Report of the

Targeted Market Conduct Examination

For the

Maine Bureau of Insurance

Of

Life Insurance Company of North America

NAIC Company # 65498
Philadelphia, Pennsylvania

Connecticut General Life Insurance Company

NAIC Company # 62308
Bloomfield, CT

And

Cigna Health and Life Insurance Company (formerly known as Alta Insurance)

NAIC Company # 67369
Bloomfield, CT

May 14, 2013

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RACKEMANN
SAWYER & BREWSTER
PROFESSIONAL CORPORATION
COUNSELLORS AT LAW

Established 1886

May 14, 2013

Honorable Eric A. Cioppa
Superintendent
State of Maine
Bureau of Insurance
76 Northern Avenue
Gardiner, ME 04345

Dear Superintendent Cioppa:

Pursuant to the authority granted by Section 24-A *Maine Revised Statutes Annotated* § 221, your instructions, and in accordance with the *NAIC Market Regulation Handbook* ("*Handbook*"), a targeted market conduct examination has been conducted of the disability income claim handling practices of:

Life Insurance Company of North America
Connecticut General Life Insurance Company
Cigna Health and Life Insurance Company
(formerly known as Alta Insurance)
(the "Companies")

The report of examination is herewith respectfully submitted.

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Foreword

This report on the targeted market conduct examination of the Companies is provided pursuant to the *Handbook*. This report is made by exception, i.e. it omits discussion of those claim files reviewed during the examination that did not show possible improprieties.

Background and Scope of Examination

In September, 2009, the Maine Bureau of Insurance initiated a targeted market conduct examination of the Companies' disability income insurance ("DI") claim handling practices.[1] This examination was organized into two phases. The first phase involved review of the Companies' DI policy forms, claim administration manuals, claim training manuals, and organizational charts. The second phase of the examination involved the review of twenty-four Maine long-term disability ("LTD") claims files, the selection methodology for which is described in further detail below.[2]

The purpose of the examination was to determine whether the Companies' claim handling practices conform with the standards reflected in the National Association of Insurance Commissioners ("NAIC") *Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance Model Act* (1972), *NAIC Claims Settlement Practices Model Act* (1990) (together, the "Model Act"), and more

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[1] The Massachusetts Division of Insurance also instituted a targeted market conduct examination of the Companies' DI claim handling practices. The two examinations were conducted simultaneously, on a coordinated basis by the same examiners.

[2] The database from which files were selected for review during the examination included all of the CIGNA Companies' LTD claim files for residents of Maine, even if the policy pursuant to which the claim was filed was issued in another state by one of the CIGNA Companies not authorized to do business in Maine.

specifically in 24-A M.R.S. §§ 2151-2187. The examiners also used the terms of the Multistate Regulatory Settlement Agreement entered into by forty-nine of the United States insurance regulatory jurisdictions and the United States Department of Labor with the principal insurers of the Unum Group in 2005 as a benchmark for their review. Initial review of the claim files was conducted by the examiners during the months of April and May of 2010.

Profile of the Companies

At all relevant times the Companies have been licensed insurance companies domiciled in the Commonwealth of Pennsylvania and State of Connecticut and authorized to write life and health insurance in the State of Maine. The Companies are wholly owned subsidiaries of CG Corporation, a Connecticut holding company. CG Corporation is in turn a wholly owned subsidiary of CIGNA Holdings, Inc., a Delaware holding company. The ultimate parent of the Companies is CIGNA, Corp., a Delaware holding company (collectively with its member insurers, the "CIGNA Companies"). The Life Insurance Company of North America is the primary member of the CIGNA Companies writing disability income insurance in the Commonwealth of Massachusetts. Maine DI claims are adjusted primarily at the Companies' Pittsburgh, Pennsylvania claim office. The Companies offer only group DI policies in Maine. The Companies do not offer individual DI policies in Maine.

Claim Selection Methodology

The Bureau's September 2009 letter requested that the Companies provide a comprehensive database including all pending DI claims for Maine residents, all DI claims for Maine residents that were closed during 2009, all DI claims for Maine

residents appealed in 2009, and all litigations respecting DI claims for Maine residents that were closed during 2008 and 2009. The examiners decided to limit their selection of claims in the second phase of the examination to group long term disability claims ("LTD Claims"). The examiners then divided claims for review by category -- closed LTD Claims, litigated LTD Claims, and appealed LTD Claims. Due to the small number of claims involved, the examiners determined to review all litigated and appealed LTD Claims. In addition, the examiners randomly selected eighteen closed LTD Claims. Several of the selected claims overlapped in that they appeared in more than one category. As a result, the examiners ultimately reviewed a total of twenty-four Maine claim files. Table 1 depicts the distribution of such claims by category for both the population and the sample.

Table 1

	Population Size	Sample Size
Closed LTD Claims	69	18
Litigated Claims	2	2
Appealed Claims	7	7
Total	78	27

Areas of Concern

The examiners' review of claim files raised several areas of concern regarding the Companies' handling of LTD Claims. These concerns include the following:

1. Imposition of standards which are inconsistent with policy provisions: In reviewing LTD Claim files, the examiners noted a number of instances in which the Companies wrote denial or termination letters to claimants (or their attorneys) that evaluated the claimant's condition and/or medical records against standards that may be

inconsistent with the standards set forth in the Companies' DI policies. This may constitute an unfair claims practice. See 24-A M.R.S. § 2164-D(3)(A) ("[k]nowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue" may constitute an unfair claims practice).

2. Claim denial or benefit termination based on incomplete or insufficient analysis of medical information: The examiners identified cases in which the Companies may have denied or terminated benefits solely on the basis of review by a nurse case manager, without sufficient consideration of the opinions of treatment providers, and/or without use of outside medical resources (such as independent medical evaluations) where it may have been appropriate to utilize such resources. This may constitute an unfair claims practice. See 24-A M.R.S. § 2164-D(3)(C) ("[f]ailing to adopt and implement reasonable standards for the prompt investigation and settlement of claims" may constitute an unfair claims practice); 24-A M.R.S. § 2164-D(3)(E) ("[r]efusing to pay claims without conducting a reasonable investigation" may constitute an unfair claims practice).

3. Claim denial or benefit terminations which reflect selective reliance on medical reports or evaluations, or a predisposed interpretation of such reports or evaluations: The examination team identified instances in which the Companies may have denied or terminated benefits based on incomplete or unduly narrow readings of medical information in a claimant's file. In such cases the Companies focused on particular statements or facts without considering context or other information that might have supported the payment of benefits. This may constitute an unfair claims practice. See 24-A M.R.S. §§ 2164-D(3)(C), 2164-D(3)(E), and 2164-D(5) ("It is an unfair claims

practice for any. . . insurer transacting business in this State to fail to deal with insureds in good faith to resolve claims made against policies of insured without just cause and with such frequency as to indicate a general business practice.").

4. Failure to give appropriate weight to Social Security Disability benefits (SSDI): The examiners noted one LTD claim file in which the Companies may have given insufficient weight to the award of SSDI benefits to a claimant. This may constitute an unfair claims practice. See 24-A M.R.S. §§ 2164-D(3)(C), 2164-D(3)(E), and 2164-D(5).

5. Claimants forced to litigate in order to receive benefits: The examiners reviewed both LTD Claim files in which claimants litigated with the Companies regarding the denial of benefits. In one instance the claimant litigated and settled for substantially all amounts claimed by his estate. In the other instance the claimant litigated and settled her claim, with a policy release, after benefits were terminated twice in four years. The Companies' conduct regarding these claims may demonstrate an unfair claims practice. See 24-A M.R.S. § 2164-D(4) ("[i]t is an unfair claims practice for any. . . insurer transacting business in this State to compel insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them with such frequency as to indicate a general business practice" unless the insurer "has a reasonable basis to contest liability").

6. Inappropriate application of offsets for other benefits: The examiners noted instances in which the Companies improperly offset pension or veterans benefits payable to Maine claimants against LTD benefits payable by the Companies. This may

constitute an unfair claims practice. See 24-A M.R.S. §§ 2164-D(3)(A) and 2164-D(3)(C).

On May 6, 2010, following completion of the claim review, the examiners provided the Companies with preliminary results to which the Companies provided written responses on June 18, 2010. Following further consultation with the Superintendent and the Massachusetts Commissioner of Insurance, the examiners, the Companies' representatives, and staff from the Bureau of Insurance and Massachusetts Division of Insurance met in February of 2011 to discuss specific LTD Claim files and the areas of concern identified by the examiners. The examiners then provided the Companies with written comments about certain LTD Claim files to which the Companies responded in writing.

In March of 2013 -- after coordinated discussion between the Companies, the examiners, the Bureau of Insurance, the Massachusetts Division of Insurance, the California Department of Insurance, the Connecticut Insurance Department, and the Pennsylvania Insurance Department (together, the "Monitoring Regulators") -- the Bureau of Insurance reached agreement with the Companies regarding a Regulatory Settlement Agreement. This agreement obviated the need for additional investigation, review of a larger claim sample, specific claim findings or reaching a formal conclusion concerning the examination objective, thereby benefiting the Companies' claimants and insureds through prompt implementation of agreed claims assessment procedures, establishment of quarterly monitoring of LTD Claim handling performance, and re-examination to ensure

successful implementation of the plan described in greater detail in the Regulatory Settlement Agreement, attached hereto as Exhibit A.

Plan of Corrective Action

The Bureau of Insurance has designed a Plan of Corrective Action ("the Plan") with the Companies, to address the concerns raised by the examination. The Plan will be implemented through the Regulatory Settlement Agreement. The Regulatory Settlement Agreement provides for: (i) a fine of $175,000; (ii) a remediation program for the redetermination of certain closed or terminated claims; (iii) monitoring of the Companies' compliance with the terms of the Regulatory Settlement Agreement at the Companies' cost through an established framework of quarterly reports and meetings; and, (iv) re-examination of the issues addressed by this examination within twenty-four months. The most significant provisions of the Regulatory Settlement Agreement are the following:

A. Enhanced Claim Procedures: The Companies will implement changes to their claim procedures in all States relating to:

- *Procedures regarding the weight to be given to awards of SSDI.* The Companies will implement agreed standards for the use of SSDI awards in claim determinations.
- *Procedures regarding gathering of additional medical information.* The Companies shall implement agreed-to enhancements to its procedures regarding the gathering of medical information, analysis of such information, the documentation of the claims personnel's conclusions, and the currency of co-morbid conditions within the context of the overall impact of such conditions on a claimant's functionality. The procedures

will require consideration of the impact of co-morbid conditions on the whole person and a determination as to the combined effect impact on the individual's ability to function in an occupational setting.

- *External medical resources.* The Companies shall implement agreed-to guidelines clarifying the use of external medical resources – including, as appropriate, an independent medical evaluation or a functional capacity evaluation – in making a disability analysis.

B. Quarterly Monitoring: The Companies will participate in quarterly monitoring of its performance both in implementing the enhanced claim procedures and in ensuring compliance with the terms of the Regulatory Settlement Agreement and the law generally.

C. Monitoring of Compliance: The Companies will designate a Quality Assessment Team to meet regularly with the Monitoring Regulators and their examiners regarding monitoring results as well as the results of the Companies' internal quality assessment of claim performance.

D. Follow-up Examination: A further examination will be conducted within twenty-four months of the Effective Date of the Regulatory Settlement Agreement.

Acknowledgment

The Examiners express their appreciation to the Companies for their cooperation throughout the course of the examination.

Report Submission

The report of examination is herewith respectfully submitted.

Sincerely,

J. David Leslie
Examiner-in-Charge

Examiners:

Rackemann, Sawyer & Brewster, P.C.
Ronald S. Duby, Esq.
Margaret L. Hayes, Esq.

Monarch Life Insurance Company
Kevin J. McAdoo, Special Deputy Receiver
John S. Coulton, Esq.

Exhibit A

[Regulatory Settlement Agreement]

IN THE MATTER OF

LIFE INSURANCE COMPANY OF NORTH AMERICA, CONNECTICUT GENERAL LIFE INSURANCE COMPANY, AND CIGNA HEALTH AND LIFE INSURANCE COMPANY (FORMERLY KNOW AS ALTA HEALTH AND LIFE INSURANCE COMPANY)

Philadelphia, Pennsylvania
NAIC # 65498

Bloomfield, Connecticut
NAIC # 67369, 62308

REGULATORY SETTLEMENT AGREEMENT

TARGETED MARKET CONDUCT EXAMINATION
DISABILITY INCOME INSURANCE CLAIM HANDLING PRACTICES

This Regulatory Settlement Agreement ("Agreement") is entered into as of this 13th day of May, 2013 (the "Effective Date"), by and among the Life Insurance Company of North America ("LINA"), Connecticut General Life Insurance Company, and Cigna Health and Life Insurance Company (formerly known as Alta Health and Life Insurance Company) (the "Company" or "Companies"), the California Department of Insurance, the Connecticut Insurance Department, the Maine Bureau of Insurance, the Massachusetts Division of Insurance, the Pennsylvania Insurance Department (the "Monitoring States") and the insurance regulators who have executed the form of "Participating State Adoption" set forth at Exhibit A (along with the Monitoring States, the "Participating States").

A. Recitals

1. At all relevant times the Companies have been licensed insurance companies domiciled in the Commonwealth of Pennsylvania and State of Connecticut and authorized to write life and health insurance in the Participating States. The Companies are wholly owned subsidiaries of CG Corporation, a Connecticut holding company. CG Corporation is in turn a wholly owned subsidiary of CIGNA Holdings, Inc., a Delaware holding company. The ultimate parent of the Companies is CIGNA, Corp., a Delaware holding company (collectively with its member insurers, the "CIGNA Companies"). The Companies are the members of the CIGNA Companies writing long term disability income insurance ("LTD") policies in the Participating States. The Companies offer only group LTD policies in the Participating States. They do not offer individual LTD policies in the Participating States.

2. On September 15, 2009, the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance initiated targeted market conduct examinations (the

"New England Examinations") of the CIGNA Companies writing disability income insurance regarding their claim handling practices in Maine and Massachusetts. Among other things, the Examinations investigated whether the Companies' claim handling practices conformed with the standards reflected in the National Association of Insurance Commissioners ("NAIC") *Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance Model Act* (1972), *NAIC Claims Settlement Practices Model Act* (1990) (together, the "Model Act"), and the Maine and Massachusetts unfair insurance trade practices acts, pursuant to the procedures established by the *NAIC Market Regulation Handbook* (the "Handbook"). The examiners also used the terms of the Multistate Regulatory Settlement Agreement entered into by forty-nine of the United States insurance regulatory jurisdictions and the United States Department of Labor with the principal insurers of the Unum Group in 2005 ("Unum RSA") as a benchmark for their review. The two examinations were conducted simultaneously, on a coordinated basis by the same examiners pursuant to the Model Act, relevant Maine and Massachusetts statutes and regulations, and the Unum RSA.

3. Examination reports regarding the New England Examinations are being released concurrently with this Agreement. Each of those examination reports contemplates the execution of this Agreement.

4. As a result of the New England Examinations, the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance engaged in discussions with the Companies with respect to regulatory concerns raised by the examiners and a plan of corrective action by the Companies to address those concerns.

5. In November 2011 examiners briefed the Connecticut Insurance Commissioner and the Pennsylvania Insurance Commissioner regarding the regulatory concerns raised by the New England Examinations.

6. On August 18, 2009 the California Department of Insurance and LINA entered into a Stipulation and Waiver Agreement addressing the findings of a market conduct examination of LINA's LTD claims handling practices as of June 20, 2006 (the "2006 California Examination"). On October 1, 2010 the California Commissioner of Insurance initiated a follow-up examination of LINA (the "2010 California Re-Examination") to discover, in general, if the Companies' group LTD claims handling practices conform to the contractual obligations of its policy forms, the California Insurance Code, the California Code of Regulations, and case law. An examination report regarding the 2010 California Re-Examination was adopted by the California Commissioner of Insurance on June 4, 2012. (Collectively, the New England Examination, the 2006 California Examination, and the 2010 California Re-Examination are referred to as the "Examinations").

7. In light of the regulatory concerns raised by the Examinations, the Monitoring States entered into discussions with the Companies regarding resolution of the regulatory concerns raised and the establishment of a uniform plan of corrective action.

8. After discussion, the Companies agreed to the plan of corrective action set forth in this Agreement, the establishment of a remediation program for the redetermination of certain LTD claims, and the payment of certain fines. The terms and conditions of this Agreement will apply in all of the Participating States.

9. The plan of corrective action addresses a number of regulatory concerns arising from the Examinations. It seeks to accomplish the following:

a. Enhance claim procedures to improve the claim handling process and benefit current and future insureds as described in this Agreement, including Exhibits B, C, and D;

b. Monitor the Companies' implementation of these claim handling procedures by means of (i) regular meetings between a management team designated by the Companies and Monitoring States (as defined in paragraph B.5, below) and (ii) a follow-up examination; and,

c. Establish a Remediation Program in which, as described more fully in Exhibit F, the Companies' enhanced claim procedures will be applied to certain previously denied or adversely terminated claims.

10. This Agreement sets forth (i) the plan of corrective action, (ii) provisions concerning the enforcement of the Companies' compliance with the plan of corrective action, (iii) the Remediation Program, and (iv) other miscellaneous provisions of this Agreement.

11. Location of Definitions. (*paragraph* at *page number*)

"2006 California Examination" .....A.6 at 2
"2010 California Re-Examination"...A.6 at 2
"Agreement" .....Preamble at 1
"CIGNA Companies" .....A.1 at 1
"Company" or "Companies"....Preamble at 1
"Effective Date".....Preamble at 1
"Examinations" .....A.6 at 2
"FCE"..... B.1.c at 4
"Handbook" .....A.2 at 2
"IME"..... B.1.c at 4
"LINA" .....Preamble at 1
"LTD" .....A.1 at 1
"Medical Director"..... Ex. D at i
"Model Act".....A.2 at 2
"Monitoring States" .....Preamble at 1
"NAIC" .....A.2 at 2
"New England Examinations" .....A.2 at 2
"Participating States".....Preamble at 1
"Plan"..... B at 4
"Professional" .....B.1.f at 5

"Remediation Period" ..... Ex. F at i
"Remediation Program" ..... B.4 at 6
"SSA" ..... Ex. B at i
"SSDI" ..... B.1.a at 4
"Unum RSA" ..... A.2 at 2

The definitions contained in this Agreement shall apply equally to the exhibits to this Agreement. Where a term is expressly defined in an exhibit, the definition in that exhibit shall control.

B. Plan of Corrective Action (the "Plan")

The procedures described below reflect the Companies' and the Participating States' view of best practices for adjusting group LTD claims and do not necessarily reflect examiner findings that the Companies have actually engaged in any of the conduct which those procedures are designed to avoid.

1. Enhanced Claim Procedures

The Companies are committed to ensuring full and fair evaluation of insureds' eligibility for and entitlement to disability benefits. A cornerstone of those evaluations is the Companies' commitment to gather and consider information that is relevant to the claim determination, as set forth below.

a. *Procedures regarding the weight to be given to awards of Social Security Disability Income ("SSDI") benefits.* Guidelines, in the form attached as Exhibit B, regarding the weight to be given to the awards of SSDI benefits have been adopted by the Companies, circulated to all personnel involved in the determination of LTD claims, and will be included in the future training of such personnel.

b. *Enhanced procedures regarding the gathering of medical information and the documentation of conclusions.* Enhanced procedures, in the form attached as Exhibit C, regarding the gathering of medical information, analysis of such information, and the documentation of claim personnel's conclusions have been adopted by the Companies, circulated to all personnel involved in the determination of LTD claims, and will be included in the future training of such personnel.

c. *Guidelines for Use of External Medical Resources.* Guidelines, in the form attached as Exhibit D, clarifying the use of external medical resources -- including, as appropriate, an Independent Medical Evaluation ("IME") or a Functional Capacity Evaluation ("FCE") -- in making a disability analysis have been adopted by the Companies, circulated to all personnel involved in the determination of LTD claims, and will be included in the future training of such personnel.

d. *Ongoing objectives.* The Companies' claim procedures shall include the following ongoing objectives:

   i. Focus on policies and procedures relating to medical and related evidence, as specifically described in this Agreement, including Exhibits B, C, and D.

   ii. Clear and express notice to claimants of the information to be provided by the claimants and the information to be collected by the Companies. If a file is determined to lack sufficient information, claim handling personnel will take reasonable steps to work with the claimant to identify and obtain such information in accordance with appropriate procedures established for such purposes.

   The Companies shall ensure that their policies and procedures are consistent with the foregoing objectives. These objectives shall constitute criteria by which the Companies' claim handling performance shall be evaluated during the course of ongoing monitoring (discussed more fully in paragraphs B.5 and B.7 below) and during the follow-up re-examination (discussed more fully in paragraph C.2 below).

e. *Selection of Evaluation Personnel.* The Companies affirm and will continue their existing practice of selecting individuals to conduct IMEs or FCEs through an outside vendor, based solely on the basis of objective, professional criteria, and without regard to the results of previous IMEs or FCEs conducted by such individuals.

f. *Professional Certification.* The Companies affirm and shall continue their existing practice of requiring each clinical, vocational, and medical professional (a "Professional") employed by the Companies to (a) execute the "Statement Regarding Professional Conduct", found at Exhibit E, which includes a commitment to provide fair and reasonable evaluations concerning all available medical, clinical, and/or vocational evidence, both objective and subjective, bearing on impairment; and (b) certify that he or she has reviewed all medical or vocation information bearing on impairment that has been provided by the Companies to that Professional for review prior to issuing his or her opinion where such opinion will be used by the Companies in making any occupational or adverse liability determination as to a claimant's impairments.

g. *Providing Medical, Clinical, and/or Vocational Evidence.* The Companies affirm and shall continue their existing process that claim personnel, in soliciting evaluations of claimant impairment by Professionals (employed by the Companies or otherwise),

shall provide to each such Professional all available medical, clinical, and/or vocational evidence in the Disability Claim File (defined below at paragraph B.8), both objective and subjective, concerning impairment.

2. Affirmations. The Companies affirm that: (i) the Companies' processes prohibit attempting to influence in-house physicians or an IME or FCE in connection with such Professional's opinion concerning the medical evidence or medical condition relating to a claimant; (ii) the Companies do not evaluate claim personnel for promotion, retention, or any other purpose on the basis of any claim outcome (or, aside from productivity considerations, any number of claim outcomes); and, (iii) the Companies do not consider any claim outcome (or, aside from productivity considerations, any number of claim outcomes) in determining any component of compensation for claim personnel. The Companies further affirm that they will not change any of these processes except in consultation with the Monitoring States.

3. Training. The Companies' claim personnel shall be provided appropriate training designed to educate them on the responsibilities arising from the changes included in paragraph B.1 as well as the objectives outlined in paragraph B.1.d of this Agreement. Emphasis in such training shall be placed on concerns raised in the Examinations and the corrective measures set forth in this Agreement. This training will include specific instruction on recognizing the special function that medical professionals perform in assessing medical information concerning claimants. Furthermore, the training will confirm the continuing force of the Companies' processes affirmed in paragraph B.2.

4. Remediation Program. The Companies shall conduct a Remediation Program ("Remediation Program") in which, as described more fully in Exhibit F, the Companies enhanced claim procedures as set forth in this Agreement, will be applied to certain claims denied during the Remediation Period (defined in Exhibit F).

5. Monitoring of Compliance. The Monitoring States, in cooperation with the Participating States, shall monitor compliance with this Agreement and the Remediation Program and shall apprise other Participating States of the results of such monitoring as may be appropriate. Such monitoring will include review of randomly sampled Disability Claim Files (defined below in paragraph B.8) denied, adversely terminated, and/or appealed on or after January 1, 2013 for claimants residing in the Participating States. The purpose of monitoring is to review claims handling on a going forward basis and to establish productive dialogue between the Monitoring States and the Companies in preparation for re-examination (see paragraph C.2. below). Accordingly, though corrective action may be required, no sanction will be imposed by the Participating States should monitoring disclose any claims that may have been erroneously handled.

6. Quality Assessment Team. For purposes of monitoring the implementation of the provisions of this Agreement, the Companies shall establish an internal Disability Claim Quality Assessment Team, which will consist of ten full-time dedicated employees, with an average experience level of eight years in the disability insurance industry. The Companies' Policies and Procedures Manager will serve as the primary lead for the team, handling all oversight and project-related functions. This team shall be in effect throughout the duration of the ongoing Quarterly Monitoring, as described in paragraph B.7 below.

A Management Advisory Group will also be established to provide additional support and direction to the Disability Claim Quality Assessment Team on topics ranging from claim specific scenarios to more global topics such as ensuring if applicable policies and procedures and/or Training materials should be modified. The Management Advisory Group will include the following representatives of the Companies: VP of Disability Operations; Group Claims Counsel; Director, Total Quality Management; and Director, Policies and Procedures.

7. Quarterly Monitoring. For purposes of discussing the results of the Companies' internal Disability Claim Quality Assessment (described in paragraph B.6), the results of the random sampling provided for in paragraph B.5, the Remediation Program, and the Companies' compliance with this Agreement, the Monitoring States, or their designees, shall meet with the Companies' Management Advisory Group on a quarterly basis beginning on a date not earlier than sixty (60) days after the Effective Date and continuing through the commencement of the re-examination described in paragraph C.2. The Companies will provide to the Monitoring States a consolidated report of reassessed claims pursuant to the Remediation Program and any remedial action taken to determine and pay additional benefits where due, based on the application of the enhanced claim procedures set forth in this Agreement. The Companies will also consolidate the findings of the Disability Claims Quality Assessment Team into a report which will be delivered to the Monitoring States monthly. Any comments or observations from the Monitoring States regarding these findings will be furnished to the Companies in writing monthly. All findings, actions, and outcomes will be recorded and tracked by the Companies. A summary statement of each monthly review period will be provided to the Monitoring States in writing prior to each meeting. These meetings will be conducted in person -- though Monitoring States may, in their sole discretion, elect to participate telephonically -- to review the previous quarter's findings and discuss the overall direction and progress of the Companies' compliance with the terms of this Agreement.

8. Disability Claim Files. A disability claim file shall include all documents relating to a claim history and/or decision, including but not limited to correspondence, medical records, vocational records, forms, internal memoranda and internal communications (including e-mail communications), and copies of the documentation and written explanation contemplated under paragraphs B.1.a and B.1.c above, which shall be maintained in the claim file either in a paper file or in electronic form.

C. Other Provisions

1. This Agreement shall be governed by and interpreted according to the laws of the Commonwealth of Pennsylvania, excluding its conflict of laws provisions.

2. The Monitoring States will conduct a re-examination of the issues addressed by this Agreement twenty-four months after the Effective Date, or at such earlier date as may be agreed upon by the Companies and the Monitoring States. The Monitoring States will make all reasonable efforts to complete such re-examination within six months of its commencement. The re-examination will review the Companies' LTD claims handling practices in the Participating States for compliance with this Agreement. This re-examination shall be conducted in accordance with the National Association of Insurance Commissioners' Market Regulation Handbook, Volume 1. The Participating States shall not conduct independent market conduct examinations of the Companies' LTD claim practices until after the Monitoring States complete such re-examination. Any claim files examined by the Monitoring States in connection with the re-examination of the Companies described in this Paragraph shall not be the subject of any future market conduct examinations of the Companies by any of the Participating States.

3. The reasonable costs of the Monitoring States for outside services incurred in monitoring the Companies' compliance with this Agreement, reviewing the Companies' conduct of the Remediation Program, and in conducting the re-examination contemplated by paragraph C.2 shall be paid by the Companies. The Companies will also pay each of the five Monitoring States a fee of $150,000, payable in two equal annual installments; one within fifteen (15) days of the Effective Date and the second on the first anniversary of the Effective Date.

4. This Agreement shall remain effective until the completion of the re-examination referenced in paragraph C.2 above. Except as set forth in paragraph C.5 below, this Agreement and its provisions terminate for all purposes pursuant to this paragraph C.4.

5. Notwithstanding the termination of this Agreement to the extent provided in accordance with paragraph C.4 above, this Agreement shall survive as to the following provisions, which also individually survive: paragraphs B.1.a through B.1.g (inclusive); paragraph B.2; and paragraph B.8 (insofar as it describes the content of a Disability Claim File.)

6. Neither this Agreement, the Remediation Program, nor any related negotiations, statements or court proceedings shall be offered by the Companies or the Participating States as evidence of or an admission, denial or concession of any liability or wrongdoing whatsoever on the part of any person or entity, including but not limited to the Companies; as a waiver by the Companies of any applicable defenses, including without limitation any applicable statute of

limitation or statute of frauds; or as a waiver by the Commissioner of any regulatory authority regarding the matters addressed in the Examination.

7. This Agreement does not constitute an admission of liability, violation, or wrongdoing by the Companies and the Companies expressly deny that any of their actions or alleged actions were knowingly committed or represented a pattern and/or business practice that would violate the insurance unfair trade practice laws, claims settlement laws, or any other applicable statutes or regulations of any of the Participating States.

8. This Agreement is entered after discussion and in order to avoid the expense, uncertainty and distractions of litigation. The Participating States and the Companies agreed to enter into this Agreement solely for the purpose of reaching a compromise settlement without the need for a hearing or further administrative action.

9. This Agreement (or its Exhibits) may be amended by the Participating States and the Companies at any time. All such amendments to this Agreement shall be in writing.

D. Remedies

1. Within fifteen (15) days of the Effective Date, the Companies shall pay the California Commissioner of Insurance a fine of $500,000, the Maine Superintendent of Insurance a fine of $175,000, and the Massachusetts Commissioner of Insurance a fine of $250,000.

2. The Companies and the California Commissioner of Insurance have entered into a separate agreement to address the California-specific issues arising from the 2006 California Examination, the 2009 Stipulation and Waiver Agreement, and the 2010 California Re-Examination.

3. If the Monitoring States determine after conducting the re-examination of the Companies, as described in paragraph C.2, above, that the Companies have not complied materially with the terms of this Agreement, they may assess a fine payable to the Participating States. The Companies retain all rights under law, without limitation, to contest the basis for and assessment of any such fine. Any fine imposed pursuant to this paragraph shall be allocated among the Participating States at their sole discretion.

4. The Participating States retain the right to impose any regulatory penalty otherwise available by law, including fines, with respect to the Companies' willful violation of the terms of this Agreement or other violations of the law. The Companies retain all rights under law, without limitation, to contest the basis for an assessment of any such regulatory penalties and fines.

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: [signature]

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: [signature]

ITS: Insurance Commissioner

DATED: May 13, 2013

CONNECTICUT INSURANCE DEPARTMENT

BY: _____

ITS: _____

DATED: _____

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____

ITS: _____

DATED: _____

MAINE BUREAU OF INSURANCE

BY: _____

ITS: _____

DATED: _____

PENNSYLVANIA INSURANCE DEPARTMENT

BY: _____

ITS: _____

DATED: _____

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: [signature]

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: _____

ITS: _____

DATED: _____

CONNECTICUT INSURANCE DEPARTMENT

BY: [signature]

ITS: Commissioner

DATED: 5-10-13

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____

ITS: _____

DATED: _____

MAINE BUREAU OF INSURANCE

BY: _____

ITS: _____

DATED: _____

PENNSYLVANIA INSURANCE DEPARTMENT

BY: [signature]

ITS: Commissioner

DATED: 3-15-13

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: [signature]

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY:

ITS:

DATED:

CONNECTICUT INSURANCE DEPARTMENT

BY:

ITS:

DATED:

MASSACHUSETTS DIVISION OF INSURANCE

BY: [signature]

ITS: Commissioner

DATED: May 8, 2013

MAINE BUREAU OF INSURANCE

BY:

ITS:

DATED:

PENNSYLVANIA INSURANCE DEPARTMENT

BY: [signature]

ITS: Commissioner

DATED: 3-15-13

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: [signature]

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: _____

ITS: _____

DATED: _____

CONNECTICUT INSURANCE DEPARTMENT

BY: _____

ITS: _____

DATED: _____

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____

ITS: _____

DATED: _____

MAINE BUREAU OF INSURANCE

BY: [signature]

ITS: Superintendent

DATED: 5/8/13

PENNSYLVANIA INSURANCE DEPARTMENT

BY: [signature]

ITS: Commissioner

DATED: 3-15-13

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: [illegible]

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: [illegible]

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: [illegible]

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: _____

ITS: _____

DATED: _____

CONNECTICUT INSURANCE DEPARTMENT

BY: _____

ITS: _____

DATED: _____

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____

ITS: _____

DATED: _____

MAINE BUREAU OF INSURANCE

BY: _____

ITS: _____

DATED: _____

PENNSYLVANIA INSURANCE DEPARTMENT

BY: [illegible]

ITS: Commissioner

DATED: 3-15-13

Exhibit A

PARTICIPATING STATE ADOPTION
of
REGULATORY SETTLEMENT AGREEMENT

TARGETED MARKET CONDUCT EXAMINATIONS OF
DISABILITY INCOME INSURANCE CLAIM HANDLING PRACTICES

IN THE MATTER OF

Life Insurance Company of North America, Connecticut General Life Insurance Company, and CIGNA Health and Life Insurance Company (f/k/a Alta Health and Life Insurance Company)

Philadelphia, Pennsylvania
NAIC # 65498, 63308

Bloomfield, Connecticut
NAIC # 67369

On behalf of [STATE INSURANCE REGULATORY AGENCY], I, [EXECUTING OFFICIAL], as [EXECUTING OFFICIAL'S TITLE], hereby adopt, agree, and approve the Regulatory Settlement Agreement dated [EFFECTIVE DATE] by and between the above-named Companies and the regulatory agencies named therein.

[STATE INSURANCE REGULATORY AGENCY]

By:_____

Title:_____

Date:_____

Exhibit B

Social Security Awards and Disability Determinations

Introduction

A Social Security Disability Income ("SSDI") award by the Social Security Administration ("SSA") will be given significant weight in a claimant's favor under certain circumstances in making a Disability analysis. For that reason, where a claimant has been awarded SSDI benefits, the Claim Manager should review the SSA records related to the award and highlight the consideration given to the SSDI award and decision in the claim file documentation. The Company will make a reasonable effort, consistent with all applicable SSA regulations, manuals, and guidelines, to obtain SSA records with the cooperation of the claimant, his/her legal representative, provider and/or the SSA, but will not delay its consideration of a claim should SSA records, despite the Company's reasonable effort, be unavailable for review in a timely manner.

This release provides direction on how SSDI-related information should be gathered and considered during the course of your claim evaluation, as well as how that information and consideration should be documented to the claim file.

Procedure

Affording significant weight to a SSDI award means that the SSA records related to the SSDI award are reviewed and consideration of the SSA's judgment that a claimant is disabled for SSDI purposes will generally be an essential element of the Disability evaluation under the governing Disability contract. There will be exceptions in some circumstances, however, where the SSDI award should not be given significant weight and may be less relevant, or of no relevance, to our liability determination. For example, the SSDI award may not be an essential element of the Disability evaluation where compelling evidence exists that, e.g.:

- The award is based on the SSA's use or application of internal administrative standards that may reduce the standard of proof required for certain claimants, e.g. transferability of skills for older claimants, and are inconsistent with the applicable Disability policy's proof requirements for Disability;

- The SSDI award is aged and/or inconsistent with other information relevant to the Disability determination, including, e.g. more current medical information and/or vocational and financial/earnings information;

- Where contractual provisions may preclude a claimant from receiving benefits regardless of Disability status, e.g. pre-existing conditions, contractual limitations, or a claimant's earnings have exceeded the maximum allowed under the policy;

- Where records relevant to the timing and/or basis of the SSDI determination are not otherwise available and the claimant has refused to provide and/or timely respond to the Company's reasonable requests for authorization to obtain the SSDI file.

In addition to these specified exceptions, there may be additional circumstances in which other evidence may clearly show that a claimant is not disabled as defined in the policy. An example of such evidence would be a situation where a claimant indicates that s/he cannot work and is not working, but the claim evaluation reveals that s/he is, in fact, working in an occupation and/or performing duties or activities that are inconsistent with his/her stated restrictions and limitations.

In those circumstances where a Claim Manager determines that a SSDI award is of lesser or no relevance, the Claim Manager should document the rationale(s) for that determination in the claim file. Specifically, upon reaching such a determination, the Claim Manager should:

- Document the specific information or circumstances supporting the determination that the award is of lesser or no relevance in the claim file;

- Clearly explain to the claimant in writing the basis(es) for the determination that the award is of lesser or no relevance. That explanation should include the specific information, circumstances and/or policy language relevant to the determination and its relation to the Disability liability decision.

Compelling Evidence: SSDI in Relation to the Disability Claim Decision

Although the SSA's disability definition uses similar terminology to the standard Any Occupation definition in our policies, it is not identical. Claim Managers must review the SSA records related to any award determination where SSA records are obtainable with reasonable effort and must always apply the Disability definition from the governing policy when making a decision on a claim.

Compelling Evidence - Determining Relevance Based on Policy Language, Limitations or Exclusions or Where SSA Processes Differ from Policy Requirements

Where the Company's policy contains a different definition of Disability (e.g. Own Occ v. Any Occ) or a benefit limitation not found in SSDI coverages (e.g. the MIL language discussed below), the difference between the wording or application of the policy language in the SSA regulations and in the Company's policy provides compelling evidence that will limit or negate the relevance of the SSDI award.

For example, if the policy contains a 24-month Mental Illness Limitation (MIL) and the SSA award of disability benefits was based on a mental illness condition, the SSDI award will be of lesser or no relevance to an adverse claim determination that is based on the 24-month MIL provision. Similarly, if the Company's claim determination is based on the fact that the claimant is not eligible for coverage or that the Disabling condition was Pre-existing as defined by the policy, then the SSDI award will not be relevant.

Similarly, the Company and the SSA may differ in their consideration of age in certain circumstances when determining whether a person is Disabled. For example, in instances that involve the transferability of skills for older claimants, the SSA regulations permit and specify a more limited analysis than the Company's policies.

Additionally, the SSA takes a similar, reduced proof approach to certain diagnoses or conditions, awarding benefits based solely upon the existence of the diagnosis or condition and presuming disability. These types of awards are referred to as compassionate allowances or presumptive disabilities. Our policies do not permit such reduced standards of proof, and the Claim Manager should continue to evaluate a claimant's Disability under the policy's terms and requirements with the medical, vocational and financial proof of loss information available.

In addition to the consideration of age or presumptive disability, another difference between the SSA regulations governing disability determinations and the Company's policies is the consideration of part-time work capacity. The SSA generally will only consider the individual's ability to perform full-time (8 hours/day) work, while the Company's policies typically require an analysis of the claimant's ability to perform part-time work in determining when benefits are payable.

Compelling Evidence - Determining Relevance When There is Inconsistent Medical Information or When There is Other Reason to Conclude that the Claimant is Not Disabled

Medical information and what it tells us about a claimant's level of functionality at the relevant time period(s) are critically important to the Disability analysis. Where an SSDI award provides relevant insight into the claimant's functional ability, it can be highly relevant to the Disability analysis. Where the medical information upon which the award is based is aged, e.g. 6 months or older, and/or provides no useful information or insight into the claimant's level of function, it will be less relevant.

In determining the relevance and impact of a SSDI award to the Disability evaluation, the Claim Manager should consider and address, as applicable, the following factors, as applicable in determining whether the SSDI award provides compelling evidence of Disability:

- A significant difference between the information reviewed by the SSA and the Company.

- A faulty, mistaken or inappropriate analysis of the available evidence by either the SSA or the medical resource relied on by the SSA in making its decision.

- The claimant's condition has changed or improved.

- The claimant's age, education and economic status.

- Whether occupations are identified within the claimant's restrictions and limitations that are appropriate based upon his or her training, education and experience.

- Agreement with the Attending Physician (Has the Attending Physician changed his/her opinion? Based on what information?).

- The amount of time since the award decision or the generation of the medical information supporting it.

- Whether SSA has reassessed the claimant's condition since its initial award decision. If so, when and what were the results of that reassessment?

The existence of any one or more of these factors is not an indication that the claimant no longer meets the policy's requirements for Disability, but may impact the Claim Manager's determination regarding the relevance of the SSDI award. Where these types of factors exist, a Claim Manager may reasonably determine that the SSDI award's relationship to the Disability determination is less compelling. As a SSDI award is generally an essential element of the Disability analysis, the Claim Manager should analyze and address these factors within the context of considering the claim file as a whole, reaching out to the claimant, his/her representative(s) and treating providers as needed to validate the information obtained, and carefully document conclusions in the claim file prior to making the claim determination.

An inability to obtain the file does not change the weight to be given to an SSDI award, unless the claimant who has been awarded SSDI benefits affirmatively indicates that s/he will not authorize the Company to obtain the SSA file and/or fails to timely respond to the Company's request for such authorization, in which case the Company will not afford significant weight to the SSA award. The file documentation should fully record the Claim Manager's efforts to obtain the SSDI file.

Validation of Information - Confirming We Have Current Medical Information

The claimant's medical record and ALJ award letter can contain information helpful in determining the reasoning behind the decision to award benefits. For claimants who have chosen SSDI representation from our offered expert vendors, the information our vendors initially submit to the SSA is provided by CGI and will mirror the information in our claim file. If the

vendor appeals the SSDI application to the ALJ/Hearing Level, the vendor may seek additional medical information from providers that is independent of the information the vendor initially received from CGI. Our SSDI assistance vendors will provide regular reports that indicate if new medical information has been gathered or generated during the SSDI appeal process, which may be independent of CGI's records.

If SSDI has been awarded, to validate that we have up-to-date medical and SSDI information, the Claim Manager should check the vendor reports during the course of gathering information and compare the recency of the vendor information to the medical in the claim file. If the Claim Manager determines there is more current information, s/he should attempt to obtain the current medical information and evaluate it accordingly, by:

1. Contacting the vendor to obtain the information or identify the treatment providers who hold the information.

2. Contacting the claimant (or claimant's representative) to confirm what, if any, additional medical records or provider information the SSDI file may contain. This step will apply where the claimant either is not represented in the SSDI application process or retained his/her own representative.

3. Reaching out to treating providers to ensure we have all of the available medical information, and any assigned restrictions and limitations.

4. If treatment providers do not timely respond to our requests, request authority from the claimant or his/her representative to obtain the SSDI file.

5. If new medical information is received, proceed with complete medical review.

6. Document the assessment of the new records and their relation to the claim determination in the context of the review of the claim file as a whole.

SUMMARY

Disability evaluations are based on conclusions drawn from multiple factors including medical, vocational, and financial documentation applied to the provisions of the governing policy. An SSDI award and the information related to it should be an element of this analysis. Various factors will determine the relevance and impact of a SSDI award to the liability determination. The Claim Manager should analyze and address these factors within the context of considering the claim file as a whole, and document the file accordingly.

Exhibit C

Gathering Medical Information & Documenting Conclusions

Table of Contents

1. Introduction
2. Gathering Medical Documentation
3. Triggers for Gathering Additional Information
4. Reviewing Medical Information
5. Evaluating Medical Support of Disability
6. Evaluating Claims with Co-Morbid or Co-Existing Conditions
7. Summary

Introduction

Standard definition of disability wording requires that disability arise from illness, sickness, or injury. Given this, documenting and confirming a claimant's medical status is an important component of disability determinations.

Documenting and confirming medical status involves forming an understanding of functional capacity, expected resolution of the disabling condition, and feasibility of return to work. To facilitate this process, this release provides guidelines for the following:

- Gathering relevant credible medical information
- Utilizing available resources to clarify restrictions and limitations
- Attempting to resolve discrepancies in medical statements or conclusions
- Outlining and documenting the medical conclusions on which a disability determination may be based
- Evaluating functional capacity with the presence of co-morbid or co-existing conditions

As stated above, this release focuses on the medical component of a disability evaluation. It does not contemplate issues of eligibility or exclusion, which may otherwise impact a claim evaluation.

Gathering Medical Documentation

Medical documentation can assist with claim management by providing a better understanding of functional capacity, expected resolution of a condition, and feasibility of return to work. Relevant medical documentation can be drawn from many sources including, but not limited to, the following:

- Medical records supplied by those providing treatment to the claimant; i.e. - office notes, treatment records and plans, clinical findings, medical tests including raw scores, pharmacy records
- Medical texts, articles, and other publications that are considered to be generally acceptable sources of medical information

Along with these most commonly utilized sources, additional information that may assist includes but is not limited to:

- The claimant's own statements, including information gathered during phone calls or personal interviews
- Observations of the claimant's activities (personal interviews, surveillance, IME or FCE observations)
- Financial records
- Data from administrative/regulatory agencies for the purpose of determining the status of licensing and/or certification

Triggers for Gathering Additional Information

Vague Statements

Vague statements of impairment made by the treating or certifying physician generally do not provide enough detail to make determinations about the nature or degree of functional impairment resulting from a claimant's condition(s). Examples include:

- "Claimant is totally disabled"
- "Claimant is temporarily totally disabled"
- "Claimant unable to do any activity"
- "Claimant cannot work"
- "Claimant off work until MM/DD/YYYY"

These types of general preclusion statements do not explain how or why the claimed impairment limits the claimant from performing his/her occupation. Statements made without clarification or specific comment to restrictions and limitations may trigger additional questions and it is appropriate to seek further clarification from the treatment provider making the vague

statements.

Co-Morbid or Co-Existing Conditions

Co-morbid or co-existing conditions can impact the overall functional capacity of an individual and should be evaluated for their combined effect on the claimant.

Claim Managers should seek further clarification from treatment providers when they identify additional conditions or symptoms for which the claimant is or has been treated - or has reported - whether or not the claimant or provider is asserting Disability based on these conditions.

Appropriate Care

Standard language in our group disability contracts require a claimant "be under the Appropriate Care of a Physician," with Appropriate Care and Physician both further defined. As medical information is gathered and reviewed, consideration of this provision may include noting the following:

- Specialty of the treating physician
- Length of time treating with and/or frequency of treatment
- Nature of the treatment being rendered or the treatment plan prescribed by the treating physician
- Correlation of nature and level of treatment to nature and level of impairment assigned/claimed
- Potential familial relationship between the claimant and treating physician
- Third party statements (employment records, etc.)

Reviewing Medical Information

Once all requested information has been gathered, review by appropriate resources occurs. Above and beyond members of the Core Teams, this review can be accomplished either by internal or external medical resources. Reviews of medical information may result in claims discussions, written documentation of conclusions, and possibly even further recommendations or suggested next steps. When our opinion of a claimant's functionality differs with the treatment provider's conclusion of the claimant's functionality, limitations and abilities, contact with the treatment providers and/or utilization of external medical resources may be appropriate in an attempt to clarify functional discrepancies.

Internal Medical Resources

Each FCO is staffed with medical resources who are available to review and provide analysis of medical information contained in a claim file. These medical resources may:

- Offer advice on the completeness of medical records on file and recommend what, if any, additional information is needed to clarify a claimant's medical status
- Assess medical information and assure it is pertinent to the claim
- Contact treatment providers in an attempt to clarify information supplied
- Assist in drafting narratives or questions for an IME, FCE, Peer Review, or communications with treating physicians
- Apply medical expertise relative to diagnosis, level of impairment, and expected recovery
- Evaluate restrictions and limitations in relation to the reported disabling condition

Releases "STD CM/NCM Medical Management Process" and "LTD CM/NCM Medical Management Process" provide additional detailed information on the workflow and referral processes for utilizing internal medical resources. The need for and use of internal medical resources may vary from claim to claim and will occur where the Claim Manager deems necessary, based on the facts of the file.

External Medical Resources

Various external medical resources are also available to review and provide analysis of medical information contained in a claim file. The need for and use of external medical resources may vary from claim to claim and will occur where the Claim Manager deems necessary, based on the facts of the file. Generally, these resources can be helpful in clarifying discrepancies in medical information or opinions and in identifying current functional status and level of impairment. This type of clarification may be particularly useful where, e.g., treatment records do not provide sufficient detail to determine the level of impairment, a treatment provider assigns restrictions and limitations that do not correlate with the clinical findings and observations documented in his/her treatment notes, there is an inconsistency of information provided by different treatment providers, etc.

Where deemed necessary, an IME, FCE, Peer Review, or other form of external review/exam can be utilized to either obtain additional information or clarify existing information. The release "Guidelines for Use of External Medical Resources" provides additional information on when the use of external resources should be considered. Releases "IME Referral Process" and "FCE Referral Process" provide additional detailed information on the workflow and referral processes for utilizing external medical resources.

Evaluating Medical Support of Disability

Non-Disputed Medical Conclusions:

Upon review of medical documentation, our internal medical resources may concur with the conclusions and functional capacity stated by the treating physician. What was reviewed, the agreed upon restrictions and limitations, expected duration, and any suggested ongoing follow-up for information will typically be documented in the claim file by the medical resource. Utilizing these conclusions, the Claim Manager will continue with the claim management process and evaluation of disability.

In the event we obtained a Peer Review, IME, and/or FCE, and the treating physician agrees with conclusions stated in these reports, the Claim Manager will also continue with the claim management process and evaluation of disability.

Disputed Medical Conclusions:

Upon review of medical documentation, our internal medical resources may disagree with the conclusions and functional capacity stated by the treating physician. What was reviewed, restrictions and limitations the reviewer feels are supported, expected duration, and any suggested next steps will typically be documented in the claim file by the medical resource.

When our opinion of claimant's functionality differs with the treatment provider's conclusion of the claimant's functionality, limitations and abilities, contact with the treatment providers may be appropriate in an attempt to clarify functional discrepancies. When these efforts do not resolve the questions of functional status and level and impairment, use of external resources may be appropriate in attempt to gain understanding of the claimant's functional capacity, or to provide additional documentation and rationale for the medical conclusions on which the evaluation of disability will be based.

Following a review of medical documentation and discussion with the treatment provider, there may be instances when agreement on functional capacity cannot be reached. When this occurs, the internal and/or external medical resource provides a summary of available documentation and detailed rationale to support the medical conclusions on which the Claim Manager's evaluation of disability will be based. If a disagreement regarding the extent of the claimant's functional capacity exists, the medical resource may consider the following in this summary:

- Cite findings from medical documentation in the claimant's own medical records or external examinations. (see "medical documentation" above for additional information

on what this may consist of).

- Utilizing the cited findings and substantial evidence contained in the file, provide rationale for functional capacity.
- Provide detailed explanation why the treating physician's conclusions exceed the findings or why these findings are inconsistent with the substantial evidence contained in the claim file.

Evaluating Claims with Co-Morbid or Co-Existing Conditions

Whole Person Analysis

When evaluating a claim with co-morbid or co-existing conditions, Claim Managers should consider the impact of those conditions on the whole person and determine if the combined effect impacts the individual's ability to function in an occupational setting. Specifically, Claim Managers should review all data available including claimants' reports of symptoms as well as physical findings.

All conditions that are relevant to the claimant's ability to function, including their combined effect on the whole person, should be considered.

Claim Managers and Expert Resources should consider and afford appropriate weight to all conditions whether or not the claimant or the claimant's physician is asserting disability on the basis of the specific condition.

When co-morbid or co-existing conditions exist, Claim Managers and Expert Resources share responsibility to ensure that all conditions are considered and afforded appropriate weight. In addition, when multiple resources are used, opinions should be coordinated to present a coherent view of the claimant's medical condition(s), capacity, and restrictions and limitations.

Co-Existing vs. Co-Morbid Conditions

- A claimant has co-existing conditions when s/he has multiple conditions, but all of the conditions may not impact his/her functionality.
- A claimant has co-morbid conditions when s/he has multiple conditions that independently impact his/her functionality.

In assessing and addressing each of these conditions within the context of their overall impact on the claimant's functionality, consideration should be given to the currency of each condition, e.g. conditions or symptoms the claimant experienced in the past may not impact

current functionality.

The following information should be evaluated and documented in the Medical Analysis Checklist as it pertains to the claimant's functional capacity:

- Each condition should be identified along with any stated or identified restrictions and limitations
- The combined effect of the diagnoses and impairments should be assessed for their impact on the whole person
- Any additional information that explains the rationale of any conclusions reached.

Summary

Reviewing a claimant's medical status and confirming functional capacity are main components of determining disability. Medical information can be gathered from a variety of sources and our medical staff should be utilized, as needed, when reviewing the information on file, drawing medical conclusions, and proposing next steps.

Medical conclusions assist a Claim Manager by providing a basis for functional capacity, expected resolution of the disabling condition, and feasibility of return to work.

The claim evaluation and determination of disability are the responsibility of the Claim Manager. Claim determinations are based on conclusions drawn from multiple factors including medical, occupational, and financial documentation applied to the policy provisions at hand.

Exhibit D

Guidelines for Use of External Medical Resources

A. *Treating Provider Related.* When medical information in the claim file lacks clarity or sufficiency to assess the claimant's medical condition, functional status and level of impairment or where the claims handler has reason to question the opinions or information provided by the claimant's treating provider, the appropriate internal medical resource should contact the treating provider either by phone or by letter for clarification or additional information. If a telephone contact cannot be arranged, a letter outlining the question(s) and issues should be sent to the treating provider, which invites a reply either by phone or by letter.

Following outreach to treating providers, if the claimant's condition, functional status and level of impairment are still unclear or if the claims handler disagrees with the opinions or information provided by the treating provider, the use of external medical resources, such as a Peer Review, an independent medical evaluation ("IME"), or a functional capacity evaluation ("FCE") should be considered under the following guidelines unless it is determined that the claimant's medical condition, functional status or level of impairment meets the policy's requirements.

1. A Peer Review consists of an independent review and analysis of the claimant's medical records. A Peer Review should be sought whenever the question primarily concerns an issue of data interpretation, and therefore an examination of the claimant would not be useful to understand the reported condition causing impairment.

2. An IME or FCE is an examination of the claimant by a healthcare professional and is typically conducted at the request of the company. These examinations can be used to supplement the claimant's medical record or provide greater detail as to the extent of the claimed impairment. An IME or FCE of the claimant should be considered when there are disputed or unclear medical conditions, functional status, or levels of impairment. These guidelines are the controlling document but Release IME Referral Process and FCE Referral Process may be consulted to provide additional detailed information on the workflow and referral processes for utilizing external medical resources.

An IME or FCE of the claimant should be sought whenever there is lack of agreement and the opinion of the company's internal medical resource is the primary basis for denial or termination of benefits unless the following conditions are satisfied and well documented in the file:

a) The Medical Director (a medical professional with the highest level credentials in the appropriate specialty relating to the reported condition regarding which there is disagreement or a lack of clarity) has reviewed the specific claim, focusing particularly on the area or areas of disagreement between the treating provider(s) and the reviewing internal medical resource;

b) The Medical Director reviewing the file performs his or her own separate analysis of the issue or issues upon which there is disagreement, including any other information in the file deemed by the Medical Director to be relevant to the claim decision; and,

c) The Medical Director reviewing the file concludes that the position of the internal medical resources involved in the claim file and in disagreement with the treating provider is correct, after having determined that the treating provider's opinion is not well supported by medically acceptable clinical or laboratory diagnostic techniques and is inconsistent with the other substantial evidence in the claim file.

If the Medical Director reviewing the file is unable to reach the conclusions outlined in subparagraphs a) through c) above, then an IME/FCE should be performed. If there is a lack of clarity or a disagreement regarding more than one reported condition, then an IME/FCE should be performed unless Medical Directors with the appropriate specialty relating to each of these conditions are able to reach and document these conclusions.

If the Medical Director agrees with the treating provider's opinion, there is agreement as to the current existence of a disabling condition and no IME/FCE is needed at the present time.

B. *Other Circumstances.* An IME/FCE (or in circumstances relating to an issue of data interpretation in which case a Peer Review) should be sought whenever any of the following occurs unless the decision is made to pay/or continue to pay the claim:

1. A prior IME/FCE found disabling limitations and the current impairment is based on the same limitations;

2. An internal medical resource or other company resource, e.g., legal, compliance, or benefit specialist responsible for the claim, states that an IME/FCE is needed;

3. There is a difference of opinion between two or more internal medical resources with respect to the existence of a disabling condition; or

4. The claimant or the treating provider requests an IME/FCE, either directly or through the claimant's representative.

C. *Professional Criteria.* A Peer Review, IME, or FCE must be obtained and conducted on the basis of objective, professional criteria:

1. The company shall select individuals to conduct Peer Reviews, IMEs, and FCEs solely on the basis of objective, professional criteria, and without regard to results of previous reviews or examinations conducted by such individuals; and,

2. Neither the company nor any of its officers or employees shall attempt to influence the impairment determinations of professionals conducting Peer Reviews, IMEs, and FCEs.

Exhibit E

LINA Clinical, Vocational, and Medical Services

Statement Regarding Professional Conduct

Dear Medical Professional:

LINA is committed to standards for the prompt, fair and reasonable evaluation and settlement of claims. As participants in the claims process we play an integral role in achieving these service standards:

With a commitment to integrity, quality and superior service, we will:

- Make appropriate decisions by providing a thorough, fair and objective evaluation of all claims.
- Pay all valid claims in a timely manner with a high level of service.
- Partner with our claimants in their efforts to return to work or to independent living.

These goals cannot be fully realized without our full commitment to our professional ethical standards. Likewise, LINA's commitment is that these standards not be compromised in the course of our work activities on its behalf. Ultimately, however, professional ethical conduct is an individual responsibility. The measure of our success is how we conduct ourselves each day.

Please review and retain the attached "LINA Clinical, Vocational, and Medical Resource Statement Regarding Professional Conduct." We are confident in your commitment to conduct yourselves in accordance with these high standards.

Sincerely,

[LINA Senior Officer]

LINA Clinical, Vocational, and Medical Professionals'
Statement Regarding Professional Conduct

Clinical, vocational, and medical professionals will:

- Comply with all applicable laws, ethical codes, and standards of professional conduct.
- Communicate promptly and professionally.
- Discuss medical and/or vocational facts in an open and honest manner.
- Provide fair and reasonable evaluations considering all available medical and/or vocational evidence, both objective and subjective, both supporting impairment and supporting capacity.
- Consider all diagnoses and impairments, and their effect on the whole person, when evaluating medical and/or vocational data in a claim file.
- Work with or refer files to other appropriate medical personnel when specialization prevents one professional from considering all impairments and diagnoses in an evaluation of the whole person.
- Represent medical and/or vocational facts accurately.
- Provide reasonable, clear, and accurate explanations of professional opinions so that clear and full explanations of decisions based on those opinions are available to the claimant.
- Avoid redundant or unnecessary requests for information, e.g. duplicate information, data not reasonably required for adequate analysis, or data not material to the analysis of the claim.
- Report any significant barriers to achieving these objectives to [designate senior official].

I have read and understand the principles and guidelines above. I agree to abide by these principles in my work on behalf of LINA, and to consult with peers and managers if I am unclear regarding my responsibilities under these principles or encounter barriers to abiding by them. In addition, prior to making each determination as to a claimant's impairment, for which I have been trained, I will certify that I have reviewed all medical, clinical, vocational and other evidence provided to me bearing upon impairment.

_____ _____
Name Date

Exhibit F

Remediation of Certain Denied Claims

The Companies will review certain claims made by residents of the Participating States and provide remediation as appropriate. The review will be in accordance with the enhanced claims procedures set forth in the Agreement and the criteria list below.

All LTD claims made by residents of Participating States that were denied by the Companies on, or adversely terminated by the Companies as of, a date during the Remediation Period (defined below) shall be subject to review and remediation if the claim was denied or adversely terminated for reasons other than: a) application of other policy provisions that are not related to medical condition(s) (e.g. coverage eligibility, exclusions, and limitations); b) withdrawal of the claim; c) death of the claimant; d) not having satisfied the elimination period; d) maximum benefit had been paid; or, e) claimant returned to work or if the claimant initiated litigation and has not withdrawn such litigation (either independently or in favor of participation in the Remediation Program). Additionally, claims where a state insurance department has notified the Companies that it has accepted a fraud referral shall be excluded from the review and remediation.

The Remediation Period ("Remediation Period") for the residents of all Participating States (except California) shall run from January 1, 2009 through December 31, 2010. The Remediation Period for residents of California shall run from January 1, 2008 through December 31, 2010.

Claims will be reviewed to determine if application of the enhanced claim procedures set forth in paragraph B.1 of the Agreement would impact the delivery of benefits due. If there would be an impact, any additional benefits will be paid. If there would not be an impact, no additional action would be taken, and if it is unclear or more information is necessary and relevant to determine if there would be an impact, the Company will pursue that additional information.

The Company is not required to analyze whether the procedures set forth in Exhibit B regarding SSDI awards would impact the delivery of benefits due where the Claimant's SSDI award date is more than one year prior to the Companies' claim determination date.

If, during the course of reviewing a claim, factors which indicate additional benefits are due are discovered, a corrected payment will be made.

When conducting this remediation, the Companies will adhere to all existing standards for request and response timing stated in:

- the Contract under which the claimant is covered,
- the Companies' existing compliance policies and procedures, and

- ERISA Regulations, if applicable.

Any remediation payment by the Companies will be subject to the following conditions:

1. Claimants accepting remediation agree to forgo litigation and release the Companies from any further liability regarding denial or termination of benefits during the Remediation Period; and,

2. Remediated claims shall not be the subject of any additional market conduct sanctions imposed by any of the Participating States.

Company Comments Submitted to Bureau of Insurance in Response to Draft Report

A.J. Charman, III, CTT+
Manager
Market Conduct
Regulatory & State Government Affairs

Cigna Legal

April 1, 2013

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The Honorable Eric Cioppa
Superintendent of Insurance
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333

Dear Superintendent Cioppa:

Thank you for the opportunity to provide company comments to the Market Conduct Examination Report – ("Draft Report") issued by the Maine Bureau of Insurance which identified six (6) areas of concern. Life Insurance Company of North America, Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company have the following comments regarding the Report. The categories from the Draft Report appear in **bold** and the Company's comments appear in *italic*.

1. Imposition of standards which are inconsistent with policy provisions

Company Comment: While the Company did not agree that its discussion of the sufficiency and relevance of the medical information received during the claim examination process potentially constituted an unfair claim settlement practice, it did agree with the examiners that it could improve the explanation of its decision rationale in its adverse determination letters.

2. Claim denial or benefit termination based on incomplete or insufficient analysis of medical information

Company Comment: The Company has utilized a scalable review approach to its review of medical information, which was intended to utilize the right level of resource at the right point – for example, using nurses to screen for completeness of medical proof of loss information prior to escalating to higher level resources for more complicated review issues. While the Company did not agree its use of a scalable review model constituted a potentially unfair claim settlement practice, it did agree with the examiners that it could seek additional, higher level reviews earlier in the claims process to address their concerns.

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3. Claim denial or benefit terminations which reflect selective reliance on medical reports or evaluations, or a predisposed interpretation of such reports or evaluations

Company Comment: While the Company did not agree that its processes for assessing medical information constitute a potentially unfair claim settlement practice, to address the examiners' concerns, it agreed that where a treatment provider's statement is non-specific or unclear and/or the Company disagrees with a treatment provider, it would seek additional clarification/input from the provider as appropriate.

4. Failure to give appropriate weight to Social Security Disability benefits (SSDI)

Company Comment: While the Company did not agree that its process for considering SSDI information constituted a potentially unfair claim settlement process, to address the examiners' concerns, it did agree to more formally address these types of awards in its claims evaluation process.

5. Claimants forced to litigate in order to receive benefits

Company Comment: The Company did not agree with the examiners' concerns that resolving disputed claims through litigation may constitute an unfair claims settlement practice.

6. Inappropriate application of offsets for other benefits

Company Comment: The Company agreed with the examiner's concerns in one instance, and promptly returned the claim file to the claim team for the necessary payment adjustments. In the other instance, the payment error had been self-corrected in October 2005, four years prior to the start of the exam. These two instances were instances and not representative of general business practices.

Again, thank you for this opportunity to provide comments to the Exam Report.

Sincerely,

A.J. Charman, III