REPORT OF TARGETED EXAMINATION

OF

ARIZONA DENTAL INSURANCE SERVICES, INC.
Doing Business As
DELTA DENTAL OF ARIZONA

NAIC# 53597

AS OF

JUNE 30, 2006

TABLE OF CONTENTS

Department of Insurance
State of Arizona
Market Oversight Division
Examinations Section
Telephone: (602) 364-4994
Fax: (602) 364-4998

JANET NAPOLITANO
Governor

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
www.id.state.az.us

CHRISTINA URIAS
Director of Insurance

Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Urias:

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

ARIZONA DENTAL INSURANCE SERVICES, INC.
Doing Business As
DELTA DENTAL OF ARIZONA

NAIC # 53597

The above examination was conducted by James R. Dargavel, FLMI, CIE, Examiner-in-Charge, and Jerry Paugh, AIE, Senior Market Examiner.

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

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

Sincerely yours,

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

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, James R. Dargavel, FLMI, CIE, being first duly sworn state that I am a duly appointed Market Examinations Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of Jerry Paugh, AIE, Senior Market Examiner, the examination of Arizona Dental Insurance Service, Inc., DBA Delta Dental of Arizona, hereinafter referred to as the "Company" was performed at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss the findings set forth in this Report. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

James R. Dargavel, FLMI, CIE
Market Examinations Examiner-in-Charge

Subscribed and sworn to before me this 2nd day of August, 2007

Elizabeth L. Sickinger
Notary Public

My Commission Expires Jan. 17, 2009

OFFICIAL SEAL
ELIZABETH L. SICKINGER
NOTARY PUBLIC-STATE OF ARIZONA
MARICOPA COUNTY
My Comm. Expires Jan. 17, 2009

FOREWORD

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

The examination consisted of a review of the following components of the Company's dental insurance business:

1. The Company conducts a reasonable and timely investigation before denial of claims, and
2. The Company has appropriate procedures in place to identify and correct errors in its claim processing system.

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

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

SCOPE AND METHODOLOGY

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

compliance with the standard. The standards applied during the examination are stated in this Report at page 13.

In accordance with Department procedures, the Examiners completed a Preliminary Finding ("PF") on those policies, claims, complaints, and/or procedures not in apparent compliance with Arizona law. The PF forms were submitted for review and comment to the Company representative designated by Company management as being knowledgeable about the files. For each PF, the Company was requested to agree, disagree, or otherwise justify the Company's noted action.

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

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

EXECUTIVE SUMMARY

This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report and the results are reported beginning on page 7.

1. The Company failed Standard No. 1 by failing, with regard to 27 (100.0%) of 27 files reviewed (Reason Code 110), to conduct a timely and reasonable

investigation of claims for dental surgical procedures before denying the claims, in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).

2. The Company failed Standard No. 2 by failing, with regard to 27 (100.0%) of 27 files reviewed (Reason Code 110), to provide a reasonable explanation for the denial of claims involving benefits for dental surgical procedures in sufficient detail to allow members and providers to appeal an adverse decision in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

3. The Company failed Standard No. 2 by failing, with regard to six (26.1%) of 23 files reviewed (Reason Code 063), to provide a reasonable explanation for the denial of claims involving benefits for tooth-colored fillings in sufficient detail to allow members and providers to appeal an adverse decision before in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a).

The Company passed Standard 3.

EXAMINATION FINDINGS

Standard 1

Based on the Examiners' review of the Company's denied dental claims, the Company failed with regard to claims for dental surgery denied under Reason Code 110 to meet the following standard for review:

#	STANDARD	Regulatory Authority
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation.	A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F)

Claim Denied Under Reason Code 110

Procedures Performed:

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

The Company provided appeal logs indicating it had processed 326 appeals from denied claims during the examination period. The Examiners selected 58 appeals for review from these

logs. During this review, the Examiners identified potential trends related to the denials of certain procedures without investigation. These potential trends appeared with regard to specific Current Dental Technology ("CDT") codes, as well as specific denial/Explanation of Benefits Denial Reason ("Reason") codes assigned by the Company at the time the claims were denied.

The Company provided a population of 203,678 claims denied during the examination period. Using the CDT codes and Reason codes identified during the review of the Company's appeals, the Examiners extracted a sub-population of 33,920 claims from which they selected a stratified random sample of 135 denied claims for review.

Findings:

The Company failed to meet the standard for claims denied under Reason code 110 as follows:

The sub-population of 33,920 denied claims included a population of 306 denied claims which were denied under Reason code 110 which states: "This procedure requires professional review and may be covered under your medical plan. If your medical insurance plan denies coverage, please resubmit the medical denial/payment information and the pathological lab report to DDAZ for consideration".

The Examiners reviewed a sample of 27 (8.8%) of 306 files denied under Reason code 110. Each of the denied claims was for a surgical procedure which was covered under the Company's policy. The Company denied these claims on the basis that the claim might be covered under group medical coverage available to the member. However, the Company had no knowledge as to whether other coverage existed or if that coverage might be applicable to the procedure which was performed. Therefore, the Company had an obligation to investigate these claims prior to denial to determine if other coverage existed and to determine if other benefits were available to the member for the services which had been provided. The Company failed to conduct a timely and reasonable investigation into the availability of other benefits prior to denying these 27 claims.

Twenty-seven (100.0%) of 27 claims denied under Reason code 110 failed Standard 1 because the Company failed to complete a reasonable and timely investigation of the claims in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C R20-6-801(F). Reference PF # 001.

DENIED CLAIMS UNDER REASON CODE 110

Files Reviewed	Population	Sample	# of Exceptions	Error Ratio
Claims	306	27	27	100.0%

A 100.0% error ratio does not meet the standard; therefore a recommendation is warranted.

Standard 2

Based on the Examiners' review of the Company's denied dental claims, the Company failed with regard to claims denied under Reason code 63 and Reason code 110 to meet the following standard for review:

#	STANDARD	Regulatory Authority
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, per A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801.	A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a)

Claim Denied Under Reason Code 110

Procedures Performed:

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

The Company provided appeal logs indicating it had processed 326 appeals from denied claims during the examination period. The Examiners selected 58 appeals for review from these logs. During this review, the Examiners identified potential trends related to the denials of certain procedures without investigation. These potential trends appeared with regard to specific Current Dental Technology ("CDT") codes, as well as specific denial/Explanation of Benefits Denial Reason ("Reason") codes assigned by the Company at the time the claims were denied.

The Company provided a population of 203,678 claims denied during the examination period. Using the CDT codes and Reason codes identified during the review of the Company's appeals, the Examiners extracted a sub-population of 33,920 claims from which they selected a stratified random sample of 135 denied claims for review.

Findings:

The Company failed to meet the standard for claims denied under Reason code 110 as follows:

The sub-population of 33,920 denied claims included a population of 306 denied claims which were denied under Reason code 110 which states: "This procedure requires professional review and may be covered under your medical plan. If your medical insurance plan denies coverage, please resubmit the medical denial/payment information and the pathological lab report to DDAZ for consideration".

The Examiners reviewed a sample of 27 of the 306 files denied under Reason code 110. Each of the 27 denied claims was for a surgical procedure which was covered under the Company's policy. The Company denied these claims on the basis that they might be covered under group medical coverage available to the member. However, the Company had no knowledge as to whether other coverage existed or if that coverage might be applicable to the procedure which was performed. Therefore, since the procedure was covered under the Company's policy, the Company failed to provide a reasonable explanation for the denial of the claim in sufficient detail to allow members and providers to appeal an adverse decision.

Twenty-seven (100.0%) of 27 claims denied under Reason code 110 failed Standard 2 because the Company failed to provide a reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PF # 002.

DENIED CLAIMS UNDER REASON CODE 110

Files Reviewed	Population	Sample	# of Exceptions	Error Ratio
Claims	306	27	27	100.0%

A 100.0% error ratio does not meet the standard; therefore a recommendation is warranted.

Claims Denied Under Reason Code 063

Procedures Performed:

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

The Company provided appeal logs indicating it had processed 326 appeals from denied claims during the examination period. The Examiners selected 58 appeals for review from these logs. During this review, the Examiners identified potential trends related to the denials of certain procedures without investigation. These potential trends appeared with regard to specific Current Dental Technology ("CDT") codes, as well as specific denial/Explanation of Benefits Denial Reason ("Reason") codes assigned by the Company at the time the claims were denied.

The Company provided a population of 203,678 claims denied during the examination period. Using the CDT codes and Reason codes identified during the review of the Company's appeals, the Examiners extracted a sub-population of 33,920 claims from which they selected a stratified random sample of 135 denied claims for review.

Findings:

The Company failed to meet the standard for claims denied under Reason code 063 as follows:

The sub-population of 33,920 denied claims included a population of 1,136 denied claims which were denied under Reason code 063, 082 and 137. The Examiners reviewed a sample of 27 (2.4%) claims which were denied under these reason codes. Twenty-three of the 27 files reviewed were denied under Reason code 063 which states: "Tooth-colored filling on a back tooth is not a benefit of your plan. An allowance for a silver filling has been made and the patient is responsible for the additional fee".

Of the 23 files reviewed, which were denied under Reason code 063, six failed to provide an allowance for a silver filling at the time that the EOB was issued to the member. The reason that the alternate benefit was not paid for a silver filling was due to the fact that the maximum benefit had been reached under the member's dental plan. The Company failed to notify the member that the alternate benefit was not being paid due to the fact that the maximum benefit had been reached. Therefore, the Company failed to provide a reasonable explanation for the denial of the claim in sufficient detail to allow members and providers to appeal the adverse decision.

Six (26.1%) of 23 claims denied under Reason code 063 failed Standard 2 because the Company failed to provide a reasonable explanation for the denial of the claim in sufficient detail to allow members and providers to appeal an adverse decision in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C R20-6-801(G)(1)(a). Reference PF # 003.

DENIED CLAIMS UNDER REASON CODE 063

Files Reviewed	Population	Sample	# of Exceptions	Error Ratio
Claims	1,136	23	6	26.1%

A 26.1% error ratio does not meet the standard; therefore a recommendation is warranted.

Subsequent Events

The Company initiated a project with its system vendor in October 2005 which was completed in November 2005 to ensure the display of reference codes on the specific service line as well as the display of the reference code and the full description displayed on the explanation of benefits (EOB).

Recommendations

Within 90 days of the filed date of this report, the Company should:

1. Provide documentation that procedures and controls are in place to ensure that the Company completes a timely investigation of claims as prescribed by A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F);

2. Provide documentation that procedures and controls are in place to ensure that the Company provides a reasonable explanation for the denial of the claim in sufficient detail to allow members and providers to appeal an adverse decision as prescribed by A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a);

3. Perform a self-audit of the 306 claims denied under Reason Code 110 during the examination period to determine if the member had major medical coverage applicable to these claims to determine whether these claims were denied inappropriately and without adequate investigation.

4. Pay restitution including interest at the legal rate of 10% per annum for any claim identified from the self-audits as having been denied inappropriately; and

5. With each payment of restitution, provide a letter indicating that an audit of claims following an examination by the Arizona Department of Insurance had resulted in the identification and correction of the previous denial.

SUMMARY OF STANDARDS

#	STANDARD FOR REVIEW	PASS	FAIL
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation, per A.R.S. §§ 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).		X
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, per A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801.		X
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims, per A.R.S. § 20-462(A).	X	