuss COCs for 2

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dental plans (a PPO Dental and a DMO Dental Plan) and 2 health plans (a PPO and a Comprehensive Plan) that were issued to groups. Certain pages of these COCs have not been filed with or approved by the Commission, placing ALIC in violation of §§ 38.2-316 A and 38.2-316 C 1 each time the COCs were issued. ALIC disagreed with the examiners' observations and provided filed and approved forms for review; however, these forms were not the same forms that were issued.

Strategic Resource Company (SRC) plans

ALIC's affiliated entity, Strategic Resources Company (SRC), administered group accident and sickness coverage with limited benefits on behalf of ALIC. The review revealed that certain policy forms associated with the SRC plans were not filed with and approved by the Commission, in violation of §§ 38.2-316 A and 38.2-316 C 1 of the Code. As discussed in Review Sheets PF12B-SRC and PF15B-SRC, certain pages of the COC and 9 riders contained within the COC were not filed with and approved by the Commission. In response to the Review Sheets, ALIC provided a list of approved form numbers and copies of corresponding forms to document that the issued forms had been filed. However, the language and format of the approved forms differed from the issued forms, and the form numbers were not the same.

Delaware Trust Blanket Policy

ALIC issued COCs to Virginia residents under an out-of-state blanket policy issued to a discretionary trust sitused in Delaware. The plan is called Aetna Advantage Plans for Individuals, Families and Self-Employed-VA. The policy forms for the plan are filed in Delaware, and ALIC made Informational Filings of the forms and rates with Virginia. The review revealed that ALIC issued COCs in Virginia for which no

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Informational Filing had been made, and the COC contained 9 riders which had been altered or changed from forms previously filed with the Commission. It is the Commission's position that the forms are required to be submitted to the Forms and Rates section of the Bureau of Insurance in an Informational Filing. As discussed in Review Sheet PF22B, ALIC is in violation of §§ 38.2-316 A and 38.2-316 C 1 of the Code in the 9 instances that the unfiled COC was issued to a Virginia resident. Although ALIC disagreed with the examiners' observations, ALIC indicated that an Informational Filing would be submitted.

Student Health

The review revealed that policy forms associated with ALIC's student health insurance plans had not been filed with and approved by the Commission. As discussed in Review Sheet PF01-SH, all 7 student health policy forms issued during the examination time frame were not filed with and approved by the Commission, in violation of §§ 38.2-316 A and 38.2-316 C 1 of the Code. In addition, ALIC failed to issue to the policyholder for delivery to each insured an individual certificate as required by § 38.2-3533 of the Code. Therefore, ALIC is in violation of § 38.2-3533 of the Code in each instance that a certificate was not issued for delivery to each person insured. The examiners also note that these unapproved policy forms included several exclusions that contained language that could result in subrogation or were otherwise inappropriate for accident and sickness student health insurance policies. ALIC disagreed with the examiners and provided approved forms for review; however, these forms were not the same as the forms that were issued. ALIC also commented that the subrogation language was due to an exclusion in the policy for intercollegiate sports

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injuries. The issue of subrogation is discussed further in the Claim Practices section of the Report.

SUMMARY

The following graph summarizes ALIC's policy form violations:

FORM NUMBER	DESCRIPTION OF FORM	CODE SECTION VIOLATION	INSTANCES	REVIEW SHEET EXAMPLE
MEOB-VA6	Explanation of Benefits	38.2-3407.4	9	PF11B
EOB (no form number)	Explanation of Payment	38.2-3407.4	Each time it was used	PF09B
GR66109 (12-08) LIFE/AD&D	Application for Conversion	38.2-316 B 38.2-316 C 1	5	PF02B
GR-23-7 (7/05)	Employer Application	38.2-316 B 38.2-316 C 1	8	PF04B PF06B
GR-65169-ED. 4-83 Virginia	Conversion Application to Aetna Life Insurance Company	38.2-316 B 38.2-316 C 1	4	PF07B
L-70040-90 (10/98) AIFS	Aetna Life Insurance Policy	38.2-316 A 38.2-316 C 1	21	PF01B
GR-86515 Ed. 5/08	Life Insurance Conversion policy	38.2-316 A 38.2-316 C 1	7	PF03B
COC (no form numbers)	HMO and PPO Dental Plan's Certificate of Coverage	38.2-316 A 38.2-316 C 1	Each time it was used (approximately 166 times)	PF05B
COC (no numbers)	Open Choice PPO and Traditional Choice certificates of coverage	38.2-316 A 38.2-316 C 1	6 groups	PF10B
Gr-29N 01-01-01 VA	Schedule of Benefits	38.2-316 A 38.2-316 C 1	Each time it was used	PF12B
Gr-9N-15-10-02 VA	Inpatient Coverage Year Maximum Benefit	38.2-316 A 38.2-316 C 1	Each time it was used	PF13B
Gr-9N 15-75-01 VA	Hospice Care Facility Expenses	38.2-316 A 38.2-316 C 1	Each time it was used	PF14B
Gr-9N 15-125-01 VA	Treatment of Jaw Disorders	38.2-316 A 38.2-316 C 1	Each time it was used	PF15B
G-9N S 15-140-01 VA	Treatment of Alcohol Abuse, Drug Abuse, Mental Biologically Based and Non-Biologically-based Mental Illness	38.2-316 A 38.2-316 C 1	Each time it was used	PF16B
Gr-9N 15-150-01 VA	Alcohol Abuse and Drug Abuse Treatment	38.2-316 A 38.2-316 C 1	Each time it was used	PF17B

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FORM NUMBER	DESCRIPTION OF FORM	CODE SECTION VIOLATION	INSTANCES	REVIEW SHEET EXAMPLE
Gr-9N 15-170-01	All Other Expenses	38.2-316 A 38.2-316 C 1	Each time it was used	PF18B
Gr-9N-005-01	Your Prescription Drug Plan	38.2-316 A 38.2-316 C 1	Each time it was used	PF19B
Gr-9N 26-020-01	Maximum Benefit	38.2-316 A 38.2-316 C 1	Each time it was used	PF20B
Gr-9N-010-01	Preferred Self-injectable Prescription Drug	38.2-316 A 38.2-316 C 1	Each time it was used	PF21B
GR-11697-R Ed. 3/08 GR-11697-2R Ed.12/08 AL DE AGR9656408 T V001 (10/08) GR-96470 GR-9 11859 PPO Plan GR-11697-7 GR-11697-R-1 05/08 GR-11742 GR-96440	Pages in the COC (from out-of-state policy issued to trust in DE) issued in Virginia and not reported in an Informational Filing	38.2-316 A 38.2-316 C 1	Each time it was used	PF22B
GR-96175 ED. 3-98 GR-96134 ED. 8-06	Student Health Insurance Policies	38.2-316 A 38.2-316 C 1 38.2-3533	7 Each time ALIC failed to issue a certificate for delivery	PF01-SH

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VII. AGENTS

Although a formal agent review was not performed, the writing agents designated in the new business files were reviewed to determine compliance with various sections of Title 38.2, Chapter 18 of the Code. A total of 73 agents/agencies were reviewed.

LICENSED AGENT REVIEW

Sections 38.2-1822 A of the Code requires that a person be licensed prior to soliciting subscription contracts. As discussed in Review Sheet AG01, ALIC accepted new business from agents and an agency that were not licensed in Virginia, in violation of this section of the Code in 3 instances. ALIC agreed with the examiners' observations.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires that an insurer shall, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent. As discussed in Review Sheet AG04, ALIC accepted new business from an agent and an agency and failed to appoint them within 30 days of the execution of the first application submitted, in violation of this section of the Code in 2 instances. ALIC agreed with the examiners' observations.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commission or other valuable consideration to an agent or agency that is not appointed and that was not licensed at the time of the transaction. As discussed in Review Sheets AG01 and AG04, ALIC paid commissions to agents and agencies that were not licensed or

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appointed in Virginia, in violation of this section of the Code in 5 instances. ALIC agreed with the examiners' observations.

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VIII. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of ALIC's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514; the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620; Article 5, Chapter 34, Coverage Offered to Employees of Small Employers; 14 VAC 5-140-10 et seq., Rules Governing the Implementation of Individual Accident and Sickness Insurance Minimum Standards Act; 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS); and 14 VAC 5-234-10 et seq., Rules Governing Essential and Standard Health Benefits Plan Contracts.

UNDERWRITING/UNFAIR DISCRIMINATION

The review was made to determine whether ALIC's underwriting guidelines were unfairly discriminatory, whether applications were underwritten in accordance with ALIC's guidelines and whether correct premiums were being charged.

UNDERWRITING REVIEW

A sample of 107 from a population of 198 group life, group dental, large and small group medical, and individual conversion policies underwritten and issued during the examination time frame was selected for review. In addition, a sample of 5 from a population of 22 stop loss policies and the entire population of 7 student health insurance policies underwritten and issued during the examination time frame were selected for review.

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The review revealed that ALIC was in substantial compliance with its underwriting guidelines and no unfair discrimination was found.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS.

The review revealed that ALIC was in substantial compliance with this section.

MECHANICAL RATING REVIEW

The review revealed that ALIC had calculated its premiums in accordance with its filed rates.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires a company to establish standards for collection, use, and disclosure of personal/privileged information gathered in connection with insurance transactions.

NOTICE OF INSURANCE INFORMATION PRACTICES (NIP)

Section 38.2-604 of the Code sets forth the requirements for a NIP, either full or abbreviated, to be provided to all individual applicants and to applicants for group insurance that are individually underwritten.

ALIC provided both a full and abbreviated NIP form, and the review revealed that ALIC was in substantial compliance with this section.

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DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of the disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The examiners reviewed the disclosure authorization forms used during the underwriting process, and the review revealed that ALIC was in substantial compliance with this section.

ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 of the Code requires that in the event of an adverse underwriting decision, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission. Section 38.2-610 B of the Code requires the insurer, upon receipt of a written request within 90 business days from the date of mailing of the notice of AUD, to furnish to such person within 21 business days from the date of receipt of the request, the specific reasons for the AUD and the specific items of personal and privileged information that support those reasons.

A sample of 84 out of a population of 283 individuals enrolled in group plans who applied for additional coverage under the group's policy and were denied was reviewed. The review revealed that ALIC was in substantial compliance with this section.

Small Employer Groups

Section 38.2-3431 C of the Code requires every small employer carrier to offer small employers the Essential and Standard plans.

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A sample of 25 from a population of 116 small groups issued during the examination time frame was selected for review.

The review revealed that ALIC was in substantial compliance with this section.

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IX. NOTICE OF PREMIUM INCREASES

Section 38.2-3407.14 A of the Code requires an insurer to provide prior written notice of intent to increase premiums by more than 35 percent. Section 38.2-3407.14 B of the Code requires that the notice be provided in writing at least 60 days prior to the proposed renewal of coverage to the policyholder, or to the designated consultant or other agent of the group policyholder if requested in writing by the policyholder.

The total population of 3 groups that received premium increases greater than 35 percent was reviewed. In 2 instances, ALIC informed the agent/broker via email that the premiums would increase. Documentation of written requests by the group policyholder that such notification be sent to the agent/broker was not provided to the examiners. ALIC was unable to provide a copy of the required 60 day notification that premiums would increase by 35 percent or more for any of the 3 files reviewed, placing ALIC in violation of §§ 38.3407.14 A and 38.2-3407.14 B of the Code in each instance. An example is discussed in Review Sheet PB01B. ALIC agreed with the examiners' observations.

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X. COMPLAINTS

ALIC's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

ALIC's complaint and appeal procedures state that "all documentation related to and created in response to complaints and appeals will be retained for a minimum of 10 years or longer as required by state or federal law or regulation, or current company policy."

A sample of 19 from a total population of 36 written complaints received during the examination time frame was reviewed. In addition, the examiners reviewed the total population of 2 complaints received during the examination time frame relating to life insurance business that is administered by Lincoln Life and Annuity Company of New York and Protective Life Insurance Company on behalf of ALIC. As discussed in Review Sheet CP01-B, the review revealed that the complaint log failed to include a complaint that was received during the examination time frame, in violation of § 38.2-511 of the Code and in non-compliance with ALIC's complaint and appeal procedures. ALIC agreed with the examiners' observations.

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XI. CLAIM PRACTICES

The examination included a review of ALIC's claim practices for compliance with §§ 38.2-510, 38.2-3115, and 38.2-3407.1 of the Code and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of life, disability, and accident and sickness insurance claims. Claims were processed internally, with the exception of vision claims and certain life insurance claims. Vision claims were processed by EyeMed Vision Care, LLC (EyeMed). Certain individual life insurance claims were administered by Lincoln Life and Annuity Company of New York and Protective Life Insurance Company on behalf of ALIC. ALIC's affiliated entity, Strategic Resources Company (SRC), administered group accident and sickness coverage with limited benefits on behalf of ALIC. ALIC provided the examiners with copies of its relevant claims procedures.

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PAID CLAIM REVIEW

Life

A sample of 10 was selected from a population of 527 claims paid during the examination time frame. In addition, a sample of 6 was selected from a population of 32 claims administered by Lincoln Life and Annuity Company of New York that were paid during the examination time frame. A sample of 4 was selected from a population of 18 claims administered by Protective Life Insurance Company that were paid during the examination time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Interest on Life Insurance Claim Proceeds

Section 38.2-3115 B of the Code states that interest upon the principal sum shall be paid at an annual rate of 2.5% or the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater. The review revealed 4 violations of this section. An example is discussed in Review Sheet CL04M in which the policy was issued in Virginia and ALIC failed to pay interest. ALIC disagreed with the examiners' observations and stated:

> Aetna did not pay interest per 38.2-3115 B as the beneficiary did not reside in VA, but in a state that does not require interest payment on this claim. Aetna understands this section to apply when the beneficiary is located in the Commonwealth of Virginia.

The examiners do not concur and replied that "individual and group life insurance policies issued in the state of Virginia are subject to the provisions of various sections of the Code of Virginia and Virginia Insurance Regulations, notwithstanding the state of residence on the date of the insured's death."

Disability

A sample of 9 was selected from a population of 368 claims paid during the examination time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in subsequent sections of the Report.

Stop Loss

A sample of 10 was selected from a population of 24 claims paid during the examination time frame. The review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy.

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Accident and Sickness

After the samples had been selected and the examiners had begun reviewing the accident and sickness insurance claims, ALIC informed the examiners that claims submitted on renewal business had not been included in the population data that had been provided. ALIC provided the examiners with additional populations of claims submitted on renewal business, and the examiners selected samples from these additional populations. The total sample sizes and populations for accident and sickness insurance claims that are noted in the Report include both the original and the additional populations and samples.

Group

A sample of 210 was selected from a population of 114,814 claims paid during the examination time frame. Of these sampled claims, 35 were mental health claims and 40 were dental claims. A separate review of mental health claims is discussed in a subsequent section of the Report.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber, or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. As discussed in Review Sheet CL01T-DEN, the review revealed that an Explanation of Benefits (EOB) failed to contain the submitted charges and the allowed amounts for the services rendered. By failing to include this information on the EOB, ALIC failed to

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disclose the method of benefit calculation and failed to accurately and clearly set forth the benefits payable under the contract, in violation of each of these sections of the Code in 1 instance. ALIC agreed with the examiners' observations.

Individual Conversion

A sample of 61 was selected from a population of 893 claims paid during the examination time frame. Of these sampled claims, 11 were mental health claims. A separate review of mental health claims is discussed in a subsequent section of the Report. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Strategic Resource Company (SRC)

A sample of 25 was selected from a population of 13,934 claims paid during the examination time frame. A separate review of mental health claims is discussed in a subsequent section of the Report. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Pharmacy

A sample of 40 was selected from a population of 147,663 claims paid during the examination time frame. The review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy.

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EyeMed

A sample of 9 was selected from a population of 195 claims paid during the examination time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Mental Health

The scope of the examination was expanded to include a review of mental health claims paid and denied between October 1, 2010, and December 31, 2010. The populations included group, individual conversion, and SRC claims. A sample of 30 was selected from a population of 842 claims paid during the expanded time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Student Health

A sample of 110 was selected from a population of 25,801 claims paid during the examination time frame. A partially paid claim from the denied claim review sample was also considered under the paid claim review.

Section 38.2-510 A 10 of the Code states that no person shall make claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The review revealed 3 instances of non-compliance with § 38.2-510 A 10 of the Code. An example is discussed in Review Sheet CL08BL-SH, where ALIC issued a claim payment in the form of a paper check but failed to send the provider or the insured a statement setting forth the coverage

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under which the payment was being made. ALIC agreed with the examiners' observations.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber, or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed 13 violations of § 38.2-514 B and 16 violations of § 38.2-3407.4 B of the Code. An example is discussed in Review Sheet CL04BW-SH in which the EOB incorrectly displayed copay amounts in the deductible column. The EOB included a separate copay column that was left blank. As a result, ALIC failed to accurately and clearly set forth the benefits payable under the contract and failed to accurately disclose the method of benefit calculation, in violation of each of these sections of the Code. ALIC agreed with the examiners' observations.

Section 38.2-3405 B of the Code prohibits subrogation of any person's right to recovery for personal injuries from a third person. Coordination of benefits provisions may not operate to reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage. The review revealed 3 violations of § 38.2-3405 B of the Code. An example is discussed in Review Sheet CL08BW-SH. The subrogation issue and ALIC's

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response to the Review Sheets are discussed further in the Denied Claim Review section of the Report.

ALIC's student health policy states, "...ancillary services (e.g., lab tests and X-rays) received at Student Health or ordered by a Student Health provider will be covered at 100% without a copay or deductible...." The review revealed that ALIC was in non-compliance with its policy in 1 instance. As discussed in Review Sheet CL16BL-SH, the benefits payable for a claim for a lab/x-ray ordered by the Student Health center were applied to the insured's deductible, in non-compliance with the policy. ALIC agreed with the examiners' observations.

ALIC's student health policy includes the following exclusion: "Expense incurred for injury resulting from the plan or practice of intercollegiate sports; in excess of $250 (participating in sports clubs; or intramural athletic activities; is not excluded)." As discussed in CLMEM01B-ASH, the examiners requested that ALIC clarify the intent of this exclusion. ALIC's response stated:

> Aetna has confirmed that the intent of the [*school name*] Policy was to exclude coverage for **any** intercollegiate sports injuries and that all claims administration accurately reflected this intent. However, due to manual errors in the drafting of the relevant member documents, including the Evidence of Coverage and Plan Brochure, the exclusion erroneously inferred coverage for intercollegiate sports injuries up to $250.
>
> Consistent with the intent of the benefit plan, Aetna will update all future [*school name*] member documents, including Evidences of Coverage and Plan Brochures, to exclude **any** coverage for intercollegiate sports injuries. In addition, Aetna will honor coverage for intercollegiate sports injuries up to $250 and will reprocess all impacted claims since the 2009-2010 plan year.
>
> In addition, Aetna has reviewed all other Virginia policies issued since the 2009-2010 plan year in order to identify any additional discrepancies in member documents relating to this exclusion pertaining to coverage for intercollegiate sports-related injuries. Below is a summary of the findings of that review: [*ALIC named 2 other school policies*]

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> For each of the identified policies above, Aetna will ensure that all future member documents reflect each policy's intended exclusion of coverage for intercollegiate sports injuries. Finally, Aetna will honor coverage for intercollegiate sports injuries up to $250 by reprocessing claims for the identified plan years.
>
> Since the 2011-2012 plan year, Aetna has begun automating its case implementation process to help ensure that discrepancies between member documents and claims administration do not occur. Likewise, Aetna is currently performing an end-to-end audit of its member documents to help ensure that all member documents accurately reflect the underlying intent of the plan sponsor.

Any violations as a result of this issue that were revealed during the examination are discussed in the Unfair Claims Settlement Practices Review. The Corrective Action Plan of this Report will include an item that addresses the completion of the steps outlined in ALIC's response above.

ALIC's student health policy indicates the following coverage for chiropractic care: "Preferred Care: After a $35 per visit Copay, 80% of the Negotiated Charge. Non-Preferred Care: After a $35 per visit Deductible, 60% of the Reasonable Charge. Please Note: Benefits are limited to $1,000 per condition, per Policy year." As discussed in CLMEM02B-ASH, the examiners requested that ALIC clarify the chiropractic coverage. ALIC's response stated:

> The $35 per visit copay and deductible referenced above also appear in the [*school name*] member documents for each subsequent plan year (2010-2011, 2011-2012 and 2012-2013).
>
> Aetna has confirmed that the intent of the [*school name*] Policy was to include a $35 per visit benefit maximum for chiropractic claims and that all chiropractic claims administration for [*school name*] accurately reflected this intent. However, due to manual errors in the drafting of the relevant member documents, including the Evidence of Coverage and Plan Brochure, the member documents erroneously reflect the $35 copay and deductible.

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> Consistent with the intent of the underlying policy, Aetna will update all future [*school name*] member documents, including Evidences of Coverage and Plan Brochures, to reference a $35 per visit benefit maximum. In addition, Aetna will honor the published $35 copay and deductible, and will reprocess all impacted claims since the 2009-2010 plan year to reflect the published benefit.
>
> In addition, Aetna will review all other Virginia policies issued since the 2009-2010 plan year to identify any additional discrepancies in member documents relating to coverage for chiropractic care. Where necessary, Aetna will make all necessary updates to member documents so as to reflect each policy's intended coverage of chiropractic care. Similarly, Aetna will identify and reprocess any claims for chiropractic services that require reprocessing.
>
> Since the 2011-2012 plan year, Aetna has begun automating its case implementation process to help ensure that discrepancies between member documents and claims administration do not occur. Likewise, Aetna is currently performing an end-to-end audit of its member documents to help ensure that all member documents accurately reflect the underlying policy and intent of the plan sponsor.

Any violations as a result of this issue that were revealed during the examination are discussed in the Unfair Claims Settlement Practices Review. The Corrective Action Plan of this Report will include an item that addresses the completion of the steps outlined in ALIC's response above.

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Interest on Accident and Sickness Claim Proceeds

Section 38.2-3407.1 B of the Code states that interest upon claim proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment.

The review revealed 11 violations of this section. An example is discussed in Review Sheet CL37BW-SH in which ALIC failed to pay interest as required. ALIC agreed with the examiners' observations.

TIME PAYMENT STUDY

The time payment study was computed by measuring the time it took ALIC, after receiving the properly executed proof of loss, to issue a check for payment. The term "working days" does not include Saturdays, Sundays or holidays. The study was conducted on the total sample of 485 paid accident and sickness claims.

PAID CLAIMS			
Claim Type	Working Days to Settle	Number of Claims	Percentage
Accident & Sickness			
	0 – 15	407	84%
	16 – 20	24	5%
	Over 20	54	11%

Of the 485 claims reviewed for the time study, 16% of claims were not settled within 15 working days. The examiners recommend that ALIC review its procedures to reduce the percentage of claims paid after 15 working days.

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DENIED CLAIM REVIEW

Life

A sample of 2 from a total population of 6 life insurance claims denied during the examination time frame was reviewed. ALIC indicated that there were no claims on life insurance policies administered by Lincoln Life and Annuity Company of New York and Protective Life Insurance Company on behalf of ALIC that were denied during the examination time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Disability

A sample of 3 was selected from a population of 40 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy.

Stop Loss

ALIC indicated that there were no stop loss claims denied during the examination time frame.

Accident and Sickness

Group

A sample of 103 was selected from a population of 8,167 claims denied during the examination time frame. Of these sampled claims, 13 were mental health claims and 20 were dental claims. A separate review of mental health claims is discussed in a subsequent section of the Report.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber, or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. As discussed in Review Sheet CL02T-DEN, the review revealed that the EOB failed to contain the submitted charges and the allowed amounts for the services rendered. By failing to include this information on the EOB, ALIC failed to disclose the method of

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benefit calculation and failed to accurately and clearly set forth the benefits payable under the contract, in violation of each of these sections of the Code in 1 instance. ALIC agreed with the examiners' observations.

Individual Conversion

A sample of 32 was selected from a population of 439 claims denied during the examination time frame. Of these sampled claims, 7 were mental health claims. A separate review of mental health claims is discussed in a subsequent section of the Report. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Strategic Resource Company (SRC)

A sample of 10 was selected from a population of 10,031 claims denied during the examination time frame. A separate review of mental health claims is discussed in a subsequent section of the Report. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Pharmacy

A sample of 10 was selected from a population of 50,501 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy.

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EyeMed

The examiners reviewed the entire population of 2 claims denied during the examination time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Mental Health

The scope of the examination was expanded to include a review of mental health claims paid and denied between October 1, 2010, and December 31, 2010. The populations included claims from group, individual conversion, and SRC. A sample of 12 was selected from a population of 249 claims denied during the expanded time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Student Health

A sample of 110 was selected from a population of 8,387 claims denied during the examination time frame.

Section 38.2-503 of the Code states that no person shall knowingly make, publish, disseminate, circulate, or place before the public a statement containing any assertion, representation or statement relating to (i) the business of insurance or (ii) any person in the conduct of his insurance business, which is untrue, deceptive or misleading. As discussed in Review Sheet CL23BL-SH, ALIC included a remark on an EOB sent to the insured for a denied claim stating that "This claim has been adjusted and as a result, an overpayment has occurred. A letter will be sent under separate cover." As no other correspondence was sent to the insured, the statement on the EOB

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indicating that the insured would receive a letter is untrue, deceptive, or misleading; therefore, ALIC is in violation of the Code in 1 instance.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber, or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed 2 violations of § 38.2-514 B and 20 violations of § 38.2-3407.4 B. An example is discussed in Review Sheet CL26BL-SH in which the EOB contained conflicting descriptions of the services performed and the amount that the provider billed for a charge is listed incorrectly. As a result, ALIC failed to accurately and clearly set forth the benefits payable under the contract and failed to accurately disclose the method of benefit calculation, in violation of each of these sections of the Code. ALIC agreed with the examiners' observations.

Section 38.2-3405 B of the Code states that coordination of benefits provisions may not operate to reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage. The review revealed 8 violations of § 38.2-3405 B of the Code. As discussed in Review Sheet CL71BW-SH, ALIC denied 8 claims and sent EOBs requesting that the claimant provide complete accident details. ALIC sent the claimants questionnaires that asked the following questions:

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> 4. Was this the result of an automobile accident YES___ NO___
> In what state did the accident occur? _____
> 5. If related to an automobile accident, have you filed a claim with your auto carrier or the other involved party's auto carrier? YES___NO___ If "YES", please supply all involved auto carrier's [sic] explanation of benefits with your claim.

ALIC denied these claims and asked the claimants to provide details of accidents and EOBs from auto carriers, in violation of the Code. ALIC disagreed with the examiners' observations, stating that:

> Disagree that the denial is unreasonable. The request for accident information was not related to a subrogation investigation. The services rendered and the diagnosis submitted for each claim provided no indication as to the root cause, nature of the injury. The reason accident information was requested is that the [*school name*] plan has an exclusion which reads "Expense incurred for injury resulting from the play or practice of intercollegiate sports; (participating in sports clubs; or intramural athletic activities; is not excluded)." When services are related to an intercollegiate injury they are not covered under the medical plan. However [*school name*] also has a separate Intercollegiate Sports Injury policy which covers accidents related to intercollegiate injuries up to $75K per condition per policy year. Therefore accident information must be requested to verify what policy the services would be covered under. Seven of the Eight claims have since been paid. Please see the below grid which shows the reprocessed claim number. Please refer to the attached for a copy of the EOB's.

The examiners do not concur, and would respond that ALIC denied claims and requested information on coordination of benefits with liability coverage, in violation of this section of the Code in 8 instances.

ALIC's student health policy indicates that Physician's Office Visits and Laboratory and X-Ray Expenses are payable at 80% for Preferred Care. ALIC's student health policy states that "Pre-existing conditions are not covered during the first 63 days that you are covered under this plan." ALIC's student health policy indicates that Durable Medical Equipment Expenses are payable at 70% for Non-Preferred Care. ALIC's student health policy indicates that Preventive Health Care Services Expenses,

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including immunizations for infectious disease, are payable at 90% for Preferred Care. ALIC's student health policy includes an exclusion that states that "Expense incurred for injury resulting from the plan or practice of intercollegiate sports; in excess of $250 (participating in sports clubs; or intramural athletic activities; is not excluded)." As discussed in Review Sheets CL30BL-SH, CL33BL-SH, CL34BL-SH, CL41BL-SH, and CL42BL-SH, the review revealed that ALIC's processing of claims was in non-compliance with its policy provisions in 5 instances. ALIC agreed with the examiners' observations.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

The total sample of 514 paid claims and 284 denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

14 VAC 5-400-40 A - In 51 instances, ALIC misrepresented insurance policy provisions related to the coverage at issue. An example is discussed in Review Sheet CL40BW-SH.

14 VAC 5-400-50 A - In 37 instances, claims were not acknowledged within 10 working days. An example is discussed in Review Sheet CL24BL-SH.

14 VAC 5-400-50 C - In 1 instance, an appropriate reply was not made within 10 working days on pertinent communications from a claimant. This is discussed in Review Sheet CL25BW-SH.

14 VAC 5-400-60 A - In 83 instances, ALIC failed to notify the first party claimant of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss. An example is discussed in Review Sheet CL34M. ALIC disagreed, and stated:

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> The acceptance of the claim was sent to the provider. The "First Party Claimant" is the provider as the provider submitted the claim for reimbursement.
> Please refer to the electronic claim screen-print below which reflects the code A2 dated 4/9/10.X. This claim was an electronic submission and the A2 code represents the acknowledgement and acceptance of the claim. Code A2 is defined as follows:
> "Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system". The provider Explanation of benefits was previously provided to the Department and this is dated 4/16/10. The reason for denial is noted on the Explanation of Benefits Statement.

The examiners responded that "regardless of which party submits the claim, the insurer is required to advise the first party claimant of the acceptance or denial of a claim within 15 working days of receipt by the insurer of properly executed proof of loss." The insured is the first party claimant, and ALIC failed to send a notification to the insured.

14 VAC 5-400-60 B - In 12 instances, a claim investigation was not completed within 45 days from the date of notification of the claim, and ALIC failed to send the claimant a letter setting forth the reason additional time was needed for investigation. An example is discussed in Review Sheet CL21BL-SH.

14 VAC 5-400-70 A – In 2 instances, a claim denial was not given to a claimant in writing. As discussed in Review Sheet EyeMedClaim01B, for 2 claims processed by EyeMed, ALIC failed to provide the insured with a written explanation of denial. ALIC disagreed, and stated:

> EyeMed, denied these claims to the providers who submitted the claim. Per the contract with Aetna, EyeMed does not send denial notice to the insured unless they are financially responsible for payment. In both cited examples, the reason for the denial was missing filing [sic] and process errors between EyeMed and the provider. The denial reasons are displayed on the bottom of the provider remittance included within the sample documentation.

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The examiners would note that ALIC's response indicates that its business practice entails not providing denials in writing, in violation of the Code.

14 VAC 5-400-70 B - In 17 instances, ALIC failed to include a reasonable explanation of the basis for denial in the written denial. An example is discussed in Review Sheet CL56BW-SH in which ALIC denied a claim and indicated that a review to determine if a condition was pre-existing needed to be completed. The policy indicated that pre-existing conditions were excluded for 63 days. Since the date of service of the claim was greater than 63 days from the effective date of the insurance coverage, ALIC failed to provide a reasonable explanation of the basis for denial. ALIC agreed with the examiners' observations.

14 VAC 5-400-70 D - In 18 instances, ALIC failed to offer a claimant an amount which is fair and reasonable in accordance with policy provisions. An example is discussed in Review Sheet CL01B, where an insured was held liable for a charge denied as being mutually exclusive to another charge on a claim submitted by a provider that was indicated as participating in ALIC's files. ALIC disagreed, stating:

> Aetna does not hold a direct contract with the billing provider; however, Aetna holds an indirect contract with the provider through the National Advantage Program (NAP), which reduces claim costs for plan sponsors and members by providing contracted rates through vendor arrangements for many hospital and physician claims (including this provider).
>
> All claims are subject to Aetna payment policies....
>
> During the claim review, if a denial is warranted based on multiple procedure codes being billed for the same member, same date of service, same provider, the highest intensive code is reimbursed. In this case, 99251 was reimbursed. The 99251 code was priced through NAP. When a claim from a non-participating provider being paid at the preferred benefit level has been externally priced, the pricing returned from the vendor is a binding contract and therefore, the member is not responsible for the discounted amount; however, the 99231 was considered mutually

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exclusive to 99251 based on Aetna payment policies and therefore, not eligible for reimbursement.

This member was covered under a PPO plan at the time the services were rendered. Under a PPO plan, the members have cost sharing expenses which are generally higher when they access out-of-network providers. The Company has noted below the portion of the Plan Brochure describing the member's cost sharing, which purports the member is responsible for non-covered expenses.

The examiners do not concur and requested a copy of the provider contracts and/or agreements between ALIC, its intermediaries and the provider. After an extensive delay, the contracts between ALIC and Beech Street, and between Beech Street and the provider, were received and reviewed by the examiners. The examiners do not concur that there is an "indirect" contract between ALIC and the provider. The contract between ALIC and Beech Street states:

"**WHEREAS,** Company wishes to contract with Entity to arrange for the access of health care services from such Participating Entity Providers to its members on the following terms and conditions...**Provision of Covered Services.** Entity shall provide Members with access to Participating Entity Provider for Members' Covered Services in the Primary Network and National Advantage Program (NAP) Service Areas."

In addition, the contract between Aetna Life and Beech Street contains a hold harmless clause which states:

"**Hold Harmless.** Entity represents and warrants that the terms and provisions of the Entity Provider Agreements shall permit Company to require Participating Entity Providers to comply with Company's hold harmless standards as set forth, in part, in this Section 5.5. Accordingly, Entity and Participating Entity Providers hereby agree that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Entity or a Participating Entity Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other res controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles or other supplemental charges made in accordance with the terms of the

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applicable Plan. Entity and Participating Entity Providers further agree that this Section 5.5 (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between a Participating Entity Provider and Members or persons acting on their behalf.
To protect Members, Participating Entity Provider agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 5.5."

There is also a contract between Beech Street and the provider that indicates that the provider will be participating. Since the provider is participating and the contract contains a hold harmless clause, the member should not be held liable for this charge. Therefore, ALIC did not provide a fair and equitable settlement of the claim and misrepresented pertinent facts and policy provisions.

The violations of 14 VAC 5-400-60 A occurred with such frequency as to indicate a general business practice, placing ALIC in violation of § 38.2-510 A 5 of the Code. These violations were also cited in a previous inquiry and are considered knowing violations. Section 38.2-218 of the Code sets forth penalties that may be imposed for knowing violations.

ALIC indicated in its response that its general business practice for EyeMed claims is to provide an explanation of denial only when there is insured responsibility, thus placing ALIC in violation of § 38.2-510 A 14 of the Code. In addition, for Student Health Claims, the violations of 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D also occurred with such frequency as to indicate a general business practice, placing ALIC in violation of §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 6, and 38.2-510 A 14 of the Code.

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THREATENED LITIGATION

ALIC provided a statement regarding the 1 file involving threatened litigation during the examination time frame. The litigation involved an affiliate company and was ongoing. No other threatened litigation files were provided.

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XII. INDEPENDENT EXTERNAL REVIEW OF ADVERSE UTILIZATION REVIEW DECISIONS

Chapter 59 of Title 38.2 of the Code requires certain actions to be taken by the Bureau of Insurance on any appeal of a final adverse decision made by a utilization review entity. 14 VAC 5-215-10 et seq. provides a process for appeals to be made to the Bureau of Insurance to obtain an independent external review of final adverse decisions and procedures for expedited consideration of appeals in cases of emergency health care.

The examiners reviewed the entire population of 1 appeal to obtain an independent external review of a final adverse decision that occurred during the examination time frame. The review revealed that ALIC was in substantial compliance with its established procedures and this section.

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XIII. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, ALIC shall:

1. Ensure that its complaint system is filed and approved, as required by § 38.2-5804 A of the Code;
2. Establish procedures to ensure that it maintains its complaint system, as required by § 38.2-5804 A of the Code;
3. Review and revise its procedures to ensure that all provider contracts contain the provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code;
4. Review and revise its procedures to ensure adherence to and compliance with the minimum fair business standards in the processing and payment of claims, as required by §§ 38.2-510 A 15, 38.2-3407.15 B 3, and 38.2-3407.15 B 8 of the Code;
5. Review and revise its procedures to ensure that its advertising log is in compliance with 14 VAC 5-41-150 C (formerly 14 VAC 5-40-60 B), and that its advertisements are in compliance with 14 VAC 5-90-50 B and 14 VAC 5-90-55 A, 14 VAC 5-90-130 A as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;
6. Review and revise its procedures to ensure that all of its policy forms and certificates of coverage are filed and approved and in compliance with 14 VAC 5-100-40 2, 14 VAC 5-100-50 1, and 14 VAC 5-100-50 3, as well as § 38.2-316 A, § 38.2-316 B, and § 38.2-316 C of the Code;

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7. Review and revise its procedures to ensure that all Explanation of Benefit (EOB) forms used by its pharmacy and vision vendors are filed with and approved by the Commission, as required by § 38.2-3407.4 A of the Code;

8. File with the Commission for approval all student health forms currently in use or contemplated for use, remove all references to subrogation and other inappropriate exclusions, and discontinue use of any forms that have not been approved in their final form, as required by 14 VAC 5-100-40 2, 14 VAC 5-100-50 1, and 14 VAC 5-100-50 3, as well as § 38.2-316 A, § 38.2-316 B, and § 38.2-316 C of the Code;

9. Review and revise its procedures to ensure that all agents representing ALIC are licensed and appointed prior to accepting new business and paying commissions in compliance with § 38.2-1822 A, § 38.2-1812 A and § 38.2-1833 A 1 of the Code;

10. Establish and maintain procedures for compliance with §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code;

11. Review all renewals of group contracts issued in Virginia for the years 2009, 2010, 2011, 2012, 2013 and the current year that resulted in a more than 35 percent increase in the annual premium charged for the coverage thereunder; determine which contract holders were not notified in writing 60 days prior to such increase, as required by §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code, and refund to the group contract holder all premium amounts collected in excess of the 35% increase for the entire policy period for which notice was not provided. Send checks for the required refund along with letters of explanation stating specifically, "As a result of a Target Market Conduct

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Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that ALIC failed to provide 60 days written notice to the policyholder of intent to increase premium by more than 35 percent. Please accept the enclosed check for the refund amount." After which, furnish the examiners with documentation that the required refunds have been paid;

12. Review and revise its procedures to ensure that its complaint log is complete and maintained, as required by § 38.2-511 of the Code;
13. Review and revise its procedures for the payment of interest on life insurance claim proceeds, as required by § 38.2-3115 B of the Code;
14. Review all paid life claims for the years of 2009, 2010, 2011, 2012, 2013, and the current year and make interest payments where necessary as required by § 38.2-3115 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid;
15. Review and revise its procedures for the payment of interest on accident and sickness claim proceeds, as required by § 38.2-3407.1 B of the Code;
16. Review all paid claims for the years of 2010, 2011, 2012, 2013, and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that, "As a result of a Target Market

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Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid;

17. Complete the corrective action plan steps outlined in its response to CLMEM01B-ASH and CLMEM02B-ASH, and provide documentation of completion to the examiners;

18. Reopen and reprocess the claim referenced in CL71BW-SH that was denied and never paid, and appropriately determine eligibility for benefits and adjudicate accordingly;

19. Review all student health claims for the years 2009, 2010, 2011, 2012, 2013 and the current year that resulted in an accident claim questionnaire being sent to the claimant or resulted in subrogation; determine which claims were not paid due to accident information not being received or were incorrectly denied in violation of § 38.2-3405 B of the Code; reopen and reprocess all affected claims so that they are paid without subrogation or, if needed, appropriate questionnaires are sent to determine eligibility for benefits. Send checks for any payments along with letters of explanation stating specifically, "As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that ALIC failed to adjudicate this claim correctly. Please accept the enclosed payment." After which, furnish the examiners with documentation of the reprocessed claims and payments;

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20. Immediately discontinue use of any questionnaires that are in violation of § 38.2-3405 B of the Code;

21. Review its contractual responsibilities with its Beech Street providers; review all claims from Beech Street providers for the years 2009, 2010, 2011, 2012, 2013 and the current year and determine which claims were not processed in accordance with the hold harmless clause of the provider contract; reopen and reprocess all affected claims so that the insured is held harmless. Send checks for any payments along with letters of explanation stating specifically, "As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that ALIC failed to adjudicate this claim correctly. Please accept the enclosed payment." After which, furnish the examiners with documentation of the reprocessed claims and payments;

22. Establish and maintain procedures to ensure that all claims payments to insureds or beneficiaries are accompanied by a statement setting forth the coverage under which payments are being made, as required by § 38.2-510 A 10 of the Code;

23. Establish and maintain procedures to ensure that benefits, coverages or other provisions of an insurance policy or contract are not obscured or concealed from claimants, either directly or by omission, as required by 14 VAC 5-400-40 A;

24. Establish and maintain procedures to ensure that it acknowledges the receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A;

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25. Establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A;

26. Review and strengthen its established procedures to ensure that notification of a claim under investigation is sent every 45 days from the date of notification of the claim and every 45 days thereafter, as required by 14 VAC 5-400-60 B;

27. Establish and maintain procedures to ensure that any denial of claim is given to the claimant in writing and ensure that its vendors working on its behalf do the same, as required by 14 VAC 5-400-70 A;

28. Establish and maintain procedures to ensure that it includes a reasonable explanation of the basis for the denial of a claim in the written denial, as required by 14 VAC 5-400-70 B;

29. Establish and maintain procedures to ensure that a claimant is offered an amount that is fair and reasonable, as required by 14 VAC 5-400-70 D; and

30. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

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XIV. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by ALIC's officers and employees during the course of this examination is gratefully acknowledged.

Bryan Wachter, FLMI, AIRC, AIE, MCM, Bill Benson, FLMI, AIE, ACS, MCM, Brant Lyons, MCM, Julie Fairbanks, AIE, FLMI, AIRC, MCM, Melissa Gerachis, FLMI, AIRC, MCM, Arthur Dodd, MBA, FLMI, MCM, AIE, AIRC, and Todd Bryant, HIA, MHP, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie R. Fairbanks

Julie Fairbanks, AIE, FLMI, AIRC, MCM
Principal Insurance Market Examiner
Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance

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XV. REVIEW SHEET SUMMARY BY AREA

MANAGED CARE HEALTH INSURANCE PLANS
§ 38.2-5804 A, 1 violation, MC01
Timeliness and Handling
§ 38.2-5804 A, 3 violations, MC01-B, MC03-B, MC04-B
Provider Contracts
§ 38.2-5805 B, 2 violations, EF03J, EF04J
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
§ 38.2-3407.15 B 1, 1 violation, EF01-B
§ 38.2-3407.15 B 2, 1 violation, EF01-B
§ 38.2-3407.15 B 3, 1 violation, EF01-B
§ 38.2-3407.15 B 4, 6 violations, EF01, EF01-B, EF01J, EF02, EF02J, EF05
§ 38.2-3407.15 B 5, 1 violation, EF01-B
§ 38.2-3407.15 B 6, 1 violation, EF01-B
§ 38.2-3407.15 B 7, 5 violations, EF01, EF01-B, EF02, EF02J, EF05
§ 38.2-3407.15 B 8, 3 violations, EF01-B, EF01J, EF02J
§ 38.2-3407.15 B 9, 7 violations, EF01, EF01-B, EF02, EF02J, EF03, EF05, EF08
§ 38.2-3407.15 B 10, 4 violations, EF01, EF01-B, EF02, EF05
§ 38.2-3407.15 B 11, 5 violations, EF01, EF01-B, EF01J, EF02J, EF08
Provider Claims
§ 38.2-3407.15 B 3, 1 violation, EFCL02-B
§ 38.2-3407.15 B 8, 4 violations, EFCL01-B
ADVERTISING
14 VAC 5-40-60 B (now 14 VAC 5-41-150 C), 1 violation, AD01
14 VAC 5-90-50 B, 7 violations, AD01B-SH

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ADVERTISING cont.
14 VAC 5-90-55 A, 4 violations, AD01SL, AD02SL, AD03SL, AD04SL
14 VAC 5-90-130 A, 7 violations, AD01B-SH
POLICY FORMS
§ 38.2-316 A, 40 violations and in each instance, PF01B, PF01-SH, PF03B, PF05B, PF06B, PF10B, PF12B, PF13B, PF14B, PF15B, PF16B, PF17B, PF18B, PF19B, PF20B, PF21B, PF22B
§ 38.2-316 B, 17 violations, PF02B, PF04B, PF06B, PF07B
§ 38.2-316 C 1, 53 violations and in each instance, PF01B, PF01-SH, PF02B, PF03B, PF04B, PF05B, PF06B, PF07B, PF10B, PF12B, PF13B, PF14B, PF15B, PF16B, PF17B, PF18B, PF19B, PF20B, PF21B, PF22B
§ 38.2-3407.4 A, 9 violations and in each instance, PF09B, PF11B
§ 38.2-3533, violation in each instance, PF01-SH
AGENTS
§ 38.2-1812 A, 5 violations, AG01, AG04
§ 38.2-1822 A, 3 violations, AG01
§ 38.2-1833 A 1, 2 violations, AG04
NOTICE OF PREMIUM INCREASES
§ 38.2-3407.14 A, 3 violations, PB01B, PB02B, PB03B
§ 38.2-3407.14 B, 3 violations, PB01B, PB02B, PB03B
COMPLAINTS
§ 38.2-511, 1 violation, CP01-B
CLAIMS PRACTICES
§ 38.2-503, 1 violation, CL23BL-SH

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CLAIMS PRACTICES cont.
§ 38.2-514 B, 17 violations, CL01T-DEN, CL02T-DEN, CL03BW-SH, CL04BW-SH, CL05BL-SH, CL06BL-SH, CL07BW-SH, CL12BW-SH, CL13BL-SH, CL18BW-SH, CL23BW-SH, CL25BW-SH, CL26BL-SH, CL27BW-SH, CL28BW-SH, CL40BW-SH, CL59BW-SH
§ 38.2-3115 B, 4 violations, CL04M, CL06M, CL07M, CL08M
§ 38.2-3405 B, 11 violations, CL07BW-SH, CL08BW-SH, CL26BW-SH, CL71BW-SH
§ 38.2-3407.1 B, 11 violations, CL02BL-SH, CL02-TB, CL05-TB, CL06-TB, CL08BW-SH, CL15BW-SH, CL16BW-SH, CL17BW-SH, CL37BW-SH, CL39M, CL44BW-SH
§ 38.2-3407.4 B, 38 violations, CL01T-DEN, CL02T-DEN, CL03BW-SH, CL04BW-SH, CL05BL-SH, CL06BL-SH, CL07BW-SH, CL08BL-SH, CL12BW-SH, CL13BL-SH, CL18BL-SH, CL18BW-SH, CL23BW-SH, CL25BW-SH, CL26BL-SH, CL27BW-SH, CL28BL-SH, CL28BW-SH, CL29BW-SH, CL30BL-SH, CL33BL-SH, CL34BL-SH, CL36BL-SH, CL37BL-SH, CL38BL-SH, CL40BW-SH, CL41BL-SH, CL42BL-SH, CL42BW-SH, CL43BW-SH, CL44BW-SH, CL48BW-SH, CL50BW-SH, CL52BW-SH, CL56BW-SH, CL57BW-SH, CL59BW-SH, CL69BW-SH, CL70BW-SH
14 VAC 5-400-40 A, 51 violations, CL01-B, CL01BW-SH, CL02BW-SH, CL03-B, CL03BW-SH, CL04BW-SH, CL05-B, CL05BL-SH, CL06-B, CL06BL-SH, CL07-B, CL07BW-SH, CL08-B, CL08BL-SH, CL08BW-SH, CL09-B, CL12BW-SH, CL13BL-SH, CL16BL-SH, CL18BL-SH, CL18BW-SH, CL23BW-SH, CL25BW-SH, CL26BL-SH, CL27BW-SH, CL28BL-SH, CL28BW-SH, CL29BW-SH, CL30BL-SH, CL33BL-SH, CL34BL-SH, CL36BL-SH, CL37BL-SH, CL37BW-SH, CL38BL-SH, CL40BW-SH, CL41BL-SH, CL42BL-SH, CL42BW-SH, CL43BW-SH, CL44BW-SH, CL48BW-SH, CL50BW-SH, CL52BW-SH, CL56BW-SH, CL57BW-SH, CL59BW-SH, CL60BW-SH, CL69BW-SH, CL70BW-SH, CL71BW-SH

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CLAIMS PRACTICES cont.
14 VAC 5-400-50 A, 37 violations, CL01BL-SH, CL01M, CL02-TB, CL03BW-SH, CL03M, CL04BW-SH, CL04M, CL05-TB, CL07BL-SH, CL08BL-SH, CL09BW-SH, CL09M, CL11-B, CL11M, CL20BL-SH, CL21BL-SH, CL24BL-SH, CL25BL-SH, CL29BW-SH, CL32BL-SH, CL32BW-SH, CL34BL-SH, CL40BL-SH, CL47BW-SH, CL48M, CL51BW-SH, CL53M, CL54BW-SH, CL54M, CL60BW-SH, CL64BW-SH, CLSRC02
14 VAC 5-400-50 C, 1 violation, CL25BW-SH
14 VAC 5-400-60 A, 83 violations, CL01-TB, CL02-TB, CL03BW-SH, CL03-TB, CL04BW-SH, CL04-TB, CL05BW-SH, CL08BW-SH, CL08-TB, CL09BW-SH, CL09-TB, CL10BW-SH, CL10M, CL10-TB, CL11-B, CL11BW-SH, CL11-TB, CL13-TB, CL14M, CL14-TB, CL15BW-SH, CL15-TB, CL016BW-SH, CL16-TB, CL17BL-SH, CL17BW-SH, CL17M, CL18-TB, CL19-TB, CL20BW-SH, CL20-TB, CL21BW-SH, CL24BW-SH, CL29BW-SH, CL34M, CL39BW-SH, CL44BW-SH, CL45BW-SH, CL46BW-SH, CL47BW-SH, CL48M, CL50BW-SH, CL51BW-SH, CL53M, CL54BW-SH, CL55BW-SH, CL60BW-SH, CL66BW-SH, CLSRC01, CLSRC02
14 VAC 5-400-60 B, 12 violations, CL10M, CL11-B, CL24BW-SH
14 VAC 5-400-70 A, 2 violations, EyeMedClaim01B
14 VAC 5-400-70 B, 17 violations, CL03-B, CL05-B, CL08-B, CL37BW-SH, CL56BW-SH, CL69BW-SH, CL71BW-SH, EyeMedClaim01B
14 VAC 5-400-70 D, 18 violations, CL01-B, CL01BW-SH, CL02BW-SH, CL03-B, CL06-B, CL07-B, CL08-B, CL08BL-SH, CL09-B, CL16BL-SH, CL29BW-SH, CL30BL-SH, CL34BL-SH, CL41BL-SH, CL42BL-SH, CL56BW-SH, CL69BW-SH, CL71BW-SH
§ 38.2-510 A 10, 3 instances of non-compliance, CL07BL-SH, CL08BL-SH, CL24BL-SH

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JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

August 27, 2014

CERTIFIED MAIL 7013 2630 0001 8681 0686
RETURN RECEIPT REQUESTED

Gail A. Yoder, Compliance Manager
Aetna Life Insurance Company
5305 Chestnut Ridge Road
Summerfield, NC 27358

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Yoder:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Aetna Life Insurance Company for the period of January 1, 2010, through June 30, 2010. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of Aetna Life Insurance Company, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. Aetna Life Insurance Company response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Julie Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Market Conduct
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Althelia Battle

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aetna

bryan.wachter@scc.virginia.gov Authenticated by aetna.com Valid Signature

From: yoderga@aetna.com
To: Julie.Fairbanks@scc.virginia.gov, Bryan.Wachter@scc.virginia.gov
Sent: Nov 17, 2014 3:11:41 PM EST
Subject: [SEND SECURE] VA ALIC Exam-Draft Response
Attached: VA ALIC Exam DRAFT Response Final.pdf (500 kb)

Good afternoon Julie and Bryan, find attached our response to the draft report for Aetna Life Insurance Company due today November 17, 2014. I uploaded the supporting documentation to the server this morning as it was too large to email (315 documents/66mgs zipped). Bryan tested the file and was able to open and view. As instructed in Bryan's email from 10/15/2014 if we had additional information or comments to include them with this response and they will be addressed accordingly. We did identify a couple memo's not listed on the Review Sheet but were in the body of your draft report, we looked at the final review sheets and there were no violations listed on those either, those being CLMEM01 and CLMEM02, we do not know what these memos are in violation of so we could not comment until we get more information from you. Also memo AG01 was noted in the body of the report but not listed on the Review Sheet but we were able to review the examiners final memo and we responded to that non-listed memo.

Please let me know if you have any questions and please confirm receipt of this response, thank you for the additional time you allowed us to review and respond.

Gail A. Yoder, MCM
Compliance Manager
Regulatory Compliance Unit
Phone: 336.643.2113 Fax: 860.262.9218
Email: YoderGA@aetna.com

Regulatory Compliance - We promote compliance one regulatory interaction at a time.

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REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

AETNA LIFE INSURANCE COMPANY

AS OF JUNE 30, 2010

COPY

Conducted from April 20, 2011

Through

February 11, 2014

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE STATE

CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 06-6033492
NAIC: 60054

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I. SCOPE OF EXAMINATION

A Target Market Conduct Examination of Aetna Life Insurance Company (hereinafter referred to as ALIC) was conducted under the authority of various sections of the Code of Virginia (hereinafter referred to as "the Code") and regulations found in the Virginia Administrative Code (hereinafter referred to as "VAC") including, but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1317.1, 38.2-1809, 38.2-3407.15 C, and 38.2-5808 B of the Code, as well as 14 VAC 5-40-60 B and 14 VAC 5-90-170 A.

A previous Market Analysis inquiry covering the period of January 1, 2003, through December 31, 2004, was concluded on September 7, 2007. As a result of this inquiry, ALIC made a monetary settlement offer which was accepted by the State Corporation Commission on May 15, 2008, in Case No. INS-2007-00279.

The current examination revealed violations that were also noted in the previous inquiry. Although ALIC had agreed after the previous inquiry to change its practices to comply with the Code and regulations, the current examination revealed a number of instances where ALIC had not done so. In the examiners' opinion, therefore, ALIC in some instances knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

The period of time covered for the current examination, generally, was January 1, 2010, through June 30, 2010. The on-site examination was conducted at ALIC's Blue Bell, Pennsylvania office from June 6, 2011, through June 9, 2011, and from June 19, 2011, through June 22, 2011, and at ALIC's Medford, Massachusetts office from April 8, 2013, through April 11, 2013, and completed at the office of the State

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Corporation Commission's Bureau of Insurance on February 11, 2014. The violations cited and the comments included in this Report are the opinions of the examiners. The examiners may not have discovered every unacceptable or non-compliant activity in which the company is engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

The purpose of the examination was to determine whether ALIC was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code. Compliance with the following regulations was considered in this examination process:

14 VAC 5-40-10 et seq.	Rules Governing Life Insurance and Annuity Marketing Practices;
14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance;
14 VAC 5-110-10 et seq.	Rules and Regulations for Simplified and Readable Accident and Sickness Insurance Policies;
14 VAC 5-130-10 et seq.	Rules Governing the Filing of Rates for Individual and Certain Group Accident and Sickness Insurance Policy Forms;
14 VAC 5-140-10 et seq.	Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act;
14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS);
14 VAC 5-215-10 et seq.	Rules Governing Independent External Review of Final Adverse Utilization Review Decisions; and

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14 VAC 5-400-10 et seq.	Rules Governing Unfair Claim Settlement Practices.

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIPs)
- Ethics & Fairness in Carrier Business Practices
- Advertising/Marketing Communications
- Policy and Other Forms
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act
- Notice of Premium Increases
- Complaints
- Claim Practices
- Independent External Review of Adverse Utilization Review Decisions

Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to ALIC during the course of the examination.

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Delays in the Examination Process

ALIC's failure to provide timely and complete responses to requests and Review Sheets significantly delayed the completion of this exam. Examples of these issues are discussed in the following paragraphs.

The Coordinator's Handbook for the examination identifies the population data that the company has been requested to provide and includes a certification section for each data request that a company representative must sign and attest to a date that the correct requested data will be provided to the examiners. These certifications specifically state that "The failure to provide correct populations to the examiners by the date specified could result in the imposition of a monetary penalty when the examination

is finalized." The examiners explained the data requests and the certifications during the preliminary meeting with ALIC on November 16, 2010. Although an email from ALIC on December 9, 2010, indicated that some certifications were being sent under separate cover, and despite the examiners inquiring about the certifications again on February 2, 2011, and February 23, 2011, the certifications were never sent to the examiners. In addition, ALIC submitted numerous corrected populations to the examiners after the initial populations had already been provided. After the examiners had performed the first on-site claims review, ALIC determined that the initial claims populations did not include any claims from coverage that had been renewed. Once the examiners received the new populations, the examiners had to select new samples and perform a separate claims review.

The Coordinator's Handbook also states that the company is expected to respond to Review Sheets within 3 working days of receipt. The examiners sent a letter to ALIC on January 23, 2013, that listed 31 Review Sheets and requests that ALIC had failed to respond to in a timely fashion. Of the 31 items, 20 had been outstanding for 16 weeks or longer at that time. One of these items, Review Sheet CL01B, was originally sent to ALIC on July 1, 2011. ALIC did not respond until August 9, 2011. The examiners responded on September 30, 2011, and requested a copy of all contracts and/or agreements linking a provider to ALIC. ALIC did not respond until over 18 months later on April 5, 2013, and ALIC's response was incomplete. The examiners sent another response on August 29, 2013, and requested any other contracts linking the provider to ALIC. On September 11, 2013, ALIC provided a copy of the remaining contract.

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II. COMPANY HISTORY

Aetna Life Insurance Company (ALIC) was incorporated in Connecticut in June, 1853. ALIC was a publicly held corporation until 1967, when all of the outstanding shares of its stock were acquired by Aetna Life and Casualty Company (AL&C) in a share exchange. In 1996, AL&C changed its name to Aetna Services, Inc. (ASI) and became a wholly owned subsidiary of Aetna Inc., a Connecticut corporation (Old Aetna). On October 31, 2000, ASI merged into Old Aetna, and on November 3, 2000, ALIC became a wholly-owned subsidiary of Aetna U. S. Healthcare Inc., a Pennsylvania corporation (New Aetna), which was a wholly owned subsidiary of Old Aetna at such time. On December 13, 2000, Old Aetna sold its financial services and international businesses and simultaneously spun-off New Aetna to its shareholders. On the same date, New Aetna was renamed Aetna Inc. Shares of New Aetna are traded on the New York Stock Exchange.

ALIC's service area includes the following counties and cities: Albemarle, Alexandria City, Amelia, Arlington, Buckingham, Caroline, Charles City, Charlotte, Charlottesville City, Chesterfield, Clarke, Colonial Heights City, Culpeper, Cumberland, Dinwiddie, Fairfax, Fairfax City, Falls Church City, Fauquier, Fluvanna, Frederick, Fredericksburg City, Goochland, Hanover, Harrisonburg City, Henrico, Hopewell City, King George, King William, Loudoun, Lunenburg, Manassas City, Manassas Park City, New Kent, Nelson, Nottoway, Orange, Petersburg City, Powhatan, Prince Edward, Prince George, Prince William, Richmond City, Shenandoah, Spotsylvania, Stafford, Warren, Westmoreland, and Winchester City.

As of December 31, 2010, ALIC's annual statement reported net admitted assets totaling $21,237,425,146, life insurance premiums and annuity considerations in Virginia totaling $64,636,416, and direct accident and health insurance premiums in Virginia totaling $349,187,689.

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III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

Section 38.2-5801 of the Code prohibits the operation of an MCHIP unless the health carrier is licensed as provided in this title. Section 38.2-5802 of the Code sets forth the requirements for the establishment of an MCHIP, including the necessary filings with the Commission and the State Health Commissioner.

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES

Section 38.2-5803 A of the Code requires that the following be provided to covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers.
2. A description of the service area or areas within which the MCHIP shall provide health care services.
3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure, if complaints may be resolved through a specific arbitration agreement.
4. Notice that the MCHIP is subject to regulation in Virginia by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.
5. A prominent notice stating, "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided, which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance."

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COMPLAINT SYSTEM

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner. Of the total population of 83 appeals and 35 medical and dental complaints received during the examination time frame, the examiners reviewed a sample of 30 appeals and a sample of 18 medical and dental complaints. In addition, the examiners selected a sample of 11 from the total population of 22 student health appeals received during the examination time frame.

As discussed in Review Sheet MC01, ALIC failed to obtain approval by the Commission for its complaint system, in violation of § 38.2-5804 A of the Code. ALIC disagreed, indicating that the complaint system had been sent with the annual complaint report. However, the complaint system must be filed for approval with the office of the Managed Care Ombudsman. Previously, when an affiliate of ALIC had filed its complaint system for approval, the office of the Managed Care Ombudsman inquired as to whether a complaint system was going to be filed for ALIC. Neither the affiliate, nor ALIC, responded to this inquiry. ALIC only provided the complaint system as a required attachment to an annual complaint report; therefore, ALIC failed to obtain approval by the Commission for its complaint system.

Since ALIC did not have an approved complaint system, the examiners reviewed the sample complaints to determine if they were handled in accordance with the complaint procedures explained in the policies and certificates and provided with its annual complaint report. As discussed in the next 2 following paragraphs, the review revealed 3 instances in which ALIC failed to maintain its complaint system, in violation of § 38.2-

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5804 A of the Code.

COMPANY RESPONSE to §38.2-5804 A of the Code: The Company agrees with memo MC01. The Company complaint system was filed and approved on February 26, 2013, please find a copy of the state approval letter attached.

TIMELINESS

ALIC's complaint and appeal procedures indicate that for post-service appeals, the appeal will be resolved and a resolution letter sent within 30 calendar days from thedate/time the appeal is received by ALIC or its designee. As discussed in Review Sheet MC03-B, the review revealed that ALIC did not send a resolution letter that was responsive to the appeal until 51 days after the appeal was received.

ALIC agreed with the examiners' observations

COMPANY RESPONSE: The Company agrees to memo MC03-B and has no further comments.

HANDLING

ALIC's complaint and appeal procedures indicate that the body of the resolution letter must contain the title of each reviewer. As discussed in Review Sheets MC01-B and MC04-B, the review revealed that in two instances the body of the resolution letter failed to include the title of each of the reviewers.

ALIC agreed with the examiners' observations

COMPANY RESPONSE: The Company agrees with memo MC04-B and has no further comments.

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PROVIDER CONTRACTS

The examiners reviewed a sample of 37 contracts from a total population of 28,340 provider contracts in force during the examination time frame.

Section 38.2-5805 B of the Code states that every contract with a provider of health care services enabling an MCHIP to provide health care services shall be in writing. ALIC contracted with an intermediary, EyeMed Vision Care LLC (EyeMed), to process vision claims and negotiate contracts with vision providers. In 2 instances, ALIC indicated that a participating vision provider did not have a direct written agreement with EyeMed. An example is discussed in Review Sheet EF03J. ALIC is in violation of § 38.2-5805 B of the Code in both instances.

COMPANY RESPONSE to §38.2-5805B of the Code:

The Company disagrees with memos EF03J and EF04J, the issued VA provider Amendment to Eye Med covers all sections of 38.2-5805 and the Eye Med network providers. See attached.

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IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 of the Code requires that every provider contract entered into by a carrier shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services.

PROVIDER CONTRACTS

The examiners reviewed a sample of 37 contracts from a total population of 28,340 provider contracts in force during the examination time frame. The provider contracts were reviewed to determine if they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

Professional and Facility

The examiners reviewed a sample of 18 professional and 6 facility contracts from a total population of 23,854 professional and 441 facility provider contracts in force during the examination time frame. The review revealed 5 instances in which ALIC's provider contracts failed to contain 1 or more of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations, and corresponding Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 4	3	EF01
§ 38.2-3407.15 B 7	3	EF01
§ 38.2-3407.15 B 9	5	EF02
§ 38.2-3407.15 B 10	3	EF05
§ 38.2-3407.15 B 11	5	EF08

Section 38.2-3407.15 B 9 of the Code states that no amendment to any provider contract shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract. As reflected in the chart above, the review revealed 5 instances in which the sample professional and facility contracts contained language that conflicted with the notification requirements set forth in § 38.2-3407.15 B 9 of the Code. An example is discussed in Review Sheet EF02, Section 10 of the Regulatory Compliance Addendum in the provider contract states, "No amendment to the Agreement shall be effective unless Provider has been provided with the applicable portion of the proposed amendment and has failed to notify Company

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within fifteen (15) business days of receipt of the amendment of the Provider's intention to terminate the Agreement in accordance with the terms thereof." This language conflicts with the requirement that the provider be provided with the applicable portion of the proposed amendment at least 60 calendar days before the effective date, and that the provider has 30 calendar days from receipt of the documentation to notify the carrier of the provider's intention to terminate the provider contract. Therefore, ALIC is in violation of § 38.2-3407.15 B 9 of the Code. ALIC disagreed with the examiners observations, but it has not commented specifically about this language.

COMPANY RESPONSE to §38.2-3407. 15 B of the Code:

EF01: The Company agrees with the noted violation for 38.2-3407 B9 and B10 – The Company has updated the Virginia Provider Addendum, see attached. The Company disagrees with violations under B4,B7 and B11as those sections are included in the Eye Med Virginia Amendment, see sections #4, 6 and 3.

EF01B: The Company agrees with memo EF01B

EF02: The Company agrees with the noted violation for 38.2-3407 B9 and B10. The Company disagrees with violation of section(s) B4 and B7 see #5 and #8 of the Regulatory Compliance Addendum attached. The Company disagrees with violation of section B11; see a copy of the provider agreement section 10.2.1 Dispute Resolution attached.

EF03: The Company disagrees with the violation under section B11, see provider contract section 8.0 Dispute Resolution. The Company agrees with the violation under section B9.

EF05: The Company disagrees with violations under section B4, this physician is part of the [redacted], and a screen shot noting this provider is under the group TIN is provided. The [redacted] contract contains the Regulatory Compliance Addendum #5. The Company disagrees with the violation of section B7, see Regulatory Addendum #8. The Company disagrees with the violation under section B11; see the Regulatory Addendum item #1.

The Company agrees to the violation under section B9

EF08: The Company agrees with memo EF08

EF01J: The Company disagrees with the violation under section B4, see Eye Med Virginia Amendment section #3 Member Authorizations. The Company disagrees with violation under section B7; see Eye Med Virginia Amendment #6 Retro Denials. The Company disagrees with violation under section B8; see a copy of the Aetna fee schedule as well as the Eye Med Virginia Amendment #7 Provider Contracting. The Company disagrees with violation under section B11; see Eye Med Virginia Amendment #3 Provider Claim Payment.

EF02J: The Company disagrees with the violation under section B4, see Eye Med Virginia Amendment section #3 Member Authorizations. The Company disagrees with violation under section B7; see Eye Med

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Virginia Amendment #6 Retro Denials. The Company disagrees with violation under section B8; see a copy of the Aetna fee schedule as well as the Eye Med Virginia Amendment #7 Provider Contracting. The Company disagrees with violation under section B11; see Eye Med Virginia Amendment #3 Provider Claim Payment.

EFCL01-B: The Company disagrees with the violation B8; please find a screen shot showing the provider was participating under the group contract. Find a copy of the group contract with the compensation terms and agreements.

EFCL02-B: The Company agrees with memo EFCL02-B

NOTE: The Company would like to have noted that we have updated the Regulatory Addendum to capture all requirements of §38.2-3407.15B 2006, find attached documentation related to that update.

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Beech Street

The examiners reviewed 1 contract that was negotiated with a provider through an intermediary organization identified as Beech Street. As discussed in Review Sheet EF01-B, the review revealed that the provider contract failed to contain all 11 provisions required by § 38.2-3407.15 B of the Code. ALIC failed to respond to the examiners' observations.

COMPANY RESPONSE: The Company agrees memo EF01-B and has no further comments

Pharmacy and Dental

The examiners reviewed a sample of 4 pharmacy and 4 dental provider contracts from a total population of 1,537 pharmacy and 1,255 dental provider contracts in force during the examination time frame.

COMPANY RESPONSE: The Company has no further comments.

Vision

The examiners reviewed a sample of 4 from a total population of 1,253 contracts

that were negotiated with vision providers through the intermediary EyeMed and were in force during the examination time frame. The review revealed 2 instances in which ALIC's provider contracts failed to contain 1 or more of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations, and corresponding Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 4	2	EF01J
§ 38.2-3407.15 B 7	1	EF02J
§ 38.2-3407.15 B 8	2	EF01J
§ 38.2-3407.15 B 9	1	EF02J
§ 38.2-3407.15 B 11	2	EF01J

An example is discussed in Review Sheet EF02J in which the provider agreement failed to contain a fee schedule and failed to contain the provisions set forth in §§ 38.2-3407.15 B 4, 38.2-3407.15 B 7, 38.2-3407.15 B 9 and 38.2-3407.15 B 11 of the Code. ALIC disagreed and provided a new Virginia Amendment to the contract. The examiners asked for confirmation that the Virginia Amendment submitted to the examiners with ALIC's review sheet response was, in fact, in effect during the examination timeframe. ALIC responded that it had "confirmed with EyeMed that the Virginia Amendments attached to the original contracts sent are the ones that were in effect during the scope of the exam." Therefore, ALIC confirmed that the original contract provided to the examiners is the entire contract that was in effect during the examination time frame, and ALIC is in violation of §§ 38.2-3407.15 B 4, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9 and 38.2-3407.15 B 11 of the Code.

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COMPANY RESPONSE to §38.23407.15 B7, B8, B9 and B11 of the Code: The Company disagrees with the noted findings under EF02J, it was confirmed that the VA Amendments were in fact issued with the provider contracts. As the amendment was not included for the examiners review does not indicate a lack of compliance but rather an oversight and possible record retention.

SUMMARY

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 of the Code. The failure of ALIC to amend its provider contracts to comply with § 38.2-3407.15 of the Code occurred with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15 of the Code.

COMPANY RESPONSE: The Company disagrees that a penalty of a General Business practice is applied because Virginia regulatory language was reviewed during the course of the examination as discussed above.

PROVIDER CLAIMS

Section 38.2-510 A 15 of the Code prohibits, as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain provisions requiring the carrier to adhere to and comply with sections 1 through 11 of these subsections in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

A sample of 143 out of a total population of 280 claims processed under the 37 sample provider contracts was reviewed for compliance with the minimum fair business standards in the processing and payment of claims.

Section 38.2-3407.15 B 3 of the Code requires that any interest due on a claim

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under § 38.2-3407.1 of the Code shall be paid at the time the claim is paid or within 60 days thereafter. Section 38.2-3407.1 of the Code requires interest to be paid on claim proceeds at the legal rate of interest from the date of 15 working days from the receipt of the proof of loss to the date of claim payment. The review revealed 1 instance in which ALIC failed to pay interest as required by this section, in violation of § 38.2-3407.15 B 3 of the Code. This violation is discussed in Review Sheet EFCL02-B in which a claim received on 1/14/2010 was not paid until 2/19/2010, and Aetna failed to pay interest as required. Although ALIC agreed that the insurance was effective on 1/1/2010, ALIC disagreed with the violation, stating:

> The Plan was effective on 1/1/10; however, due to the late receipt of the paperwork from the Plan Sponsor, the Plan was not set-up on our systems when the sample claim was received on 1/14/10. The Company completed plan set-up and testing on 2/12/10 and the sample claim was paid on 2/19/10. The Company respectfully disagrees that interest is due on this claim.

The examiners acknowledge ALIC's comments regarding its time-frame for system set-up; however, ALIC's internal system issues do not exempt ALIC from complying with the requirements of § 38.2-3407.15 B 3 of the Code.

COMPANY RESPONSE to §38.2-3407.15 B 3 of the Code: The Company agrees with memo EFCL02-B and has no further comments

Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis. The review of the sample claims revealed that ALIC underpaid the fee schedule amount

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specified for the health care service provided in 4 instances, in violation of § 38.2-3407.15 B 8 of the Code. These violations are discussed in Review Sheet EFCL01-B. ALIC disagreed with the examiners' observations and provided a contract with a physician group signed in 2003. The examiners would note that the 2003 contract included with ALIC's response contained no evidence that the provider who submitted the claims was a participating physician with that particular group, and the direct contract between ALIC and that provider was signed on 2/4/2009 and appeared to still be in effect on the dates of service.

ALIC's failure to perform the required provider contract provisions did not occur with such frequency as to indicate a general business practice.

COMPANY RESPONSE to 38.2-3407.15 B 8 of the Code:

EFCL01-B: The Company disagrees with the violation B8; please find a screen shot showing the provider was participating under the group contract. Find a copy of the group contract with the compensation terms and agreements.

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V. ADVERTISING/MARKETING COMMUNICATIONS

A review was conducted of Aetna Life's advertisements/marketing communications to determine compliance with the Unfair Trade Practices Act, specifically §§ 38.2-502, 38.2-503, and 38.2-504 of the Code, as well as 14 VAC 5-40-10 et seq., Rules Governing Life Insurance and Annuity Marketing Practices and 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement/marketing communication has actually misled or

deceived any individual to whom the advertisement was presented. An advertisement/marketing communication may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed (14 VAC 5-90-50), or that a marketing communication has the capacity or tendency to mislead or deceive from the overall impression that the marketing communication may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed (14 VAC 5-40-40 A).

14 VAC 5-40-60 B and 14 VAC 5-90-170 A require each insurer to maintain at its home or principal office a complete file of all advertising/marketing communications with a notation indicating the manner and extent of distribution and the form number of any policy referred to in the advertisement/marketing communication.

The review revealed 1 violation of 14 VAC 5-40-60 B. As discussed in Review Sheet AD01, ALIC failed to indicate the manner and extent of distribution of the marketing communication files selected for review.

ALIC agreed with the examiners' observations

COMPANY RESPONSE to 14 VAC 5-40-60 B: The Company agrees with memo AD01 and has no further comments.

The examiners reviewed the entire population of 8 life and annuity marketing communications, the entire population of 4 stop loss advertisements, a sample of 15 from a population of 56 advertisements relating to individual health insurance

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certificates issued under an out-of-state group health insurance policy, and a sample of 8 from a population of 55 student health advertisements used in the Commonwealth of Virginia during the examination time frame. In the aggregate, there were 18 violations, which are discussed in the following paragraphs.

14 VAC 5-90-55 A requires that an invitation to inquire shall contain a provision in the following or substantially similar form: "This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [write] your insurance agent or the company [whichever is applicable]."

The review revealed 4 violations of this section which are discussed in Review Sheets AD01SL, AD02SL, AD03SL, and AD04SL. An example is discussed in Review Sheet AD01SL in which the advertisement failed to contain the required provision.

COMPANY RESPONSE to 14 VAC 5-90-55 A: The Company disagrees with memos AD03SL and AD04SL.

AD03SL and AD04SL: The Company believes that the following language already contained in this ad currently complies with **14 VAC 5-90-55 A:**

This material is for informational purposes only and contains a partial, general description of plan benefits or programs and does not constitute a contract. The availability of a plan or program may vary by group demographics including location. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.
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Furthermore, Aetna believes that this ad is not "untrue, deceptive or misleading" as prohibited under VAC 38.2-503, nor does it have "the capacity or tendency to mislead a prospective purchaser of the policy" as the VA insurance examiner has written as an observation. Finally, even if hypothetically this ad did have such a "capacity or tendency to mislead a prospective purchaser of the policy," having the "capacity or tendency" does not rise to the level of actually being "untrue, deceptive or misleading" as prohibited under VAC 38.2-503. The VA insurance examiner's observation sets a lower standard for violation than the actual statute does. We are to be held to the standard set forth in VA 38.2-503 and not some other standard such as having the potential, "capacity or tendency" to possibly violate that statute.

The Company agrees to the noted violations for memos AD01SL and AD02SL.

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14 VAC 5-90-50 B states that advertisements shall be truthful and not misleading in fact or by implication. 14 VAC 5-90-130 A states that the name of the actual insurer, the form number or numbers of the policies advertised, and the form number of any application shall be stated on all invitations to contract.

The review revealed 7 violations of each of these sections. As discussed in Review Sheet AD01B-SH, ALIC sent brochures that contained incorrect and misleading statements and failed to contain the policy form number of the student health insurance coverage being advertised. ALIC disagreed, stating:

> The brochures are educational and informational materials sent to students who are covered under student health plans. The brochures set forth the benefits each student health plan covers and provide information about how the plans are administered. The brochures do not contain any materials relating to increasing, decreasing, terminating or expanding coverage. For the reasons stated, the brochures are excluded from the definition of "advertisement" in Chapter 90 of the Virginia Administrative Code....

The examiners do not concur. ALIC had previously indicated that the brochures, along with an application, are provided to all students, not just those students that elect to purchase the coverage offered. Therefore, the brochures are being utilized as advertisements and must comply with 14 VAC 5-90-10 et seq.

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COMPANY RESPONSE to 14 VAC 5-90-130 A and 14 VAC 5-90-50 B:

The Company disagrees with memo AD01B-SL. The brochures are educational and informational materials sent to students who are covered under student health plans. The brochures set forth the benefits each student health plan covers and provide information about how the plans are administered. The brochures do not contain any materials relating to increasing, decreasing, terminating or expanding coverage. For the reasons stated, the brochures are excluded from the definition of "advertisement" in Chapter 90 of the Virginia Administrative Code. This conclusion is supported by the Bureau of Insurance (the "Bureau") requirement that Aetna Life Insurance Company file the brochures with the Bureau as "informational". An Informational filing was submitted on November 12, 2014 SERFF # AENX-G129805074 to the Bureau, the filing was denied by the Bureau and the Company was informed that the health plan guide and brochure are not subject to filing and approval requirements in Virginia.

SUMMARY

ALIC violated 14 VAC 5-40-60 B, 14 VAC 5-90-50 B, 14 VAC 5-90-55 A, and 14 VAC 5-90-130 A, placing it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

VI. POLICY AND OTHER FORMS

Although a formal review of policy forms was not performed, the examiners reviewed the policy forms contained in the sample underwriting and claims files to determine if ALIC complied with various statutory, regulatory, and administrative requirements governing the filing and approval of forms.

Section 38.2-316 of the Code sets forth the filing and approval requirements for forms and rates that are to be issued or issued for delivery in Virginia.

14 VAC 5-100-40 2 states that where forms are submitted as replacements, revisions or modifications of previously approved forms, such must be clearly indicated in the letter of transmittal which shall set forth the exact changes that are intended.

14 VAC 5-100-50 1 states that the form number must appear on each form submitted in the lower left-hand corner of the first page.

14 VAC 5-100-50 3 states that a form must be submitted in the final form in which it is to be marketed or issued, sufficiently completed in "John Doe" fashion to indicate how it is intended to be used, if formal approval is sought.

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EXPLANATIONS OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer file its EOBs with the Commission for approval.

As discussed in Review Sheet PF11B, the review revealed that the EOBs sent to ALIC's insureds regarding vision claims processed by ALIC's vision intermediary EyeMed were not filed for approval as required, placing ALIC in violation of this section in 9 instances (and in each instance that the unfiled, altered form was used). ALIC disagreed and initially responded by providing an approved form that had a different form number than the issued form. ALIC responded further by providing an approved form with the same form number as the issued form, but the approved form differed from the issued form.

As discussed in Review Sheet PF09B, the review revealed that ALIC failed to file the form EXPLANATION OF PAYMENT (no form number) used for prescription drug claims, placing ALIC in violation of this section in each instance that the form was used.

COMPANY RESPONSE to §38.2-3407.4 of the Code: The Company agrees with the examiners' observations for memo PF09B. The Company disagrees with memo PF11B – find attached the filed and approved Explanation of Benefits labeled PF11B.

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APPLICATION/ENROLLMENT FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application forms prior to use. As discussed in Review Sheet PF02B, the review revealed that, in 5 instances, ALIC used an application form, GR-66109 (12-98) LIFE/AD&D, that was not filed with and approved by the Commission. As discussed in Review Sheets PF04B and PF06B, the review revealed

that, in 8 instances, ALIC used an application form, EMPLOYER APPLICATION GR-23-7 (7/05), that was not filed with and approved by the Commission. As discussed in Review Sheet PF07B, the review revealed that, in 4 instances, ALIC used an application form, GR-65169-2 ED 4-83 Virginia, that was not filed with and approved by the Commission. In the aggregate, there were 17 violations of §§ 38.2-316 B and 38.2-316 C 1 of the Code associated with the use of non-approved application/enrollment forms.

ALIC agreed with the examiners' observations regarding Review Sheets PF02B, PF04B and PF06B.

COMPANY RESPONSE to §38.2-316 B and C1 of the Code: The Company agrees with memos PF02B, PF04B and PF06B and has no further comments.

ALIC's response to Review Sheet PF07B failed to directly address the examiners' observations.

COMPANY RESPONSE: The Company agrees to memo PF07B and has no further comments.

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OTHER POLICY FORMS

Sections 38.2-316 A and 38.2-316 C of the Code set forth the requirements for the filing and approval of policy forms prior to use.

Life Insurance

The review revealed that 2 life insurance policy forms, AETNA LIFE INSURANCE and LIFE INSURANCE CONVERSION POLICY, had not been filed with and approved by the Commission. Both forms had originally been filed and approved under a specific form number and then issued using a different form number and with significant alterations. As discussed in Review Sheet PF01B, although it was similar to the filed and

approved policy form number L-70040, the policy issued in 21 instances was policy form number L-70040-90 (10/98) AIFS, which was not filed with and approved by the Commission, in violation of §§ 38.2-316 A and 38.2-316 C of the Code. As discussed in Review Sheet PF03B, although it was somewhat similar to the filed and approved policy form number GR-86515, the policy issued in 7 instances was policy form number GR-86515 Ed. 5/08, which was not filed with and approved by the Commission, in violation of §§ 38.2 316 A and 38.2-316 C of the Code.

ALIC agreed with the examiners' observations in both instances.

COMPANY RESPONSE: The Company agrees with memo PF01B and PF03B and has no further comments.

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Accident and Sickness

ALIC's Certificates of Coverage (COCs) consist of a compilation of riders which explain the specific benefits of the coverage provided. The review revealed that, while some of the individual pages of the COCs are riders that have been filed and approved, certain pages of the COCs including the cover or title page and the table of contents have not been filed with or approved by the Commission. Review Sheets PF05B and PF10B discuss COCs for 2 dental plans (a PPO Dental and a DMO Dental Plan) and 2 health plans (a PPO and a Comprehensive Plan) that were issued to groups. Certain pages of these COCs have not been filed with or approved by the Commission, placing ALIC in violation of §§ 38.2-316 A and 38.2-316 C each time the COCs were issued. ALIC disagreed with the examiners' observations and provided filed and approved forms for review; however, these forms were not the same forms that were issued.

COMPANY RESPONSE to §38.2-316 A and C of the Code: The Company disagrees with both PF05B and PF10B – see a stamped approved copy of the filed table of Contents labeled PF10B. With respect to PF05B and the Cover page of the approved certificates, it is noted in the draft report 730 violations, the Company

would like to correct this number as the examiner reviewed a list of eligible members not actual members, the total number of actual members was 166, see the attached spreadsheet labeled PF05. Additionally, the Company has never been directed to submit the cover sheet of the certificates and historically has not filed those pages.

Strategic Resource Company (SRC) plans

ALIC's affiliated entity, Strategic Resources Company (SRC), administered group accident and sickness coverage with limited benefits on behalf of ALIC. The review revealed that certain policy forms associated with the SRC plans were not filed with and approved by the Commission, in violation of §§ 38.2-316 A and 38.2-316 C of the Code. As discussed in Review Sheets PF12B-SRC and PF15B-SRC, certain pages of the COC and 9 riders contained within the COC were not filed with and approved by the Commission. In response to the Review Sheets, ALIC provided a list of approved form numbers and copies of corresponding forms to document that the issued forms had been filed. However, the language and format of the approved forms differed from the issued forms, and the form numbers were not the same.

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COMPANY RESPONSE to 38.2-316 A and C of the Code: The Company disagrees with PF12B-SRC and PF13B. The parenthetical form number listed under the "Schedule of Benefits" is incorrect. The GR-9N form numbers are only used for policy forms, not schedule of benefits. The number shown on the form and referenced by the BOI also is missing the "S" (which is used to differentiate the Schedules of Benefits from the Certificate of Coverage form number). In addition, as noted above we agree generally do not include the "VA" as part of the form number. It may be used as a reference point for the drafters. The Correct form number is noted above (GR-9N S-01-01-01) Please see the approval for GR-9N S01-01-01 labeled PF12B.

Delaware Trust Blanket Policy

ALIC issued COCs to Virginia residents under an out-of-state blanket policy issued to a discretionary trust sitused in Delaware. The plan is called Aetna Advantage Plans for Individuals, Families and Self-Employed-VA. The policy forms for the plan are filed in Delaware, and ALIC made Informational Filings of the forms and rates with Virginia. The

review revealed that ALIC issued COCs in Virginia for which no Informational Filing had been made, and the COC contained 9 riders which had been altered or changed from forms previously filed with the Commission. It is the Commission's position that the forms are required to be submitted to the Forms and Rates section of the Bureau of Insurance in an Informational Filing. As discussed in Review Sheet PF22B, ALIC is in violation of §§ 38.2-316 A and 38.2-316 C of the Code in the 9 instances that the unfiled COC was issued to a Virginia resident. Although ALIC disagreed with the examiners' observations, ALIC indicated that an Informational Filing would be submitted.

COMPANY RESPONSE to §38.2-316 A and C of the Code: The Company disagrees with PF22B – The noted form(s) under the PF22B memo was filed and approved on May 20, 2004, see the approval document labeled PF22B.

Student Health

The review revealed that policy forms associated with ALIC's student health insurance plans had not been filed with and approved by the Commission. As discussed in Review Sheet PF01-SH, all 7 student health policy forms issued during the examination time frame were not filed with and approved by the Commission, in violation of §§ 38.2-316 A and 38.2-316 C of the Code. In addition, ALIC failed to issue to the policyholder for delivery to each insured an individual certificate as required by § 38.2-3533 of the Code. Therefore, ALIC is in violation of § 38.2-3533 of the Code in each instance that a certificate was not issued for delivery to each person insured.

COMPANY RESPONSE to §38.2-316 A, 38.2-316 C and 38.2-3533 and C of the Code:

The Company disagrees - attached is the stamped approved copy of the certificate filing (exhibit 2) that was approved on May 14, 2003. Please note that historically Virginia has not required the filing of school specific policies and certificates of coverage.
The [redacted] form #GR-96175 ED. 3-98 that was previously provided was the policy, attached please find the certificate of coverage form #GR-96134 ED. 08-06 (exhibit 3).

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A complete master policy and certificate of coverage is provided to the school (policyholder). The certificate of coverage is posted on the Aetna Student Health website and the attached postcard (exhibit 1) is sent to the students so they can access a copy online and advises them how to request a paper copy if needed.

The examiners also note that these unapproved policy forms included several exclusions that contained language that could result in subrogation or were otherwise inappropriate for accident and sickness student health insurance policies. ALIC disagreed with the examiners and provided approved forms for review; however, these forms were not the same as the forms that were issued. ALIC also commented that the subrogation language was due to an exclusion in the policy for intercollegiate sports injuries. The issue of subrogation is discussed further in the Claim Practices section of the Report.

Company response to Subrogation: This is being handled in conjunction with the claims portion of the exam.

COPY

SUMMARY

The following graph summarizes ALIC's policy form violations:

FORM NUMBER	DESCRIPTION OF FORM	CODE SECTION VIOLATION	INSTANCES	REVIEW SHEET EXAMPLE
MEOB-VA6	Explanation of Benefits	38.2-3407.4	9	PF11B
EOB (no form number)	Explanation of Payment	38.2-3407.4	Each time it was used	PF09B
GR66109 (12-08) LIFE/AD&D	Application for Conversion	38.2-316 B 38.2-316 C	5	PF02B
GR-23-7 (7/05)	Employer Application	38.2-316 B 38.2-316 C	8	PF04B PF06B
GR-65169-ED. 4-83 Virginia	Conversion Application to Aetna Life Insurance Company	38.2-316 B 38.2-316 C	4	PF07B
L-70040-90 (10/98) AIFS	Aetna Life Insurance Policy	38.2-316 A 38.2-316 C	21	PF01B
GR-86515 Ed. 5/08	Life Insurance Conversion policy	38.2-316 A 38.2-316 C	7	PF03B

COC (no form numbers)	HMO and PPO Dental Plan's Certificate of Coverage	38.2-316 A 38.2-316 C	Each time it was used (approximately 730 times)	PF05B
COC (no numbers)	Open Choice PPO and Traditional Choice certificates of coverage	38.2-316 A 38.2-316 C	6 groups	PF10B
Gr-29N 01-01-01 VA	Schedule of Benefits	38.2-316 A 38.2-316 C	Each time it was used	PF12B
Gr-9N-15-10-02 VA	Inpatient Coverage Year Maximum Benefit	38.2-316 A 38.2-316 C	Each time it was used	PF13B
Gr-9N 15-75-01 VA	Hospice Care Facility Expenses	38.2-316 A 38.2-316 C	Each time it was used	PF14B
Gr-9N 15-125-01 VA	Treatment of Jaw Disorders	38.2-316 A 38.2-316 C	Each time it was used	PF15B
G-9N S 15-140-01 VA	Treatment of Alcohol Abuse, Drug Abuse, Mental Biologically Based and Non-Biologically-based Mental Illness	38.2-316 A 38.2-316 C	Each time it was used	PF16B
Gr-9N 15-150-01 VA	Alcohol Abuse and Drug Abuse Treatment	38.2-316 A 38.2-316 C	Each time it was used	PF17B

COPY

FORM NUMBER	DESCRIPTION OF FORM	CODE SECTION VIOLATION	INSTANCES	REVIEW SHEET EXAMPLE
Gr-9N 15-170-01	All Other Expenses	38.2-316 A 38.2-316 C	Each time it was used	PF18B
Gr-9N-005-01	Your Prescription Drug Plan	38.2-316 A 38.2-316 C	Each time it was used	PF19B
Gr-9N 26-20-01	Maximum Benefit	38.2-316 A 38.2-316 C	Each time it was used	PF20B
Gr-9N-01-01	Preferred Self-injectable Prescription Drug	38.2-316 A 38.2-316 C	Each time it was used	PF21B
GR-11697-R Ed. 3/08 GR-11697-2R Ed.12/08 AL DE AGR9656408 T V001 (10/08) GR-96470 GR-9 11859 PPO Plan GR-11697-7 GR-11697-R-1 05/08 GR-11742 GR-96440	Pages in the COC (from out-of-state policy issued to trust in DE) issued in Virginia and not reported in an Informational Filing	38.2-316 A 38.2-316 C	Each time it was used	PF22B
GR-96175 ED. 3-98 GR-96134 ED. 8-06	Student Health Insurance Policies	38.2-316 A 38.2-316 C 38.2-3533	7 Each time ALIC failed to issue a certificate for delivery	PF01-SH

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Additional Company Comments:

PF12B – The Company disagrees, the text is supported by the approved form GR-9N S-15-10 02 and its corresponding Explanation of Variability (EVO). The form number in parentheses reflect the section and subsection of the GR-9N filing from which language that follows was taken.

PF13B-SRC – The Company disagrees, the text is supported by form GR-9N S-15-10-02, which was approved by the Bureau on April 25, 2008 SERFF # AENX-125250751.

PF14B-SRC – The Company disagrees, the text is supported by the approved form GR-9N S-15-10 02 and its corresponding Explanation of Variability (EVO). The form number in parentheses reflect the section and subsection of the GR-9N filing from which language that follows was taken.

PF15B-SRC – The Company disagrees, the text is supported by the approved form GR-9N S-15-10 02 and its corresponding Explanation of Variability (EVO). The form number in parentheses reflect the section and subsection of the GR-9N filing from which language that follows was taken.

PF16B-SRC - The Company disagrees, the text is supported by the approved form GR-9N S-15-10 02 and its corresponding Explanation of Variability (EVO). The form number in parentheses reflect the section and subsection of the GR-9N filing from which language that follows was taken.

PF17B-SRC - The Company disagrees, the text is supported by the approved form GR-9N S-15-10 02 and its corresponding Explanation of Variability (EVO). The form number in parentheses reflect the section and subsection of the GR-9N filing from which language that follows was taken.

PF18B-SRC - The Company disagrees, the text is supported by the approved form GR-9N S-15-10 02 and its corresponding Explanation of Variability (EVO). The form number in parentheses reflect the section and subsection of the GR-9N filing from which language that follows was taken.

PF19B-SRC - The Company disagrees, the text is supported by the approved form GR-9N S-15-10 02 and its corresponding Explanation of Variability (EVO). The form number in parentheses reflect the section and subsection of the GR-9N filing from which language that follows was taken.

PF20B-SRC - The Company disagrees, the text is supported by the approved form GR-9N S-15-10 02 and its corresponding Explanation of Variability (EVO). The form number in parentheses reflect the section and subsection of the GR-9N filing from which language that follows was taken.

PF21B-SRC - The Company disagrees, the text is supported by the approved form GR-9N S-15-10 02 and its corresponding Explanation of Variability (EVO). The form number in parentheses reflect the section and subsection of the GR-9N filing from which language that follows was taken.

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VII. AGENTS

Although a formal agent review was not performed, the writing agents designated in the new business files were reviewed to determine compliance with various sections of Title 38.2, Chapter 18 of the Code. A total of 73 agents/agencies were reviewed.

LICENSED AGENT REVIEW

Sections 38.2-1822 A of the Code requires that a person be licensed prior to soliciting subscription contracts. As discussed in Review Sheet AG01, ALIC accepted new business from agents and an agency that were not licensed in Virginia, in violation

of this section of the Code in 3 instances.

ALIC agreed with the examiners' observations.

COMPANY RESPONSE to §38.2-1822 A of the Code: The Company agrees with memo AG01 and has no further comments.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires that an insurer shall, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent. As discussed in Review Sheets AG01 and AG04, ALIC accepted new business from an agent and an agency and failed to appoint them within 30 days of the execution of the first application submitted, in violation of this section of the Code in 2 instances.

ALIC agreed with the examiners' observations

COMPANY RESPONSE §38.2-1833 A 1 of the Code: The Company agrees with memos AG01 and AG04 and has no further comments.

***Note Memo AG01 is not listed on the summary page of the issued report under §38.2-1833 A 1**

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COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commission or other valuable consideration to an agent or agency that is not appointed and that was not licensed at the time of the transaction. As discussed in Review Sheets AG01 and AG04, ALIC paid commissions to agents and agencies that were not licensed or appointed in Virginia, in violation of this section of the Code in 5 instances.

ALIC agreed with the examiners' observations

COMPANY RESPONSE to §38.2-1812 A of the Code: The Company agrees with memo AG01 and AG04 and has no further comments.

VIII. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of ALIC's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514; the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620; Article 5, Chapter 34, Coverage Offered to Employees of Small Employers; 14 VAC 5-140-10 et seq., Rules Governing the Implementation of Individual Accident and Sickness Insurance Minimum Standards Act; 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS); and 14 VAC 5-234-10 et seq., Rules Governing Essential and Standard Health Benefits Plan Contracts.

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UNDERWRITING/UNFAIR DISCRIMINATION

The review was made to determine whether ALIC's underwriting guidelines were unfairly discriminatory, whether applications were underwritten in accordance with ALIC's guidelines and whether correct premiums were being charged.

UNDERWRITING REVIEW

A sample of 107 from a population of 198 group life, group dental, large and small group medical, and individual conversion policies underwritten and issued during the examination time frame was selected for review. In addition, a sample of 5 from a population of 22 stop loss policies and the entire population of 7 student health insurance policies underwritten and issued during the examination time frame were

selected for review.

The review revealed that ALIC was in substantial compliance with its underwriting guidelines and no unfair discrimination was found.

ALIC was in substantial compliance

COMPANY RESPONSE: The Company has no further comments.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS.

The review revealed that ALIC was in substantial compliance with this section.

ALIC was in substantial compliance with this section

COMPANY RESPONSE: The Company has no further comments.

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MECHANICAL RATING REVIEW

The review revealed that ALIC had calculated its premiums in accordance with its filed rates.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires a company to establish standards for collection, use, and disclosure of personal/privileged information gathered in connection with insurance transactions.

NOTICE OF INSURANCE INFORMATION PRACTICES (NIP)

Section 38.2-604 of the Code sets forth the requirements for a NIP, either full or abbreviated, to be provided to all individual applicants and to applicants for group

insurance that are individually underwritten.

ALIC provided both a full and abbreviated NIP form, and the review revealed that ALIC was in substantial compliance with this section.

ALIC was in substantial compliance with this section

COMPANY RESPONSE: The Company has no further comments.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of the disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The examiners reviewed the disclosure authorization forms used during the underwriting process, and the review revealed that ALIC was in substantial compliance with this section.

ALIC was in substantial compliance with this section

COMPANY RESPONSE: The Company has no further comments.

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ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 of the Code requires that in the event of an adverse underwriting decision, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission. Section 38.2-610 B of the Code requires the insurer, upon receipt of a written request within 90 business days from the date of mailing of the notice of AUD, to furnish to such person within 21 business days from the date of receipt of the request, the specific reasons for the AUD and the specific items of personal and privileged information that support those reasons.

A sample of 84 out of a population of 283 individuals enrolled in group plans

who applied for additional coverage under the group's policy and were denied was reviewed. The review revealed that ALIC was in substantial compliance with this section.

ALIC was in substantial compliance with this section

COMPANY RESPONSE: The Company has no further comments.

Small Employer Groups

Section 38.2-3431 C of the Code requires every small employer carrier to offer small employers the Essential and Standard plans.

A sample of 25 from a population of 116 small groups issued during the examination time frame was selected for review.

The review revealed that ALIC was in substantial compliance with this section.

ALIC was in substantial compliance with this section

COMPANY RESPONSE: The Company has no further comments.

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IX. NOTICE OF PREMIUM INCREASES

Section 38.2-3407.14 A of the Code requires an insurer to provide prior written notice of intent to increase premiums by more than 35 percent. Section 38.2-3407.14 B of the Code requires that the notice be provided in writing at least 60 days prior to the proposed renewal of coverage to the policyholder, or to the designated consultant or other agent of the group policyholder if requested in writing by the policyholder.

The total population of 3 groups that received premium increases greater than 35 percent was reviewed. In 2 instances, ALIC informed the agent/broker via email that the premiums would increase. Documentation of written requests by the group

policyholder that such notification be sent to the agent/broker was not provided to the examiners. ALIC was unable to provide a copy of the required 60 day notification that premiums would increase by 35 percent or more for any of the 3 files reviewed, placing ALIC in violation of §§ 38.3407.14 A and 38.2-3407.14 B of the Code in each instance. An example is discussed in Review Sheet PB01B. ALIC agreed with the examiners' observations.

COMPANY RESPONSE to §38.2.3407.14 A and 14 B: The Company agrees with memos PB01B, PB02B and PB03B has no further comments.

X. COMPLAINTS

ALIC's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

ALIC's complaint and appeal procedures state that "all documentation related to and created in response to complaints and appeals will be retained for a minimum of 10 years or longer as required by state or federal law or regulation, or current company policy."

A sample of 19 from a total population of 36 written complaints received during the examination time frame was reviewed. In addition, the examiners reviewed the total population of 2 complaints received during the examination time frame relating to life insurance business that is administered by Lincoln Life and Annuity Company of New

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York and Protective Life Insurance Company on behalf of ALIC.

As discussed in Review Sheet CP01-B, the review revealed that the complaint log failed to include a complaint that was received during the examination time frame, in violation of § 38.2-511 of the Code and in non-compliance with ALIC's complaint and appeal procedures. ALIC agreed with the examiners' observations.

COMPANY RESPONSE to §38.22-511 of the Code: The Company agrees with memo CP01-B and has no further comments.

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XI. CLAIM PRACTICES

The examination included a review of ALIC's claim practices for compliance with §§ 38.2-510, 38.2-3115, and 38.2-3407.1 of the Code and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of life, disability, and accident and sickness insurance claims. Claims were processed internally, with the exception of vision claims and certain life insurance claims. Vision claims were processed by EyeMed Vision Care, LLC (EyeMed). Certain individual life insurance claims were administered by Lincoln Life and Annuity Company of New York and Protective Life Insurance Company on behalf of ALIC. ALIC's affiliated entity, Strategic Resources Company (SRC), administered group accident and sickness coverage with limited benefits on behalf of ALIC. ALIC provided the examiners with copies of its relevant claims procedures.

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PAID CLAIM REVIEW

Life

A sample of 10 was selected from a population of 527 claims paid during the examination time frame. In addition, a sample of 6 was selected from a population of 32 claims administered by Lincoln Life and Annuity Company of New York that were paid during the examination time frame. A sample of 4 was selected from a population of 18 claims administered by Protective Life Insurance Company that were paid during the examination time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Interest on Life Insurance Claim Proceeds

Section 38.2-3115 B of the Code states that interest upon the principal sum shall be paid at an annual rate of 2.5% or the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater. The review revealed 4 violations of this section. An example is discussed in Review Sheet CL04M in which the policy was issued in Virginia and ALIC failed to pay interest. ALIC disagreed with the examiners' observations and stated:

> Aetna did not pay interest per 38.2-3115 B as the beneficiary did not reside in VA, but in a state that does not require interest payment on this claim. Aetna understands this section to apply when the beneficiary is located in the Commonwealth of Virginia.

The examiners do not concur and replied that "individual and group life insurance policies issued in the state of Virginia are subject to the provisions of various sections of the Code of Virginia and Virginia Insurance Regulations, notwithstanding the state of residence on the date of the insured's death."

COMPANY RESPONSE To §38.2-3115 B of the Code: The Company agrees with memos CL04M, CL06M, CL07M and CL08M.

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Disability

A sample of 9 was selected from a population of 368 claims paid during the examination time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in subsequent sections of the Report.

Stop Loss

A sample of 10 was selected from a population of 24 claims paid during the examination time frame. The review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy.

Accident and Sickness

After the samples had been selected and the examiners had begun reviewing the accident and sickness insurance claims, ALIC informed the examiners that claims submitted on renewal business had not been included in the population data that had been provided. ALIC provided the examiners with additional populations of claims submitted on renewal business, and the examiners selected samples from these additional populations. The total sample sizes and populations for accident and sickness insurance claims that are noted in the Report include both the original and the additional populations and samples.

Group

A sample of 210 was selected from a population of 114,814 claims paid during the examination time frame. Of these sampled claims, 35 were mental health claims and 40 were dental claims. A separate review of mental health claims is discussed in a subsequent section of the Report.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber, or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider

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of services. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. As discussed in Review Sheet CL01T-DEN, the review revealed that an Explanation of Benefits (EOB) failed to contain the submitted charges and the allowed amounts for the services rendered. By failing to include this information on the EOB, ALIC failed to disclose the method of benefit calculation and failed to accurately and clearly set forth the benefits payable under the contract, in violation of each of these sections of the Code in 1 instance. ALIC agreed with the examiners' observations.

COMPANY RESPONSE to §38.2.3407. 4 B of the Code: The Company agrees with memo CL01T-DEN, the dental explanation of benefits was corrected on May, 2012. See Attached.

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Individual Conversion

A sample of 61 was selected from a population of 893 claims paid during the examination time frame. Of these sampled claims, 11 were mental health claims. A separate review of mental health claims is discussed in a subsequent section of the Report. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Strategic Resource Company (SRC)

A sample of 25 was selected from a population of 13,934 claims paid during the examination time frame. A separate review of mental health claims is discussed in a subsequent section of the Report. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Pharmacy

A sample of 40 was selected from a population of 147,663 claims paid during the examination time frame. The review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy.

EyeMed

A sample of 9 was selected from a population of 195 claims paid during the examination time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Mental Health

The scope of the examination was expanded to include a review of mental health claims paid and denied between October 1, 2010, and December 31, 2010. The populations included group, individual conversion, and SRC claims. A sample of 30 was selected from a population of 842 claims paid during the expanded time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Student Health

A sample of 110 was selected from a population of 25,801 claims paid during the examination time frame. A partially paid claim from the denied claim review sample was also considered under the paid claim review.

Section 38.2-510 A 10 of the Code states that no person shall make claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The review revealed 3 instances of

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non-compliance with § 38.2-510 A 10 of the Code. An example is discussed in Review Sheet CL08BL-SH, where ALIC issued a claim payment in the form of a paper check but failed to send the provider or the insured a statement setting forth the coverage under which the payment was being made. ALIC agreed with the examiners' observations.

COMPANY RESPONSE to §38.2-510 A 10 of the Code: The Company agrees with memo CL08BL-SH and has no further comments.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber, or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed 13 violations of § 38.2-514 B and 16 violations of § 38.2-3407.4 B of the Code. An example is discussed in Review Sheet CL04BW-SH in which the EOB incorrectly displayed copay amounts in the deductible column. The EOB included a separate copay column that was left blank. As a result, ALIC failed to accurately and clearly set forth the benefits payable under the contract and failed to accurately disclose the method of benefit calculation, in violation of each of these sections of the Code. ALIC agreed with the examiners' observations.

COMPANY RESPONSE TO §38.2-514 B of the Code

(Dental) - The Company agrees with memos CL01T-DEN and CL02T-DEN, the dental explanation of benefits was corrected May, 2012.

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(ASH) The Company disagrees with memo CL28BW-SH, The sample claim was processed correctly and the EOB accurately reflects the deductible applied in the appropriate column. There was another claim on the member EOB, not in the states sample selection, which was not displayed correctly on the EOB. We are disagreeing as this is not the sample claim. See attached documentation

The Company agrees to the remaining memos – (ASH) – CL03BW-SH, CL04BW-SH, CL05BL-SH, CL06BL-SH, CL07BW-SH, CL12BW-SH, CL13BL-SH, CL18BW-SH, CL23BW-SH, CL25BW-SH, CL26BL-SH, CL27BW-SH, CL40BW-SH and CL59BW-SH.

Section 38.2-3405 of the Code prohibits subrogation of any person's right to recovery for personal injuries from a third person. Coordination of benefits provisions may not operate to reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage. The review revealed 3 violations of § 38.2-3405 of the Code. An example is discussed in Review Sheet CL08BW-SH. The subrogation issue and ALIC's response to the Review Sheets are discussed further in the Denied Claim Review section of the Report.

ALIC's student health policy states, "...ancillary services (e.g., lab tests and X-rays) received at Student Health or ordered by a Student Health provider will be covered at 100% without a copay or deductible...." The review revealed that ALIC was in non-compliance with its policy in 1 instance. As discussed in Review Sheet CL16BL-SH, the benefits payable for a claim for a lab/x-ray ordered by the Student Health center were applied to the insured's deductible, in non-compliance with the policy. ALIC agreed with the examiners' observations.

ALIC's student health policy includes the following exclusion: "Expense incurred for injury resulting from the plan or practice of intercollegiate sports; in excess of $250 (participating in sports clubs; or intramural athletic activities; is not excluded)." As

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discussed in CLMEM01B-ASH, the examiners requested that ALIC clarify the intent of this exclusion. ALIC's response stated:

> Aetna has confirmed that the intent of the [*school name*] Policy was to exclude coverage for **any** intercollegiate sports injuries and that all claims administration accurately reflected this intent. However, due to manual errors in the drafting of the relevant member documents, including the Evidence of Coverage and Plan Brochure, the exclusion erroneously inferred coverage for intercollegiate sports injuries up to $250.
>
> Consistent with the intent of the benefit plan, Aetna will update all future [*school name*] member documents, including Evidences of Coverage and Plan Brochures, to exclude **any** coverage for intercollegiate sports injuries. In addition, Aetna will honor coverage for intercollegiate sports injuries up to $250 and will reprocess all impacted claims since the 2009-2010 plan year.
>
> In addition, Aetna has reviewed all other Virginia policies issued since the 2009-2010 plan year in order to identify any additional discrepancies in member documents relating to this exclusion pertaining to coverage for intercollegiate sports-related injuries. Below is a summary of the findings of that review: [*ALIC named 2 other school policies*]
>
> For each of the identified policies above, Aetna will ensure that all future member documents reflect each policy's intended exclusion of coverage for intercollegiate sports injuries. Finally, Aetna will honor coverage for intercollegiate sports injuries up to $250 by reprocessing claims for the identified plan years.
>
> Since the 2011-2012 plan year, Aetna has begun automating its case implementation process to help ensure that discrepancies between member documents and claims administration do not occur. Likewise, Aetna is currently performing an end-to-end audit of its member documents to help ensure that all member documents accurately reflect the underlying intent of the plan sponsor.

Any violations as a result of this issue that were revealed during the examination are discussed in the Unfair Claims Settlement Practices Review. The Corrective Action Plan of this Report will include an item that addresses the completion of the steps outlined in ALIC's response above.

COMPANY RESPONSE TO MEMO CLMEM01B-SH: The Company is unable to respond to this memo as no violation is noted per our previous response; this memo is also not listed under the Review Sheet Summary to identify any noted violations. The Company has no additional comments to our previous response above.

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ALIC's student health policy indicates the following coverage for chiropractic care: "Preferred Care: After a $35 per visit Copay, 80% of the Negotiated Charge. Non-Preferred Care: After a $35 per visit Deductible, 60% of the Reasonable Charge. Please Note: Benefits are limited to $1,000 per condition, per Policy year." As discussed in CLMEM02B-ASH, the examiners requested that ALIC clarify the chiropractic coverage. ALIC's response stated:

> The $35 per visit copay and deductible referenced above also appear in the [*school name*] member documents for each subsequent plan year (2010-2011, 2011-2012 and 2012-2013).
>
> Aetna has confirmed that the intent of the [*school name*] Policy was to include a $35 per visit benefit maximum for chiropractic claims and that all chiropractic claims administration for [*school name*] accurately reflected this intent. However, due to manual errors in the drafting of the relevant member documents, including the Evidence of Coverage and Plan Brochure, the member documents erroneously reflect the $35 copay and deductible.
>
> Consistent with the intent of the underlying policy, Aetna will update all future [*school name*] member documents, including Evidences of Coverage and Plan Brochures, to reference a $35 per visit benefit maximum. In addition, Aetna will honor the published $35 copay and deductible, and will reprocess all impacted claims since the 2009-2010 plan year to reflect the published benefit.
>
> In addition, Aetna will review all other Virginia policies issued since the 2009-2010 plan year to identify any additional discrepancies in member documents relating to coverage for chiropractic care. Where necessary, Aetna will make all necessary updates to member documents so as to reflect each policy's intended coverage of chiropractic care. Similarly, Aetna will identify and reprocess any claims for chiropractic services that require reprocessing.

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Any violations as a result of this issue that were revealed during the examination are discussed in the Unfair Claims Settlement Practices Review. The Corrective Action Plan of this Report will include an item that addresses the completion of the steps outlined in ALIC's response above.

COMPANY RESPONSE TO MEMO CLMEM02B-SH: The Company is unable to respond to memo CLMEM02 as no violation is noted on our previous response; this memo is also not listed under the Review Sheet Summary to identify any noted violations. The Company has no additional comments to our previous response above. Additionally there is language in our response to CLMEM02 that was omitted from this report, please include the following from our previous response:

> Since the 2011-2012 plan year, Aetna has begun automating its case implementation process to help ensure that discrepancies between member documents and claims administration do not occur. Likewise, Aetna is currently performing an end-to-end audit of its member documents to help ensure that all member documents accurately reflect the underlying intent of the plan sponsor.

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Interest on Accident and Sickness Claim Proceeds

Section 38.2-3407.1 B of the Code states that interest upon claim proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment.

The review revealed 15 violations of this section. An example is discussed in Review Sheet CL37BW-SH in which ALIC failed to pay interest as required. ALIC agreed with the examiners' observations.

COMPANY RESPONSE TO §38.2-3407.1 of the Code:

The Company disagrees with the following violations:

CL07BW-SH - The original claim, as noted above, was pended for an accident questionnaire. Response to the questionnaire was received on 02/18/10 and processed timely following receipt of the requested information on 3/9/10 issuing a benefit in the amount of $102.60. No interest is due.

CL17BL-SH - The original claim, as noted above, was pended for an accident questionnaire. Response to the questionnaire was received on 05/17/10 and processed timely following receipt of the requested information on 5/26/10 issuing a benefit in the amount of $159.18. No interest is due.

CL24BW-SH - The Company respectfully disagrees that the interest due is $36.78, less the amount Aetna Life has made ($18.16). Aetna Life disagrees interest is under paid in the amount of $18.62. Interest previously paid was overpaid. No additional interest is due.

CL48M - The total eligible charge for these services under the plan is $88.00 and this amount was applied to the patient's annual deductible. No benefit was paid on this claim; therefore, no delayed claim interest is due.

The Company agrees with the following memos as listed – CL02BL-SH, CL02-TB, CL05-TB, CL06-TB, CL08BW-SH, CL15BW-SH, CL16BW-SH, CL17BW-SH, CL37BW-SH, CL39M, CL44BW-SH.

TIME PAYMENT STUDY

The time payment study was computed by measuring the time it took ALIC, after receiving the properly executed proof of loss, to issue a check for payment. The term "working days" does not include Saturdays, Sundays or holidays. The study was conducted on the total sample of 485 paid accident and sickness claims.

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PAID CLAIMS			
Claim Type	Working Days to Settle	Number of Claims	Percentage
Accident & Sickness			
	0 – 15	407	84%
	16 – 20	24	5%
	Over 20	54	11%

Of the 485 claims reviewed for the time study, 16% of claims were not settled within 15 working days. The examiners recommend that ALIC review its procedures to reduce the percentage of claims paid after 15 working days.

DENIED CLAIM REVIEW

Life

A sample of 2 from a total population of 6 life insurance claims denied during theexamination time frame was reviewed. ALIC indicated that there were no claims on life insurance policies administered by Lincoln Life and Annuity Company of New York and Protective Life Insurance Company on behalf of ALIC that were denied during the examination time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Disability

A sample of 3 was selected from a population of 40 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy.

Stop Loss

ALIC indicated that there were no stop loss claims denied during the examination time frame.

Accident and Sickness

Group

A sample of 103 was selected from a population of 8,167 claims denied during the examination time frame. Of these sampled claims, 13 were mental health claims and 20 were dental claims. A separate review of mental health claims is discussed in a subsequent section of the Report.

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Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber, or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. As discussed in Review Sheet CL02T-DEN, the review revealed that the EOB failed to contain the submitted charges and the allowed amounts for the services rendered. By failing to include this information on the EOB, ALIC failed to disclose the method of benefit calculation and failed to accurately and clearly set forth the benefits payable under the contract, in violation of each of these sections of the Code in 1 instance. ALIC agreed with the examiners' observations.

COMPANY RESPONSE TO §38.2-514 B of the Code

(Dental) - The Company agrees with memo CL02T-DEN, the dental explanation of benefits was corrected May, 2012.

(ASH) The Company disagrees with memo CL28BW-SH, see attached.

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Individual Conversion

A sample of 32 was selected from a population of 439 claims denied during the examination time frame. Of these sampled claims, 7 were mental health claims. A separate review of mental health claims is discussed in a subsequent section of the Report. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Strategic Resource Company (SRC)

A sample of 10 was selected from a population of 10,031 claims denied during the examination time frame. A separate review of mental health claims is discussed in a subsequent section of the Report. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Pharmacy

A sample of 10 was selected from a population of 50,501 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy.

EyeMed

The examiners reviewed the entire population of 2 claims denied during the examination time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement practices are discussed in a subsequent section of the Report.

Mental Health

The scope of the examination was expanded to include a review of mental health claims paid and denied between October 1, 2010, and December 31, 2010. The populations included claims from group, individual conversion, and SRC. A sample of 12 was selected from a population of 249 claims denied during the expanded time frame. While the review revealed that the claims were processed in accordance with ALIC's established procedures and the terms of the policy, unfair claims settlement

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practices are discussed in a subsequent section of the Report.

Student Health

A sample of 110 was selected from a population of 8,387 claims denied during the examination time frame.

Section 38.2-503 of the Code states that no person shall knowingly make, publish, disseminate, circulate, or place before the public a statement containing any assertion, representation or statement relating to (i) the business of insurance or (ii) any person in the conduct of his insurance business, which is untrue, deceptive or misleading. As discussed in Review Sheet CL23BL-SH, ALIC included a remark on an EOB sent to the insured for a denied claim stating that "This claim has been adjusted and as a result, an overpayment has occurred. A letter will be sent under separate cover." As no other correspondence was sent to the insured, the statement on the EOB indicating that the insured would receive a letter is untrue, deceptive, or misleading; therefore, ALIC is in violation of the Code in 1 instance.

COMPANY RESPONSE TO §38.2-503 of the Code:

The Company agrees to memo CL23BL-SH and has no further comments.

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Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber, or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed 2 violations of § 38.2-514 B and 20 violations of § 38.2-3407.4 B. An example

is discussed in Review Sheet CL26BL-SH in which the EOB contained conflicting descriptions of the services performed and the amount that the provider billed for a charge is listed incorrectly. As a result, ALIC failed to accurately and clearly set forth the benefits payable under the contract and failed to accurately disclose the method of benefit calculation, in violation of each of these sections of the Code. ALIC agreed with the examiners' observations.

Section 38.2-3405 B of the Code states that coordination of benefits provisions may not operate to reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage. The review revealed 8 violations of § 38.2-3405 B of the Code. As discussed in Review Sheet CL71BW-SH, ALIC denied 8 claims and sent EOBs requesting that the claimant provide complete accident details. ALIC sent the claimants questionnaires that asked the following questions:

> 4. Was this the result of an automobile accident YES___NO____
> In what state did the accident occur? _____
> 5. If related to an automobile accident, have you filed a claim with your auto carrier or the other involved party's auto carrier? YES___NO___
> If "YES",
> please supply all involved auto carrier's [sic] explanation of benefits with your claim.

ALIC denied these claims and asked the claimants to provide details of accidents and EOBs from auto carriers, in violation of the Code. ALIC disagreed with the examiners' observations, stating that:

> Disagree that the denial is unreasonable. The request for accident information was not related to a subrogation investigation. The services rendered and the diagnosis submitted for each claim provided no indication as to the root cause, nature of the injury. The reason accident

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information was requested is that the [*school name*] plan has an exclusion which reads "Expense incurred for injury resulting from the play or practice of intercollegiate sports; (participating in sports clubs; or intramural athletic activities; is not excluded)." When services are related to an intercollegiate injury they are not covered under the medical plan. However [*school name*] also has a separate Intercollegiate Sports Injury policy which covers accidents related to intercollegiate injuries up to $75K per condition per policy year. Therefore accident information must be requested to verify what policy the services would be covered under. Seven of the Eight claims have since been paid. Please see the below grid which shows the reprocessed claim number. Please refer to the attached for a copy of the EOB's.

The examiners do not concur, and would respond that ALIC denied claims and requested information on coordination of benefits with liability coverage, in violation of this section of the Code in 8 instances.

COMPANY RESPONSE TO §38.2-3405 B of the Code: The Company disagrees, when the Company requests accident details it is done to ensure which school policy the claim will be applied to, there are school policies that do not cover intercollegiate injuries, however for clarity purposes the Company will remove any questions related to automobile accidents from the accident questionnaire.

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ALIC's student health policy indicates that Physician's Office Visits and Laboratory and X-Ray Expenses are payable at 80% for Preferred Care. ALIC's student health policy states that "Pre-existing conditions are not covered during the first 63 days that you are covered under this plan." ALIC's student health policy indicates that Durable Medical Equipment Expenses are payable at 70% for Non-Preferred Care. ALIC's student health policy indicates that Preventive Health Care Services Expenses, including immunizations for infectious disease, are payable at 90% for Preferred Care. ALIC's student health policy includes an exclusion that states that "Expense incurred for injury resulting from the plan or practice of intercollegiate sports; in excess of $250 (participating in sports clubs; or intramural athletic activities; is not excluded)." As discussed in Review Sheets CL30BL-SH, CL33BL-SH, CL34BL-SH, CL41BL-SH, and

CL42BL-SH, the review revealed that ALIC's processing of claims was in non-compliance with its policy provisions in 5 instances. ALIC agreed with the examiners' observations.

COMPANY RESPONSE: The Company agrees with memos CL30BL-SH, CL33BL-SH, CL34BL-SH, CL41BL-SH AND CL42BL-SH.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

The total sample of 514 paid claims and 284 denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

14 VAC 5-400-40 A - In 52 instances, ALIC misrepresented insurance policy provisions related to the coverage at issue. An example is discussed in Review Sheet CL40BW-SH.

14 VAC 5-400-50 A - In 42 instances, claims were not acknowledged within 10 working days. An example is discussed in Review Sheet CL24BL-SH.

14 VAC 5-400-50 C - In 1 instance, an appropriate reply was not made within 10 working days on pertinent communications from a claimant. This is discussed in Review Sheet CL25BW-SH.

14 VAC 5-400-60 A - In 87 instances, ALIC failed to notify the first party claimant of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss. An example is discussed in Review Sheet CL34M. ALIC disagreed, and stated:

> The acceptance of the claim was sent to the provider. The "First Party Claimant" is the provider as the provider submitted the claim for reimbursement.
> Please refer to the electronic claim screen-print below which reflects the code A2 dated 4/9/10.X. This claim was an electronic submission and the A2 code represents the acknowledgement and acceptance of the claim.

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Code A2 is defined as follows:
"Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system". The provider Explanation of benefits was previously provided to the Department and this is dated 4/16/10. The reason for denial is noted on the Explanation of Benefits Statement.

The examiners responded that "regardless of which party submits the claim, the insurer is required to advise the first party claimant of the acceptance or denial of a claim within 15 working days of receipt by the insurer of properly executed proof of loss." The insured is the first party claimant, and ALIC failed to send a notification to the insured.

Company Response to 14 VAC 5-400-60-A :

The Company respectfully disagrees. 14VAC5-400-20- "Definitions" conveys the following:
"Claimant" means either a first party claimant, a third party claimant, or both, and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;
"First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract issued to such individual, corporation, association, partnership or other legal entity arising out of the occurrence of the contingency or loss covered by such policy or contract;
We agree that a member under a health plan can be considered a first party claimant – if the member actually submits a claim. However, when the member has assigned the right to present a claim to the member's provider, the member has assigned the benefits under the policy to the provider, the member never submits a claim, and the provider submits the claim which will result in direct payment to the provider, the provider becomes the first party claimant.

The Company respectfully disagrees that the Member/Insured is the "First Party Claimant" on claims where the Member has assigned benefits to the provider or on participating provider claims. The Member/Insured would be the "First Part Claimant" on unassigned claims as the Member/Insured is submitting the claim and requesting the applicable benefits payable under the Plan.

COMPANY RESPONSE to §38.2-3407.4 B of the Code: The Company disagrees with the following memos:

CL18BL-SH: Please refer to the attached response and applicable documentation

CL28BW-SH: Please refer to the attached response and applicable documentation

CL57BW-SH: Please refer to the attached response and applicable documentation

CL69BW-SH: Please refer to the attached response and applicable documentation

The Company agrees with the following memos: CL01T-DEN, CL02T-DEN, CL03BW-SH, CL04BW-SH, CL05BL-SH, CL06BL-SH, CL07BW-SH, CL08BL-SH, CL12BW-SH, CL13BL-SH, CL18BW-SH, CL23BW-SH, CL25BW-SH, CL26BL-SH, CL27BW-SH, CL28BL-SH, CL29BW-SH, CL30BL-SH, CL33BL-SH, CL34BL-SH, CL36BL-SH, CL37BL-SH, CL40BW-SH, CL41BL-SH, CL42BL-SH, CL42BW-SH, CL43BW-SH, CL44BW-SH, CL48BW-SH, CL50BW-SH, CL52BW-SH,

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CL56BW-SH, CL59BW-SH, CL70BW-SH

COMPANY RESPONSE TO 14 VAC 5-400-40 A: The Company disagrees on the following memos:

CL01B: Please refer to the attached response

CL03B: Please refer to the attached response and applicable documentation

CL05B: Please refer to the attached response and applicable documentation

CL06B: Please refer to the attached response and applicable documentation

CL08BW-SH: Please refer to the attached response and applicable documentation

CL10B: Please refer to the attached response and applicable documentation

CL18BL-SH: Please refer to the attached response and applicable documentation

CL28BW-SH: Please refer to the attached response and applicable documentation

CL57BW-SH: Please refer to the attached response and applicable documentation

CL69BW-SH: Please refer to the attached response and applicable documentation

CL70BW-SH: Please refer to the attached response and applicable documentation

CL71BW-SH: Please refer to the attached response and applicable documentation

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The Company agrees to the following memos: CL01BW-SH, CL02BW-SH, CL03BW-SH, CL04BW-SH, CL05BL-SH, CL06BL-SH, CL07-B, CL07BW-SH, CL08-B, CL08BL-SH, CL09-B, CL12BW-SH, CL13BL-SH, CL16BL-SH, CL18BW-SH, CL23BW-SH, CL25BW-SH, CL26BL-SH, CL27BW-SH, CL28BL-SH, CL29BW-SH, CL30BL-SH, CL33BL-SH, CL34BL-SH, CL36BL-SH, CL37BW-SH, CL38BL-SH, CL40BW-SH, CL41BL-SH, CL42BL-SH, CL43BW-SH, CL44BW-SH, CL48BW-SH, CL50BW-SH, CL52BW-SH, CL56BW-SH, CL59BW-SH, CL60BW-SH.

COMPANY RESPONSE TO 14 VAC 5-400-50 A:

EyeMedClaim01B (2 Claims) -The Company agrees that a member under a health plan can be considered a first party claimant – if the member actually submits a claim. However, when the member has assigned the right to present a claim to the member's provider, the member has assigned the benefits under the policy to the provider, the member never submits a claim, and the provider submits the claim which will result in direct payment to the provider, the provider becomes the first party claimant.

EyeMed claim # 88886003508 was received by the Company on 01/17/2010. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 01/25/2010 within 10WD.

EyeMed Claim # 88886263802 was received by the Company on 05/03/2010. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 05/10/2010 within 10WD.

Please refer to the attached documentation.

CL11-B (BOI 19) - The Company agrees that the claim associated with BOI 19 was not acknowledged timely.

The DRAFT report does not specify if the Department is applying violations to any other claims associated with CL11-B. The Company previously provided documentation to the Department to support that the following claims were acknowledged within 10WD: BOI 17 (GRP PD MH); BOI 2 (GRP PD MH-Replacement); BOI 4 (GRP PD MH-Replacement); BOI 3 (Group Denied MH); BOI 4 (Group Denied MH); BOI 6 (Group Denied MH); BOI 7 (Group Denied MH); BOI 14 (Group Denied MH); BOI 15 (Group Denied MH); BOI 2 (Ind Conv Denied Reg); BOI 8 (Grp Denied Reg); BOI 9 (Grp Denied Reg); BOI 24 (Grp Denied Reg) and BOI 27 (Grp Denied Reg)

Please refer to the attached documentation.

CL17BL-SH- The Company respectfully disagrees. The Company initially disagreed with the acknowledgment and notification violation as this was an adjustment not the initial processing of the claim. The Department responded indicating "Aetna Life's response has been received and reviewed. As no documentation has been provided in regard to the company's assertion that this is not the initial processing of the claim, the violations regarding the failure to acknowledge receipt and failure to affirm or deny within 15 working days will remain." The Company is attaching documentation regarding the initial claim (Claim # 101130019E); receipt of the additional information (accident questionnaire) and reprocessing of the claim following receipt of the requested information (Claim #101130019F). The initial claim and adjusted claim comply with 14 VAC 5-400-50 A.

CL23BL-SH- The Company respectfully disagrees. This claim was received by the Company on 10/27/09 and was acknowledged 10/28/09. Please refer to the attached documentation.

CL32BW-SH- The sample claim, claim # 100814623E was processed within 10 working days after the receipt of the claim. Claim was received on 03/22/10 and processed on 04/05/10. Please refer to the attached documentation

CL35BL-SH- The Company respectfully disagrees. The Company initially disagreed with the acknowledgment and notification violation. The Bureau responded "As no documentation has been provided to support the company's statement that this is not the initial processing of the claim, the violations regarding the failure to acknowledge receipt and the failure to affirm or deny within 15 working days will remain." The Company is attaching documentation regarding the initial claim (Claim # 100551035E); receipt of the additional information (Certificate of prior coverage) and reprocessing of the claim following receipt of the requested information (Claim #100551035E). The initial claim and adjusted claim comply with 14 VAC 5-400-50 A.

CL40BL-SH- The Company agrees that the claims associated with BOI 9 and BOI 37 were not acknowledged timely.

The DRAFT report does not specify if the Bureau is applying violations to any other claims associated with CL40BL-SH. The Company previously provided documentation to the Bureau to support that the following claims were acknowledged within 10WD; BOI #'s 32; 73; 83; 85; 86 and 99

CL43BW-SH- The Company respectfully disagrees. This claim was received by the Company on 02/10/10 and was acknowledged 2/20/10. Please refer to the attached documentation.

CL01M (Group) – The Company agrees with the memo

CL03M (Group) – The Company agrees with the memo

CL04M- (Group) - The Company respectfully disagrees with the memo: as noted previously, the notification

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of claim was received by Aetna on March 18, 2010. Per the attached, page #5 the claim was actually paid on March 31, 2010. Therefore, the claim was paid within 9 working days from receipt of the notification of claim.

CL06M (Group) – The Company respectfully disagree with the memo: as noted the notification of claim was received by Aetna on January 25, 2010. On February 8, 2010 Aetna received a call from the plan sponsor and advised that the claim had been received and assigned to a claim examiner. Acknowledgement of the claim was made at this time.

CL09M (Group) – The Company respectfully disagrees with the memo: as noted the notification of claim was received by Aetna on February 1, 2010. A 'Delay' letter was sent acknowledging receipt of the claim on February 8, 2010. This is noted in the diary notes on page two of the attached (page #2 of attached). The material requested in this letter were received and scanned into the claim system on February 24, 2010 and are on pages #11-#13 of the attached. A sample letter can be seen on page #10 of the attached.

CL11M (Group) – The Company agrees with the memo

COMPANY RESPONSE to 14 VAC 5-400-50 C: The Company agrees to memo CL25BW-SH

COMPANY RESPONSE TO 14 VAC 5-400-60 A:

The Company disagrees that the following Observations-Samples are in violation of 14 VAC 5-400-60 A. EyeMedClaim01B (2 Claims) -The Company agrees that a member under a health plan can be considered a first party claimant – if the member actually submits a claim. However, when the member has assigned the right to present a claim to the member's provider, the member has assigned the benefits under the policy to the provider, the member never submits a claim, and the provider submits the claim which will result in direct payment to the provider, the provider becomes the first party claimant.

EyeMed claim # 88886003508 was received by the Company on 01/17/2010. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 01/25/2010 within 10WD.

EyeMed Claim # 88886263802 was received by the Company on 05/03/2010. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 05/10/2010 within 10WD.

Please refer to the attached documentation.

CLSRC02 The sample claim was received by the Company on 11/11/09 and acknowledged 11/12/09. Letters were sent to the provider and member on 11/25/09, within 15 working days. Please refer to the attached documentation (Bottom portion of the attached document).

CL02-TB The sample claim was received by the Company on 2/22/10. Please refer to the attached Explanation of Benefits Statement which was sent on 3/12/10, within 15 WD.

CL03BW-SH The sample claim was received by the Company on 12/11/09. Please refer to the attached Explanation of Benefits Statement which was sent on 1/5/10, within 15 WD.

CL03-TB- This claim was received by the Company on 4/28/10. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 5/6/10, within 15WD. Please refer to the attached documentation.

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CL04-TB- This claim was received by the Company on 2/4/10. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 2/11/10, within 15WD. Please refer to the attached documentation.

CL08-TB- This claim was received by the Company on 6/11/10. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 6/18/10, within 15WD. Please refer to the attached documentation.

CL09-TB- This claim was received by the Company on 5/22/10. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 6/2/10, within 15WD. Please refer to the attached documentation.

CL10-TB- The sample claim was received by the Company on 11/30/09. Please refer to the attached Member EOB sent 12/5/09, within 15WD.

CL11-B- This sample includes multiple claims as follows:
Sample: Group paid MH
BOI # 17 Claim P6YZJD6B3 Member [redacted] DOS 12/15/2009 - 12/19/2009
BOI # 19 Claim P4FAL4N5T Member [redacted] DOS 3/31/2010 - 4/23/2010
Sample: Additional (replacement) group paid MH
BOI # 2 Claim EJFAMCH31 Member [redacted] DOS 5/4/2010
BOI # 4 Claim E0PAKSBHL Member [redacted] DOS 1/8/2010
Sample: Group denied MH
BOI # 3 Claim E8YZG50HW Member [redacted] DOS 5/6/2009
BOI # 4 Claim ESYZK0V6W Member [redacted] DOS 1/28/2010 - 2/1/2010
BOI # 6 Claim ECAAKQ3GH Member [redacted] DOS 11/9/2009
BOI # 7 Claim ECJKKQ1RW Member [redacted] DOS 11/16/2009
BOI # 14 Claim E2PAHMBAJ Member [redacted] DOS 6/11/2009
BOI # 15 Claim ETTVJ12FZ Member [redacted] DOS 11/3/2009

Sample: Ind conversion denied regular
BOI #2 Claim EPFAK8BVR Member [redacted] DOS 1/28/2010

Sample: Group denied regular
BOI # 8 Claim E8YZL7B2S Member [redacted] DOS 5/10/2010
BOI # 9 Claim ERFAL3BKN Member [redacted] DOS 4/16/2010
BOI # 24 Claim EVAAKV8PV Member [redacted] DOS 1/4/2010
BOI # 27 Claim EMTVLK1ZP Member [redacted] DOS 3/1/2010
BOI # 39 Claim EFYZK3Z95 Member [redacted] DOS 1/15/2010 - 1/16/2010

The Company has reviewed the Examiners response to CL11-B dated 2/3/14
.
The Company respectfully disagrees that the following BOI #'s, associated with CL11-B, are in violation of 14 VAC 5-400-60 A:

BOI 6 (Group Denied MH) -The Company respectfully disagrees that BOI 6, claim # ECAAKQ3GH is in violation of 14 VAC 5-400-60 A. The sample claim was received on 12/28/2009 which was a Monday and is counted as Day 1. The following conveys the working day calculation:

- 12/29/2009 through 12/31/2009 (Tuesday through Thursday) represent days 2

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through 4.
- 01/01/2010 (Friday) was a Federal Holiday. 01/04/2010 through 01/08/2010 (Monday through Friday) represent days 5 through 9.
- 01/11/2010 through 01/15/2010 (Monday through Friday) represent days 10 through 14.
- 01/18/2010 (Monday) was a Federal Holiday. 01/19/2010 represents the 15th working day and the date of the Member EOB.

Please refer to the attached documentation

BOI 7 (Group Denied MH) - The Company respectfully disagrees that BOI 6, claim # ECJKKQ1RW is in violation of 14 VAC 5-400-60 A. The sample claim was received on 12/28/2009 which was a Monday and is counted as Day 1. The following conveys the working day calculation:

- 12/29/2009 through 12/31/2009 (Tuesday through Thursday) represent days 2 through 4.
- 01/01/2010 (Friday) was a Federal Holiday. 01/04/2010 through 01/08/2010 (Monday through Friday) represent days 5 through 9.
- 01/11/2010 through 01/15/2010 (Monday through Friday) represent days 10 through 14.
- 01/18/2010 (Monday) was a Federal Holiday. 01/19/2010 represents the 15th working day and the date of the Member EOB.

Please refer to the attached documentation.

BOI 15 (Group Denied MH) - This claim was received by the Company on 11/10/09. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 11/20/09, within 15WD. Please refer to the attached documentation.
BOI # 27 (Grp Denied Reg) - The Company has reviewed the examiners response and respectfully

disagrees. This claim was received by the Company on 3/8/10 and the Member EOB is dated 3/26/10. This

EOB was within 15WD of the receipt date of this claim. Please refer to the attached documentation.

Total Violations- CL11-B-14 VAC 5-400-60 A- 8 - Group Paid M/H- Claims BOI 17 and BOI 19; Additional (replacement) Group Paid M/H- Claims BOI 2 and BOI 4; Group Denied Regular-Claim BOI 24 and BOI 39; Ind Conversion Denied Regular- BOI 2; Group Regular Denied-BOI 9

CL13-TB- This claim was received by the Company on 6/14/10. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 6/25/10, within 15WD. Please refer to the attached documentation.

CL14M- This claim was received by the Company on 4/17/10. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 4/29/10, within 15WD. Please refer to the attached documentation.

CL14-TB- This Observation sheet has the same # as CL11-TB. Violations are duplicated for the same claim number. The State clarified CL-14 TB on 10/15/14 and indicated they believe the claim number discussed in this review sheet should be P3JKLJK8B. The Company has reviewed claim # P3JKLJK8B and agrees with the violation.

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CL16-TB- The Company has re-reviewed this sample claim and noted that the Member EOB was sent within 15WD. Claim was received 3/19/10. Member EOB was sent on 4/8/10. Please refer to the attached documentation.

CL17BL-SH- The Company respectfully disagrees. The Company initially disagreed with the acknowledgment and notification violation as this was an adjustment not the initial processing of the claim. The Department responded indicating "Aetna Life's response has been received and reviewed. As no documentation has been provided in regard to the company's assertion that this is not the initial processing of the claim, the violations regarding the failure to acknowledge receipt and failure to affirm or deny within 15 working days will remain." The Company is attaching documentation regarding the initial claim (Claim # 101130019E); receipt of the additional information (accident questionnaire) and reprocessing of the claim following receipt of the requested information (Claim #101130019F). The initial claim and adjusted claim comply with 14 VAC 5-400-50 A and VAC 5-400-60 A.

CL17M- This claim was received by the Company on 4/1/10. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 4/13/10, within 15WD. Please refer to the attached documentation.

CL18-TB- This claim was received by the Company on 3/20/10. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 3/26/10, within 15WD. Please refer to the attached documentation.

CL19-TB- This claim was received by the Company on 4/26/10. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 5/5/10, within 15WD. Please refer to the attached documentation.

CL20-TB-The Company has re-reviewed this sample claim and noted that the Member EOB was sent within 15WD. Claim was received 6/14/10. Member EOB was sent on 7/3/10. Please refer to the attached documentation.

CL22BL-SH- Although the original claim was not processed timely, the sample claim selected by the Examiners represents a reprocessing of the claim upon receipt of accident information by the student. A phone call received on 03/10/10 from the student indicated that the accident occurred during an intercollegiate baseball game. As Student Health plans do not cover accidents as a result of intercollegiate sports, the claim was denied on 03/16/10, within 15 working days of receipt of the information necessary to process the claim. Please refer to the attached documentation.

CL34M- This claim was received by the Company on 4/9/10. The member has assigned the right to present a claim to the provider and has also assigned the benefits under the policy to the provider. Due to the assignment of benefits, the provider becomes the First Party Claimant. The attached Explanation of Benefits Statement was sent to the provider on 4/16/10, within 15WD. Please refer to the attached documentation.

CL35BL-SH-The Company respectfully disagrees. The Company initially disagreed with the acknowledgment and notification violation. The Department responded "As no documentation has been provided to support the company's statement that this is not the initial processing of the claim, the violations regarding the failure to acknowledge receipt and the failure to affirm or deny within 15 working days will remain." The Company is attaching documentation regarding the initial claim (Claim # 100551035E); receipt of the additional information (Certificate of prior coverage) and reprocessing of the claim following receipt of the requested information (Claim #100551035E). The initial claim and adjusted claim comply with 14 VAC 5-400-60 A.

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CL39M- The Company has re-reviewed this sample claim and noted that the Member EOB was sent within 15WD. Claim was received 10/6/10. Member EOB was sent on 10/14/10. Please refer to the attached documentation.

CL40BW-SH- The Company respectfully disagrees that this claim is in violation of 14 VAC 5-400-60. The original claim, #093430745E, was received by the Company on 12/9/09 and processed timely on 12/19/10 at the non-par benefit level under the individual provider of service name. Please refer to the attached Explanation of Benefits Statements. The Company was contacted by the provider of service on 01/27/10 indicating that they were participating under the group name. The sample claim, # 093430745F is the reconsideration of the original claim based on the additional information provided. The claim was adjusted at the in-network level of benefits on 01/28/10 and the Explanation of Benefits Statements were sent on 01/30/10. Both the original and adjusted claims are in compliance with 14 VAC 5-400-60.

CL48BW-SH- Disagree. There is no violation for 14 VAC 5-400-60 A noted on the Observation Sheet. Please refer to the attached documentation.

CL53M-The sample claim was received by the Company on 11/15/10. Please refer to the attached Explanation of Benefits Statement sent on 12/06/10, within 15 WD.

CL54M- The sample claim was received by the Company on 11/10/10. Please refer to the attached Explanation of Benefits Statement sent on 11/30/10, within 15 WD

14 VAC 5-400-60 B - In 12 instances, a claim investigation was not completed within 45 days from the date of notification of the claim, and ALIC failed to send the claimant a letter setting forth the reason additional time was needed for investigation. An example is discussed in Review Sheet CL21BL-SH.

COMPANY RESPONSE TO 14 VAC 5-400-60 B:

The Company agrees with the following memos – CL03BL-SH, CL13BL-SH, CL21BL-SH, CL22BL-SH, CL24BL-SH, CL31BL-SH, CL32BL-SH, CL34BL, SH, CL35BL-SH, CL10M and CL11B

14 VAC 5-400-70 A – In 3 instances, a claim denial was not given to a claimant in writing. An example is discussed in Review Sheet EyeMedClaim01B. In 2 claims processed by EyeMed, ALIC failed to provide the insured with a written explanation of denial. ALIC disagreed, and stated:

> EyeMed, denied these claims to the providers who submitted the claim. Per the contract with Aetna, EyeMed does not send denial notice to the insured unless they are financially responsible for payment. In both cited examples, the reason for the denial was missing filing [sic] and process errors between EyeMed and the provider. The denial reasons are displayed on the bottom of the provider remittance included within the sample documentation.

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The examiners would note that ALIC's response indicates that its business practice entails not providing denials in writing, in violation of the Code.

COMPANY RESPONSE to 14 VAC 5-400 70 A:

EyeMedClaims01B: Please refer to the attached documentation. The Company agrees that a member under a health plan can be considered a first party claimant – if the member actually submits a claim. However, when the member has assigned the right to present a claim to the member's provider, the member has assigned the benefits under the policy to the provider, the member never submits a claim, and the provider submits the claim which will result in direct payment to the provider, the provider becomes the first party claimant.

CL34M: Please refer to the attached response and applicable documentation

14 VAC 5-400-70 B - In 20 instances, ALIC failed to include a reasonable explanation of the basis for denial in the written denial. An example is discussed in Review Sheet CL56BW-SH in which ALIC denied a claim and indicated that a review to determine if a condition was pre-existing needed to be completed. The policy indicated that pre-existing conditions were excluded for 63 days. Since the date of service of the claim was greater than 63 days from the effective date of the insurance coverage, ALIC failed to provide a reasonable explanation of the basis for denial. ALIC agreed with the examiners' observations.

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COMPANY RESPONSE FOR 14 VAC 5-400-70 B:

The Company disagrees with the following memos – EYEMED-CL01B, CL03B, CL05B, CL10B, CL34M, CL69BW-SH, CL70BW-SH and CL71BW-SH, please refer to the attached documentation.

The Company agrees to the following memos – CL08B, CL37BW-SH, CL56BW-SH and CL70BW-SH

14 VAC 5-400-70 D - In 20 instances, ALIC failed to offer a claimant an amount which is fair and reasonable in accordance with policy provisions. An example is discussed in Review Sheet CL01B, where an insured was held liable for a charge denied as being mutually exclusive to another charge on a claim submitted by a

provider that was indicated as participating in ALIC's files. ALIC disagreed, stating:

> Aetna does not hold a direct contract with the billing provider; however, Aetna holds an indirect contract with the provider through the National Advantage Program (NAP), which reduces claim costs for plan sponsors and members by providing contracted rates through vendor arrangements for many hospital and physician claims (including this provider).
>
> All claims are subject to Aetna payment policies....
>
> During the claim review, if a denial is warranted based on multiple procedure codes being billed for the same member, same date of service, same provider, the highest intensive code is reimbursed. In this case, 99251 was reimbursed. The 99251 code was priced through NAP. When a claim from a non-participating provider being paid at the preferred benefit level has been externally priced, the pricing returned from the vendor is a binding contract and therefore, the member is not responsible for the discounted amount; however, the 99231 was considered mutually exclusive to 99251 based on Aetna payment policies and therefore, not eligible for reimbursement.
>
> This member was covered under a PPO plan at the time the services were rendered. Under a PPO plan, the members have cost sharing expenses which are generally higher when they access out-of-network providers. The Company has noted below the portion of the Plan Brochure describing the member's cost sharing, which purports the member is responsible for non-covered expenses.

The examiners do not concur and requested a copy of the provider contracts and/or agreements between ALIC, its intermediaries and the provider. After an extensive delay, the contracts between ALIC and Beech Street, and between Beech Street and the provider, were received and reviewed by the examiners. The examiners do not concur that there is an "indirect" contract between ALIC and the provider. The contract between ALIC and Beech Street states:

> "**WHEREAS,** Company wishes to contract with Entity to arrange for the access of health care services from such Participating Entity Providers to its members on the following terms and conditions...**Provision of Covered Services.** Entity shall provide Members with access to Participating Entity Provider for Members' Covered Services in the Primary Network and National Advantage Program (NAP) Service Areas."

In addition, the contract between Aetna Life and Beech Street contains a hold harmless

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clause which states:

> "**Hold Harmless.** Entity represents and warrants that the terms and provisions of the Entity Provider Agreements shall permit Company to require Participating Entity Providers to comply with Company's hold harmless standards as set forth, in part, in this Section 5.5. Accordingly, Entity and Participating Entity Providers hereby agree that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Entity or a Participating Entity Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other res controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles or other supplemental charges made in accordance with the terms of the applicable Plan. Entity and Participating Entity Providers further agree that this Section 5.5 (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between a Participating Entity Provider and Members or persons acting on their behalf.
>
> To protect Members, Participating Entity Provider agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 5.5."

There is also a contract between Beech Street and the provider that indicates that the provider will be participating. Since the provider is participating and the contract contains a hold harmless clause, the member should not be held liable for this charge. Therefore, ALIC did not provide a fair and equitable settlement of the claim and misrepresented pertinent facts and policy provisions.

COMPANY RESPONSE TO 14 VAC 5-400-70 D:

The Company disagrees with the following memos – CL01B, CL03B, CL05B, CL06B, CL10B, CL69BW-SH and CL71BW-SH, please refer to the attached documentation.

The Company agrees with the following memos – CL01BW-SH, CL02BW-SH, CL07B, CL08B, CL08BL-SH, CL09B, CL16BL-SH, CL29BW-SH, CL30BL-SH, CL34BL-SH, CL41BL-SH, CL42BL-SH, CL56BW-SH

The violations of 14 VAC 5-400-60 A occurred with such frequency as to indicate a general business practice, placing ALIC in violation of § 38.2-510 A 5 of the Code.

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These violations were also cited in a previous inquiry and are considered knowing violations. Section 38.2-218 of the Code sets forth penalties that may be imposed for knowing violations.

ALIC indicated in its response that its general business practice for EyeMed claims is to provide an explanation of denial only when there is insured responsibility, thus placing ALIC in violation of § 38.2-510 A 14 of the Code. In addition, for Student Health Claims, the violations of 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D also occurred with such frequency as to indicate a general business practice, placing ALIC in violation of §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 6, and 38.2-510 A 14 of the Code.

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THREATENED LITIGATION

ALIC provided a statement regarding the 1 file involving threatened litigation during the examination time frame. The litigation involved an affiliate company and was ongoing. No other threatened litigation files were provided.

XII. INDEPENDENT EXTERNAL REVIEW OF ADVERSE UTILIZATION REVIEW DECISIONS

Chapter 59 of Title 38.2 of the Code requires certain actions to be taken by the Bureau of Insurance on any appeal of a final adverse decision made by a utilization review entity. 14 VAC 5-215-10 et seq. provides a process for appeals to be made to the Bureau of Insurance to obtain an independent external review of final adverse decisions and procedures for expedited consideration of appeals in cases of emergency health care.

The examiners reviewed the entire population of 1 appeal to obtain an independent external review of a final adverse decision that occurred during the examination time frame. The review revealed that ALIC was in substantial compliance with its established procedures and this section.

ALIC was in substantial compliance with its established procedures and this section.

COMPANY RESPONSE: The Company has no further comments

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XIII. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, ALIC shall:

1. Ensure that its complaint system is filed and approved, as required by § 38.2-5804 A of the Code;
2. Establish procedures to ensure that it maintains its complaint system, as required by § 38.2-5804 A of the Code;
3. Review and revise its procedures to ensure that all provider contracts contain the provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code;
4. Review and revise its procedures to ensure adherence to and compliance with the minimum fair business standards in the processing and payment of claims, as required by §§ 38.2-510 A 15, 38.2-3407.15 B 3, and 38.2-3407.15 B 8 of the Code;
5. Review and revise its procedures to ensure that its advertising log is in compliance with 14 VAC 5-41-150 C (formerly 14 VAC 5-40-60 B), and that its advertisements are in compliance with 14 VAC 5-90-50 B and 14 VAC 5-90-55 A, 14 VAC 5-90-130 A as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;
6. Review and revise its procedures to ensure that all of its policy forms and certificates of coverage are filed and approved and in compliance with

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14 VAC 5-100-40 2, 14 VAC 5-100-50 1, and 14 VAC 5-100-50 3, as well as § 38.2-316 A, § 38.2-316 B, and § 38.2-316 C of the Code;

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7. Review and revise its procedures to ensure that all Explanation of Benefit (EOB) forms used by its pharmacy and vision vendors are filed with and approved by the Commission, as required by § 38.2-3407.4 A of the Code;

8. File with the Commission for approval all student health forms currently in use or contemplated for use, remove all references to subrogation and other inappropriate exclusions, and discontinue use of any forms that have not been approved in their final form, as required by 14 VAC 5-100-40 2, 14 VAC 5-100-50 1, and 14 VAC 5-100-50 3, as well as § 38.2-316 A, § 38.2-316 B, and § 38.2-316 C of the Code;

9. Review and revise its procedures to ensure that all agents representing ALIC are licensed and appointed prior to accepting new business and paying commissions in compliance with § 38.2-1822 A, § 38.2-1812 A and § 38.2-1833 A 1 of the Code;

10. Establish and maintain procedures for compliance with §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code;

11. Review all renewals of group contracts issued in Virginia for the years 2009, 2010, 2011, 2012, 2013 and the current year that resulted in a more than 35 percent increase in the annual premium charged for the coverage thereunder; determine which contract holders were not notified in writing 60 days prior to such increase, as required by §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code, and refund to the group contract holder all premium amounts collected in excess of the 35% increase for the entire policy period for which notice was not provided. Send checks for the required refund along with letters of explanation stating specifically, "As a result of a Target Market Conduct

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Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that ALIC failed to provide 60 days written notice to the policyholder of intent to increase premium by more than 35 percent. Please accept the enclosed check for the refund amount." After which, furnish the examiners with documentation that the required refunds have been paid;

12. Review and revise its procedures to ensure that its complaint log is complete and maintained, as required by § 38.2-511 of the Code;
13. Review and revise its procedures for the payment of interest on life insurance claim proceeds, as required by § 38.2-3115 B of the Code;
14. Review all paid life claims for the years of 2009, 2010, 2011, 2012, 2013, and the current year and make interest payments where necessary as required by § 38.2-3115 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid;
15. Review and revise its procedures for the payment of interest on accident and sickness claim proceeds, as required by § 38.2-3407.1 B of the Code;
16. Review all paid claims for the years of 2010, 2011, 2012, 2013, and the current year and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that, "As a result of a Target Market

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Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid;

17. Complete the corrective action plan steps outlined in its response to CLMEM01B-ASH and CLMEM02B-ASH, and provide documentation of completion to the examiners;

18. Reopen and reprocess the claim referenced in CL71BW-SH that was denied and never paid, and appropriately determine eligibility for benefits and adjudicate accordingly;

19. Review all student health claims for the years 2009, 2010, 2011, 2012, 2013 and the current year that resulted in an accident claim questionnaire being sent to the claimant or resulted in subrogation; determine which claims were not paid due to accident information not being received or were incorrectly denied in violation of § 38.2-3405 B of the Code; reopen and reprocess all affected claims so that they are paid without subrogation or, if needed, appropriate questionnaires are sent to determine eligibility for benefits. Send checks for any payments along with letters of explanation stating specifically, "As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that ALIC failed to adjudicate this claim correctly. Please accept the enclosed payment." After which, furnish the examiners with documentation of the reprocessed claims and payments;

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20. Immediately discontinue use of any questionnaires that are in violation of § 38.2-3405 B of the Code;

21. Review its contractual responsibilities with its Beech Street providers; review all claims from Beech Street providers for the years 2009, 2010, 2011, 2012, 2013 and the current year and determine which claims were not processed in accordance with the hold harmless clause of the provider contract; reopen and reprocess all affected claims so that the insured is held harmless. Send checks for any payments along with letters of explanation stating specifically, "As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that ALIC failed to adjudicate this claim correctly. Please accept the enclosed payment." After which, furnish the examiners with documentation of the reprocessed claims and payments;

22. Establish and maintain procedures to ensure that all claims payments to insureds or beneficiaries are accompanied by a statement setting forth the coverage under which payments are being made, as required by § 38.2-510 A 10 of the Code;

23. Establish and maintain procedures to ensure that benefits, coverages or other provisions of an insurance policy or contract are not obscured or concealed from claimants, either directly or by omission, as required by 14 VAC 5-400-40 A;

24. Establish and maintain procedures to ensure that it acknowledges the receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A;

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25. Establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A;
26. Review and strengthen its established procedures to ensure that notification of a claim under investigation is sent every 45 days from the date of notification of the claim and every 45 days thereafter, as required by 14 VAC 5-400-60 B;
27. Establish and maintain procedures to ensure that any denial of claim is given to the claimant in writing and ensure that its vendors working on its behalf do the same, as required by 14 VAC 5-400-70 A;
28. Establish and maintain procedures to ensure that it includes a reasonable explanation of the basis for the denial of a claim in the written denial, as required by 14 VAC 5-400-70 B;
29. Establish and maintain procedures to ensure that a claimant is offered an amount that is fair and reasonable, as required by 14 VAC 5-400-70 D; and
30. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

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XIV. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by ALIC's officers and employees during the course of this examination is gratefully acknowledged.

Bryan Wachter, FLMI, AIRC, AIE, MCM, Bill Benson, FLMI, AIE, ACS, MCM, Brant Lyons, MCM, Julie Fairbanks, AIE, FLMI, AIRC, MCM, Melissa Gerachis, FLMI, AIRC, MCM, Arthur Dodd, MBA, FLMI, MCM, AIE, AIRC, and Todd Bryant, HIA, MHP, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie Fairbanks, AIE, FLMI, AIRC, MCM
Principal Insurance Market Examiner
Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance

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XV. REVIEW SHEET SUMMARY BY AREA

MANAGED CARE HEALTH INSURANCE PLANS
§ 38.2-5804 A, 1 violation, MC01
Timeliness and Handling
§ 38.2-5804 A, 3 violations, MC01-B, MC03-B, MC04-B
Provider Contracts
§ 38.2-5805 B, 2 violations, EF03J, EF04J
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
§ 38.2-3407.15 B 1, 1 violation, EF01-B
§ 38.2-3407.15 B 2, 1 violation, EF01-B
§ 38.2-3407.15 B 3, 1 violation, EF01-B
§ 38.2-3407.15 B 4, 6 violations, EF01, EF01-B, EF01J, EF02, EF02J, EF05
§ 38.2-3407.15 B 5, 1 violation, EF01-B
§ 38.2-3407.15 B 6, 1 violation, EF01-B
§ 38.2-3407.15 B 7, 5 violations, EF01, EF01-B, EF02, EF02J, EF05
§ 38.2-3407.15 B 8, 3 violations, EF01-B, EF01J, EF02J
§ 38.2-3407.15 B 9, 7 violations, EF01, EF01-B, EF02, EF02J, EF03, EF05, EF08
§ 38.2-3407.15 B 10, 4 violations, EF01, EF01-B, EF02, EF05
§ 38.2-3407.15 B 11, 8 violations, EF01, EF01-B, EF01J, EF02, EF02J, EF03, EF05, EF08
Provider Claims
§ 38.2-3407.15 B 3, 1 violation, EFCL02-B
§ 38.2-3407.15 B 8, 4 violations, EFCL01-B
ADVERTISING
14 VAC 5-40-60 B (now 14 VAC 5-41-150 C), 1 violation, AD01
14 VAC 5-90-50 B, 7 violations, AD01B-SH

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ADVERTISING cont.
14 VAC 5-90-55 A, 4 violations, AD01SL, AD02SL, AD03SL, AD04SL
14 VAC 5-90-130 A, 7 violations, AD01B-SH
POLICY FORMS
§ 38.2-316 A, 40 violations and in each instance, PF01B, PF01-SH, PF03B, PF05B, PF06B, PF10B, PF12B, PF13B, PF14B, PF15B, PF16B, PF17B, PF18B, PF19B, PF20B, PF21B, PF22B
§ 38.2-316 B, 17 violations, PF02B, PF04B, PF06B, PF07B
§ 38.2-316 C, 53 violations and in each instance, PF01B, PF01-SH, PF02B, PF03B, PF04B, PF05B, PF06B, PF07B, PF10B, PF12B, PF13B, PF14B, PF15B, PF16B, PF17B, PF18B, PF19B, PF20B, PF21B, PF22B
§ 38.2-3407.4 A, 9 violations and in each instance, PF09B, PF11B
§ 38.2-3533, violation in each instance, PF01-SH
AGENTS
§ 38.2-1812 A, 5 violations, AG01, AG04
§ 38.2-1822 A, 3 violations, AG01
§ 38.2-1833 A 1, 2 violations, AG04
NOTICE OF PREMIUM INCREASES
§ 38.2-3407.14 A, 3 violations, PB01B, PB02B, PB03B
§ 38.2-3407.14 B, 3 violations, PB01B, PB02B, PB03B
COMPLAINTS
§ 38.2-511, 1 violation, CP01-B
CLAIMS PRACTICES
§ 38.2-503, 1 violation, CL23BL-SH

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CLAIMS PRACTICES cont.
§ 38.2-514 B, 17 violations, CL01T-DEN, CL02T-DEN, CL03BW-SH, CL04BW-SH, CL05BL-SH, CL06BL-SH, CL07BW-SH, CL12BW-SH, CL13BL-SH, CL18BW-SH, CL23BW-SH, CL25BW-SH, CL26BL-SH, CL27BW-SH, CL28BW-SH, CL40BW-SH, CL59BW-SH
§ 38.2-3115 B, 4 violations, CL04M, CL06M, CL07M, CL08M
§ 38.2-3405 B, 11 violations, CL07BW-SH, CL08BW-SH, CL26BW-SH, CL71BW-SH
§ 38.2-3407.1 B, 15 violations, CL02BL-SH, CL02-TB, CL05-TB, CL06-TB, CL07BW-SH, CL08BW-SH, CL15BW-SH, CL16BW-SH, CL17BL-SH, CL17BW-SH, CL24BW-SH, CL37BW-SH, CL39M, CL44BW-SH, CL48M
§ 38.2-3407.4 B, 38 violations, CL01T-DEN, CL02T-DEN, CL03BW-SH, CL04BW-SH, CL05BL-SH, CL06BL-SH, CL07BW-SH, CL08BL-SH, CL12BW-SH, CL13BL-SH, CL18BL-SH, CL18BW-SH, CL23BW-SH, CL25BW-SH, CL26BL-SH, CL27BW-SH, CL28BL-SH, CL28BW-SH, CL29BW-SH, CL30BL-SH, CL33BL-SH, CL34BL-SH, CL36BL-SH, CL37BL-SH, CL38BL-SH, CL40BW-SH, CL41BL-SH, CL42BL-SH, CL42BW-SH, CL43BW-SH, CL44BW-SH, CL48BW-SH, CL50BW-SH, CL52BW-SH, CL56BW-SH, CL57BW-SH, CL59BW-SH, CL69BW-SH, CL70BW-SH
14 VAC 5-400-40 A, 52 violations, CL01-B, CL01BW-SH, CL02BW-SH, CL03-B, CL03BW-SH, CL04BW-SH, CL05-B, CL05BL-SH, CL06-B, CL06BL-SH, CL07-B, CL07BW-SH, CL08-B, CL08BL-SH, CL08BW-SH, CL09-B, CL10-B, CL12BW-SH, CL13BL-SH, CL16BL-SH, CL18BL-SH, CL18BW-SH, CL23BW-SH, CL25BW-SH, CL26BL-SH, CL27BW-SH, CL28BL-SH, CL28BW-SH, CL29BW-SH, CL30BL-SH, CL33BL-SH, CL34BL-SH, CL36BL-SH, CL37BL-SH, CL37BW-SH, CL38BL-SH, CL40BW-SH, CL41BL-SH, CL42BL-SH, CL42BW-SH, CL43BW-SH, CL44BW-SH, CL48BW-SH, CL50BW-SH, CL52BW-SH, CL56BW-SH, CL57BW-SH, CL59BW-SH, CL60BW-SH, CL69BW-SH, CL70BW-SH, CL71BW-SH

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CLAIMS PRACTICES cont.
14 VAC 5-400-50 A, 42 violations, CL01BL-SH, CL01M, CL02-TB, CL03BW-SH, CL03M, CL04BW-SH, CL04M, CL05-TB, CL06M, CL07BL-SH, CL08BL-SH, CL09BW-SH, CL09M, CL11-B, CL11M, CL17BL-SH, CL20BL-SH, CL21BL-SH, CL23BL-SH, CL24BL-SH, CL25BL-SH, CL29BW-SH, CL32BL-SH, CL32BW-SH, CL34BL-SH, CL35BL-SH, CL40BL-SH, CL43BW-SH, CL47BW-SH, CL48M, CL51BW-SH, CL53M, CL54BW-SH, CL54M, CL60BW-SH, CL64BW-SH, CLSRC02
14 VAC 5-400-50 C, 1 violation, CL25BW-SH
14 VAC 5-400-60 A, 87 violations, CL01-TB, CL02-TB, CL03BW-SH, CL03-TB, CL04BW-SH, CL04-TB, CL05BW-SH, CL08BW-SH, CL08-TB, CL09BW-SH, CL09-TB, CL10BW-SH, CL10M, CL10-TB, CL11-B, CL11BW-SH, CL11-TB, CL13-TB, CL14M, CL14-TB, CL15BW-SH, CL15-TB, CL016BW-SH, CL16-TB, CL17BW-SH, CL17M, CL18-TB, CL19-TB, CL20BW-SH, CL20-TB, CL21BW-SH, CL24BW-SH, CL29BW-SH, CL34M, CL39BW-SH, CL39M, CL40BW-SH, CL44BW-SH, CL45BW-SH, CL46BW-SH, CL47BW-SH, CL48BW-SH, CL48M, CL50BW-SH, CL51BW-SH, CL53M, CL54BW-SH, CL54M, CL55BW-SH, CL60BW-SH, CL66BW-SH, CLSRC01, CLSRC02
14 VAC 5-400-60 B, 12 violations, CL10M, CL11-B, CL24BW-SH
14 VAC 5-400-70 A, 3 violations, CL34M, EyeMedClaims01B
14 VAC 5-400-70 B, 20 violations, CL03-B, CL05-B, CL08-B, CL10-B, CL34M, CL37BW-SH, CL56BW-SH, CL69BW-SH, CL70BW-SH, CL71BW-SH, EyeMedClaims01B
14 VAC 5-400-70 D, 20 violations, CL01-B, CL01BW-SH, CL02BW-SH, CL03-B, CL05-B, CL06-B, CL07-B, CL08-B, CL08BL-SH, CL09-B, CL10-B, CL16BL-SH, CL29BW-SH, CL30BL-SH, CL34BL-SH, CL41BL-SH, CL42BL-SH, CL56BW-SH, CL69BW-SH, CL71BW-SH
§ 38.2-510 A 10, 3 instances of non-compliance, CL07BL-SH, CL08BL-SH, CL24BL-SH

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JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

April 10, 2015

CERTIFIED MAIL 7014 1200 0001 3578 9747
RETURN RECEIPT REQUESTED

Gail Yoder, Compliance Manager
Aetna Life Insurance Company
5305 Chestnut Ridge Road
Summerfield, NC 27358

Re: Market Conduct Examination Report
Exposure Draft

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Dear Ms. Yoder:

The Bureau of Insurance (Bureau) has completed its review of your November 17, 2014, response to the Market Conduct Examination Report of Aetna Life Insurance Company (ALIC), sent with my letter of August 27, 2014.

Your response indicates that ALIC has concerns regarding the writing of the Report. This letter addresses these concerns in the same order as presented in your November 17th response. However, since ALIC's response will also be attached to the final Report, this response does not address those issues where ALIC indicated agreement and/or action taken as a result of the Report. ALIC should note that upon finalization of this exam, ALIC will be given approximately 120 days to document compliance with all of the corrective actions in the Report.

Provider Contracts

Section 38.2-5805 B of the Code of Virginia (the Code): ALIC disagrees with the violations noted in EF03J and EF04J. ALIC's response refers to the attached "VA provider Amendment to Eye Med". However, as indicated in ALIC's response to Memo EFMEM01-Eyemed, the providers discussed in EF03J and EF04J do not have a direct written agreement with EyeMed. Thus, the amendment submitted is not applicable since there was no contract with EyeMed to amend during the examination time frame.

The Report appears correct as written.

Section 38.2-3407.15 B of the Code:
EF01: Although ALIC's response directs the examiners to consider the "Eye Med Virginia Amendment," this provider is a PCP and does not appear to provide vision

services under an EyeMed agreement. Therefore, the EyeMed amendment would not be applicable.

EF02: It does not appear that ALIC has submitted any new information for the examiners' consideration. As discussed in the examiners' response to EF02, the contract does not comply with §§ 38.2-3407.15 B 4, 38.2-3407.15 B 7, and 38.2-3407.15 B 11 of the Code. Regarding § 38.2-3407.15 B 4 of the Code, the Regulatory Compliance Addendum attached to the provider contract does not include the contact information that the provider may use to request specific bundling and downcoding policies, nor does section 3.1 of the provider contract. Regarding § 38.2-3407.15 B 7 of the Code, the Regulatory Compliance Addendum does not specify that the carrier will provide in writing the claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, and that the written communication shall also include an explanation of why the claim is being retroactively adjusted. Regarding § 38.2-3407.15 B 11 of the Code, section 10.2.1 of the provider contract does not include how the provider may access information on the claims payment dispute mechanism.

EF03: It does not appear that ALIC has submitted any new information for the examiners' consideration. Regarding § 38.2-3407.15 B 11 of the Code, section 8.0 of the provider contract does not include how the provider may access information on the claims payment dispute mechanism.

EF05: It does not appear that ALIC has submitted any new information for the examiners' consideration. As discussed in the examiners' response to EF05, the contract does not comply with §§ 38.2-3407.15 B 4, 38.2-3407.15 B 7, and 38.2-3407.15 B 11 of the Code. Regarding § 38.2-3407.15 B 4 of the Code, section 5 of the Regulatory Compliance Addendum does not include the contact information that the provider may use to request specific bundling and downcoding policies. Regarding § 38.2-3407.15 B 7 of the Code, section 8 of the Regulatory Compliance Addendum does not specify that the carrier will provide in writing the claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, and that the written communication shall also include an explanation of why the claim is being retroactively adjusted. Regarding § 38.2-3407.15 B 11 of the Code, ALIC refers the examiners to "the Regulatory Addendum item 1." Item 1 does not appear to contain the wording required by § 38.2-3407.15 B 11 of the Code. As indicated in the examiners' previous response to the review sheet, section 10.1 of the provider contract does not include how the provider may access information on the claims payment dispute mechanism.

EF01J and EF02J: The examiners do not concur with ALIC's response. Although, ALIC's response indicates that it confirmed that the VA Amendment was sent to the providers, this is substantiated neither by its current and previous responses nor by the dates on the amendments themselves. The examiners requested confirmation that the VA Amendment submitted to the examiners with ALIC's previous review sheet responses was, in fact, in effect during the examination timeframe, along with documentation to verify that this amendment was mailed to the providers in question

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prior to or during the examination timeframe. The examiners would note that the VA Amendment has a version date of "12/12" in the lower left hand corner, which would be more recent than the examination time frame. In an e-mail dated April 5, 2013, the examination coordinator at ALIC stated that she had: "…confirmed with EyeMed that the Virginia Amendments attached to the original contracts sent are the ones that were in effect during the scope of the exam. Those can be found at the end of each document." The VA Amendment referenced in ALIC's previous response to these review sheets was not attached to the original contracts; therefore, it appears that the amendment was not in effect during the exam timeframe. The examiners' original observations were based on the original contract and the VA Amendments that were included in that pdf file. Since ALIC confirmed that the original contract provided to the examiners is the entire contract that was in effect during the examination timeframe, the examiners observations remained, and the examiners' response to ALIC reflected this information. The examiners' would also note that the VA Amendment sent with ALIC's response to the draft report also has a version date of "12/12" in the lower left hand corner, and the revised fee schedule sent with ALIC's response to the draft report has a version date of "As of 1/4/12" in the lower right hand corner. Both of these dates are after the time frame of the examination. In addition, documentation verifying that these amendments were mailed to the providers in question (and the date of mailing) was not provided to the examiners.

EFCL01-B: Please refer to the Provider Claims section of this response letter.

ALIC included a note that: "the Company would like it to be noted that we have updated the Regulatory Addendum to capture all requirements of § 38.2-3407.15 B 2006, find attached documentation related to that update." The examiners would note that ALIC would need to provide evidence substantiating that the Regulatory Addendum was attached or amended as per the terms of the contract to each provider contract reviewed in order for the examiners to consider the Regulatory Addendum during the review.

"Company response to § 38.2-3407.15 B 7, B 8, B 9, and B 11 of the Code": The examiners do not concur with ALIC's response. This item concerns the vision provider contracts and Review Sheets EF01J and EF02J; therefore, please refer to the examiners' comments regarding EF01J and EF02J above. The VA Amendments referenced in ALIC's response to the draft report have not been verified as existing in the submitted form or being properly amended to the sample vision provider contracts during the examination time frame.

"Company response" (to violations noted as a general business practice): The examiners do not concur with ALIC's response. The existence of a general business practice is determined after reviewing the sample files and the policies and procedures of the company during an examination. ALIC, and/or ALIC's intermediaries acting on its behalf, failed to amend its provider contracts to comply with § 38.2-3407.15 of the Code with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15 of the Code

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The Report appears correct as written.

Provider Claims

EFCL01-B: The examiners do not concur with ALIC's response. ALIC has provided information that this provider was a part of a group practice, and ALIC has provided a group contract that appears to have been amended with a fee schedule in 2007. The direct contract with the provider that was originally submitted to the examiners was executed in 2009, and it also indicated that the provider was a part of the group practice and included the address of the group practice (see p.19 and p.34 of the contract). However, it appears that the fee schedule in the 2009 contract originally provided to the examiners and the 2007 amended fee schedule from the group contract submitted with ALIC's current response are actually the same. The CPT codes in question, 99396 and 99213, appear to have a fee schedule rate that is higher than what was allowed by ALIC on the sample claims. The violations will remain.

The report appears correct as written.

Advertising

AD03SL and AD04SL: The language contained in the advertisement, "This material is for informational purposes only and contains a partial, general description of the plan benefits or programs...," is not substantially similar to the language required by 14 VAC 5-90-55 A. In addition, as this advertisement did not contain the provision required by 14 VAC 5-90-55 A, it is misleading and in violation of § 38.2-503 of the Code. The examiners' initial observation regarding the advertisement having "the capacity or tendency" to mislead in no way precludes or diminishes the examiners' final determination of a violation.

AD01B-SH (referred to as AD01B-SL in ALIC's response): ALIC has previously stated that the policy brochure, with an application, is provided to all students, and this brochure becomes the "coverage document" once the student enrolls. The brochure is a document containing an explanation of plan benefits. Since this document, along with an application, is being provided to all students, not just existing insureds, this document is being utilized as an advertisement, as defined in Chapter 90 of the Virginia Administrative Code. ALIC's response regarding its SERFF filing of this document is not applicable as advertisements for student health insurance are not required to be filed for approval or informational purposes. The company is; however, required to ensure that its advertisements are in compliance with the Virginia Administrative Code. If this document were to be used for other purposes, such as an evidence of coverage, the document would be subject to the applicable filing requirements for its use, which should be specifically identified when filed.

The Report appears correct as written.

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Policy Forms

PF11B: The examiners do not concur with ALIC's response. The approved form sent with ALIC's response appears to be for Aetna Health, Inc., as indicated by the company name and address at the top of the form. The violations will remain.

PF05B and PF10B: The examiners have no further comments regarding the cover or title page of the Certificates of Coverage (COCs). The examiners do not concur with ALIC's disagreement regarding the Table of Contents. The Table of Contents pages on the issued documents lack form numbers and differ significantly from the filed version provided to the examiners. ALIC provided a spreadsheet that indicates that the actual number of insureds that received these forms was 166. The Report will be revised to remove references to the cover or title page and to indicate 166 instances for PF05B on the policy forms summary chart.

PF12B – PF21B (Both in ALIC's response regarding the SRC plans and the additional company comments after the policy forms summary chart): ALIC has provided filed and approved forms in its response, but the policy form numbers on these filed and approved forms **do not match** the policy form numbers on the forms that were included in the sample new business files and subsequently cited by the examiners. It is not relevant that ALIC has presented filed and approved forms that are similar to the ones that were issued. The policy form numbers on the issued forms are **different** from the policy form numbers on the filed and approved forms. 14 VAC 5-100-50 requires the company to file a form in its final form in which it is to be issued and to include the policy form number in the lower left hand corner; therefore, the issued forms **have not been filed and approved.** The examiners have included a list of each Review Sheet number, the policy form number on the issued form cited by the examiners, and the policy form number of the form provided in ALIC's response:

Review Sheet	Policy form # on issued form	Policy form # on ALIC response
PF12B	GR 29N 01-01-01 VA	GR-9N S-01-01 01
PF13B	GR-9N-15-10-02 VA	GR-9N S-15-10 01
PF14B	GR-9N-15-75-01 VA	GR-9N S-15-75 01
PF15B	GR-9N-15-125-01 VA	GR-9N S-15-125 01
PF16B	GR-9N-S-15-140-01 VA	GR-9N S-15-140 01
PF17B	GR-9N-15-150-01 VA	GR-9N S-15-150 01
PF18B	GR-9N-15-170-01	GR-9N S-15-170 01
PF19B	GR-9N-005-01	GR-9N S-26-005 01
PF20B	GR-9N 26-020 01	GR-9N S-26-020 01
PF21B	GR-9N-010-01	GR-9N S-26-010 01

The examiners note that the policy form summary chart in the Report is missing a "0" in the issued policy form number related to PF20B and PF21B- the chart in the Report will be revised to reflect the policy form number exactly as it is shown on the issued form. The violations will remain.

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PF22B: ALIC has submitted filed forms from May, 2004, in its response. However, the policy form numbers on these filed forms **do not match** the policy form numbers on the forms cited by the examiners that were issued to insureds. Since the company must display the correct policy form number when using a filed form, the issued forms **have not been filed.** The violations will remain.

PF01-SH: ALIC provided a copy of a certificate, GR-96134 ED. 6-02, that has been stamped filed and approved. However, this policy form number **does not match** the policy form number on the issued forms cited by the examiners, GR-96134 ED. 8-06. Therefore, GR-96134 ED. 8-06 is **not** a filed and approved form. The forms issued by ALIC with policy form number GR-96175 ED. 3-98 all **differ significantly** from the filed and approved version. Regarding the certificate of coverage, ALIC's response included a postcard sent to students. ALIC stated that the postcard is sent: "...so that they can access a copy online and advises them how to request a paper copy if needed." In accordance with § 38.2-325 of the Code, the parties must agree to conduct business by electronic means. The postcard makes the assumption that the insured agrees to electronic delivery of the certificate of coverage, rather than first seeking agreement by the insured. The postcard is not in conformity with the electronic delivery requirements in the Code. The violations will remain.

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Agents

AG01: The Appointed Agent Review section of the Report has been revised to remove the reference to Review Sheet AGO1. The number of violations remains the same.

Claim Practices

Throughout the Claim Practices section of this response letter, the examiners will, when possible, address ALIC's multiple concerns regarding the violations on a Review Sheet all at once and refer ALIC back to the original comments to avoid repetition.

Paid Claim Review

Student Health

CL28BW-SH: ALIC's response objects to the fact that the violation cited was for a claim that was on the same EOB as the sample claim but was not the sample claim. The examiners cannot ignore a violation that is discovered during the course of the review solely because it occurred on a claim that was not a part of the original sample. The examiners reserve the right to expand the review to include the additional claim on the EOB. The violations will remain.

CLMEM01B-ASH and CLMEM02B-ASH: These Memorandums were sent to request additional information concerning a policy exclusion and to clarify the chiropractic coverage provided in certain student health policies. ALIC's responses to the Memorandums included information about corrective actions that ALIC would take to rectify any claim handling errors that had occurred. During the claims review, the

examiners sent Review Sheets to ALIC that cited any violations of the Code or regulations that were revealed in the sample claims as a result of these issues. Therefore, since there are no violations cited in CLMEM01B-ASH and CLMEM02B-ASH, and since they are Memorandums and not Review Sheets, they were not included in the Review Sheet Summary by Area. The Report will be revised to include ALIC's additional comments from its response to CLMEM02B-ASH.

Interest on Accident and Sickness Claim Proceeds

CL07BW-SH: The violation of § 38.2-3407.1 of the Code will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL17BL-SH: The violation of § 38.2-3407.1 of the Code will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL24BW-SH: The violation of § 38.2-3407.1 of the Code will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL48M: The violation of § 38.2-3407.1 of the Code will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

Denied Claim Review

Accident and Sickness

Student Health

CL28BW-SH: Please refer to the comments under Paid Claim Review, Student Health.

Regarding all violations of § 38.2-3405 B of the Code (Paid and Denied): ALIC's response indicates that it was required to request accident details to ensure which policy the claim would be applied to, as there are school policies that do not cover intercollegiate injuries. However, the questionnaire also asks whether the injury was the result of an auto accident and requests that all auto carrier explanation of benefits be submitted with the claim. ALIC denied or pended claims and sent a questionnaire that requested information on coordination of benefits with automotive liability coverage, in violation of the Code. The violations will remain. The examiners note that ALIC has stated that "...for clarity purposes, the Company will remove any questions related to automobile accidents from the accident questionnaire."

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Unfair Claim Settlement Practices Review

Regarding the Company's general response to 14 VAC 5-400-60 A (first party claimant): The examiners do not concur with ALIC's response. As previously communicated in the Bureau's April 17, 2008, letter to ALIC, the insured is considered to be the first party claimant and the provider is the third party claimant. The insurance policy was issued to the insured, not to the provider, and the insured is asserting a right to payment for services provided to him/her under that insurance policy. Regardless of which party submits the claim, 14 VAC 5-400-60 A requires that the insurer advise the first party claimant of the acceptance or denial of a claim within 15 working days of receipt by the insurer of properly executed proof of loss. The violations will remain.

§ 38.2-3407.4 B of the Code

CL18BL-SH: ALIC's response indicates that CPT code 88175 falls under the "Routine Physical Exam" benefits; however, the examiners note that the EOB lists the service as a "Preventive Service". The student brochure lists "Preventive Health Care Services" as a distinct category of services which includes routine preventive and primary care services rendered to a covered dependent child under seven years of age on an outpatient basis. There is no copay associated with Preventive Health Care Services, and the plan pays 90% of the negotiated charge. There is a separate category of "Routine Physical Exam Expenses" that indicates that the plan pays 90% of the negotiated charge after a $20 copay. Since these laboratory charges are associated with a routine physical of a person greater than 7 years of age, the EOB should indicate that the services are "Routine Physical Exam Expenses", not "Preventive Services". In addition, the examiners would note that this claim was cited because the EOB did not accurately and clearly set forth the benefits payable under the contract, and pertinent facts and provisions regarding the coverage were misrepresented. The insured would not be able to determine if the claim was processed correctly because the services were not identified appropriately according to the categories listed in the student brochure or the policy. The examiners have no comment regarding the claim being processed incorrectly. Further, ALIC submitted an additional EOB with its draft response and stated: "The copay was combined with the deducible [sic] of $28.27 which was also applied on this claim so the total amount listed in the deductible column on the EOB is $48.27." This EOB shows the copay amount incorrectly listed in the deductible column; therefore, although no additional violations are being cited at this time, the additional EOB that ALIC provided in its response would also be in violation of these sections of the Code. The violations will remain.

CL28BW-SH: Please refer to the comments under Paid Claim Review, Student Health.

CL57BW-SH: ALIC's response indicates that the examiners selected the same claim twice and labeled it as both BOI # 62 and BOI # 106. The examiners do not concur. As indicated in the student health denied claim sample spreadsheet, BOI # 106 is a different claim than BOI # 62. It appears that the claim number is listed incorrectly on Review Sheet CL70BW-SH, but BOI # 106 is listed correctly. The correct claim number for CL70BW-SH is 101543228E. As this is not a duplicate, the violations cited under

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CL57BW-SH will remain. Review Sheet CL70BW-SH will be discussed further in a subsequent section of this response letter.

CL69BW-SH: ALIC's response does not reference the claim that was discussed in this Review Sheet. The claim number was incorrect on the original Review Sheet. Please refer to the examiners' response to this Review Sheet dated September 23, 2013, (CL69BW-SH exr.docx). This Review Sheet is regarding BOI #104 in the student health denied claim sample (claim # 101204545E). The claim number and student ID were corrected on the Review Sheet response. Both the population information and the screen prints provided to the examiners for BOI # 104 indicate that the date of service is 4/22/2010. The diagnosis code is V7232 and the CPT code is 88305. The violations will remain.

14 VAC 5-400-40 A

CL01B: The examiners do not concur. ALIC's contract with the intermediary and provider indicate that the provider is participating. The member was held liable for the entire amount of the denied charge. However, since the provider is participating and the provider's contract contains a hold harmless clause, the member should not be held liable for this charge. In addition, please note the following language from ALIC's contract with Beech Street (bolding added by examiners):

> 5.4 Billing of Members. Entity represents and warrants that the terms and provisions of the Entity Provider Agreements shall permit Company to require Participating Entity Providers to comply with Company's member billing standards as set forth, in part, in this Section 5.4. Accordingly, Participating Entity Providers may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles not collected at the time that Covered Services are rendered; (b) a Payor (other than Company) becomes insolvent or otherwise fails to pay Hospital in accordance with applicable Federal law or regulation (e.g., ERISA) provided that Participating Entity Provider has first exhausted all reasonable efforts to obtain payment from such Payor; and **(c) services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing, prior to the services being rendered, to pay for such services after being so advised. Entity and Participating Entity Providers acknowledge that Company's denial or adjustment of payment to Participating Entity Provider based on Company's performance of utilization management as described in Section 5.2.1 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 5.4.** Participating Entity Providers may bill or charge individuals who were not Members at the time that services were rendered.

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Therefore, ALIC did not provide a fair and equitable settlement of the claim and misrepresented pertinent facts and policy provisions. The violations will remain.

CL03B: ALIC's response indicates that the policy specifies a $10 maximum amount payable for this service, and that the Medicare Medical Expense Benefit Calculation was applied during processing. However, the EOB provided in ALIC's response shows a payment of only $7.26 on date of service 10/24/2009, which represents the remaining balance due for that claim after Medicare's payment. However, there would be another $2.74 in benefits available for the sampled claim discussed in CL03B. The policy language would support this assertion, as it states (emphasis added by examiners):

> If a physician renders medical treatment for a disease or injury to a Covered Person who is confined in a hospital, Aetna will pay a benefit. It will be an amount equal to the charge made by the physician for such treatment; but not more than $10 will be payable for **all treatments furnished on any one day**.

There were multiple treatments furnished on the same day, but ALIC did not apply the remaining $2.74 of benefit towards the sample claim, and ALIC has not provided evidence that this benefit was paid on another claim. It is not clear if ALIC is asserting that it has fulfilled the maximum benefit by making the $7.26 payment; however, the policy clearly addresses the benefit payable when more than one treatment is furnished on the same date of service. The violations will remain.

CL05B: ALIC has provided documentation that indicates that an online payment was received and the reinstatement was processed on 6/29/2010. The EOB sent to the insured was dated 7/03/2010, and at that time, ALIC had already accepted the payment and reinstated the coverage. Therefore, the 7/03/2010 EOB sent to the insured incorrectly showed that no coverage was in force on the date of service. In addition, ALIC has provided documentation that a different claim for the same services was processed and the explanation of payment to the provider is dated 10/15/2010. When ALIC accepts a payment and reinstates coverage, ALIC is responsible for providing insurance coverage during the time period for which coverage is reinstated. As soon as coverage was reinstated, any claims denied (due to terminated coverage) during the reinstated coverage period should have been reprocessed to reflect the updated eligibility information. Since a subsequent claim for these services was eventually processed with correct eligibility information, the examiners have removed the violation of 14 VAC 5-400-70 D. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated. The examiners would caution ALIC that it is responsible for ensuring that benefits are provided for any reinstated coverage period, and it should not wait for new claims to be submitted for services provided on impacted dates of service. Because the EOB sent to the insured did not reflect the correct eligibility information at the time it was sent, the violations of 14 VAC 5-400-40 A and 14 VAC 5-400-70 B will remain.

CL06B: ALIC's response does not address the examiners' observations discussing the incorrect information provided on the EOBs. The EOB, sent to the insured and dated 5/17/2010, shows both claim ESFAL0P2K00 and claim ESFAL0P2K01; however, the

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EOB incorrectly indicates $61.09 of patient liability ($6.09 too much), and it does not reflect the fact that claim ESFAL0P2K01 was a re-processing of claim ESFAL0P2K00. Separately, the provider explanation of payment, dated 5/6/2010, shows $0 patient liability for claim ESFAL0P2K01, but this explanation of payment does not indicate that it replaces any prior processing of the claim. Therefore, ALIC did not provide a fair and equitable settlement of the claim and the EOBs misrepresented pertinent facts and policy provisions related to the coverage at issue. The violations will remain.

CL08BW-SH: ALIC's response indicates that it was required to request accident details to ensure which policy the claim would be applied to, as there are school policies that do not cover intercollegiate injuries. ALIC also stated that "…accident information must be requested to verify what policy the services would be covered under." The examiners do not concur. ALIC did not solely ask about whether the services were related to intercollegiate sports injuries. ALIC denied or pended claims and sent a questionnaire that requested information on coordination of benefits with automotive liability coverage, in violation of the Code. The violations will remain.

CL10B: The examiners have no further comments regarding this denied claim. The examiners will remove the violations of 14 VAC 5-400-40 A, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D. The Report will be revised to reflect one less violation of each section and the Review Sheet Summary by Area will be updated.

CL18BL-SH: Please refer to the comments under Unfair Claim Settlement Practices Review, § 38.2-3407.4 B of the Code.

CL28BW-SH: Please refer to the comments under Paid Claim Review, Student Health.

CL57BW-SH: Please refer to the comments under Unfair Claim Settlement Practices Review, § 38.2-3407.4 B of the Code.

CL69BW-SH: Please refer to the comments under Unfair Claim Settlement Practices Review, § 38.2-3407.4 B of the Code.

CL70BW-SH: ALIC's response indicates that the examiners selected the same claim twice and labeled it as both BOI # 62 and BOI # 106. The examiners do not concur. As indicated in the student health denied claim sample spreadsheet, BOI # 106 is a different claim than BOI # 62. It appears that the claim number is listed incorrectly on Review Sheet CL70BW-SH, but BOI # 106 is listed correctly. The correct claim number for CL70BW-SH is 101543228E. As the claim cited under CL70BW-SH is not a duplicate, the examiners will remove the violation of 14 VAC 5-400-70 B. The rest of the violations will remain. The Report has been revised to reflect one fewer violation of 14 VAC 5-400-70 B.

CL71BW-SH: ALIC's response indicates that it was required to request accident details to ensure which policy the claim would be applied to, as there are school policies that do not cover intercollegiate injuries. ALIC stated that "…accident information must be requested to verify what policy the services would be covered under." The examiners

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do not concur. ALIC did not only ask about whether the services were related to intercollegiate sports injuries. The EOBs state: "Please provide complete accident details, including how, when (date and time), and where accident occurred and whether this was a motor vehicle accident, or occurred at work." ALIC denied or pended claims and sent a questionnaire that requested information on coordination of benefits with automotive liability coverage, in violation of the Code. The violations will remain.

14 VAC 5-400-50 A

EyeMedClaim01B: This section was not cited on these claims. ALIC's response referencing this section appears to be in error.

CL11-B: ALIC's response indicates that it agrees that the claim associated with BOI # 19 was not acknowledged timely. Regarding ALIC's question about the other claims cited, the examiners' response to CL11B was sent on 2/3/2014. The examiners' response indicates that only 1 instance of non-compliance with 14 VAC 5-400-50 A was cited for CL11-B, and it also indicates that the examiners had no further comment regarding the other claims noted by ALIC.

CL17BL-SH: The violation of 14 VAC 5-400-50 A will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL23BL-SH: The violation of 14 VAC 5-400-50 A will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL32BW-SH: The examiners do not concur. ALIC's response states that the claim was received on 3/22/2010 and the process date of the claim was 4/5/2010. According to ALIC's procedures provided to the examiners to determine mailing date, this EOB was not mailed until 4/8/2010. The procedures state that since the claim was processed on 4/5/2010, which is a Monday, 3 calendar days are added to the date to determine the mailing date (4/8/2010). ALIC failed to acknowledge the claim within 10 working days after receipt. The violation will remain.

CL35BL-SH: The violation of 14 VAC 5-400-50 A will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL40BL-SH: ALIC's response indicates that it agrees that the claims associated with BOI # 9 and BOI # 37 were not acknowledged timely. Regarding ALIC's question about other claims cited, the examiners' response to CL40BL-SH was sent on 10/3/2013. The examiners' response indicates that only 2 instances of non-compliance with 14 VAC 5-400-50 A were cited, and it also indicates that the examiners had no further comment regarding the other claims noted by ALIC.

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CL43BW-SH: The violation of 14 VAC 5-400-50 A will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL04M: The examiners do not concur. Although ALIC indicates that a claim payment was processed on the 9th working day, ALIC's response that the claim payment was made within 10 working days does not appear to account for mailing days. The violation will remain.

CL06M: The violation of 14 VAC 5-400-50 A will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL09M: The examiners do not concur. Although ALIC provided documentation that a notation was made in the file that a delay letter was sent on 2/8/2010, ALIC could not provide a copy of the actual delay letter. ALIC did provide a sample letter, but the sample letter contains the same information as the actual letter in the file dated 2/24/2010. The violation will remain.

14 VAC 5-400-60 A

EyeMedClaim01B: The examiners do not concur with ALIC's response. As previously communicated in the Bureau's April 17, 2008, letter to ALIC, the insured is considered to be the first party claimant and the provider is the third party claimant. The insurance policy was issued to the insured, not to the provider, and the insured is asserting a right to payment for services provided to him/her under that insurance policy. Regardless of which party submits the claim, 14 VAC 5-400-60 A requires that the insurer advise the first party claimant of the acceptance or denial of a claim within 15 working days of receipt by the insurer of properly executed proof of loss. The violations will remain.

CLSRC02: The examiners do not concur. Although ALIC has provided documentation that a letter was sent to the insured and provider requesting additional information, ALIC did not affirm or deny coverage within 15 working days of receipt of proof of loss. The violation will remain.

CL02-TB: The examiners do not concur. According to ALIC's procedures provided to the examiners to determine mailing date, this EOB was not mailed until 3/16/2010 at the earliest. The procedures state that since the claim was processed on 3/11/2010, which is a Thursday, 5 calendar days are added to the date to determine the mailing date (3/16/2010). ALIC failed to affirm or deny the claim within 15 working days after receipt of proof of loss. The violation will remain.

CL03BW-SH: The examiners do not concur. According to ALIC's procedures provided to the examiners to determine mailing date, this EOB was not mailed until 1/7/2010. The procedures state that since the claim was processed on 1/3/2010, which is a Sunday, 4 calendar days are added to the date to determine the mailing date

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(1/7/2010). ALIC failed to affirm or deny the claim within 15 working days after receipt of proof of loss. The violation will remain.

CL03-TB, CL04-TB, CL08-TB, CL09-TB, CL13-TB, CL14M, CL17M, CL18-TB, CL19-TB, and CL34M: The examiners do not concur with ALIC's response. As previously communicated in the Bureau's April 17, 2008, letter to ALIC, the insured is considered to be the first party claimant and the provider is the third party claimant. The insurance policy was issued to the insured, not to the provider, and the insured is asserting a right to payment for services provided to him/her under that insurance policy. Regardless of which party submits the claim, 14 VAC 5-400-60 A requires that the insurer advise the first party claimant of the acceptance or denial of a claim within 15 working days of receipt by the insurer of properly executed proof of loss. The violations will remain.

CL10-TB: The examiners do not concur. The EOB provided shows the original processing of the claim, which resulted in a denial. New information was received on 12/20/2010. ALIC failed to affirm or deny the claim within 15 working days of receipt of the new proof of loss. The violation will remain.

CL11B: *BOI # 6 and # 7(Group Denied MH)*: The examiners do not concur. Although ALIC indicates that the EOB was dated on the 15th working day, ALIC's response does not appear to account for mailing days. ALIC's response does not mention or provide documentation of the process date, which is used in determining the mailing date. The violations will remain.
BOI # 15(Group Denied MH): The examiners do not concur with ALIC's response. As previously communicated in the Bureau's April 17, 2008, letter to ALIC, the insured is considered to be the first party claimant and the provider is the third party claimant. The insurance policy was issued to the insured, not to the provider, and the insured is asserting a right to payment for services provided to him/her under that insurance policy. Regardless of which party submits the claim, 14 VAC 5-400-60 A requires that the insurer advise the first party claimant of the acceptance or denial of a claim within 15 working days of receipt by the insurer of properly executed proof of loss. The violation will remain.
BOI # 27(Group Denied Regular): The examiners do not concur. The process date of this claim is 3/25/2010. According to ALIC's procedures, the mailing date for the EOB sent to the insured for this claim is 3/30/2010, which is greater than 15 working days after receipt of complete proof of loss. The violation will remain.

CL16-TB: The examiners do not concur. Although ALIC indicates that the EOB was dated 4/8/2010, ALIC's response does not appear to account for mailing days. ALIC's response does not mention or provide documentation of the process date, which is used in determining the mailing date. The violation will remain.

CL17BL-SH: The examiners do not concur. ALIC has not provided any documentation that, within 15 working days of receipt of proof of loss, it advised the first party claimant (the insured) of the acceptance or denial of the claim or that additional time was needed. ALIC provided a copy of an explanation of payment addressed to the provider

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that was dated 5/6/2010. ALIC did not provide any evidence that a notice was sent to the insured within 15 working days. The violation will remain.

CL20-TB: The examiners do not concur. Although ALIC indicates that the EOB was dated 7/3/2010, ALIC's response does not appear to account for mailing days. ALIC's response does not mention or provide documentation of the process date, which is used in determining the mailing date. The violation will remain.

CL22BL-SH: ALIC's response objects to the fact that the violation cited was for the original processing of the claim and not the reprocessing represented by the sample claim selected by the examiners. The examiners cannot ignore a violation that is discovered during the course of the review solely because it occurred on a claim that was not a part of the original sample. The examiners reserve the right to expand the review to include the original processing of the sample claim. The violation will remain.

CL35BL-SH: The examiners do not concur. ALIC has not provided any documentation that it advised the first party claimant (the insured) of the acceptance or denial of the claim within 15 working days of receipt of proof of loss, or, if additional time is needed, the insurer must notify the first party claimant (the insured) within 15 working days. ALIC provided a copy of an explanation of payment addressed to the provider that was dated 3/9/2010. This explanation of payment indicated that a pre-existing condition review must be completed. ALIC did not provide any evidence that a notice was sent to the insured within 15 working days. The violation will remain.

CL39M: The examiners do not concur. Although ALIC indicates that the EOB was dated 10/14/2010, ALIC's response does not mention or provide documentation of the process date, which is used in determining the mailing date. The violation will remain.

CL40BW-SH: The examiners do not concur. Although ALIC indicates that the EOB was dated 12/19/2009, ALIC's response does not mention or provide documentation of the process date, which is used in determining the mailing date. In addition, ALIC indicates that this claim was first processed under the individual provider name as non-participating, and then re-processed under the group name as a participating provider; however, all of the EOBs and explanations of payment provided to the examiners (including those dated 12/19/2009) have the same group name for the provider. ALIC also indicates that the provider contacted ALIC on 1/27/2010, but no claim notes or documentation regarding this communication were provided. The violation will remain.

CL48BW-SH: The violation of 14 VAC 5-400-60 A will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL53M: The examiners do not concur. ALIC's current response contains an explanation of payment sent to the provider; however, 14 VAC 5-400-60 A requires that the insurer advise the first party claimant (the insured) of the acceptance or denial of a claim within 15 working days of receipt by the insurer of properly executed proof of loss. In addition, even if the notice was sent to the insured, ALIC's response does not appear

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to account for mailing days. The sample claim file previously provided to the examiners contains an EOB dated (Monday) 12/6/2010. According to the mailing procedures provided, the examiners would calculate that the EOB was mailed on Wednesday, 12/8/2010. In addition, the procedures indicate that ALIC can track the actual date that an EOB was picked up by the USPS. The violation will remain.

CL54M: The violation of 14 VAC 5-400-60 A will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

14 VAC 5-400-70 A

EyeMedClaim01B: The examiners do not concur with ALIC's response. As previously communicated in the Bureau's April 17, 2008, letter to ALIC, the insured is considered to be the first party claimant and the provider is the third party claimant. The insurance policy was issued to the insured, not to the provider, and the insured is asserting a right to payment for services provided to him/her under that insurance policy. The violations will remain.

CL34M: The violation of 14 VAC 5-400-70 A will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

14 VAC 5-400-70 B

EyeMedClaim01B: The examiners do not concur with ALIC's response. The examiners have no comment regarding the correctness of the processing of the claim. ALIC failed to send the insured a reasonable written explanation of the basis for denial. The violations will remain.

CL03B: Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

CL05B: Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

CL10B: Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

CL34M: The violation of 14 VAC 5-400-70 B will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL69BW-SH: Please refer to the comments under Unfair Claim Settlement Practices Review, § 38.2-3407.4 B of the Code

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CL70BW-SH: Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

CL71BW-SH: Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

14 VAC 5-400-70 D

CL01B: Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

CL03B: Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

CL05B: Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

CL06B: Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

CL10B: Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

CL69BW-SH: Please refer to the comments under Unfair Claim Settlement Practices Review, § 38.2-3407.4 B of the Code.

CL71BW-SH: (The examiners note that ALIC's response indicates that it disagrees with the violation of 14 VAC 5-400-70 D for Review Sheet CL71BW-SH, but ALIC did not include supporting documentation relating to this review sheet in the "14 VAC 5-400-70 D Documentation" folder attached to its response. The examiners reviewed the documentation relating to this review sheet that ALIC provided in a different folder and responded accordingly.) Please refer to the comments under Unfair Claim Settlement Practices Review, 14 VAC 5-400-40 A.

The examiners note that, for clarification purposes, references to § 38.2-316 C in the Report will be changed to § 38.2-316 C 1, and the references to § 38.2-3405 on page 38 of the Report will be changed to § 38.2-3405 B.

We have attached a copy of the report incorporating the revisions discussed above for your review. If you have additional questions, please feel free to contact us.

Once the matter has been concluded, ALIC will receive a final copy of the Report, which will include any revisions, copies of any additional responses you care to make, and copies of relevant correspondence up to and including any order issued by the State Corporation Commission.

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On the basis of our review of this entire file, it appears that ALIC has violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 5, 38.2-510 A 6, 38.2-510 A 14, 38.2-510 A 15, 38.2-511, and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-1812 A, 38.2-1822 A, 38.2-1833 A 1, 38.2-3115 B, 38.2-3405 B, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.14 A, 38.2-3407.14 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3533, 38.2-5804 A, 38.2-5805 B of the Code, as well as 14 VAC 5-40-60 B, Rules Governing Life Insurance and Annuity Marketing Practices, and 14 VAC 5-90-50 B, 14 VAC 5-90-55 A, and 14 VAC 5-90-130 A, Rules Governing Advertisement of Accident and Sickness Insurance, and 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-50 C, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 A, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D, Rules Governing Unfair Claim Settlement Practices.

Violations of the above sections of the Code of Virginia can subject ALIC to monetary penalties of up to $5,000 for each violation and suspension or revocation of its license to transact business in Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter. The Report will not become a public document until the settlement process has been completed.

Very truly yours,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS, MCM
Principal Insurance Market Examiner
Market Conduct Section
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:
Enclosures
cc: Bob Grissom
Althelia P. Battle

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May 12, 2015

VIA EMAIL

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS, MCM
Principal Insurance Market Examiner
Commonwealth of Virginia
Market Conduct Section - Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

RE: Market Conduct Examination Report—Exposure Draft

Dear Ms. Fairbanks,

The purpose of this letter is to provide a response to your letter dated April 10, 2015 regarding the Aetna Life Insurance Company (ALIC) "Market Conduct Examination Report Exposure Draft". In our most recent response it is noted that ALIC expressed a few concerns regarding some of the findings referenced in the draft report. Prior to finalization of the exam, we appreciate the opportunity from the Bureau of Insurance (Bureau) to perform a final review of the remaining items to which we have expressed concerns.

Based on our review of the remaining concerns as presented in the November 17th response, in the attached document we have provided additional commentary and/or documentation which we believe demonstrates compliance and request the Bureau to consider this information prior to finalization of the exam report.

Again, we thank the Bureau for the opportunity to respond to the draft report. If you have any questions, please feel free to contact me at 540-524-8939 or via email at whitakerc2@aetna.com.

Respectfully,

Carrie Whitaker
Compliance Lead

CC: James P. Wolf, Regional General Counsel
Darcey Gartner, Sr. Director, Regulatory Compliance Unit

Attachments

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ADDITIONAL RESPONSES TO
"MARKET CONDUCT EXAMINATION REPORT – EXPOSURE DRAFT"

Provider Contracts

EF02—*It does not appear that ALIC has submitted any new information for the examiners' consideration. As discussed in the examiners' response to EF02, the contact does not comply with 38.2-3407.15B 4, 38.2-3407.15B 7, and 38.2-3407.15B 11 of the Code. Regarding 38.2-3407.15B 4 of the Code, the Regulatory Compliance Addendum attached to the provider contract does not include the contact information that the provider may use to request specific bundling and down-coding policies nor does section 3.1 of the provider contract. Regarding 38.2-3407.15B 7 of the Code, the Regulatory Compliance Addendum does not specify that the carrier will provide in writing the claim or claims for which retroactive denial is to be imposed or the recovery or refund is sought, and that the written communication shall also include an explanation of why the claim is being retroactively adjusted. Regarding 38.2-3407.15B 11 of the Code, section 10.2.1 of the provider contract does not include how the provider may access information on the claims payment dispute mechanism.*

ALIC Response: In accordance with 38.2-3407.15 B 11 of the VA Code "all carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers." In our opinion, the Code does not explicitly state that this information must be included in the provider contract, nor does it require that the contract is the only mechanism pursuant to which the information is made available. The claims payment dispute mechanism and information for submitting a claims payment dispute is made available to the provider through the secure portal. All providers are educated on use of the portal upon signing a provider contract with ALIC. To illustrate the information in the provider portal, attached are screen shots that reflect the portal which contain all necessary information required per the Code. See attachment "***EF02ALICResponse.docx.***"

EF03—*It does not appear that ALIC has submitted any new information for the examiners' consideration. Regarding 38.2-3407.15B 11 of the Code, section 8.0 of the provider contract does not include how the provider may access information on the claims payment dispute mechanism.*

ALIC Response: ALIC requests that the examiners consider the information provided above in the response for EF02. All providers are trained on using the portal upon signing a contract with ALIC. ALIC believes the claims payment dispute information available through the provider portal complies with this requirement and is also supported by the provider web portal toolkit which was established in 2003.

EF05—*It does not appear that ALIC has submitted any new information for the examiners' consideration. As discussed in the examiners' response to EF05, the contract does not comply with 38.23407.15B 4, 38.2-3407.15B 7, and 38.12-3407.15B 11 of the Code. Regarding 38.2-3407.15B4 of the Code, section 5 of the Regulatory Compliance Addendum does not include the contact information that the provider may use to request specific bundling and down coding policies. Regarding 38.2-3407.15B7 of the Code, section 8 of the Regulatory Compliance Addendum does not specify that that carrier will provide in writing the claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, and that the written communication shall also include an explanation of why the claim is being retroactively adjusted. Regarding 38.2-3407.15B11 of the Code, ALIC refers the examiners to "the Regulatory Addendum item 1". Item 1 does not appear to contain the*

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wording required by 38.2-3407.15B11 of the Code. As indicated in the examiners' previous response to the review sheet, section 10.1 of the provider contract does not include how the provider may access information on the claims payment dispute mechanism.

ALIC Response: ALIC requests that the examiners consider the information provided above in the response for EF02. All providers are trained on using the portal upon signing a contract with ALIC. ALIC submits that the fact that the claims payment dispute information, as well as information regarding bundling and down-coding policies, is available through the provider portal supports this requirement and is also supported by the provider web portal toolkit which was established in 2003.

EFCL01B—*The examiners do not concur with ALIC's response. ALIC has provided information that this provider was a part of a group practice, and ALIC has provided a group contract that appears to have been amended with a fee schedule in 2007. The direct contract with the provider that was originally submitted to the examiners was executed in 2009, and it also indicated that the provider was a part of the group practice and included the address of the group practice. However, it appears that the fee schedule in the 2009 contract originally provided to the examiners and the 2007 amended fee schedule from the group contract submitted with ALIC's current response are actually the same. The CPT codes in question, 99396 and 99213, appear to have a fee schedule rate that is higher than what was allowed by ALIC on the sample claims. The violations will remain.*

ALIC Response: The original response indicated how the claims were processed and pricing from our system was provided and is attached again for your review. Upon further review, the billing provider was [redacted] and the servicing provider was [redacted]. [redacted]s group is on the VA PCP fee schedule. Her individual contract was provided and is listed with the AMFS rates for VA01. Her group contract supersedes, so the rates paid on the attached spreadsheet were correct. The correct rates for the claims listed below are $86.58 for CPT code 99213 and $138.90 for CPT code 99396.

Please see attachment "[redacted].docx" for screenshots which reflect the 2008 Medicare rate for GPCI 0090400 where [redacted]s office is located. The rates are the same for all four dates of service:

- [redacted]32 EK34KZNDDN 1/18/2010
- [redacted]34 E5TVK87ZQ 3/01/2010
- [redacted]35 ESPALVWDR 4/15/2010
- [redacted]33 ETTVL25GP 5/05/2010

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Advertising

AD01B-SH—*ALIC has previously stated that the policy brochure, with an application, is provided to all students, and this brochure becomes the "coverage document" once the student enrolls. The brochure is a document containing an explanation of plan benefits. Since this document, along with an application, is being provided to all students, not just existing insureds, this document is being utilized as an advertisement, as defined in Chapter 90 of the Virginia Administrative Code. ALIC's response regarding its SERFF filing of this document is not applicable as advertisements for student health insurance are not required to be filed for approval or informational purposes. The company is, however, required to ensure that its advertisements are in compliance with the Virginia Administrative Code. If this document were to be used for other purposes, such as an evidence of coverage, the document would be subject to the applicable filing requirements for its use, which should be specifically identified when filed.*

ALIC Response: To clarify, the policy brochure is available on the website and is not placed in a pre-enrollment kit; therefore, the brochure in intended for only those student health members who are already enrolled in the plan. Based on this method of distribution, ALIC believes that this does not meet the definition of an advertisement as it is not intended nor distributed to someone who intends to purchase a plan rather it is distributed to those already actively enrolled. We apologize for any prior confusion.

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Policy Forms

PF11B—*The examiner's do not concur with ALIC's response. The approved form sent with ALIC's response appears to be for Aetna Health, Inc., as indicated by the company name and address at the top of the form. The violations will remain.*

ALIC Response: According to our records, the ALIC MEOB-VA6 form was filed with the VBOI under form submission number 007-0000028413 and was approved on 9/17/2007.

PF05B and PF10B—*The examiners have no further comments regarding the cover or title page of the Certificates of Coverage (COCs). The examiners do not concur with ALIC's disagreement regarding the Table of Contents. The Table of Contents pages on the issued documents lack form numbers and differ significantly from the filed version provided to the examiners. ALIC provided a spreadsheet that indicates that the actual number of insureds that received these forms was 166. The Report will be revised to remove references to the cover or title page and to indicate 166 instances for PF05B on the policy forms summary chart.*

ALIC Response: Please see attachment "***PF10B TOC Booklet_Certificate (GR-9N). pdf.***" This attachment contains the stamped approval of the table of contents (TOC). ALIC previously held discussions with the BOI regarding our E-pub (publication system) and how the system generates documents that only lists the "GR-9N" form number in the footer. ALIC's representative Greg Martino (former Government Affairs Director for VA) discussed this issue previously with Althelia Battle and Jackie Cunningham at the BOI to explain the issue and obtain approval on same. ALIC files a basic Word document with significant variable, bracketed text, and due to our system, the final version may appear different in layout for aesthetic purposes in publishing. This would account for the variation in appearance. Please see attachment labeled "***FORMMEMOS.docx"*** for a copy of the email sent by ALIC to the BOI regarding this issue.

PF22B—*ALIC has submitted filed forms from May, 2004, it its response. However, the policy form numbers on these filed forms do not match the policy form numbers on the forms cited by the examiners that were issued to insureds. Since the company must display the correct policy form number when using a filed form, the issued forms have not been filed. The violations will remain.*

ALIC Response: ALIC Individual plans, during this examination timeframe, were sold under Delaware Trust. The corresponding forms were not filed and approved in Virginia since they were filed and approved in Delaware and subject to Delaware law. On May 11, 2015, ALIC submitted an informational filing to the Bureau under ***SERFF Tracking Number:*** *AENX-G129863239.*.

PF01-SH—*ALIC provided a copy of a certificate, GR-96134 ED. 6-02, that has been stamped filed and approved. However, this policy form number does not match the policy form number on the issued forms cited by the examiners, GR-96134 ED. 8-06. Therefore, GR-96134 ED. 8-06 is not a filed and approved form. The forms issued by ALIC with policy form number GR-96175 ED. 3-98 all differ significantly from the filed and approved version. Regarding the certificate of coverage, ALIC's response included a postcard sent to students. ALIC stated that the postcard is sent: "...so that they can access a copy online and advises them how to request a paper copy if needed." In accordance with 38.2-325 of the Code, the parties must agree to conduct business by electronic means. The postcard makes the assumption that the insured agrees to electronic delivery of the certificate of coverage, rather*

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than first seeking agreement by the insured. The postcard is not in conformity with the electronic delivery requirements in the Code. The violations will remain.

ALIC Response: ALIC disagrees with the position that the insured agrees to electronic delivery of the Certificate of Coverage, rather than first seeking agreement by the insured. The postcard is mailed to each member and notifies the member that the Certificate of Coverage is available either electronically or in paper copy. Instructions about how to access these documents are included on the postcard. The purpose of the postcard is not to replace the delivery of the Certificate of Coverage.

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Interest on Accident and Sickness Claim Proceeds

CL17BL-SH—*The examiners do not concur. ALIC has not provided any documentation that, within 15 working days of receipt of proof of loss, it advised the first party claimant (the insured) of the acceptance or denial of the claim or that additional time was needed. ALIC provided a copy of an explanation of payment address to the provider that was dated 5/6/2010. ALIC did not provide any evidence that a notice was sent to the insured within 15 working days. The violation will remain.*

ALIC Response: ALIC has attached a copy of the explanation of benefits that was mailed to the member within the 15 working day timeframe. Please see attachment "***CL17BL-SH Member EOB 101130019E.pdf.***"

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Unfair Claim Settlement Practices Review—*Regarding the Company's general response to 14 VAC 5-400-60 A (first party claimant): The examiners do not concur with ALIC's response. As previously communicated in the Bureau's April 17, 2008, letter to ALIC, the insured is considered to be the first party claimant and the provider is the third party claimant. The insurance policy was issued to the insured, not to the provider, and the insured is asserting a right to payment for services provided to him/her under that insurance policy. Regardless of which party submits the claim, 14 VAC 5-400-60 A requires that the insurer advise the first party claimant of the acceptance or denial of a claim within 15 working days of receipt by the insurer of properly executed proof of loss. The violations will remain.*

ALIC Response: ALIC asserts that the provider is the first party claimant since he/she is the one submitting the claim for payment. The member has assigned all benefits under the policy to the provider and the provider submits the claim on behalf of the provider, as it is the claimant by virtue of the assignment of benefits. Any rights the member may have had to submit the claim or to receive payment on the claim were given up and assigned to the provider, by virtue of the assignment to the provider. "First party claimant" is defined by 14 VAC5-400-20 as an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy. In this instance, that is the provider.

§ 38.2-3407.4 B of the Code

CL18BL-SH—*The examiners have no comment regarding the claim being processed incorrectly. However, ALIC submitted an additional EOB with its draft response and stated: "The copay was combined with the deductible of $28.27 which was also applied on this claim so the total amount listed in the deductible column on the EOB is $48.27." This EOB shows the copay amount incorrectly listed in the deductible column; therefore, although no additional violations are being cited at this time, the additional EOB that ALIC provided in its response would also be in violation of these section of the Code. The violations will remain.*

ALIC Response: While ALIC agrees with the fact that the EOB originally submitted showed the copay amount incorrectly listed in the deductible column, an attachment is being provided for review to substantiate that this error has since been corrected. Please see attachment labeled "***CL18BW Example EOB CopayDeductible_Redacted.pdf.***"

14 VAC 5-400-40 A

CL06B—*ALIC's response does not address the examiners' observations discussing the incorrect information provided on the EOBs. The EOB, sent to the insured and dated 5/17/2010, shows both claim ESFAL0P2K00 and claim ESFAL0P2K01; however, the EOB incorrectly indicates $61.09 of patient liability ($6.09 too much), and it does not reflect the fact that claim ESFAL0P2K01 was a re-processing of claim ESFAL0P2K00. Separately, the provider explanation of payment, dated 5/6/2010, shows $0 patient liability for claim ESFAL0P2K01 but this explanation of payment does not indicate that it replaces any prior processing of the claim. Therefore, ALIC did not provide a fair and equitable settlement of the claim and the EOBs misrepresented pertinent facts and policy provisions related to the coverage at issue. The violations will remain.*

ALIC Response: ALIC agrees with the examiners' observation. The member EOB contains all 3 claims processed (ESFAL0P2K00 and 01, ERWXL7BR400) as the action dates (processed dates) are 4/30/2010 and 5/01/2010. As all 3 claims are listed on one member EOB, the patient liability is shown as $61.09 instead of the actual amount of

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$55.00 from ERWXL7BR400 and $0.00 from ESFAL0P2K01. The reprocessed claim does not indicate that it replaces a prior processed claim. However, ESFAL0P2K01 indicates the following for the $14.00 venipuncture charge: "You are not responsible for this amount. Your plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. The charge for this service is not payable because it is considered part of another procedure performed on the same date of service." As the member EOB indicates that there is no patient liability for the $14.00 venipuncture charge, ***ALIC disagrees*** that it did not provide a fair and equitable settlement of the claim. As soon as claim ERWXLBR400 was entered on the claim system platform, ESFAL0P2K00 was reprocessed to correct the initial processing of the claim based on two separate blood charges received. Please see attachments "***CL06B1, CL06B2, and CL06B3***."

CL08BW-SH—*ALIC's response indicates that it was required to request accident details to ensure which policy the claim would be applied to, as there are school policies that do not cover intercollegiate injuries. ALIC also stated that "... accident information must be requested to verify what policy the services would be covered under." The examiners do not concur. ALIC did not solely ask about whether the services were related to intercollegiate sports injuries. ALIC denied or pended claims and sent a questionnaire that requested information on coordination of benefits with automotive liability coverage, in violation of the Code. The violations will remain.*

ALIC Response: The request for accident information was not related to a subrogation investigation. The reason accident information was requested is that ALIC needed to determine to which policy the claim would be applied. Please note that ALIC had previously agreed to remove all references to auto liability in the questionnaire and this has been completed as promised. Please see attachment labeled "***New VA Accident Letter***."

CL71BW-SH—*ALIC's response indicates that it was required to request accident details to ensure which policy the claim would be applied to, as there are school policies that do not cover intercollegiate injuries. ALIC stated that "... accident information must be requested to verify what policy the services would be covered under." The examiners do not concur. ALIC did not only ask about whether the services were related to intercollegiate sports injuries. The violations will remain.*

ALIC Response: The request for accident information was not related to a subrogation investigation. The reason accident information was requested is that ALIC needed to determine to which policy the claim would be applied. Please note that ALIC has previously agreed to remove all references to auto liability in the questionnaire and this has been completed as promised. Please see attachment labeled "***New VA Accident Letter***."

14 VAC 5-400-60 A

CL11B: BOI #6 and #7: *The examiners do not concur. Although ALIC indicates that the EOB was dated on the 15th working day, ALIC's response does not appear to account for mailing days. ALIC's response does not mention or provide documentation of the process date, which is used in determining the mailing date. The violations will remain.*

ALIC Response: Please see chart in response to CL39M, which shows the process date for these claims. ALIC asserts that the provider is the first party claimant since he/she is the one submitting the claim for payment on its own behalf. "First party claimant" is defined as an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy, per 14 VAC 5-400-20. In this instance, that is the provider. The member has assigned both right to submit the claim and the right to receive benefits to the provider.

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Any rights the member may have had to submit the claim or to receive payment were given up by virtue of assignment of benefits to the provider. Please see attachments labeled "***CL11B, CL11B1, CL11B2, CL11B3, and CL11B4***" for claim details.

BOI#15—*The examiners do not concur with ALIC's response. As previously communicated in the Bureau's April 17, 2008, letter to ALIC, the insured is considered to be the first party claimant and the provider is the third party claimant. The insurance policy was issued to the insured, not the provider, and the insured is asserting a right to payment for services provided to him/her under that insurance policy. Regardless of which party submits the claim, 14 VAC 5-400-60 A requires that the insurer advise the first party claimant of the acceptance or denial of a claim within 15 working days of receipt by the insurer of properly executed proof of loss. The violations will remain.*

ALIC Response: ALIC asserts that the provider is the first party claimant since he/she is the one submitting the claim for payment. The member has assigned all benefits under the policy to the provider and the provider submits the claim on behalf of the provider, as it is the claimant by virtue of the assignment of benefits. Any rights the member may have had to submit the claim or to receive payment on the claim were given up and were assigned to the provider by virtue of the assignment to the provider. "First party claimant" is defined by 14 VAC5-400-20 as an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy. In this instance, that is the provider.

BOI#27—*The examiners do not concur. The process date of this claim is 3/25/2010. According to ALIC's procedures, the mailing date for the EOB sent to the insured for this claim is 3/30/2010, which is greater than 15 working days after receipt of complete proof of loss. The violation will remain.*

ALIC Response: Please see chart in response to CL39M, which shows the process date for these claims. ALIC asserts that the provider is the first party claimant since he/she is the one submitting the claim for payment. The member has assigned all benefits under the policy to the provider and the provider submits the claim on behalf of the provider, as it is the claimant by virtue of the assignment of benefits. Any rights the member may have had to submit the claim or to receive payment on the claim were given up and were assigned to the provider, by virtue of assignment to the provider. "First party claimant" is defined by 14 VAC5-400-20 as an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy. In this instance, that is the provider. Please see attachments labeled "***BOI27, BOI271, and BOI272***" for claim details.

CL16-TB: *The examiners do not concur. Although ALIC indicates that the EOB was dated 4/8/2010, ALIC's response does not appear to account for mailing days. ALIC's response does not mention or provide documentation of the process date, which is used in determining the mailing date. The violation will remain.*

ALIC Response: Please see chart in response to CL39M, which shows the process date for these claims. ALIC asserts that the provider is the first party claimant since he/she is the one submitting the claim for payment. The member has assigned all benefits under the policy to the provider and the provider submits the claim on behalf of the provider, as it is the claimant by virtue of the assignment of benefits. Any rights the member may have had to submit the claim or to receive payment on the claim were given up and assigned to the provider, by virtue of the assignment to the provider. "First party claimant" is defined by 14 VAC5-400-20 as an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy. In this instance, that is the provider. Please see attachments labeled "***CL161, CL162, and CL163***" for claim details.

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CL20-TB: *The examiners do not concur. Although ALIC indicates that the EOB was dated 7/3/2010, ALIC's response does not appear to account for mailing days. ALIC's response does not mention or provide documentation of the process date, which is used in determining the mailing date. The violation will remain.*

ALIC Response: Please see chart in response to CL39M, which shows the process date for these claims. ALIC asserts that the provider is the first party claimant since he/she is the one submitting the claim for payment. The member has assigned all benefits under the policy to the provider and the provider submits the claim on behalf of the provider, as it is the claimant by virtue of the assignment of benefits. Any rights the member may have had to submit the claim or to receive payment on the claim were given up and were assigned to the provider by virtue of the assignment to the provider. "First party claimant" is defined by 14 VAC5-400-20 as an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy. In this instance, that is the provider. Please see attachments labeled ***CL201, CL202, and CL203*** for claim details.

CL39M—*The examiners do not concur. Although ALIC indicates that the EOB was dated 10/14/2010, ALIC's response does not mention or provide documentation of the process date, which is used in determining the mailing date. The violation will remain.*

ALIC Response: Please see chart below which shows the date the claim was processed. Please see attachments ***CL39M1, CL39M2, and CL39M3*** for claim details.

Item #	Claim Number	Date Claim Received	Date Claim Processed	Member EOB Date	Provider EOB Date
CL11-B	ECAAKQ3GH (BOI 6)	12/28/2009	12/30/2009	01/19/2010	01/01/2010
CL11-B	ECJKKQ1RW (BOI 7)	12/28/2009	12/30/2009	01/19/2010	01/01/2010
BOI #27	EMTVLK1ZP00	03/08/2010	03/25/2010	03/26/2010	03/26/2010
CL16-TB	EJFALQR6C00	03/19/2010	03/19/2010	04/08/2010	03/25/2010
CL20-TB	E2YZMH1WR00	06/14/2010	06/14/2010	07/03/2010	06/17/2010
CL39M	EVJKNVRMT00	10/06/2010	10/07/2010	10/14/2010	10/28/2010

CL40BW-SH—*The examiners do not concur. Although ALIC indicates that the EOB was dated 12/19/2009, ALIC's response does not mention or provide documentation of the process date, which is used in determining the mailing date. In addition, ALIC indicates that this claim was first processed under the individual provider name as non-participating, and then re-processed under the group name as a participating provider; however, all of the EOBs and explanations of payment provided to the examiners (including those dated 12/19/2009) have the same group name for the provider. ALIC also indicates that the provider contacted ALIC on 1/27/2010, but no claim notes or documentation regarding this communication were provided. The violation will remain.*

ALIC Response: The original claim #093430745E was received on 12/9/2009 and processed on 12/17/2009 and the EOB was dated 12/19/2009. For this particular claim, the mail date would be 9 working days. The claim was first processed under the individual provider name as non-participating. Please see the attached provider payment detail screenshot showing the individual provider as [redacted]. The provider name reflected on the EOB is the owner of the TIN. A copy of the Enterprise Provider Data Base System is also attached which shows the TIN owner

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as [redacted]. We have attached a copy of the customer service log entry which reflects the provider contacted ALIC on 1/27/2010. The attachments are labeled as "***CL40BW Provider Payment Detail Screen, CL40BW Screen Print EPDB System and CL40BW Customer Service Log Entry Screen.***"

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14 VAC 5-400-70 B

EyeMedClaim01B: *The examiners do not concur with ALIC's response. As previously communicated in the Bureau's April 17, 2008, letter to ALIC, the insured is considered to be the first party claimant and the provider is the third party claimant. The insurance policy was issued to the insured, not to the provider, and the insured is asserting a right to payment for services provided to him/her under that insurance policy. Regardless of which party submits the claim, 14 VAC 5-400-6-A requires that the insurer advise the first party claimant of the acceptance of denial of a claim within 15 working days of receipt by the insurer of properly executed proof of loss. The violations will remain.*

ALIC Response: ALIC asserts that the provider is the first party claimant since he/she is the one submitting the claim for payment. The member has assigned all benefits under the policy to the provider and the provider submits the claim on behalf of the provider, as it is the claimant by virtue of the assignment of benefits. Any rights the member may have had to submit the claim or to receive payment were given up and assigned to the provider, by virtue of assignment to the provider. "First party claimant" is defined by 14 VAC5-400-20 as an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy. In this instance, that is the provider.

COPY

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

July 27, 2015

CERTIFIED MAIL 7014 1200 0001 3578 7873
RETURN RECEIPT REQUESTED

Gail Yoder, Compliance Manager
Aetna Life Insurance Company
5305 Chestnut Ridge Road
Summerfield, NC 27358

Re: Market Conduct Examination Report
Exposure Draft

COPY

Dear Ms. Yoder:

The Bureau of Insurance (Bureau) has completed its review of your May 12, 2015, response to the Market Conduct Examination Report of Aetna Life Insurance Company (ALIC).

Your response indicates that ALIC continues to have concerns regarding the writing of the Report. This letter addresses these concerns in the same order as presented in your May 12th response. However, since ALIC's response will also be attached to the final Report, this response does not address those issues where ALIC indicated agreement and/or action taken as a result of the Report. ALIC should note that upon finalization of this exam, ALIC will be given approximately 120 days to document compliance with all of the corrective actions in the Report.

Provider Contracts

EF02, EF03: The violation of § 38.2-3407.15 B 11 of the Code of Virginia will be removed for Review Sheets EF02 and EF03. The Report will be revised to reflect two less violations and the Review Sheet Summary by Area will be updated. The examiners would caution ALIC that the Code requires that the provider contract contain a provision that the claims payment dispute mechanism be established, in writing, by the carrier and that the carrier shall make this information available to the provider. The language identified in ALIC's response doesn't specifically reference a claims payment dispute mechanism (it is a broad internal dispute mechanism), and it doesn't necessarily specify that the claims payment dispute mechanism will be established in writing. The examiners would recommend that ALIC strengthen the language in its current provider contracts to ensure compliance with the required provision. The examiners would also

note that unless the provider portal is formally incorporated into the contract, the examiners cannot consider the information contained therein. In addition, since the portal is web-based, ALIC would need to be able to provide the examiners with archived documentation of what information was provided on the portal during specified time frames.

EF05: The violation of § 38.2-3407.15 B 11 of the Code of Virginia will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated. The examiners would caution ALIC that the Code requires that the provider contract contain a provision that the claims payment dispute mechanism be established, in writing, by the carrier and that the carrier shall make this information available to the provider. The language identified in ALIC's response doesn't specifically reference a claims payment dispute mechanism (it is a broad internal dispute mechanism), and it doesn't necessarily specify that the claims payment dispute mechanism will be established in writing. The examiners would recommend that ALIC strengthen the language in its current provider contracts to ensure compliance with the required provision. The examiners would also note that unless the provider portal is formally incorporated into the contract, the examiners cannot consider the information contained therein. In addition, since the portal is web-based, ALIC would need to be able to provide the examiners with archived documentation of what information was provided on the portal during specified time frames. Regarding §§ 38.2-3407.15 B 4 and 38.2-3407.15 B 7 of the Code of Virginia, the provider contract does not include the contact information (telephone number, fax, or email address) to use to request specific bundling or downcoding policies, and the provider contract does not specify that the carrier will provide in writing the claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, and that the written communication shall also include an explanation of why the claim is being retroactively adjusted. Therefore, the violations of §§ 38.2-3407.15 B 4 and 38.2-3407.15 B 7 of the Code of Virginia will remain.

EFCL01B: The examiners do not concur. The examiners would note that the reimbursement rates referenced in ALIC's current response, ("....The correct rates for the claims listed below are $85.58 for CPT code 99213 and $138.90 for CPT code 99396."), are higher than the reimbursement rates that ALIC allowed on the sampled claims. The examiners would also note that the rates quoted above from ALIC's current response do not appear to match the screen prints provided by ALIC or the 2008 Medicare reimbursement rates.

Regardless of the reimbursement rates referenced in ALIC's current response, ALIC has not provided any evidence or legal opinion to support its assertion that the group practice's provider contract, signed in 2003, would supersede the provider's individual contract signed in 2009. The provider's individual contract specifically indicates that the provider is a part of the group practice (on the Service and Billing Location Form, p.34 of the contract) and lists the group practice's name and address as the Reimbursement address on the signature page of the contract (p.19). The only location listed for this individual provider is the group practice's address. When would this contract apply, if not for claims for services rendered at the group practice?

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Further, since ALIC negotiated and accepted the terms of the individual contract with the provider AFTER the contract between ALIC and the group practice had already been signed, it is the most recent contractual agreement with this provider.

Therefore, the examiners have determined that the most recent contract signed in 2009, that ALIC entered into with the individual provider as a part of the group practice, is the appropriate contract to use to determine the reimbursement rate for the sample provider claims. The sample provider claims were not paid according to the fee schedule attached or amended to the contract, in violation of § 38.2-3407.15 B 8 of the Code of Virginia. The violations will remain.

Advertising

AD01B-SH: The examiners do not concur. The examiner's acknowledge that ALIC has now determined that the brochure is not provided to each student, but it is available on ALIC's website. The examiners also acknowledge that ALIC has now determined that this brochure was not intended for someone who intends to purchase the plan. Regardless of ALIC's intent of distribution, since this is an informational brochure that is available to anyone on ALIC's website, it is an advertisement, as defined by the regulation. The violations will remain.

Policy Forms

PF11B: The examiners do not concur. Although ALIC has provided a submission number and approval date of a filing for form MEOB-VA 6, this was a paper filing. ALIC must provide a copy of the complete filed form, stamped approved by the BOI, in order for the examiners to consider ALIC's response. The violations will remain.

PF05B and PF10B: The examiners do not concur with ALIC's disagreement. The email provided in ALIC's response discusses ALIC's practice of providing the form number next to the headers of the certificate rather than at the bottom of each page, due to ALIC's chosen publishing system. There are NO form numbers on the Table of Contents pages in the certificates issued to the insureds. Therefore, the Table of Contents pages have not been filed and approved. In addition, even if the examiners were to consider the filed and approved Table of Contents page provided in ALIC's response (form GR-9N 01-005 01), it differs significantly from the multiple-page Table of Contents that was included in the certificates that were issued to the insureds. These differences go far beyond the variable, bracketed text that is present in the filed and approved Table of Contents page. The violations will remain.

PF22B: The examiners do not concur. It is the Commission's position that, even if the forms were filed and approved in Delaware, the forms are required to be submitted to the Forms section of the Bureau in an informational filing. Although the examiners acknowledge that ALIC has indicated that it submitted an informational filing on May 11, 2015, the forms that ALIC issued during the examination time frame had not been filed. The violations will remain.

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PF01-SH: The examiners do not concur. The default method of delivery of a certificate should be a paper certificate delivered to the insured. In accordance with § 38.2-325 of the Code and the Uniform Electronic Transactions Act (UETA) (§ 59.1-479 et seq.), the parties must agree to conduct business by electronic means PRIOR to such occurrences. The insured should not be required to "opt-in" to access a paper certificate by following additional instructions to phone or write ALIC to receive a paper copy of a certificate. The postcard is not in conformity with the electronic delivery requirements in the Code. The violations will remain.

Interest on Accident and Sickness Claims Proceeds

CL17BL-SH: As indicated in the examiners' April 10, 2015, letter to ALIC, the violation regarding interest due for this claim has already been removed from the Report.

Unfair Claim Settlement Practices Review

(For the examiners' response to ALIC's general response to 14 VAC 5-400-60 A, please see that specific section of this response letter.)

14 VAC 5-400-40 A

CL06B: The examiners do not concur. Although ALIC contends that the EOB states that the member is not responsible for a $14 venipuncture charge, the same EOB also indicated that the member was responsible for $6.09 for the $14 venipuncture charge. In addition, neither the member EOB nor the provider explanation of payment indicates that the second processing of the claim replaces any prior processing of that specific charge. The member liability is indicated as $61.09, which is $6.09 more than the correct amount of $55.00. The violations will remain.

CL08BW-SH and CL71BW-SH: The examiners do not concur. Although ALIC continues to assert that the accident questionnaire was not related to a subrogation investigation, the fact remains that the accident questionnaire sent by ALIC specifically requests information regarding automotive liability coverage, and coverage is denied until the questionnaire is returned, in violation of the Code. The examiners would also caution ALIC that the revised accident questionnaire letter provided with its response may not be in compliance with the current Code of Virginia and Virginia Administrative Code. The violations will remain.

14 VAC 5-400-60 A

General response regarding 14 VAC 5-400-60 A: The examiners do not concur. Even if ALIC produces a valid, signed assignment for each claim in question, the fact that the member may have assigned payment to the provider does not change the fact that the member is the first party claimant. The member is insured under the policy, not the provider, and the member remains the first party claimant. In addition, ALIC's response failed to include the entire definition under 14 VAC 5-400-20. The entire definition (with the missing language added and bolded) reads:

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> "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract **issued to such individual, corporation, association, partnership or other legal entity arising out of the occurrence of the contingency or loss covered by such policy or contract**.

The definition specifies that the first party claimant is the individual, corporation, association, partnership or other legal entity to whom the insurance contract is issued; in this case, the insurance contract is issued to the member, not to the provider, and the member is the first party claimant.

CL11B:

BOI #6 and **BOI #7**- As indicated above, the examiners do not concur with ALIC's assertion that the provider is the first party claimant. In addition, ALIC provided a process date of 12/30/2009 for both claims. Both member EOBs are dated 1/19/2010. The dates on the member EOBs conflict with the procedures provided to the examiners, as they are both dated over a week after the presumed mailing date based upon ALIC's procedures. Thus, the examiners cannot determine from ALIC's procedures when the member EOBs were mailed, and the violations will remain.

BOI #15- As previously indicated, the examiners do not concur with ALIC's assertion that the provider is the first party claimant. The violations will remain.

BOI # 27- As previously indicated, the examiners do not concur with ALIC's assertion that the provider is the first party claimant. In addition, according to ALIC's procedures, the mailing date for the EOB sent to the insured is 3/30/2010, which is greater than 15 working days after the receipt of proof of loss. The violations will remain.

CL16-TB: As previously indicated, the examiners do not concur with ALIC's assertion that the provider is the first party claimant. In addition, ALIC provided a process date of 3/19/2010 for the claim. The member EOB is dated 4/8/2010. The date on the member EOB conflicts with the procedures provided to the examiners, as it is dated over a week after the presumed mailing date based upon ALIC's procedures. Thus, the examiners cannot determine from ALIC's procedures when the member EOB was mailed, and the violations will remain.

CL20-TB: As previously indicated, the examiners do not concur with ALIC's assertion that the provider is the first party claimant. In addition, ALIC provided a process date of 6/14/2010 for the claim. The member EOB is dated 7/3/2010. The date on the member EOB conflicts with the procedures provided to the examiners, as it is dated over a week after the presumed mailing date based upon ALIC's procedures. Thus, the examiners cannot determine from ALIC's procedures when the member EOB was mailed, and the violations will remain.

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CL39M: The violation of 14 VAC 5-400-60 A will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated.

CL40BW-SH: The violation of 14 VAC 5-400-60 A will be removed. The Report will be revised to reflect one less violation and the Review Sheet Summary by Area will be updated. Although ALIC has already been cited for a violation of 14 VAC 5-400-40 A for this claim, the examiners would note that ALIC's initial processing of this claim was incorrect, and, as ALIC noted in its response, the provider TIN included on the original claim form did, in fact, belong to a participating provider.

14 VAC 5-400-70 B

EyeMedClaim01B: As previously indicated, the examiners do not concur with ALIC's assertion that the provider is the first party claimant. The violations will remain.

We have attached a copy of the revised pages of the report incorporating the revisions discussed above for your review. If you have additional questions, please feel free to contact us.

Once the matter has been concluded, ALIC will receive a final copy of the Report, which will include any revisions, copies of any additional responses you care to make, and copies of relevant correspondence up to and including any order issued by the State Corporation Commission.

On the basis of our review of this entire file, it appears that ALIC has violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 5, 38.2-510 A 6, 38.2-510 A 14, 38.2-510 A 15, 38.2-511, and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-1812 A, 38.2-1822 A, 38.2-1833 A 1, 38.2-3115 B, 38.2-3405 B, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.14 A, 38.2-3407.14 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3533, 38.2-5804 A, 38.2-5805 B of the Code, as well as 14 VAC 5-40-60 B, Rules Governing Life Insurance and Annuity Marketing Practices, and 14 VAC 5-90-50 B, 14 VAC 5-90-55 A, and 14 VAC 5-90-130 A, Rules Governing Advertisement of Accident and Sickness Insurance, and 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-50 C, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 A, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D, Rules Governing Unfair Claim Settlement Practices.

Violations of the above sections of the Code of Virginia can subject ALIC to monetary penalties of up to $5,000 for each violation and suspension or revocation of its license to transact business in Virginia.

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In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter. The Report will not become a public document until the settlement process has been completed.

Very truly yours,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS, MCM
Principal Insurance Market Examiner
Market Conduct Section
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:
Enclosures
cc: Bob Grissom
Althelia P. Battle

COPY

Gail Yoder, Compliance Manager
Aetna Life Insurance Company
5305 Chestnut Ridge Road
Summerfield, NC 27358

Althelia P. Battle, FLMI, HIA, AIE, MHP, AIRC, ACS
Deputy Commissioner
Bureau of Insurance
Post Office Box 1157
Richmond, VA 23218

RE: Alleged violations of the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 5, 38.2-510 A 6, 38.2-510 A 14, 38.2-510 A 15, 38.2-511, and 38.2-514 B of the Code of Virginia. In addition, there were violations of §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-1812 A, 38.2-1822 A, 38.2-1833 A 1, 38.2-3115 B, 38.2-3405 B, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.14 A, 38.2-3407.14 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3533, 38.2-5804 A and 38.2-5805 B of the Code, as well as 14 VAC 5-40-60 B, Rules Governing Life Insurance and Annuity Marketing Practices, and 14 VAC 5-90-50 B, 14 VAC 5-90-55 A, and 14 VAC 5-90-130 A, Rules Governing Advertisement of Accident and Sickness Insurance, and 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-50 C, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 A, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D, Rules Governing Unfair Claim Settlement Practices.

COPY

Dear Ms. Battle:

This will acknowledge receipt of your letter dated August 3, 2015, concerning the above-captioned matter.

ALIC wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of $63,000, payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement; it is entitled to a hearing in this matter and waives its right to such a hearing and agrees to cease and desist from future violations of §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-510 A 1, 38.2-510 A 5, 38.2-3405 B, 38.2-3407.14 A, 38.2-3407.14 B, 38.2-3533, and 38.2-5804 A of the Code, as well as 14 VAC 5-400-40 A, 14 VAC 5-400-60 A, and agrees to comply with the Corrective Action Plan contained in the Market Conduct Examination Report as of June 30, 2010.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Yours very truly,

Thomas J Stutz

Company Representative

8/12/2015

Date

Enclosure (check)

COPY

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, SEPTEMBER 2, 2015

150910036

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2015 SEP -2 A 10:58

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2015-00132

AETNA LIFE INSURANCE COMPANY,
Defendant

COPY

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that Aetna Life Insurance Company ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia") violated §§ 38.2-316 A, 38.2-316 B, and 38.2-316 C (1) of the Code of Virginia ("Code") by failing to comply with policy and form filing requirements; violated §§ 38.2-502 (1) and 38.2-503 of the Code, as well as 14 VAC 5-90-50 B, 14 VAC 5-90-55 A, and 14 VAC 5-90-130 A of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.*, by failing to comply with advertising requirements; violated §§ 38.2-510 A (1), 38.2-510 A (2), 38.2-510 A (5), 38.2-510 A (6), 38.2-510 A (14), and 38.2-510 A (15) of the Code by failing to properly handle claims with such frequency as to indicate a general business practice, as well as 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-50 C, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 A, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D of the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.*, by failing to properly handle claims; violated § 38.2-511 of the Code by failing to have complete complaint registers; violated § 38.2-514 B of the Code by failing to make proper disclosures in

the explanation of benefits; violated § 38.2-1812 A of the Code by paying commissions for services as an agent to persons who were not properly licensed and appointed; violated § 38.2-1822 A of the Code by knowingly permitting unlicensed persons to act as agents; violated § 38.2-1833 A (1) of the Code by failing to comply with agent licensing requirements; violated § 38.2-3115 B of the Code by failing to properly pay interest on life insurance proceeds; violated § 38.2-3405 B of the Code by improperly allowing the subrogation of a claims payment; violated § 38.2-3407.1 B of the Code by failing to pay interest at the legal rate of interest from the date of 15 working days from the Defendant's receipt of proof of loss to the date that the claim was paid; violated §§ 38.2-3407.4 A and 38.2-3407.4 B of the Code by failing to comply with explanation of benefits requirements; violated §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code by failing to comply with the requirements regarding notice of premium increases; violated §§ 38.2-3407.15 B (1), 38.2-3407.15 B (2), 38.2-3407.15 B (3), 38.2-3407.15 B (4), 38.2-3407.15 B (5), 38.2-3407.15 B (6), 38.2-3407.15 B (7), 38.2-3407.15 B (8), 38.2-3407.15 B (9), 38.2-3407.15 B (10), and 38.2-3407.15 B (11) of the Code by failing to comply with ethics and fairness requirements for business practices; violated § 38.2-3533 of the Code by failing to comply with the requirements regarding individual certificates; violated § 38.2-5804 A of the Code by failing to comply with procedures to establish and maintain an approved complaint system for each of its Managed Care Health Insurance Plans (MCHIPS); violated § 38.2-5805 B of the Code by failing to comply with the requirements governing provider contracts; and violated 14 VAC 5-40-60 B of the Commission's Rules Governing Life Insurance and Annuity Marketing Practices, 14 VAC 5-40-10 *et seq.*, by failing to maintain a complete file of every printed, published, or prepared marketing communication.[1]

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[1] 14 VAC 5-40-60 B has been repealed; this requirement is now located at 14 VAC 5-41-150 C of the Commission's Rules Governing Advertisement of Life Insurance and Annuities, 14 VAC 5-41-10 *et seq.*

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of its right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has tendered to Virginia the sum of Sixty-three Thousand Dollars ($63,000), waived its right to a hearing, agreed to the entry by the Commission of a cease and desist order, and agreed to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau, is of the opinion that the Defendant's offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.

(2) The Defendant shall cease and desist from future violations of §§ 38.2-316 A, 38.2-316 B, 38.2-316 C (1), 38.2-510 A (1), 38.2-510 A (5), 38.2-3405 B, 38.2-3407.14 A, 38.2-3407.14 B, 38.2-3533, and 38.2-5804 A of the Code, as well as 14 VAC 5-400-40 A or 14 VAC 5-400-60 A.

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(3) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Gail Yoder, Compliance Manager, Aetna Life Insurance Company, 5305 Chestnut Ridge Road, Summerfield, North Carolina 27358; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Althelia P. Battle.

A True Copy
Teste: Joel H. Peck
Clerk of the
State Corporation Commission

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