Report of the

Multistate Targeted Market Conduct Examination

for the

California Department of Insurance

Connecticut Insurance Department

Maine Bureau of Insurance

Massachusetts Division of Insurance

Pennsylvania Insurance Department

and

Other Participating Jurisdictions:
Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming

of

Life Insurance Company of North America

NAIC Company # 65498
Philadelphia, Pennsylvania

Connecticut General Life Insurance Company

NAIC Company # 62308
Bloomfield, CT

and

Cigna Health and Life Insurance Company

(formerly known as Alta Insurance)
NAIC Company # 67369
Bloomfield, CT

April 7, 2020

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April 7, 2020

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Commissioner Jessica K. Altman
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Dear Commissioner Lara, Commissioner Mais, Superintendent Cioppa, Commissioner Anderson, and Commissioner Altman:

Pursuant to the authority granted by CAL. INS. CODE §§ 729 et seq., CONN. GEN. STAT. § 38a-15, ME. REV. STAT. ANN. tit. 24-A, § 221, MASS. GEN. LAWS c. 175, § 4, 40 PA. STAT. § 323.5, your instructions, and in accordance with the *NAIC Market Regulation Handbook* ("*Handbook*"), a multistate targeted market conduct examination has been conducted of the long term disability income ("LTD") claim handling practices of:

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

The report of examination is herewith respectfully submitted.

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Executive Summary

The examiners have investigated LINA's compliance with the terms of a 2013 regulatory settlement agreement and the insurance laws generally. The regulatory settlement agreement addressed concerns raised in various single-state examinations of the Company's LTD claim handling practices, required implementation of certain "enhanced business practices", and included a remediation program in which the "enhanced business practices" were applied retrospectively to certain denied/terminated claims. An examination conducted by the Lead States in 2016/17 produced negative preliminary results. The 2019 re-examination that is the subject of this report produced significantly better results which suggest that the Company has satisfied its remediation obligations and that the LTD claim handling reforms implemented by LINA's new management team have begun to achieve success. The examiners recommend:

1. Closure of the Multistate Examination. The monitoring and multistate examination process contemplated by the regulatory settlement agreement has precluded individual state examinations of the Company's LTD claim handling practices since 2013. Though some work remains to be done (e.g. overseeing completion of the remediation program), the examiners believe it can be accomplished outside of the multistate framework and recommend that this proceeding be closed so that the Company can be released to standard market conduct oversight.
2. No Adverse Regulatory Action. The examiners recommend that, on the basis of the examination findings, the Lead States conclude that LINA is in material compliance with the terms of the regulatory settlement agreement, that no fines/penalties are necessary, and that no adverse regulatory action should be taken; and,
3. Accelerated Review. Examination results show that the Company's LTD claim handling practices have improved substantially but that the frequency of LTD claim handling concerns remains elevated. The examiners also note that agreement has been reached to sell the subject companies in the third quarter of 2020 (subject to the receipt of the necessary regulatory approvals) and that, though current operational management is expected to remain in place, a risk of disruption is inherent in such corporate transactions. The examiners therefore recommend that the Lead States conduct individual state examinations, on an accelerated basis, to verify continuation of current positive trends and to verify that the sale has not disturbed LTD claim handling operations.

Foreword

This report on the multistate targeted market conduct examination of LINA is provided pursuant to the *Handbook*. Portions of this report are made by test while other portions are made by exception.

Background

The California Department of Insurance, Maine Bureau of Insurance, and Massachusetts Division of Insurance conducted single state examinations of the Company's LTD claim handling practices in 2009 and 2010. The concerns raised in those examinations were discussed with the Company and its domiciliary regulators and addressed in a Regulatory Settlement Agreement ("RSA") dated May 13, 2013 by and between LINA and the California Department of Insurance, Connecticut Insurance Department, Maine Bureau of Insurance, Massachusetts Division of Insurance, Pennsylvania Insurance Department (together, the "Monitoring States"), and insurance regulators from forty-four other jurisdictions that elected to subscribe to the RSA ("Subscribing Jurisdictions").[1] The RSA includes a three-part plan of corrective action:

1. "Enhanced Claim Procedures" – LINA agreed to implement procedures regarding the investigation of claims, weight to be given certain information, and use of external medical resources that were designed to improve the claim handling process and benefit both current and future insureds;
2. Monitoring – The Monitoring States and the Company committed to:
   - Meet regularly over the course of a twenty-four month monitoring period to discuss LTD claim handling operations and the results of ongoing random sample reviews of LTD claim files; and,

[1] A copy of the RSA (omitting the Subscribing Jurisdiction signature pages) is attached hereto as Exhibit A. The Cigna Life Insurance Company of New York ("CLICNY") (NAIC # 64548) does not operate in the Monitoring States and did not, therefore, become a party to the RSA. When the New York Department of Financial Services subscribed to the RSA, however, the Company applied the RSA terms to CLICNY and CLICNY has since been included in all remediation and examination activity.

- Participate in a re-examination for the purposes of evaluating RSA implementation and LTD claim handling generally;

3. Remediation – The Company agreed to implement a remediation program that would apply the enhanced claim procedures to certain previously denied or adversely terminated claims.

Implementation of the enhanced claims procedures and remediation program is enforceable by the Monitoring States which "may assess a fine payable to the [Subscribing Jurisdictions]" if they determine "after conducting the re-examination… that the Companies have not complied materially with the terms of this Agreement." RSA, ¶ D.3.

The monitoring period was conducted as an extension of the California, Maine, and Massachusetts single state examinations. During the course of the monitoring period, the examiners drew three random samples of LTD claim files, reviewed them, and presented their findings to the Monitoring States and the Company. The examiners also audited the Company's compliance with the remediation program established by RSA Exhibit F. See infra, p. 8. LINA responded constructively to the issues presented by the Monitoring States and the examiners and established a productive and professional dialogue. That dialogue resulted in agreement between the Company and the Monitoring States as to various training and procedural initiatives designed to improve LTD claim handling and resolve certain examiner concerns.

To facilitate implementation of these initiatives, the Monitoring States and LINA agreed to postpone the re-examination to early 2016. The Monitoring States also determined that, to clarify procedures and roles, it would be helpful to restructure the proceeding as a multistate targeted market conduct examination. The Monitoring States therefore referred the matter to the NAIC's Market Actions Working Group and received authorization to proceed as a multistate targeted market conduct examination. As a result of this transition, which occurred in December

of 2015, the Monitoring States became the "Lead States" while the Subscribing Jurisdictions became the "Participating Jurisdictions".

The examiners prepared a sampling plan involving random selections subject to a control that ensured the sample would be geographically representative. The Lead States approved the sampling plan in December of 2015 and the Company expressed no objections. Applying that plan to the population of LTD claims denied or adversely terminated during the period February 1, 2016 to April 30, 2016, the examiners selected a total of 128 claim files which the Company promptly produced. The examiners reviewed the selected files in the summer and fall of 2016 and produced preliminary findings to the Lead States in December of 2016. The preliminary findings raised significant concerns which the Lead States shared with the Company in January of 2017. The examiners and the Company then engaged in a claim-by-claim discussion which resolved the examiners' concerns regarding the handling of several files. Though discussion was professional and constructive, the examiners were concerned that preliminary results remained negative.

In the summer and fall of 2017, the Company made organizational changes at both the holding company and operational levels -- establishing the position of Global Compliance Officer and appointing a new President of group insurance and Vice President of claims operations. The examiners and Lead States met with this new management team, discussed the disappointing preliminary re-examination results, and evaluated potential next steps. The new management team described plans to shift the Company's LTD operations from a systems-oriented model to one centered on professional judgment and the empowerment of individual claim handlers. Management also explained that LINA would be introducing a new role for "Quality Review Specialists" -- senior claim handlers tasked with reviewing claim

determinations, mentoring front line claims staff, and facilitating the spread of best practices. Finally, management agreed to reopen the remediation program to address a continuing examiner concern. See infra, p. 9 at note 3. The Lead States were encouraged by the new management team's approach and understood its proposals as reflecting a substantive change in direction. The Lead States therefore agreed to a further monitoring period while the Company embedded its new practices and procedures followed by a fresh re-examination. That re-examination is the subject of this report.

Scope of Examination

The purpose of the re-examination was to determine whether the Company's claim handling practices conform with the standards reflected in the National Association of Insurance Commissioners ("NAIC") *Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance Model Act* (1972), *NAIC Claims Settlement Practices Model Act* (1990), the RSA, and the laws of the Lead States and Participating Jurisdictions. See, e.g., CAL. INS. CODE § 790 *et seq.*, 38a CONN. GEN. STAT. tit. 381, ch. 704, ME. REV. STAT. ANN. tit. 24-A, c. 23, MASS. GEN. LAWS c. 176D, and 40 PA. STAT. ch. 4. The examination also included verification that the Company had adequately implemented the remediation program contemplated by RSA Exhibit F.

Profile of the Company

At all relevant times, LINA and its affiliated insurers writing LTD coverage 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 Lead States and Participating Jurisdictions. The LINA companies writing LTD coverage 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 corporate

parent is CIGNA, Corp., a Delaware holding company. The Life Insurance Company of North America is the primary member of the Cigna Group (NAIC Group # 901) writing group LTD coverage. Cigna Group LTD claims are primarily handled at its Pittsburgh, Pennsylvania claim office.

In December of 2019, the Company advised that CIGNA, Corp., had reached agreement to sell its group life and disability insurance business to the New York Life Group (NAIC Group # 826). The contemplated transaction will involve, among other things, the consolidation of the Company's LTD business in the Life Insurance Company of North America (NAIC # 65498) and Cigna Life Insurance Company of New York (NAIC # 64548) and the subsequent sale of all stock in those entities as well as associated assets and systems infrastructure. The sale (which remains subject to receipt of the necessary regulatory approvals) is scheduled to close in the third quarter of 2020 and the New York Life Group has expressed its intention to keep the group insurance management team in place after the change in ownership. Because of this stability in senior personnel and the fact that group insurance operations will be moving as a unit, management does not anticipate that the transition will have any disruptive effects on the handling of LTD claims. In the closing letter attached as Exhibit B ("Closing Letter"), LINA expresses its agreement that the duties and obligations set forth in the RSA are applicable to the entities that participated in that agreement and that the RSA will remain applicable to the Life Insurance Company of North America and CLICNY after their purchase by New York Life.

Factual Findings

The RSA directed that the Monitoring States (subsequently the Lead States) "monitor compliance with this Agreement and the Remediation Program" and apprise the Participating Jurisdictions of the results. RSA ¶ B.5. The RSA also contemplated that the re-examination would be an investigation "of the issues addressed by th[e] Agreement" including "the

Companies' LTD claim handling practices". RSA ¶ C.2. Having completed that monitoring and investigation, the examiners report as follows:

A. Monitoring of the Remediation Program

The remediation program set forth in RSA Exhibit F required that the Company review eligible claim files in accordance with the "Enhanced Claim Procedures" described in RSA Exhibits B, C, and D. To monitor compliance with the remediation program the examiners reviewed both the process by which the Company identified claims eligible to participate in remediation and the process by which it conducted substantive review.

To identify claims eligible to participate in the remediation process, the Company began with a population database containing all LTD claim files regarding residents of the Subscribing/Participating Jurisdictions for which LTD benefits had been denied/adversely terminated during the remediation period.[2] The Company then applied various "screens" to exclude claims that are ineligible for remediation pursuant to RSA Exhibit F (e.g. withdrawn claims, claims not involving medical determinations, and litigated claims). The examiners verified that the Company had begun with a complete database then evaluated the various "screens" applied in the eligibility review process. The examiners raised concerns regarding one screen and the Company agreed to eliminate it. Accordingly, the examiners are satisfied that the Company's procedures for identifying the universe of claims eligible to participate in remediation were appropriate and compliant with RSA Exhibit F.

With regard to substantive remediation determinations, the Company established a claim handling team tasked with assessing whether application of the RSA's enhanced claim

[2] The remediation period was January 1, 2008 to December 31, 2010 in California and January 1, 2009 to December 31, 2010 in all other Subscribing/Participating Jurisdictions.

procedures may have had an impact on the delivery of benefits and, if so, applying the enhanced procedures. To review the Company's remediation determinations, the examiners drew a randomly selected sample of forty-five LTD claims from a population containing all files for which LINA had completed remediation work. (The sample included both claims for which LINA paid additional benefits as well as claims for which the Company concluded no further benefits were owed). Review of the remediation work performed on the sampled LTD claim files raised several concerns. Discussion with the Company resolved several of these concerns leaving a single "open issue". The Monitoring States advised the Company that they would not consider the remediation program to be completed until that "open issue" – the circumstances in which RSA Exhibits C and D require outreach to treating providers[3] – was resolved. The matter was therefore left "open" through the monitoring period and the 2016-17 re-examination.

The vast majority of remediation work was completed by January of 2016 though work on three final claims continued into mid-2017. A complete report of payments to consumers as a result of this process – totaling more than $10.6 million – is attached as Exhibit C and a summary is presented below in Table 1.

Table 1 – Summary of Initial Remediation Process Results

Claims Eligible to Participate	Claims Receiving Add'l Benefits	Claims Reopened	Benefits Paid	Interest Paid	Total Benefits & Interest
7,150	664	98	$ 8,954,897	$ 1,706,205	$ 10,661,101

At the Lead States' request, LINA's new management team agreed in 2018 to revisit the remediation program and to apply the agreed provider outreach standards. The examiners

[3] The examiners and Lead States believed that RSA Exhibits C and D requires provider outreach in the event of disagreement regarding the claimant's condition and capacity. The Company agreed to implement this outreach requirement in mid-2014 as a "best practice" but did not agree that it was mandatory under the RSA such that prior application of a different practice would require reopening the remediation process.

reviewed this supplementary remediation process in September of 2018 by drawing a sample of twenty-five randomly selected claim files, evaluating whether the Company had properly identified circumstances in which outreach was required, and verifying that LINA made appropriate efforts to contact treating providers where required. The examiners found that LINA had made the proper outreach determination in twenty-three of the twenty-five selected files. The examiners discussed these results with the Company and advised the Lead States that the supplementary remediation process appears to be adequate and appropriately implemented. The supplementary review process is ongoing as of the date of this report and results through March 13, 2020, are set forth below in Exhibit D and a summary is presented below in Table 2.

Table 2 – Summary of Supplementary Remediation Process Results (through 3/13/20)

Claims Included in Supplemental Review	Claims Receiving Add'l Benefits	Claims Reopened	Benefits Paid	Interest Paid	Total Benefits & Interest
6,486	288	45	$ 8,830,825	$ 2,032,387	$ 10,863,211

As of March 13, 2020, there were ten claim files in the supplementary remediation process requiring further information or action. The process of collecting and evaluating aged medical records can be very time consuming, however, and the Lead States have determined that it is unnecessary to hold this multistate examination open pending completion of the remediation program. Instead, the Lead States have requested and received binding commitments from the Company that it will continue the supplementary remediation process to its conclusion and provide associated reports for the duration of that process. See Closing Letter at 2.

B. Review of the Company's LTD Claim Handling Practices

The RSA provides that, at the close of the monitoring period, LINA's LTD claim handling practices will be reviewed in a re-examination. As discussed in the "Background" section of this report (see, supra, p. 5), the examiners conducted a re-examination in 2016-17 that produced unsatisfactory preliminary results. After discussion with LINA (and in reliance on

commitments from the new management team), the Lead States agreed in 2018 to a further monitoring period and to conduct a second re-examination.

During the course of the 2018 monitoring period, the examiners reviewed a number of judgmentally selected LTD claim files and discussed their reactions with the Lead States and the Company on an "information only" basis. The examiners and Lead State representatives also met with LINA management and LTD claim handling leadership to discuss both the "information only" claim files, industry best practices, and the reorientation of the LTD operation. Following the third round of "information only" review and subsequent discussions in January of 2019, the Lead States directed the examiners to begin the second re-examination.

The examiners proposed a sampling plan that called for a minimum sample size of 125 claim files and included the same geographic distribution control as the sampling plan used for the 2017 re-examination. The 2019 sampling plan also added a control to ensure that no individual LINA claim handler was anomalously over-represented in the examination sample. The Lead States approved the sampling plan which the examiners then circulated to the Company for comment. LINA did not object to the proposed sampling plan. Applying the plan to a database containing all LTD claim files denied or adversely terminated during the month of February 2019, the examiners generated a random selection of 125 LTD claim files for review. The examiners circulated the selections to LINA on May 13, 2019. The Company produced claim files on a rolling basis in May and June of 2019 and made supplemental production on an ad hoc basis as requested by the examiners.

The examiners reviewed the selected claim files during the summer and fall of 2019 and presented both quantitative and qualitative findings to the Lead States in November of 2019. With regard to quantitative findings, the examiners raised concerns with LINA's handling of

eighteen out of 125 LTD claims – a 14.4% error rate. In four of the eighteen files, all concerns raised by the examiners related to claim handling activity prior to 2019.[4] The most frequently cited concerns involved:

- Performing independent medical evaluations ("IMEs") in the circumstances required by RSA Exhibit D;
- Proper application of policy language (e.g. recognizing where different policy provisions place the burden of proof);
- Conducting a thorough investigation (e.g. reaching out to all relevant treating providers); and,
- Inadequate vocational analysis (e.g. correctly analyzing job duties and documenting the basis for concluding an occupation is suitable).

The examiners note that certain problematic practices which had been identified as "recurring issues" during the initial monitoring period (and observed during the 2016/17 re-examination) were not material concerns during the current re-examination. With regard to qualitative findings, the examiners identified no current LTD claim handling practices or procedures that would tend to impede claimants' opportunity to prove their claims and observed no indications of anti-claimant bias. The examiners also noted that the Company appears to be using IMEs much more broadly than in past periods (i.e. in circumstances not required by RSA Exhibit D) to gather additional information or resolve ambiguities and that there were several files in which the claim handlers had made exceptional efforts to assist claimants in presenting their claims.

Summarization & Recommendations

Remediation. The examiners' review of remediation claim files raised some concerns regarding both eligibility and substantive determinations. As discussed above, the Company

[4] Claim files were eligible for review (i.e. included in the population from which the sample was drawn) if they were denied or adversely terminated in the month of February 2019. The examiners did not limit review, however, to claim handling activity during that period and instead reviewed all claim handling from inception to-date.

agreed to address those concerns and they have now been resolved to the examiners' satisfaction. The examiners therefore recommend that (upon completion of the supplementary remediation process) the Lead States make a determination that the LINA has materially complied with the remediation requirement of RSA Exhibit F and that no fine should be assessed. See RSA, ¶ D.3.

RSA Compliance. The examiners' review of claims denied or adversely terminated during the month of February 2019 raised concerns regarding the handling of eighteen out of 125 LTD files, a 14.4% error rate. This result exceeds the 7% threshold set forth in the *Handbook* but is not, in the examiners' view, so high that adverse regulatory action is compelled.[5] The question whether LINA has "complied materially with the terms of th[e RSA]" (RSA, ¶ D.3) is therefore one requiring the exercise of regulatory discretion and professional judgment.

In considering the issue, the examiners recommend that the Lead States consider the qualitative findings of the re-examination. In particular, the examiners believe that it is important to consider the absence of anti-claimant bias as well as the absence of practices and procedures that would tend to impede claimants' ability to prove their entitlement to LTD benefits. The fact that problems previously identified as "recurring issues" were not observed during the re-examination also suggests that the new management team has accepted regulatory feedback and been effective at driving change through the organization. As a result, the concerns raised in the re-examination reflected "execution" or "human" errors rather than

[5] "Historically a benchmark error rate of 7 percent has been established for auditing claim practices… [and] [e]rror rates exceeding th[at] benchmark[] are presumed to indicate a general business practice contrary to th[e insurance] laws." See *Handbook* (2017 ed.) at 182. This benchmark means that error rates below 7% generally indicate a pattern of compliant claim handling while higher error rates may reflect non-compliant practices but do not compel such a conclusion. The examiners therefore see error rates in excess of 7% as falling within a range of regulatory discretion.

problematic policies and procedures. Finally, the examiners note that though the re-examination error rate exceeds the 7% threshold, it also shows a strong positive trend in the Company's handling of LTD claims during the RSA period and the fact that this trend has accelerated following the 2017 change in management.[6] In light of these findings and in view of this context, the examiners recommend that the Lead States make a determination that the Company has materially complied with the terms of the RSA. See RSA, ¶ D.3.

Additional Regulatory Action. While the examiners do not recommend drawing adverse inferences from the re-examination error rate, they do view it as raising regulatory concerns. In addition, while the new LINA management team has inspired confidence, shifted the Company's LTD operations in a positive direction, and expressed commitment to establishing a culture of "continuous improvement", significant work remains to be done to drive the error rate below the *Handbook*'s 7% threshold. Finally, while the change in corporation ownership is not expected to have adverse effects on the quality of LTD claim handling, it is a significant corporate event and therefore has the inherent potential to unsettle the trajectory of current operations. The examiners therefore recommend that, leveraging their experience in the multistate examination, one or more of the Lead States conduct follow-up single jurisdiction examinations of the Company's LTD claim handling practices on an accelerated timetable.

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[6] The examiners note that error rates calculated in certain prior rounds of random sample review (e.g. the monitoring period reviews and the 2016/17 re-examination) were preliminary, were not accepted or agreed by the Company, and are subject to statutory confidentiality and thus not matters of public record. These figures have been shared with the Subscribing/Participating Jurisdictions on a confidential basis, however, and discussed extensively with the Monitoring/Lead States. They are, accordingly, important background and contextual information that is appropriately considered in evaluating the re-examination findings.

Acknowledgment

The examiners express their appreciation to the Company for its cooperation throughout the examination process and, in particular, for its transparency in connection with the remediation program and 2019 re-examination. The examiners also thank the United States Department of Labor for its collaborative approach in reviewing issues of common federal and State interest.

Report Submission

The report of examination is herewith respectfully submitted.

Sincerely,

J. David Leslie
Examiner-in-Charge

Examiners:
Rackemann, Sawyer & Brewster, P.C.
Stuart T. Leslie, Esq.
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Monarch Life Insurance Company
Kevin J. McAdoo, Special Deputy Receiver
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Exhibit A

IN THE MATTER OF

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

Philadelphia, Pennsylvania
NAIC # 65498

Bloomfield, Connecticut
NAIC # 67369, 62308

REGULATORY SETTLEMENT AGREEMENT

TARGETED MARKET CONDUCT EXAMINATION
DISABILITY INCOME INSURANCE CLAIM HANDLING PRACTICES

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

A. Recitals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Enhanced Claim Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Other Provisions

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

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

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

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

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

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

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

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

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

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

D. Remedies

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

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

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

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

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: [signature]

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: [signature]

ITS: Insurance Commissioner

DATED: May 13, 2013

CONNECTICUT INSURANCE DEPARTMENT

BY: _____

ITS: _____

DATED: _____

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____

ITS: _____

DATED: _____

MAINE BUREAU OF INSURANCE

BY: _____

ITS: _____

DATED: _____

PENNSYLVANIA INSURANCE DEPARTMENT

BY: _____

ITS: _____

DATED: _____

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: [signature]

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: _____

ITS: _____

DATED: _____

CONNECTICUT INSURANCE DEPARTMENT

BY: [signature]

ITS: Commissioner

DATED: 5-10-13

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____

ITS: _____

DATED: _____

MAINE BUREAU OF INSURANCE

BY: _____

ITS: _____

DATED: _____

PENNSYLVANIA INSURANCE DEPARTMENT

BY: [signature]

ITS: Commissioner

DATED: 3-15-13

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: [signature]

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: _____

ITS: _____

DATED: _____

CONNECTICUT INSURANCE DEPARTMENT

BY: _____

ITS: _____

DATED: _____

MASSACHUSETTS DIVISION OF INSURANCE

BY: Joseph G. Murphy

ITS: Commissioner

DATED: May 8, 2013

MAINE BUREAU OF INSURANCE

BY: _____

ITS: _____

DATED: _____

PENNSYLVANIA INSURANCE DEPARTMENT

BY: [signature]

ITS: Commissioner

DATED: 3-15-13

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: [signature]

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: _____

ITS: _____

DATED: _____

CONNECTICUT INSURANCE DEPARTMENT

BY: _____

ITS: _____

DATED: _____

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____

ITS: _____

DATED: _____

MAINE BUREAU OF INSURANCE

BY: [signature]

ITS: Superintendent

DATED: 5/8/13

PENNSYLVANIA INSURANCE DEPARTMENT

BY: [signature]

ITS: Commissioner

DATED: 3-15-13

LIFE INSURANCE COMPANY OF NORTH AMERICA

BY: [signature]

ITS: President

DATED: March 14, 2013

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CIGNA HEALTH AND LIFE INSURANCE COMPANY

BY: [signature]

ITS: President

DATED: March 14, 2013

CALIFORNIA DEPARTMENT OF INSURANCE

BY: _____

ITS: _____

DATED: _____

CONNECTICUT INSURANCE DEPARTMENT

BY: _____

ITS: _____

DATED: _____

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____

ITS: _____

DATED: _____

MAINE BUREAU OF INSURANCE

BY: _____

ITS: _____

DATED: _____

PENNSYLVANIA INSURANCE DEPARTMENT

BY: [signature]

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: Jim L. Ridling

Title: Commissioner

Date: 05/21/13

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

Introduction

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

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

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

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

Gathering Medical Documentation

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

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

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

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

Triggers for Gathering Additional Information

Vague Statements

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

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

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

statements.

Co-Morbid or Co-Existing Conditions

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

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

Appropriate Care

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

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

Reviewing Medical Information

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

Internal Medical Resources

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

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

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

External Medical Resources

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

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

Evaluating Medical Support of Disability

Non-Disputed Medical Conclusions:

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

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

Disputed Medical Conclusions:

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

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

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

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

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

Evaluating Claims with Co-Morbid or Co-Existing Conditions

Whole Person Analysis

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

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

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

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

Co-Existing vs. Co-Morbid Conditions

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

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

current functionality.

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

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

Summary

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

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

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

Exhibit D

Guidelines for Use of External Medical Resources

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit E

LINA Clinical, Vocational, and Medical Services

Statement Regarding Professional Conduct

Dear Medical Professional:

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

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

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

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

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

Sincerely,

[LINA Senior Officer]

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

Clinical, vocational, and medical professionals will:

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

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

_____ _____

Name Date

Exhibit F

Remediation of Certain Denied Claims

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

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

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

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

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

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

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

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

- ERISA Regulations, if applicable.

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

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

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

Exhibit B

RACKEMANN
SAWYER & BREWSTER
COUNSELLORS AT LAW

Established 1886

J. David Leslie
617-951-1131
dleslie@rackemann.com

March 16, 2020

BY E-MAIL (William.Smith@Cigna.com)

William J. Smith
President, Cigna Group Insurance
1601 Chestnut Street – Two Liberty, Routing Code TL11V
Philadelphia, PA 19192

Re: Regulatory Settlement Agreement ("RSA")
Closing of Multistate Targeted Market Conduct Examination

Dear Mr. Smith:

As you know, in my role as examiner-in-charge for the multistate targeted market conduct examination of the Cigna Group's long term disability income insurance ("LTD") claim handling practices, I circulated preliminary examination findings to the Lead States in the fall of 2019. At the Lead States' direction, I also circulated those preliminary findings to your team for comment and reaction. I appreciate the company's thoughtful and constructive comments and have relayed them to the Lead States.

In consideration of the preliminary examination findings, the company's responses, and the examiners' analysis, the Lead States have determined that the results of the multistate targeted market conduct examination are mixed but that current trends are strongly positive. In particular, the Lead States are encouraged by the direction, tone, and strategy that you, Tom O'Neil, and Lynn Goldbach have set and the culture of "continuous improvement" your team is working to embed. The Lead States are also mindful, however, that work on the RSA remediation program remains ongoing, that the frequency of LTD claim handling concerns remains elevated, and that agreement has been reached to sell the life and disability components of the Cigna Group Insurance operation to the New York Life Group with the transaction expected to close (subject to regulatory approvals) in the third quarter of 2020.

In light of these circumstances, the Lead States are considering closure of the multistate examination with a determination that the company is in material compliance with the RSA and without adverse regulatory action. The Lead States are also considering calling single-state examinations of the transitioned LTD operation in 2021 that would be conducted on a coordinated basis using the same examination team, applying the same standards as the 2019

re-examination, and reporting results informally to other NAIC members. This would permit the Cigna/LINA LTD entities to be released to the standard market conduct oversight regime while allowing the Lead States to remain engaged and verify both that LTD claim handling results continue to improve and that the ownership transition has not disrupted the LTD claim handling operation. The proposed strategy would rest upon various facts and undertakings by the company that the Lead States ask you to confirm:

1. To fulfill the obligations set forth in the RSA, and consistent with Cigna's organizational commitment to legal and regulatory compliance, the Life Insurance Company of North America (NAIC # 65498) and Cigna Life Insurance Company of New York (NAIC # 64548) (together, the "Subject Companies") have, among other things, established a compliance committee and created a new Quality Review Specialist role. The Subject Companies have also revised existing, and developed new policies, training programs, compliance and operational processes, and practices. Many of these initiatives were informed by evolving best business practices in the industry and all are consistent with the requirements and spirit of the RSA. The Subject Companies will continue to comply with the RSA and to implement these undertakings, refining or revising them periodically, as warranted, after their acquisition by the New York Life Group.

2. The Subject Companies will continue the supplemental remediation process described in Tom O'Neil's letter of May 21, 2018 with that process subject to audit by the Lead States. The Subject Companies will continue providing status reports to the Lead States for the duration of the supplemental remediation process.

3. During the period between closure of the multistate examination and initiation of coordinated individual state market conduct examinations by California, Connecticut, Maine, Massachusetts, and/or Pennsylvania in 2021, senior management will participate in conference calls with those States on a quarterly basis and the Subject Companies will advise them in advance regarding any material changes to:

   a. The senior management team responsible for LTD claim handling;

   b. Staffing levels within the LTD claim handling operations;

   c. Budget levels for the LTD claim handling operation; or,

   d. LTD claim handling manuals, policies, or procedures.

The Lead States understand that New York Life has asked that you remain in your current position through and beyond the closing of the transaction and that you have agreed to do so. I therefore thank you for your assistance to date and look forward to working with you through the remainder of this process. Please let me know if you have any questions.

Very truly yours,

J. David Leslie
Examiner-in-Charge

Affirmation

I, William J. Smith, being sworn, confirm the statements set forth in the foregoing paragraphs 1-3 and agree, on behalf of the Life Insurance Company of North America and the Cigna Life Insurance Company of New York to the undertakings set forth in those paragraphs.

William J. Smith
President -- Cigna Group Insurance
Life Insurance Company of North America
Cigna Life Insurance Company of New York

Exhibit C

Initial Remediation Process Results

Jurisdiction	Claims Eligible to Participate	Claims Receiving Add'l Benefits	Claims Reopened	Benefits Paid	Interest Paid	Total Benefits & Interest
Alabama	166	13	1	$ 215,298.57	$ 34,002.32	$ 249,300.89
Alaska	3	0	0	-	-	-
Arizona	96	9	1	27,236.08	14,438.69	41,674.77
Arkansas	37	3	0	20,940.61	-	20,940.61
California	633	88	18	1,611,034.47	619,244.92	2,230,279.39
Colorado	93	5	1	144,331.14	-	144,331.14
Connecticut	77	2	0	12,434.40	3,367.85	15,802.25
Delaware	40	4	2	38,960.71	-	38,960.71
Dist. of Columb.	8	0	0	-	-	-
Florida	423	31	7	284,303.12	69,272.29	353,575.41
Georgia	245	23	2	218,192.45	472.24	218,664.69
Hawaii	24	0	0	-	-	-
Idaho	24	1	0	9,082.50	-	9,082.50
Illinois	269	31	3	572,185.77	72,462.36	644,648.13
Indiana	168	23	7	471,795.74	48,875.95	520,671.69
Iowa	68	5	1	36,017.50	-	36,017.50
Kansas	22	2	0	17,052.23	-	17,052.23
Kentucky	172	16	3	268,428.81	119,048.25	387,477.06
Louisiana	160	19	1	289,500.74	-	289,500.74
Maine	32	4	1	41,393.08	-	41,393.08
Maryland	157	14	1	293,944.33	-	293,944.33
Massachusetts	218	21	4	289,315.85	-	289,315.85
Michigan	349	27	3	565,899.30	322,127.37	888,026.67
Minnesota	110	5	1	62,870.66	-	62,870.66
Mississippi	61	11	1	149,828.32	97,937.64	247,765.96
Missouri	100	14	2	168,343.09	7,695.69	176,038.78
Montana	12	0	0	-	-	-
Nebraska	43	4	1	30,264.80	-	30,264.80
Nevada	43	6	1	116,767.69	-	116,767.69
New Hampshire	48	2	0	2,592.00	-	2,592.00
New Jersey	227	12	1	195,083.01	-	195,083.01
New Mexico	31	0	0	-	-	-
New York	293	24	3	309,564.38	430.45	309,994.83
North Dakota	10	0	0	-	-	-
Ohio	331	25	5	308,839.73	22,794.34	331,634.07
Oklahoma	76	8	1	196,019.76	55,983.87	252,003.63
Oregon	58	4	0	10,413.57	-	10,413.57
Pennsylvania	764	56	5	381,548.01	-	381,548.01
Rhode Island	22	1	0	3,033.33	-	3,033.33
South Carolina	151	14	2	162,347.45	-	162,347.45
South Dakota	4	0	0	-	-	-
Tennessee	182	22	5	98,948.45	-	98,948.45
Texas	544	62	9	526,195.80	80,936.50	607,132.30
Utah	44	1	0	35,165.21	17,513.46	52,678.67
Vermont	14	3	1	179,253.52	34,515.81	213,769.33
Virginia	242	25	2	186,947.87	23,298.23	210,246.10
Washington	119	6	1	118,572.25	-	118,572.25
West Virginia	46	7	0	71,392.15	20.81	71,412.96
Wisconsin	78	9	1	99,829.43	61,765.79	161,595.22
Wyoming	13	2	0	113,728.72	-	113,728.72
TOTAL	**7,150**	**664**	**98**	**$ 8,954,896.60**	**$ 1,706,204.83**	**$ 10,661,101.43**

Exhibit D

Supplemental Remediation Process Results (through 3/13/20)

Jurisdiction	Claims Included in Supp. Review	Claims Receiving Add'l Benefits	Claims Reopened	Benefits Paid	Interest Paid	Total Benefits & Interest
Alabama	153	8	2	$ 176,001.38	$ 21,011.90	$ 197,013.28
Alaska	3	-	-	-	-	-
Arizona	87	8	1	235,111.70	122,554.03	357,665.73
Arkansas	34	3	-	7,206.05	4,262.48	11,468.53
California	545	23	1	825,817.49	666,872.22	1,492,689.71
Colorado	88	3	1	78,242.73	-	78,242.73
Connecticut	75	1	-	7,307.06	18,982.59	26,289.65
Delaware	36	1	-	100.00	-	100.00
Dist. of Columb.	8	-	-	-	-	-
Florida	392	22	2	1,013,647.87	177,026.07	1,190,673.94
Georgia	222	8	1	255,693.06	-	255,693.06
Hawaii	24	1	-	5,782.16	-	5,782.16
Idaho	23	1	-	10,765.00	-	10,765.00
Illinois	238	13	3	385,845.65	176,583.91	562,429.56
Indiana	145	11	3	278,819.64	29,678.15	308,497.79
Iowa	63	3	-	54,509.70	-	54,509.70
Kansas	20	1	1	118,241.07	-	118,241.07
Kentucky	156	7	1	95,886.99	47,650.80	143,537.79
Louisiana	141	8	-	312,039.24	-	312,039.24
Maine	28	1	-	17,945.00	-	17,945.00
Maryland	143	6	-	16,752.36	1,713.92	18,466.28
Massachusetts	197	4	1	85,640.73	-	85,640.73
Michigan	322	18	6	446,091.44	235,977.13	682,068.57
Minnesota	105	2	1	77,163.30	-	77,163.30
Mississippi	50	6	2	100,284.08	28,886.03	129,170.11
Missouri	86	4	-	251,348.70	99,471.75	350,820.45
Montana	12	-	-	-	-	-
Nebraska	39	2	-	11,761.60	-	11,761.60
Nevada	37	-	-	-	-	-
New Hampshire	46	3	-	127,634.88	-	127,634.88
New Jersey	215	5	1	183,321.15	-	183,321.15
New Mexico	31	1	-	10,696.60	11,115.82	21,812.42
New York	269	10	4	358,490.87	4,691.30	363,182.17
North Dakota	10	-	-	-	-	-
Ohio	306	14	4	346,907.45	-	346,907.45
Oklahoma	68	5	-	287,827.30	236,133.86	523,961.16
Oregon	54	1	-	5,350.00	-	5,350.00
Pennsylvania	708	24	4	548,644.25	-	548,644.25
Rhode Island	21	-	-	-	-	-
South Carolina	137	9	2	332,013.89	-	332,013.89
South Dakota	4	-	-	-	-	-
Tennessee	160	6	-	189,068.77	-	189,068.77
Texas	482	32	3	999,696.20	69,792.44	1,069,488.64
Utah	43	1	-	3,123.47	-	3,123.47
Vermont	11	1	-	83,328.87	-	83,328.87
Virginia	217	5	1	210,224.12	79,982.12	290,206.24
Washington	113	4	-	186,085.87	-	186,085.87
West Virginia	39	1	-	64,147.18	-	64,147.18
Wisconsin	69	-	-	-	-	-
Wyoming	11	1	-	26,260.00	-	26,260.00
TOTAL	**6,486**	**288**	**45**	**$ 8,830,824.87**	**$ 2,032,386.52**	**$ 10,863,211.39**