

By Mail: Office of Regulations and Interpretations,  
Employee Benefits Security Administration  
Room M-5655  
U.S. Dept. of Labor  
200 Constitution Avenue NW  
Washington D.C. 20210

Re: Re-Examination of Claims Procedure Regulations for Plans Providing  
Disability Benefits  
RIN No.: 1210-AB39  
Regulation: 29 C.F.R. §2560.503

Dear Deputy Assistant Secretary Hauser:

I am writing to discourage the Department from modifying or further delaying the final disability claims regulations (Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016)) that are now scheduled to go into effect on April 1, 2018.

For eight years I represented claimants in ERISA benefit matters both in the internal appeal process and in litigation. The vast majority of my clients were seeking to reverse denials of disability claims. For the last five years I have worked as a consultant to other ERISA benefits attorney for whom I provide advice, perform research and analyze legal decisions. In that capacity I read hundreds of ERISA decisions and court filings each year. Most of these address full and fair review in some way.

Thank you for the opportunity to comment on the Department's re-examination of the costs of the final rules governing disability claims, and thank you for clarifying that the Department will accept more comments as needed in response to the industry's submissions. However, it is not clear to me that this process is necessary, as it appears to be the industry's attempt to re-litigate questions that the Department has already addressed in the final rules. As I mentioned in previous comments, I am concerned with the lack of transparency in the process and question the Department's decision to reexamine the rules because of private meetings between industry players and the Department, where one-sided perspectives were allowed to dominate.

Nevertheless, I will address the objections that have been raised that I feel are most in need of a response.

### **Costs Will Not Increase**

The industry's logic - that the rules will increase administration costs, which in turn will cause premium increases, which in turn will reduce employees' access to disability plans - has no basis. I would not allow the industry to prescribe what is good for ERISA

disability plan participants. The Department has already acknowledged that the disability claims industry has been needlessly adversarial toward ERISA disability plan participants, and it has received many comments confirming that this is so. The industry's argument that the final rules are bad for participants – despite all evidence to the contrary - cannot be taken seriously. The industry is not trustworthy advocate for participants.

Indeed, there is data already available that shows the parade of horrors predicted by the industry will not take place. The Bureau of Labor Statistics' February 2015 publication, *Beyond the Numbers, Disability Insurance Plans; Trends in Employee Access and Employer Costs*, addresses these concerns. <https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm>. There was an increase in participation between the years of 1999 and 2014, a period of time that obviously covers the promulgation of the 2000 claims regulations. This increase occurred despite that employment in the service industry has increased, an industry in which employees are less likely to have access to employer-based disability coverage. This increase also occurred despite a number of court decisions that continued to heighten the plans' obligations. I would therefore be suspicious of any data supplied by the industry now that suggests employers would abandon disability coverage due to the final rules. This BLS document also demonstrates that the cost of disability insurance is low, a possible explanation for why modest increases don't seem to lead to less participation.

The Department has also asked for data about whether disability premiums increased in response to the adoption of state statutory bans on discretionary language clauses in disability policies. Notably, during the time period covered by the BLS publication, many states enacted discretionary clause bans. A list of these states includes, but is not limited to, Arkansas Admin. Code 054.00.101-4 (2013); Cal. Ins. Code §10110.6 (2012); Colo. Rev. Stat. §16-3-1116 (2008); 50 Ill. Admin. Codes 2001.3 (2005); Md. Code ann. Ins. §12-211; Mich. Admin. Codes. R. 500.2201-2202 (2007); R.I. Gen. Law §§ 27-18-79; Tex. Admin. Code §3.1202-1203; Tex. Ins. Code §1701.062, §1701.002 (2011); WAC §284-96-012 (2009). These state regulations have not affected access or participation.

Also, during the period covered by the BLS publication, two major insurers with significant market share, UNUM and CIGNA, were examined by the states for poor claims handling practices. As a result they became subject to fines and Regulatory Settlement Agreements that raised the bar for their disability claims administration. [http://www.maine.gov/pfr/insurance/publications\\_reports/exam\\_rpts/2004/unum\\_multistate/unum\\_multistate.html](http://www.maine.gov/pfr/insurance/publications_reports/exam_rpts/2004/unum_multistate/unum_multistate.html). (Although I am sure the Department has access to it, A Copy of the Cigna Regulatory Settlement Agreement is uploaded with these comments.) Nonetheless, during this period access and participation increased.

An additional reason that employers are not likely to stop providing disability benefits is that these benefits play a role in recruitment and retention. MetLife, one of the industry's

large disability insurers, urges employers to consider how benefits, including disability benefits, increase loyalty and productivity and reduce the apparently rampant worries of financial insecurity. <https://benefittrends.metlife.com/us-perspectives/work-redefined-a-new-age-of-benefits/>;  
[https://benefittrends.metlife.com/media/1168/2016\\_ebts\\_opportunityknocks\\_insights.pdf](https://benefittrends.metlife.com/media/1168/2016_ebts_opportunityknocks_insights.pdf).

To the extent that the industry also argues that increased costs will lead to employers requiring employees to pay their own disability premiums, this is not necessarily an unwelcome thing. Where the disability claimant pays his own premiums with after-tax dollars, his disability benefits are tax-free. This is an enormous benefit to many disability claimants.

The Department should not change the final rules in response to the industry's cost argument. Nor should the industry's cost argument cause the Department to extend the effective date further.

### **The Benefits Outweigh the Costs**

Regulations are not improper just because they affect the market. *Mkt. Synergy Grp. v. United States Dep't of Labor*, 2016 U.S. Dist. LEXIS 163663, 2016 WL 6948061 (D. Kan. 11/28/2016).

But assuming that the final regulations have some impact on cost, the costs will not outweigh the benefits. The Department has already articulated its purposes – to make sure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. The Department should ignore the industry's invitation to abandon these purposes. Moreover, these benefits cannot be outweighed by costs where ERISA claimants are at such a procedural disadvantage.

ERISA disability claimants who are denied their benefits face a process that is far below the standard for regular civil disputes. These procedural hurdles include: (1) there are no jury trials; (2) there is a closed record from the claims process that can rarely be supplemented in litigation; (3) courts often apply an unfavorable standard of review, and (4) there are no remedies to discourage unfair and self-serving behavior on the part of plans. This will never be a level playing field much less one that favors plan participants. *United States v. Aegerion Pharmaceuticals, Inc.*, 2017 WL 5586728, at \*7 (D.Mass. 11/20, 2017)("The insurance industry found it could largely immunize itself from suit due to the Employee Retirement Income Security Act ("ERISA").) Even with the final rules in place, plan participants will not have achieved the "higher-than-marketplace standards" that the Supreme Court insists are required in processing ERISA claims. *MetLife v. Glenn*, 554 U.S. 105, 115 (2008). Any consideration the Department makes about the benefits of the final rules relative to costs should take these "higher-than-marketplace" standards into account. It cannot be the case that any minor increase in

costs justifies denying ERISA claimants the limited protections that the final rules provide.

Furthermore, from the perspective of plan participants, an inexpensive but illusory disability plan is worse than no plan at all. It is important to note that when a disability claimant is unfairly denied benefits that she thought were promised through an employer's plan, it is too late for him to purchase private individual insurance to cover the risk of becoming destitute. It is only at the point of becoming disabled that claimants discover the procedural hurdles that are unique to ERISA claims. Attorneys often have to turn down representation of ERISA disability cases that are otherwise meritorious because the record is closed or the claimant had not realized that a contractual limitations period had passed. To the extent that increased protections bring disability claims administration in line with the reasonable expectations of the employee-participants, the costs are outweighed by the benefits. This is what is meant by higher-than-marketplace standards.

In sum, if there are costs associated with the final regulations, these costs could and should be tolerated in the name of supplying a modicum of protection for plan participants.

**Requiring the Plan to Discuss the Basis for Disagreement with Social Security Decisions or Other Contrary Opinions is Not Costly.**

This rule merely requires disability plans to observe a fundamental due process principle that is imbedded in ERISA—namely the principle that a claimant is entitled to a well-articulated explanation for the adverse benefits decision so that the participant may fairly dispute it. The 2000 regulations require no less.

As the Department has already noted, it is doubtful that there are costs associated with the requirement of discussing the reasons for disagreeing with a favorable Social Security decision. ERISA disability benefits have always been deeply intertwined with the Social Security system and mostly are simply supplemental to Social Security benefits. For some employees a Social Security award will wipe out their entire ERISA benefit or reduce it to a mere \$100 per month. Most disability plans require claimants to apply for the SSA benefit, and the plans usually provide representation for claimants. This is done so that the plan may take advantage of the plan term that the SSDI benefit will offset the LTD benefit. In order to decide which claimants qualify for this representation, claims handlers need to know the standard that the SSA uses. Comment #114, p.8 (ACLI). As such, their claims manuals tend to include pages of instructions related to Social Security disability and its standards. Both the Unum and Cigna Regulatory Settlement Agreements required the insurers to give greater weight to the Social Security awards. The insurers are no strangers to the SSA process or its standards.

To the extent that the industry argues that increasing the cost of disability insurance will burden the government, and more specifically the SSA, the Bureau of Labor Statistics publication speaks to this:

It is important to note that expanding access to employer-provided disability insurance would not necessarily relieve the burden on SSDI. The ability to access disability insurance does not affect a worker's eligibility for SSDI. People can receive SSDI benefits and long-term disability payments, but the private disability insurance payment is usually reduced by the amount of the SSDI payment.

<https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm>.

Additionally, courts in many jurisdictions require an explanation of a favorable Social Security award. *Montour v. Hartford Life & Acc. Ins. Co.*, 588 F.3d 623, 635-637 (9th Cir. 2009); *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 679 (9th Cir. 2011); *Bennett v. Kemper Nat. Services Inc.*, 514 F.3d 547, 553-554 (6th Cir. 2008); *Brown v. Hartford Life Ins. Co.*, 301 F. App'x 777, 776 (10<sup>th</sup> Cir. 2008). As a matter of Supreme Court precedent, it is arbitrary and capricious for the claims administrator to advocate for Social Security benefits, reap the benefit of the Social Security award by means of an offset, and then ignore the SSA's determination. *Metropolitan Life v. Glenn*, 554 U.S. 105 (2008). As the industry comments often acknowledged, requiring an explanation of the reasons for disagreeing with the Social Security decision and other contrary evidence tracks the existing standard. Logically, it should not increase costs to simply codify this standard.

A rule clarifying that an explanation of the basis for disagreeing with a Social Security decision is a requirement will increase uniformity and predictability in the process, which is generally associated with costs savings and not cost increases.

### **The Deemed Exhausted Rule is Not Costly**

The industry's concern about this rule seems to be that plaintiffs and their attorneys will race into court, increasing the volume of ERISA litigation and hence the overall costs of administering disability claims. This is incorrect. Plaintiff's attorneys are ever mindful of building a record on which the court will make its decision and therefore would rather engage in the appeal process and exhaust internal remedies. This serves the dual purpose of possibly resolving the dispute and creating a record for the court to review in case the dispute cannot be resolved internally. Under the final rule, the plaintiff will mostly obtain a remand with instructions for the plan to do its job. Because plaintiff's attorneys usually work on a contingent fee basis, it does not make sense to undertake litigation that is not absolutely necessary and that will not result in resolving the case on the merits.

Further, a court will only award attorney fees for litigation where the plaintiff has achieved some degree of success on the merits. *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255 (2010). In other words, the industry comments are seriously out of step with litigation in the real world and how the incentives are aligned to discourage litigation. While this rule may appear to create additional trips to court, it will not do so except in the most extreme cases. I take it that addressing these extreme cases is the purpose of the final deemed denied rule.

Additionally, as with most of the other final rules, this rule is mostly a codification of existing judge-made law. Claimants are already able to get into court when the claims process has failed them in a meaningful way. *See e.g. Brown v. J.B. Hunt Transp. Servs.*, 586 F.3d 1079, 1085-86 (8th Cir. 2009) (failure to respond to request for documents excused claims from exhaustion requirement because there was no full and fair review). It is not likely that additional costs will result from this regulation. *Hall v. National Gypsum Co.*, 105 F.3d 225, 231-32 (5th Cir. 1997); *LaAsmar v. Phelps Dodge Corp. Life*, 605 F.3d 789 (10th Cir. 2010); *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98 (2d Cir. 2005); *Jebian v. Hewlett-Packard Co. Employee. Benefits Org. Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2003); *Dunnigan v. Metropolitan Life Ins. Co.*, 277 F.3d 223, 231 n.5 (2d Cir. 2002).

**Providing the Right to Review and Respond to New Evidence or Rationale From the Plan During the Appeal Review is Not Costly.**

This rule is fundamental to full and fair review. The Department has already acknowledged the importance of this rule and that it is already the standard in some jurisdictions. The industry complains that providing the claimant with new evidence or rationales before making a final decision is costly. The industry's claim to cost impact is suspect for several reasons.

First, several disability plans or insurers already provide for the right to review and respond. They do so on a voluntary basis, as their comments to the proposed rules admit. Second, courts require plans or insurers to do this in many cases. Last, whether they provide this information to the claimant during the ERISA appeal process, they will have to provide it eventually in one form or another. New reasons or evidence will need to be included in the claim file and likely again in 26(a)(1) disclosures. Thus, the industry's portrayal of the chaos that might ensue if they were required to locate and supply these documents is not credible. If the issue is the cost of mailing, such a concern should not be permitted to interfere with such basic a due process right.

It is important to note what this rule does. It permits a claimant to respond to a disability claims administrator's assertions in a way that will make the response a part of the record if the claimant has to go to court to vindicate her rights. This is because most ERISA cases are decided on a closed record. Without this rule, the claims administrator's new

evidence or rationale will be included in the record that the court reviews, but the claimant's rebuttal will not. Perhaps what the industry is really chafing about is the loss of its ability to strategically withhold information that would help the claimant achieve reversal or win his case in court.

If the industry's concern is that the claims handlers need to do more in the same amount of time, this could be addressed by modifying the rule instead of eliminating the rule altogether. Commenters from both sides have suggested this approach.

I strongly disagree with industry comments to the effect that a second appeal, which is offered with some plans, serves the same purpose as the right to respond to new evidence or rationales before a final decision. This is absurd, as a second appeal permits the claims administrators the same sandbagging opportunity as the first appeal. Second appeals are not necessarily a boon to plan participants. The disability claims regulations acknowledge as much by limiting the number of appeals a plan can require to two. Additionally, second appeals are not universal and are not required. The second appeals that the industry touts are a matter of plan design and can be changed at any time by plan sponsors. It may be that second appeals will become obsolete where the claimant has a true right to respond.

## **Other Provisions**

### **The Impartiality Rule**

Few industry commenters complained about the proposed rule requiring that consulting experts be impartial. Comment #76 (UNUM), Comment #92 (NFL), Comment #129 (AHIP). These muted objections are understandable, since it is hard to argue that disability claims administrators should be free to hire biased experts. The majority of those who object to this rule admitted that the proposed rule reflects the existing law. Comment #76, (UNUM), Comment #92 (NFL). The industry complaints seem to be based on the fear of increased litigation, particularly in the form of discovery. First, federal judges are well versed at limiting discovery in ERISA cases in proportion to the needs of the case. See e.g. *Paquin v. Prudential Ins. Co. of Am.* 2017 WL 3189550 (D. Colo. 7/10/2017); *Heartsill v. Ascension Alliance*, 2017 WL 2955008 (E.D. Mo. 7/11/2017); *Ashmore v. NFL Player Disability and Neurocognitive Benefit Plan*, 2017 WL 4342197 (S.D. Fla. 9/27/2017); *Baty v. Metropolitan Life Ins. Co.*, 2017 WL 4516825 (D. Kan. 10/10/2017); *Harding v. Hartford Life and Accident Ins. Co.*, 2017 WL 1316264 (N.D. Ill. 4/10/2017); *Hancock v. Aetna Life Ins. Co.*, 321 F.R.D. 383 (W.D. Wash. 2017); *Kroll v. Kaiser Foundation Health Plan Long Term Disability Plan*, 2009 WL 3415678 (N.D. Cal. 10/22/2009).

Next, if the impartiality rule is already the law, it is not clear how more discovery would result from codifying it. Additionally, the credibility of experts who are opining on

whether a claimant qualifies for benefits should be subject to *some* sort of scrutiny. If a claimant needs to conduct discovery into whether a physician hired by the administrator is well known to support denials, the cost of conducting this discovery cannot possibly outweigh the benefits. ERISA claimants are entitled to a process that does not have a predetermined outcome based on which reviewing physician is hired by the plan.

#### The Rule Requiring Disclosure of any Internal Limitations Period

Few industry commenters focused on the final rule requiring claims administrators to provide the claimant with the date when any internal time limit for filing suit will expire. I am assuming, therefore, that these objectors are not claiming that this rule has a cost impact. The claims administrators are in a position to satisfy this rule, since the expiration date of an internal limitations period is essentially a plan term that should be accessible to the plan administrator and not be hidden from unsuspecting plan participants. As with most of the final rules, information respecting the period of limitations is required to be disclosed in several jurisdictions, so it is unlikely to incur additional costs to create uniformity. *Santana-Diaz v. Metro. Life Ins. Co.*, 816 F.3d 172, 179 (1st Cir. 2016); *Moyer v. Metro. Life Ins. Co.*, 762 F. 3 503, 505 (6th Cir. 2014); *Mirza v. Ins. Adm'r of America, Inc.*, 800 F. 3d 129, 134 (3d Cir. 2015).

#### The Rule Requiring Disclosure of Internal Guidelines

Few commenters objected to the proposed rule requiring claims administrator to disclose internal guidelines or certify that none exist. Comment #50 (DRI), Comments #76 (UNUM). These commenters complained that internal guidelines tend to be procedural rather than substantive, implying that the guidelines are irrelevant. As this lengthy rulemaking process has shown, procedure affects substantive outcomes. So even if internal guidelines are procedural, that is no reason to withhold those guidelines from claimants. The disclosure of claims manuals and internal guidelines, which often contain additional plan terms that are hidden from the ERISA participants, will ultimately cut down on litigation, since discovery of these documents is often disputed. *See Glista v. Unum Life Ins. Co. Of Am.*, 378 F.3d 113, 123-125 (1<sup>st</sup> Cir. 2004); *Mullins v. AT&T Corp.*, 290 Fed. Appx. 642, 646 (4<sup>th</sup> Cir. 2008).

Yours Truly,

Sally Mermelstein, Attorney at Law  
Minneapolis, Minnesota



**IN THE MATTER OF**  
**LIFE INSURANCE COMPANY OF NORTH AMERICA, CONNECTICUT**  
**GENERAL LIFE INSURANCE COMPANY, AND CIGNA HEALTH AND LIFE**  
**INSURANCE COMPANY (FORMERLY KNOWN 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	"LINA" .....	Preamble at 1
"2010 California Re-Examination" ...	A.6 at 2	"LTD" .....	A.1 at 1
"Agreement" .....	Preamble at 1	"Medical Director" .....	Ex. D at i
"CIGNA Companies" .....	A.1 at 1	"Model Act" .....	A.2 at 2
"Company" or "Companies" ...	Preamble at 1	"Monitoring States" .....	Preamble at 1
"Effective Date" .....	Preamble at 1	"NAIC" .....	A.2 at 2
"Examinations" .....	A.6 at 2	"New England Examinations" .....	A.2 at 2
"FCE" .....	B.1.c at 4	"Participating States" .....	Preamble at 1
"Handbook" .....	A.2 at 2	"Plan" .....	B at 4
"IME" .....	B.1.c at 4	"Professional" .....	B.1.f at 5

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

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: Mark J. Mander

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: Mark J. Mander

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: Mark J. Mander

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: Dore Jones

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: Mark G. M... ..  
ITS: President  
DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: Mark G. M... ..  
ITS: President  
DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: Mark G. M... ..  
ITS: President  
DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: \_\_\_\_\_  
ITS: \_\_\_\_\_  
DATED: \_\_\_\_\_

CONNECTICUT INSURANCE DEPARTMENT

BY: Steven B. Green  
ITS: Commissioner  
DATED: 5-10-13

MASSACHUSETTS DIVISION OF INSURANCE

BY: \_\_\_\_\_  
ITS: \_\_\_\_\_  
DATED: \_\_\_\_\_

MAINE BUREAU OF INSURANCE

BY: \_\_\_\_\_  
ITS: \_\_\_\_\_  
DATED: \_\_\_\_\_

PENNSYLVANIA INSURANCE DEPARTMENT

BY: Michael C. ... ..  
ITS: Commissioner  
DATED: 3-15-13

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: Mark J. Munn

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: Mark J. Munn

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: Mark J. Munn

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: \_\_\_\_\_

ITS: \_\_\_\_\_

DATED: \_\_\_\_\_

CONNECTICUT INSURANCE DEPARTMENT

BY: \_\_\_\_\_

ITS: \_\_\_\_\_

DATED: \_\_\_\_\_

MASSACHUSETTS DIVISION OF INSURANCE

BY: Joseph G. Murphy

ITS: Commissioner

DATED: May 8, 2013

MAINE BUREAU OF INSURANCE

BY: \_\_\_\_\_

ITS: \_\_\_\_\_

DATED: \_\_\_\_\_

PENNSYLVANIA INSURANCE DEPARTMENT

BY: Michael Cardone

ITS: Commissioner

DATED: 3-15-13

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: Mark J. Munn  
ITS: President  
DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: Mark J. Munn  
ITS: President  
DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: Mark J. Munn  
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: Eric Coffey  
ITS: Superintendent  
DATED: 5/8/13

PENNSYLVANIA INSURANCE DEPARTMENT

BY: Michael Cardone  
ITS: Commissioner  
DATED: 3-15-13

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: Matthew M...

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: Matthew M...

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: Matthew M...

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: Michael Cardone

ITS: Commissioner

DATED: 3-15-13

**PARTICIPATING STATE ADOPTION  
of  
REGULATORY SETTLEMENT AGREEMENT**

**TARGETED MARKET CONDUCT EXAMINATIONS OF  
DISABILITY INCOME INSURANCE CLAIM HANDLING PRACTICES**

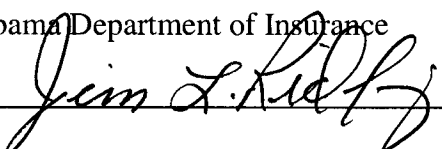
**IN THE MATTER OF**

**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 the Alabama Department of Insurance, I, Jim Ridling as Commissioner of Insurance, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

Alabama Department of Insurance  
By:   
Title: Commissioner  
Date: 05/21/13

**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 Department of Commerce, Community, & Economic Development,  
Division of Insurance, I, Bret S. Kolb, as Director, hereby adopt, agree, and approve the  
Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named  
Companies and the regulatory agencies named therein.

DEPARTMENT OF COMMERCE,  
COMMUNITY, & ECONOMIC  
DEVELOPMENT, DIVISION OF  
INSURANCE

By: Bret S. Kolb  
Bret S. Kolb

Title: Director, Division of Insurance

Date: May 21, 2013



**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 ARIZONA DEPARTMENT OF INSURANCE, I, GERMAINE L.  
MARKS, As DIRECTOR, hereby adopt, agree, and approve the Regulatory Settlement  
Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory  
agencies named therein.

ARIZONA DEPARTMENT OF INSURANCE

By: Germaine L. Marks

Title: Director

Date: June 11, 2013

**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

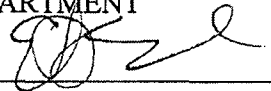
On behalf of the State of Arkansas , I, Ashley Fisher, as Market Conduct Manager,  
hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by  
and between the above-named Companies and the regulatory agencies named therein.

ARKANSAS INSURANCE  
DEPARTMENT

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_



Market Conduct Mgr

6/5/13

**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 the Colorado Division of Insurance, I, Jim Riesberg, as Insurance Commissioner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

Colorado Division of Insurance

By: Jim Riesberg

Title: Insurance Commissioner

Date: May 30, 2013

**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 the Delaware Department of Insurance, I, Karen Weldin Stewart, CIR-ML,  
as Insurance Commissioner for the State of Delaware, hereby adopt, agree, and approve the  
Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named  
Companies and the regulatory agencies named therein.

DELAWARE DEPARTMENT OF  
INSURANCE

By:  KW

Title: Commissioner

Date: July 17, 2013

**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 the District of Columbia Department of Insurance, Securities and Banking,  
I, Margaret Schruender, as Deputy Commissioner, hereby adopt, agree, and approve the  
Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named  
Companies and the regulatory agencies named therein.

District of Columbia Department of  
Insurance, Securities and Banking.

By: Margaret Schruender  
Title: Deputy Commissioner  
Date: 5 June 2013

**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 May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

[STATE INSURANCE REGULATORY  
AGENCY]

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

*[Handwritten Signature]*  
*[Title: Ins. Commissioner of Florida]*  
*[Date: June 28, 2013]*

**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 the Georgia Insurance Department, I, Ralph T. Hudgens, as Commissioner of Insurance of the State of Georgia, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

GEORGIA INSURANCE DEPARTMENT

By: 

Title: Commissioner of Insurance

Date: 06/10/2013

**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 Idaho Department of Insurance, I, Georgia Siehl, as Bureau Chief/Chief Examiner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

**IDAHO DEPARTMENT OF INSURANCE**

By: Georgia Siehl 3/17/13

**Title: BUREAU CHIEF/CHIEF  
EXAMINER**



**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 the **ILLINOIS DEPARTMENT OF INSURANCE**, I, Andrew Boron, as  
Director, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13,  
2013 by and between the above-named Companies and the regulatory agencies named therein.

[STATE INSURANCE REGULATORY  
AGENCY]

By: Andrew Boron

Title: Director \_\_\_\_\_

Date: May 28, 2013 \_\_\_\_\_

**PARTICIPATING STATE ADOPTION  
of  
REGULATORY SETTLEMENT AGREEMENT**

TARGETED MARKET CONDUCT EXAMINATIONS OF  
DISABILITY INCOME INSURANCE CLAIM HANDLING PRACTICES

IN THE MATTER OF

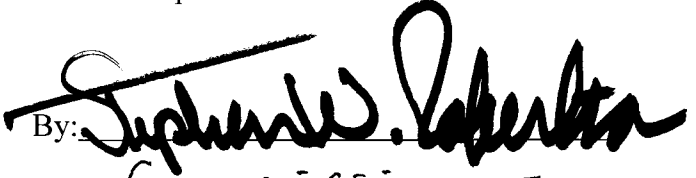
Life Insurance Company of North America, Connecticut General  
Life Insurance Company, and CIGNA Health and Life Insurance  
Company (f/k/a Alta Health and Life Insurance Company)

Philadelphia, Pennsylvania  
NAIC # 65498, 63308

Bloomfield, Connecticut  
NAIC # 67369

On behalf of Indiana Department of Insurance, I, Stephen W. Robertson, as  
Commissioner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated  
May 13, 2013 by and between the above-named Companies and the regulatory agencies named  
therein.

Indiana Department of Insurance

By:   
Title: Commissioner  
Date: June 13, 2013

**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 the Iowa Insurance Division, I, Rosanne Mead, as Iowa Assistant Insurance Commissioner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

Iowa Insurance Division

By: \_\_\_\_\_

Title: Assistant Insurance Commissioner

Date: \_\_\_\_\_

6-11-13

**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 the Kansas Insurance Department I, Sandy Praeger, as Commissioner of Insurance, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

KANSAS INSURANCE DEPARTMENT

By: *Sandy Praeger*

Title: Commissioner of Insurance

Date: 6/25/13

**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 NO. 65498, 63308

Bloomfield, Connecticut  
NAIC NO. 67369

On behalf of the Commonwealth of Kentucky, Department of Insurance, I, Shaun T. Orme, General Counsel, hereby adopt, agree, and approve the Regulatory Settlement Agreement date May 13, 2013, by and between the above-named companies and the regulatory agencies named therein.

COMMONWEALTH OF KENTUCKY  
DEPARTMENT OF INSURANCE

By: \_\_\_\_\_



Title: \_\_\_\_\_

*General Counsel*

Date: \_\_\_\_\_

*6/13/2013*

**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 the Louisiana Department of Insurance, I, James J. Donelon, as  
Commissioner of Insurance, hereby adopt, agree, and approve the Regulatory Settlement  
Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory  
agencies named therein.

Louisiana Department of Insurance

By: 

Title: Commissioner of Insurance

Date: 6/14/13

**The 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 the State of Maryland Insurance Administration, I, Therese M. Goldsmith,  
as Insurance Commissioner, hereby adopt, agree, and approve the Regulatory Settlement  
Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory  
agencies named therein.

**THERESE M. GOLDSMITH  
INSURANCE COMMISSIONER**

By: 

Thomas L. Marshall  
Associate Commissioner,  
Compliance & Enforcement

Date: June, 27, 2013

**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 the State of Michigan, Department of Insurance and Financial Services, I, R. Kevin Clinton, as Director, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

STATE OF MICHIGAN  
DEPARTMENT OF INSURANCE AND  
FINANCIAL SERVICES

By:   
R. Kevin Clinton

Title: Director

Date: June 26, 2013



**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 the Minnesota Department of Commerce, I, Mike Rothman as  
Commissioner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated  
May 13, 2013 by and between the above-named Companies and the regulatory agencies named  
therein.

Minnesota Department of Commerce

By: 

Title: Commissioner

Date: 7-22-13

**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 the Mississippi Insurance Department, I, Mark Haire, as Deputy  
Commissioner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated  
May 13, 2013 by and between the above-named Companies and the regulatory agencies named  
therein.

MISSISSIPPI INSURANCE DEPARTMENT

By: Mark Haire  
Title: Deputy Commissioner  
Date: 6-19-13

**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 May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

[STATE INSURANCE REGULATORY  
AGENCY]

By: 

Title: Director, DIFP

Date: 6/19/13

**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 the Office of the Commissioner of Securities and Insurance, Montana State Auditor (CSI), Monica J. Lindeen, as Commissioner of Securities and Insurance, Montana State Auditor, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013, by and between the above-named Companies and the regulatory agencies named therein.

Office of the Commissioner of Securities  
and Insurance, Montana State Auditor

By: 

Monica J. Lindeen

Title: Commissioner of Securities and  
Insurance, Montana State Auditor

Date: July 8, 2013

**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 the State of Nebraska Department of Insurance, I, Bruce R. Range, as Director of Insurance, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

STATE OF NEBRASKA  
DEPARTMENT OF INSURANCE

By: Bruce R. Range  
Title: Director  
Date: 5-20 2013

**PARTICIPATING STATE ADOPTION  
of  
REGULATORY SETTLEMENT AGREEMENT**

**TARGETED MARKET CONDUCT EXAMINATIONS OF  
DISABILITY INCOME INSURANCE CLAIM HANDLING PRACTICES**

IN THE MATTER OF

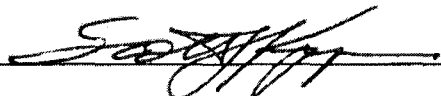
Life Insurance Company of North America, Connecticut General  
Life Insurance Company, and CIGNA Health and Life Insurance  
Company (f/k/a Alta Health and Life Insurance Company)

Philadelphia, Pennsylvania  
NAIC # 65498, 63308

Bloomfield, Connecticut  
NAIC # 67369

On behalf of STATE OF NEVADA, DEPARTMENT OF BUSINESS AND  
INDUSTRY, DIVISION OF INSURANCE, I, SCOTT J. KIPPER, as NEVADA  
COMMISSIONER OF INSURANCE, hereby adopt, agree, and approve the Regulatory  
Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the  
regulatory agencies named therein.

**STATE OF NEVADA,  
DEPARTMENT OF BUSINESS AND INDUSTRY,  
DIVISION OF INSURANCE**

By: 

Title: Nevada Commissioner of Insurance

Date: June 19, 2013

**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 the New Hampshire Insurance Department, I, Roger A. Sevigny, as Commissioner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

New Hampshire Insurance Department

By:  \_\_\_\_\_

Title: Insurance Commissioner

Date: 6-4-13

**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 the State of New Jersey Department of Banking and Insurance I, Kenneth E. Kobylowski as Commissioner of the New Jersey Department of Banking and Insurance hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

New Jersey Department of Banking and  
Insurance

By:  \_\_\_\_\_

Title: Commissioner

Date: 5/29/13 \_\_\_\_\_



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 New Mexico Insurance Division, Public Regulation Commission, I, Mark Jordan, as Chief Examiner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

[STATE INSURANCE REGULATORY  
AGENCY]

By:  \_\_\_\_\_

Title: Chief Examiner

Date: June 24, 2013

**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 the New York State Department of Financial Services, I, Robert H. Easton, as Executive Deputy Superintendent, Insurance Division, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

NEW YORK STATE DEPARTMENT OF  
FINANCIAL SERVICES

By: \_\_\_\_\_

Title: Executive Deputy Superintendent, Insurance  
Division

Date: 5/28/13

**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 the North Dakota Insurance Department, I, Adam Hamm, as North Dakota Insurance Commissioner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013, by and between the above-named Companies and the regulatory agencies named therein.

North Dakota Insurance Department

By: \_\_\_\_\_

Title: Insurance Commissioner

Date: June 19, 2013

**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 the State of Ohio, Department of Insurance, I, Mary Taylor, as Lt.  
Governor/Director, hereby adopt, agree, and approve the Regulatory Settlement Agreement  
dated May 13, 2013 by and between the above-named Companies and the regulatory agencies  
named therein.

Ohio Department of Insurance

By: Mary Taylor

Title: Lt. Governor/Director

Date: 6/13/13

**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 Oklahoma, I, Paul Wilkening, as First Deputy Insurance Commissioner,  
hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by  
and between the above-named Companies and the regulatory agencies named therein.

Oklahoma Insurance Department

By: 

Title: First Deputy Insurance Commissioner

Date: 5/23/13

**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, 62308

Bloomfield, Connecticut  
NAIC # 67369

On behalf of Oregon Department of Consumer and Business Services, Insurance  
Division, I, Lou Savage, as the Insurance Commissioner, hereby adopt, agree, and approve the  
Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named  
Companies and the regulatory agencies named therein.

Oregon Department of Consumer and  
Business Services, Insurance Division

By: 

Title: Insurance Commissioner

Date: JUN 13 2013

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**PARTICIPATING STATE ADOPTION  
of  
REGULATORY SETTLEMENT AGREEMENT**

**TARGETED MARKET CONDUCT EXAMINATIONS OF  
DISABILITY INCOME INSURANCE CLAIM HANDLING PRACTICES**

IN THE MATTER OF

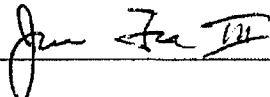
Life Insurance Company of North America, Connecticut General  
Life Insurance Company, and CIGNA Health and Life Insurance  
Company (f/k/a Alta Health and Life Insurance Company)

Philadelphia, Pennsylvania  
NAIC # 65498, 63308

Bloomfield, Connecticut  
NAIC # 67369

On behalf of the Rhode Island Department of Business Regulation, Division of Insurance,  
I, Joseph Torti III, as Superintendent of Insurance, hereby adopt, agree, and approve the  
Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named  
Companies and the regulatory agencies named therein.

Rhode Island Department of Business  
Regulation, Division of Insurance

By: 

Title: Superintendent of Insurance

Date: June 12<sup>th</sup>, 2013

**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 South Carolina Department of Insurance, I, Michael Bailes, as Market Regulation Supervisor, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

South Carolina Department of Insurance

By: Michael Bailes

Title: Market Regulation Supervisor

Date: 7/12/13



**PARTICIPATING STATE ADOPTION  
of  
REGULATORY SETTLEMENT AGREEMENT**

TARGETED MARKET CONDUCT EXAMINATIONS OF  
DISABILITY INCOME INSURANCE CLAIM HANDLING PRACTICES

IN THE MATTER OF

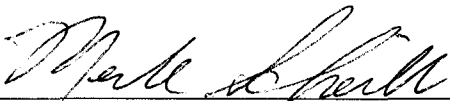
Life Insurance Company of North America, Connecticut General  
Life Insurance Company, and CIGNA Health and Life Insurance  
Company (f/k/a Alta Health and Life Insurance Company)

Philadelphia, Pennsylvania  
NAIC # 65498, 63308

Bloomfield, Connecticut  
NAIC # 67369

On behalf of the South Dakota Division of Insurance, I, Merle Scheiber, as Director,  
hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by  
and between the above-named Companies and the regulatory agencies named therein.

South Dakota Division of Insurance

By: 

Merle Scheiber, Director, South Dakota  
Division of Insurance

Date: 6-24-13

**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 TENNESSEE, I, JULIE MIX MCPEAK as COMMISSIONER, hereby  
adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and  
between the above-named Companies and the regulatory agencies named therein.

TENNESSEE DEPARTMENT OF  
COMMERCE & INSURANCE

By: Julie Mix McPeak  
Title: Commissioner  
Date: 6/21/13

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 May 13, 2013 by and between the above-named  
Companies and the regulatory agencies named therein.

[STATE INSURANCE REGULATORY  
AGENCY] .

By: Julia Battaglini

Title: Commissioner of Insurance

Date: 7/11/13

**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 May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

[STATE INSURANCE REGULATORY  
AGENCY]

By:

Title:

Date:

*Todd E. Kybur*  
*Commissioner*  
*6.21.13*

**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, 62308

Bloomfield, Connecticut  
NAIC # 67369

On behalf of the Vermont Department of Financial Regulation, I, Christina R. Rouleau, as Director of Market Regulation, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

VERMONT DEPT. OF FINANCIAL  
REGULATION

By:   
Christina R. Rouleau

Title: Director of Market Regulation

Date: May 21, 2013

COMMONWEALTH OF VIRGINIA  
STATE CORPORATION COMMISSION

IN THE MATTER OF

LIFE INSURANCE COMPANY OF NORTH AMERICA,

CONNECTICUT GENERAL LIFE INSURANCE COMPANY, and

CIGNA HEALTH AND LIFE INSURANCE COMPANY

CASE NO. INS-2013-00155

*Ex Parte:* In the matter of Approval of a  
Regulatory Settlement Agreement  
between the Life Insurance Company of North America,  
Connecticut General Life Insurance Company, and CIGNA  
Health and Life Insurance Company and the Insurance  
Commissioners or Superintendent of the States of  
California, Connecticut, Maine, Massachusetts, and  
Pennsylvania, for and on behalf of the  
Virginia State Corporation Commission's Bureau of Insurance

PARTICIPATING REGULATOR ADOPTION

ON THIS DAY this matter came before the Virginia Bureau of Insurance, State  
Corporation Commission ("Bureau") for consideration and, upon consideration thereof, the  
Commissioner of Insurance finds:

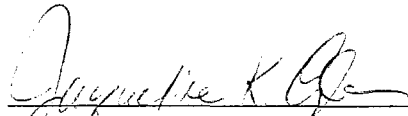
1. Life Insurance Company of North America, Connecticut General Life Insurance Company, and CIGNA Health and Life Insurance Company (formerly known as Alta Health and Life Insurance Company) (collectively, the "Companies") are licensed to transact the business of insurance in the Commonwealth of Virginia. As affecting the Commonwealth of Virginia, the Bureau has jurisdiction over the subject matter of this proceeding and the Companies.
2. The Insurance Commissioners or Superintendent from the States of California, Maine, and Massachusetts, (collectively, "Lead Regulators") conducted targeted market conduct examinations of the Companies to review the Companies' disability income claim handling practices.
3. A settlement has been presented to the Bureau, the terms of which are set forth in a Regulatory Settlement Agreement ("Agreement") that has been signed by the Companies

and the Lead Regulators. The Companies understand that they have a right to a hearing in this matter, and have agreed to waive such right, in accordance with the Agreement.

4. The Bureau expressly adopts, agrees and approves this Agreement as a fair and proper disposition of the matters addressed herein.

THEREFORE, IT IS DIRECTED that the Agreement dated May 13, 2013, and attached hereto as "Exhibit A" be, and is hereby approved, adopted, and fully incorporated herein by reference. The Companies shall initiate compliance with all the terms and conditions of the Agreement as incorporated herein.

A COPY hereof shall be filed with the Clerk of the Commission and thereby placed in Case No. INS-2013-00155.



Jacqueline K. Cunningham  
Commissioner of Insurance  
Bureau of Insurance  
State Corporation Commission  
Commonwealth of Virginia

6/28/2013  
Date

**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 Washington state Office of the Insurance Commissioner, I Mike Kreidler, as Insurance Commissioner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

Washington state Office of the Insurance  
Commissioner

By:  \_\_\_\_\_

Title: Insurance Commissioner

Date: June 6, 2013



**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 West Virginia Offices of the Insurance Commissioner, I, Michael D. Riley, as Insurance Commissioner, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

West Virginia Offices of the Insurance  
Commissioner

By: Michael D. Riley

Title: Insurance Commissioner

Date: May 21<sup>st</sup>, 2013

**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 the Wisconsin Office of the Commissioner of Insurance, I, Theodore Nickel, as Commissioner of Insurance, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

Wisconsin Office of the Commissioner of  
Insurance

By: 

Title: Commissioner of Insurance

Date: 8 July 13

**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 the Wyoming Department of Insurance, I, James Mitchell, as Staff Attorney, hereby adopt, agree, and approve the Regulatory Settlement Agreement dated May 13, 2013 by and between the above-named Companies and the regulatory agencies named therein.

WYOMING DEPARTMENT OF INSURANCE

By: James S. Mitchell

Title: Staff Attorney

Date: 6-10-13

## **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].

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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.

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Name

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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.