

**[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938, THIS
REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE
CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]**

**WEBSITE PUBLISHED REPORT OF THE MARKET CONDUCT
EXAMINATION OF THE CLAIMS PRACTICES OF**

**CONNECTICUT GENERAL LIFE INSURANCE COMPANY
NAIC # 62308 CDI # 0409-3**

AS OF SEPTEMBER 30, 2011

ADOPTED MONTH DECEMBER 18, 2015

STATE OF CALIFORNIA



**DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU**

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

TABLE OF CONTENTS

SALUTATION	1
FOREWORD.....	2
SCOPE OF THE EXAMINATION.....	3
EXECUTIVE SUMMARY	4
RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, AND PREVIOUS EXAMINATIONS	6
DETAILS OF THE CURRENT EXAMINATION	7
TABLE OF TOTAL ALLEGED VIOLATIONS	9
SUMMARY OF EXAMINATION RESULTS	13

DEPARTMENT OF INSURANCE

Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013



December 18, 2015

The Honorable Dave Jones
Insurance Commissioner
State of California
300 Capitol Mall
Sacramento, California 95814

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims practices and procedures in California of:

Connecticut General Life Insurance Company

NAIC # 62308

Hereinafter, the Company listed above also will be referred to as CGLIC or the Company.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

FOREWORD

The examination covered the claims handling practices of the aforementioned Company during the period October 1, 2010, through September 30, 2011. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law.

The report is written in a “report by exception” format. The report does not present a comprehensive overview of the subject insurer’s practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer’s proposals for correcting the deficiencies. When a violation that resulted in an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. While this report contains violations of law that were cited by the examiner, additional violations of CIC § 790.03, or other laws, not cited in this report may also apply to any or all of the non-compliant or problematic activities that are described herein.

All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company’s responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.
2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.
3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the period October 1, 2010, through September 30, 2011; and a review of prior CDI market conduct examination reports on this Company; and a review of prior CDI enforcement actions.
4. A review of electronic paid claims data for timeliness of payment of claims, and the proper payment of interest if payment was issued beyond 30 working days from date of receipt.
5. A review of the Company's response to a CDI questionnaire pertaining to Company procedures during the review period (prior to implementation of SB 946) for complying with the California Mental Parity Act (CIC §10144.5).

The sample of individual claims files reviewed was conducted at the offices of the company in Visalia and Los Angeles, California.

EXECUTIVE SUMMARY

The Company's written premium for the lines of business reviewed was \$875,563,262 for 2011 and \$677,595,568 for 2012.

The Group and Individual Health claims reviewed were closed between October 1, 2010 and September 30, 2011, commonly referred to as the "review period". The examiners randomly selected 340 sample files (140 paid, 140 denied 30 provider disputes and 30 member appeals). The examiners cited 243 alleged claims handling violations of the California Insurance Code and other specified codes from this sample file review. Additionally, 140 Group and Individual contested claims were reviewed. The examiners cited 135 alleged claims handling violations of the California Insurance Code and other specified codes in these files.

Findings of this examination included failure to supply a statement to the provider in a contested or denied claim advising of its right to enter into the dispute resolution process, failure to advise the insured of the right to request an independent medical review, failure to provide a clear explanation of the computation of benefits, failure to maintain all documents, notes and work papers, failure to conduct and diligently pursue a thorough, fair and objective investigation or persistence in seeking information not reasonably required for or material to the resolution of a claims dispute, and failure to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The total amount of money recovered as a result of the examination was \$16,885.93.

The examination also included an electronic analysis of all paid claims within the review period to determine compliance with requirements for timeliness of payment and payment of interest in California law. The electronic data field parameters were: Date Received, Date Acknowledged and Date Paid or Closed. The electronic review identified 30,708 alleged violations of the California Insurance Code. Findings included failure to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim, and failure to include interest on an uncontested claim paid after 30

working days. Although the Company asserted that 57,443 claims initially identified by the electronic analysis as having been paid late were in fact contested and ultimately paid timely following receipt of additional information, and that instead only 190 claims were paid beyond 30 days from date of receipt and failed to include required interest, a review of a randomly selected sample of 140 files from within the population the Company identified as contested revealed a significant number (37, or 26.4%) that should have been paid within 30 working days of the date of original receipt or of receipt of the additional information but were not, and which should have included interest in the payment. After evaluating the Company's self-report of 190 cases and the results of the testing of the sample of contested claims, the Department is alleging that liability was clear in a similar percentage (26.4%) of the population of 57,443 but that payment was not made within 30 days and interest as not included in the payment, resulting in violations of each type on an additional 15,164 claims beyond those the Company identified. The final section of the report provides more detail on these findings in items 23 and 24, and describes the 135 alleged claim handling violations in the sample of contested claims.

Since the time the work on this examination was conducted, provisions of the Affordable Care Act have become effective. There have been significant changes in the state and federal laws with which health insurers must comply, and insurers, in general, have modified practices and procedures as a result of the changes in the law. As a result, some practices discussed and cited as non-compliant in this examination report may no longer be applicable. The Department has initiated a new examination of CGLIC that will review compliance with state and federal mental health parity laws, and will, as part of the new examination, re-evaluate in relation to current law the practices this report identifies as non-compliant

RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, PREVIOUS EXAMINATIONS

The results of the market analysis review revealed that during 2010, enforcement actions were taken in the states of Kentucky and New York. Both actions alleged a trend of delayed payments. The examiner focused on this issue during the course of the file review.

The Company was the subject of 59 California consumer complaints and inquiries closed from October 1, 2010 and September 30, 2011, in regard to the lines of business reviewed in this examination. Of the complaints and inquiries, the CDI determined eight complaints were justified consisting of improper claims handling and unsatisfactory settlement offers. The examiners focused on these issues during the course of the file review.

The previous claims examination reviewed a period between January 1, 2004 and January 31, 2006. The action identified in the prior examination report was the Company's attempt to settle claims by making a settlement offer that was unreasonably low, and failing to pay interest on uncontested claims. These issues were identified as problematic in the current examination.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

CGLIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	ALLEGED VIOLATIONS
Accident and Disability Group Health Paid	952,480	70	41
Accident and Disability Group Health Denied	47,651	70	86
Accident and Disability Group Member Appeals	1,251	25	14
Accident and Disability Group Provider Appeals	3,082	25	15
Accident and Disability Individual Health Paid	40,435	70	36
Accident and Disability Individual Health Denied	2,501	70	48
Accident and Disability Individual Provider Appeals	45	5	3
Accident and Disability Individual Member Provider Appeals	41	5	0
TOTALS	1,047,486	340	243

CGLIC ELECTRONIC PAID CLAIMS REVIEW		
LINE OF BUSINESS / CATEGORY	NUMBER OF CLAIMS	NUMBER OF ALLEGED VIOLATIONS
Accident and Disability / Group and Individual Health - Claims Paid	992,915	30,708

CCGLIC CONTESTED CLAIM FILE REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Group and Individual Health – Contested	57,443	140	135

TABLE OF TOTAL ALLEGED VIOLATIONS

CONNECTICUT GENERAL INSURANCE COMPANY				
Citation	Description of Allegation	Number of Alleged Violations		
		Sample File Review	Electronic Review	Contested Claim File Review
CIC §10123.13(a) [CIC §790.03(h)(3)]*	The Company failed to include a statement to the provider in a contested or denied claim advising of its right to enter into the dispute resolution process described in CIC §10123.13.7	67	0	0
CIC §10169(i) [CIC §790.03(h)(1)]*	The Company failed to advise the insured of the right to request an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers	67	0	23
CIC §10123.13(a) [CIC §790.03(h)(3)]*	The Company failed to include in its notice of a claim being contested or denied that either the insured or the provider may seek a review by the Department.	17	0	17
CCR §2695.11(b) [CIC §790.03(h)(3)]*	The Company failed to provide a clear explanation of the computation of benefits.	15	0	0
CCR §2695.3(a) [CIC §790.03(h)(3)]*	The Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.	12	0	13
CIC §10123.13(a) [CIC §790.03(h)(5)]*	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim.	12	15,354	37
CCR §2695.7(d) [CIC §790.03(h)(3)]*	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation, or persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.	11	0	1

CONNECTICUT GENERAL INSURANCE COMPANY

Citation	Description of Allegation	Number of Alleged Violations		
		Sample File Review	Electronic Review	Contested Claim File Review
CCR §2695.7(g) [CIC §790.03(h)(5)]*	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	8	0	1
CIC §10123.13(a) [CIC §790.03(h)(13)]	The Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim.	6	0	4
CIC §10123.137(c) [CIC §790.03(h)(3)]	The Company failed to resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.	4	0	0
CIC §10123.13(b) [CIC §790.03(h)(5)]*	The Company failed to pay interest on an uncontested claim after 30 working days.	5	15,354	1
CCR §2695.11(d) [CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date.	4	0	13
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverage's at issue.	2	0	0
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	3	0	7
CCR §2695.7(h) [CIC §790.03(h)(5)]	The Company failed, upon acceptance of the claim, to tender payment within 30 calendar days.	1	0	0
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.	2	0	3

CONNECTICUT GENERAL INSURANCE COMPANY

Citation	Description of Allegation	Number of Alleged Violations		
		Sample File Review	Electronic Review	Contested Claim File Review
CIC §796.04 [CIC §790.03(h)(5)]	The Company authorized payment for health care services and rescinded the authorization after the provider(s) rendered the services in good faith	2	0	0
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	The Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.	1	0	0
CIC §10198.7(a) [CIC §790.03(h)(1)]	The Company failed to apply the time period specified by the code for any individual on the basis of a pre-existing condition provision.	1	0	7
CCR §2695.7(b) [CIC §790.03(h)(4)]	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	1	0	0
CCR §2695.5(e)(1) [CIC §790.03(h)(2)]	The Company failed to acknowledge notice of claim within 15 calendar days.	1	0	0
CIC §10123.13(a) [CIC §790.03(h)(13)]	The Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied.	1	0	0
CIC §10123.13(c) [CIC §790.03(h)(5)]*	The Company failed to pay interest on a contested claim after 30 working days.	0	0	6
CCR §2695.3(b)(2) [CIC §790.03(h)(3)]	The Company failed to record in the file the date the Company received, processed, transmitted or mailed every relevant document pertaining to the claim.	0	0	1
CIC §10198.7(e) [CIC §790.03(h)(5)]	The Company failed to waive the pre-existing period when a certificate of creditable coverage had been presented to the Company.	0	0	1
TOTAL NUMBER OF ALLEGED VIOLATIONS		243	30,708	135

***DESCRIPTONS OF APPLICABLE
UNFAIR CLAIMS SETTLEMENT PRACTICES**

- CIC §790.03(h)(1) The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverage's at issue.
- CIC § 790.03(h)(2) The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- CIC §790.03(h)(3) The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
- CIC §790.03(h)(4) The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.
- CIC §790.03(h)(5) The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.
- CIC §790.03(h)(13) The Company failed to provide promptly a reasonable explanation of the bases relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked if it intends to take appropriate corrective action in all jurisdictions where applicable. The Company intends to implement corrective actions in all jurisdictions.

Money recovered within the scope of this report was \$16,885.93 as described in section numbers 6, 8, 11, 14, 20, 24, 30, 32, 37, and 38 below.

ACCIDENT AND DISABILITY (HEALTH) – SAMPLE FILE REVIEW

1. **In 67 instances, the Company failed to provide a copy of the statement advising the insured's providers of the right to enter into the dispute resolution process described in CIC §10123.137.** The Company failed to provide the insured's health care provider with a copy of the statement advising the provider of the provider's right to enter into the dispute resolution process. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings and states a programming error occurred during the period July 2011 through September 2011 which resulted in the explanations of benefits or remittance advices for denied claims failing to give providers information on the dispute resolution process. In September 2011 the Company resolved the programming error. The Company also states all providers (network and non-network) may access the Company's external website at www.cignaforhcp.com to get a copy of Cigna's reference guide on its dispute resolution process. The Company further states non-contracted providers may also access the website to determine the process for dispute resolution.

The Company states that historically it included the provider dispute process (PDR) only on denied claims. However, CGLIC has agreed to add the PDR language to the Explanations of Payment (EOPs) for all claims modified, and delayed, in addition to those that are denied, for both contracted and non-contracted providers. The Company is scheduled to implement this addition in May 2016.

The Company states that information on the PDR process continues to be included in the Company's enrollees' certificates of coverage and also within the contracted healthcare professional reference manual; it is also available on the Company website at www.cignaforhcp.com.

2. In 67 instances the Company failed to advise the insured of the right to request an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. These instances were found in the sample files reviewed. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

In addition to the instances cited above, there may be additional violations for any or all letters of denials or written responses to grievances sent during this same period.

Summary of the Company's Response: The Company respectfully disagrees with the Department's interpretation of the statute requiring IMR language to be added to letters of denials and grievances when claims were paid according to the provider's reimbursement contract. Nonetheless, the Company agrees to implement a programming change to its EOB to include IMR language for claims denied, modified or delayed on the grounds that services were not medically necessary. The Company is scheduled to implement the updates to the IMR language to the customer's Explanations of Benefits (EOBs) in May 2016.

3. In 17 instances the Company failed to include in its notice of a claim being contested or denied that either the insured or the provider may seek a review by the Department. In 17 instances the Explanation of Benefits ("EOB") mentioned the Department of Managed Health Care ("DMHC") only; the right to review by the Department of Insurance was not noted on the EOB. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: CGLIC responds, "The Company agrees to add the CDI right to a review language process for all member EOBs and provider EOPs for contracted and non-contracted providers when claims have been denied, modified, or delayed. The Company's previous position and understanding was that CIC §§ 10123.13(a) and 790.03(h)(3) applied to denied claims only and did not apply to paid claims based upon the provider's negotiated contract. Currently, CGLIC prints the CDI right to a review language on "denied" claims only for California-sitused plans. The Company will expand this to also include providers located outside of California who rendered care to members of California-sitused plans. CGLIC will work diligently to enhance its EOBs/EOPs by implementing the addition of the CDI right to a review language on all EOBs/EOPs for claims denied, modified, or delayed, pursuant to CIC §§ 10123.13(a) and 790.03(h)(3)."

4. In 15 instances, the Company failed to provide a clear explanation of the computation of benefits. In the first instance the Company provided an explanation that had no relevance to the claim presented. In the other 14 instances the Company failed to send an EOB to the insured. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings and states EOBs were not generated in 12 of 16 instances. The Company states its Network product for non-California members with California situs contracts was not programmed to generate EOBs when the member liability was zero or equal to the co-payment. In all other instances of denials, deductions or coinsurance members were issued an EOB. As a result of this examination, on November 25, 2014, the Company updated its EOB logic on Network plan types situated in California to issue EOBs on claims for non-California members to be compliant with California regulations.

Further, in two instances claims were misdirected from CGLIC to a Third Party Administrator in error. The claims processor did not follow Standard Operating procedures. The Company has provided refresher training as well as vendor protocol changes to its entire claims staff to reinforce regulatory compliance.

In one instance, the Company acknowledges an incorrect remark code was used that provided misinformation the EOB. As a result of the audit examination, the Company notified the IT Division and corrections were implemented on August 14, 2012.

5. In 12 instances, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed. In these instances the following information could not be reproduced by the Company: letters that requested additional information, EOBs and EOPs documenting calculation of benefits, provider's contract or fee schedules and one instance where the claimant's eligibility file was not updated when a certificate of creditable coverage was provided. The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings. Regarding reproduction of the additional information letters, CGLIC states, "For the time period included in the examination, the Company's Proclaim claims system could retain follow up request letters for a period of 90 days. CGLIC worked with its Information Technology Department to make the necessary updates to the claims system. As of November 1, 2012, the Proclaim claims system retains all follow up request letters for ten years." Regarding updating the eligibility file the Company states, "CGLIC has addressed this issue with its Eligibility Department Management Team. The COCC system has been updated to reflect the Certificate of Creditable Coverage." Further, CGLIC's management team provided feedback and coaching to claims processors to reinforce statutory requirements and Company procedures.

6. In 12 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. In 11 instances, the Company failed to reimburse the uncontested claims within 30 days after receipt of the claim by the insurer. In one instance, the Company incorrectly calculated the timeline for reimbursement of claims submitted directly to CGLIC. The Company began the 30-day timeline when the third party affiliate (TPA) American Specialty Health Network (ASHN) received the claim as opposed to the date CGLIC received the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company responds that it begins the adjudication timeline for reimbursement when CGLIC receives the claim. The Company agrees 11 claims were paid more than 30 days after receipt of the claim, and interest was owed. As a result of the examination \$623.72 was paid to claimants. Additionally, the Claims Management Department has been notified of the claim processing errors and has provided coaching and feedback to the claims processors.

In the other instance the Company states claims that are submitted directly to CGLIC in error are re-routed to the third party affiliate (TPA) American Specialty Health Network (ASHN). As a result of the examination, the Company will begin the adjudication process on uncontested claims within 30 working days after receipt of the claim regardless of whether the claim was submitted to CGLIC or ASHN. Further, as a remedial action the Company is developing an automated solution that will allow claims to be forwarded electronically to all claim paying vendors. This new process is scheduled to be implemented on or before December 2015.

7. In 10 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings and states feedback and coaching has been provided to the Company's Management Team and Claims Processors. The Company also states while there were some pre-existing condition limitation issues identified during the course of this examination, the Company's position changed prior to the examination. Effective September 23, 2010, all members under 19 years of age, the pre-existing condition limitation process was waived. Further, on January 1, 2014, CGLIC also waived the pre-existing condition limitation process on all other insureds, pursuant to the Patient Protection and Affordable Care Act (PPACA).

8. In eight instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. Benefits were incorrectly paid resulting in underpayments. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges the eight instances and states these were claims processing errors. As a result of the examination,

the Company issued payments totaling \$2,487.69. Additionally, CGLIC's Management Team reviewed the claim samples with the Claims Processors and provided coaching and training.

9. In six instances, the Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim. In three instances, the EOB contained a remark code that did not identify the specific policy provision or exclusion for which the denial was based. In two instances the Company failed to send EOB statements explaining the denial of the claim. In the last instance, the Company improperly denied a claim with instructions to forward the claim to a Third Party Administrator. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company agrees it failed to identify the specific policy provision or exclusion for which the claim denial was based. As a result of the examination, the Company re-adjusted the claims and provided the Department with corrected copies of the EOBs. Feedback and coaching has been provided to the Company's Management Team and Claims Processors. For those involving remark codes that didn't identify the specific policy provision or exclusion applied, the Company agreed to amend the EOB remark codes to include specific language that refers claimants to the "Exclusions and Limitations" provision of the policy for which the benefit limit or exclusion is based. Further, EOB statements and denial letters will advise if a benefit determination is based on a pre and post medical necessity review; and/or any medical reviews completed by Utilization Management.

10. In four instances, the Company failed to resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute. The Department alleges these acts are in violation of CIC §10123.137(c) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees it failed to respond to the providers request for information within the statutory timeframe. The Company states effective February 17, 2011 Standard Operating Procedures were enhanced to ensure compliance in communication requirements in provider's disputes.

11. In five instances, the Company failed to pay interest on an uncontested claim after 30 working days. The Department alleges these acts are in violation of CIC §10123.13(b) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees with the findings and states the claim processors inadvertently entered the incorrect received date in the claims system which resulted in the claims bypassing the automated late payment interest process. As a result of the examination, interest payments totaling \$258.40 was paid to claimants.

12. In four instances, the Company failed to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings and states, "For the time period included in the examination, the Company's Proclaim claims system could retain follow up request letters for a period of 90 days. CGLIC worked with its Information Technology Department to make the necessary updates to the claims system. As of November 1, 2012, the Proclaim claims system now retains all follow up request letters for ten years. While the Company concedes that a retention issue occurred, CGLIC respectfully submits that the Correspondence screen in Proclaim did accurately track request letters and the number of times it had been sent out, and to whom the letters were mailed."

13. In two instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. In one instance the Company failed to apply the time period specified by the policy provisions for an individual on the basis of a preexisting condition. In another instance a denial letter included incorrect information although the Company received accurate information in a telephone call from the member. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company agrees in two instances it misrepresented pertinent facts. As a result of the examination, in the first instance the Company agrees the review period used to apply the pre-existing condition provision was incorrect. Consequently, the Company reviewed all claims related to the denial and paid according to the correct pre-existing condition review period. In the second instance, the Company reviewed the insured's claims payment history and determined no other misstatements of treatment limitations were made. The Company has coached the adjusters to ensure compliance on future claims. Additionally, CGLIC will continue to conduct standard quality assurance audits of its benefit system to ensure information is accurately loaded with respect to applicable state law requirements.

14. In three instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In one instance the Company improperly denied the claim for Durable Medical Equipment (DME) which is a covered medical benefit in the policy provisions. The correction did not occur until 63 days after initial receipt of the claim. In another instance, the Company used an inaccurate reimbursement rate for emergency medical services that resulted in an underpayment of the claim. In the third instance, the Company improperly denied an entire claim when the policy covered non-network claims at 70%. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges the errors. In the first two instances, the corrections were made prior to the examination. In the

remaining instance the claim was re-adjudicated and \$101.69 was paid to the claimant. Additionally, the Company's Management Team provided feedback and coaching to Claims Processors following the examination.

15. In one instance, the Company failed, upon acceptance of the claim, to tender payment within 30 calendar days. The Company improperly conducted a pre-existing condition investigation which delayed payment of the claim. The Department alleges these acts are in violation of CCR §2695.7(h) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges the finding which was corrected prior to the examination. The delayed claim acceptance was applied towards the insured's deductible. Additionally, the Company's Management Team provided feedback and coaching to Claims Processors following the examination.

16. In two instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. In the first instance the Company received a claim from the provider for chiropractic services which is processed by American Specialty Health Network (ASHN), a third party administrator contracted to process and provide reimbursement for chiropractic claims. The Company did not have procedures in place to forward the claim to its TPA. The Company auto-denied the claim, and advised the insured and provider that the claim should be submitted to ASHN for processing. In the other instance the Company received a mental health claim underwritten by CGLIC, and administered by Cigna Behavioral Health (CBH), Inc. This claim was also submitted by a provider directly to CGLIC for consideration. The Company referred the claim to CBH. In this case, the acknowledgement, claim handling and processing failed to comply with California regulation. In each of these instances, the Company failed to utilize operational guidelines and procedures to monitor and follow-up on claims it received which should have been processed by its TPA. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the finding in the first instance. As a remedial action the Company states "Connecticut General Life Insurance Company ("CGLIC" or "the Company") is currently in the process of developing an automated solution that will allow claims to be forwarded electronically to all claim paying vendors. The go-live implementation date is planned for February 2016 contingent upon the success of the program requirements and the transmission testing that will occur as part of CGLIC's quality audit process. The Company reports based on the contingency, the forecast implementation date may be subject to change.

In the second instance, the Company agrees and states, "Misdirected behavioral claims re-routed from the Company's medical claim system to CBH's claim system are dropped to paper with the corresponding Julian receipt date; the paper is then provided to Affiliated Computer Services, Inc. (ACS) for data entry; and electronically sent over to CBH's claim system, via a daily 837 transaction. The output report will provide CBH the number of claims requiring manual adjudication. All claim records are retained by the Company and CBH to remain compliant with the Company's Record Retention policy. CGLIC's Corporate

Audit Department also conducts routine exams of CBH to ensure that CBH is fulfilling their responsibilities pursuant to the Administrative Service Agreement with the Company.” Additional attention will be paid to timely processing for claims that were initially misdirected.

17. In two instances, the Company authorized payment for health care services and rescinded the authorization after the provider(s) rendered the services in good faith. The Department alleges these acts are in violation of CIC §796.04 and are unfair practices under CIC §790.03(h)(5).

Summary of the Company’s Response: The Company agrees with the findings and states the member appeals were pre-certified and denied in error because the providers rendering the services were non-participating and the Claims Processors did not follow the Company’s Standard Operating Procedures to allow the services by enhancing them to the in-network benefit levels. The Company states these examples are isolated Claims Processor errors and do not represent the Company’s practices. As a result of the examination, CGLIC’s Management Team provided feedback and coaching to the Claims Processors to reinforce procedures and statutory compliance.

18. In one instance, the Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days. The Company received a mental health claim on March 25, 2011 and forwarded it to CBH on April 16, 2011 (22 days). The Company utilizes an administrator, CBH, for processing of these types of claims. CBH did not send instructions to the member until June 16, 2011. The Department alleges this act is in violation of CCR §2695.5(e)(2) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company’s Response: The Company acknowledges the finding and states, “Misdirected behavioral claims re-routed from the Company’s medical claim system to CBH’s claims system are dropped to paper with the corresponding Julian receipt date; the paper is then provided to Affiliated Computer Services, Inc. (ACS) for data entry; and electronically sent over to CBH’s claim system, via a daily 837 transaction. The output report will provide CBH the number of claims requiring manual adjudication. All claim records are retained by the Company and CBH to remain compliant with the Company’s Record Retention policy. CGLIC’s Corporate Audit Department also conducts routine exams of CBH to ensure that CBH is fulfilling their responsibilities pursuant to the Administrative Service Agreement with the Company”. Additional attention will be paid to timely processing for claims that were initially misdirected.

19. In one instance, the Company failed to apply the time period specified by the code for any individual on the basis of a pre-existing condition provision. The Company applied a period longer that provided by statute. The Department alleges this act is in violation of CIC §10198.7(a) and is an unfair practice under CIC §790.03(h)(1).

Summary of the Company’s Response: The Company acknowledges the error and states, “This one-time occurrence was a result of data entry error made by the Eligibility Analyst when updating the Pre-Existing Condition Limitation date in CGLIC

eligibility system.” To ensure future compliance CGLIC’s Management Team provided feedback and the coaching to the Analyst.

20. In one instance, the Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days. The Company received additional information and proof of claim on November 2, 2011. The claim was reopened and accepted on March 28, 2012 as a result of the examination. The Department alleges this act is in violation of CCR §2695.7(b) and is an unfair practices under CIC §790.03(h)(4).

Summary of the Company’s Response: The Company agrees with the error and as a result of DOI’s inquiry the Company states, “CGLIC requested the claim be released for immediate processing. The Company will also apply applicable late payment interest to the claim.” This resulted in recovery of \$25.81

21. In one instance, the Company failed to acknowledge notice of claim within 15 calendar days. The Company failed to acknowledge within regulatory requirement upon notice of claim. The claim was received on March 25, 2011 and acknowledged on May 12, 2011. The Department alleges this act is in violation of CCR §2695.5(e)(1) and is an unfair practices under CIC §790.03(h)(2).

Summary of the Company’s Response: The Company acknowledges the error and states that CGLIC is currently in the process of developing an automated solution that will allow claims to be forwarded electronically to all claim paying vendors. This new process will ensure timely acknowledgment of claims. The Company will implement the vendor claim forwarding process in February 2016.

22. In one instance, the Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied. Upon receipt of additional information and proof of claim, the Company failed to notify the insured and provider that the claim was denied within 30 working days. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company’s Response: The Company states, “CGLIC agrees that it failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied. This one-time claim processor error was addressed by the Company’s Claim Management Team and education coaching provided to its processing staff.”

ACCIDENT AND DISABILITY (HEALTH) - ELECTRONIC REVIEW

23. In 15,354 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. When the paid claim population was initially tested for the timeliness of payment parameters of

CIC §10123.13(a), the electronic analysis identified 59,480 claims that were potentially paid beyond 30 working days from the date of receipt of the claim. The Company performed a re-evaluation of these claims and identified 190 (147 group claims and 43 individual claims) that were not reimbursed as soon as practical, but no later than 30 working days of receipt of the claim by the Company. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Further analysis on the initial population identified 57,443 claims that initially appeared to be paid later than required by statute; the Company indicated it believed these were contested pending receipt of additional information. A sample of 140 claims from the 57,443 were randomly selected for review. The results of this testing, as described in section 25 below, revealed that in 37 instances (26.4% of the sample) the Company either did not require any further information to determine liability but failed to issue payments within 30 days, or received the necessary additional information but then failed to pay within 30 days of the date the information was received. After evaluating the Company's self-audit, the Department is alleging that liability was clear in a similar percentage (26.4%) of the population of 57,443 but that payment was not made within 30 days, resulting in violations on an additional 15,164 claims beyond those the Company identified.

Summary of the Company Response: The Company states, on July 27, 2011, it confirmed the requested claim count for the time period of December 1, 2009, through June 30, 2011. There were a total of 1,455,407 claims in scope for this examination.

The Department then generated contested claim reports from the 1,455,407 claims, and in one report captured only those claims that appeared to have been processed over 30 working days. This report identified a total of 57,443 claims.

After reviewing the 57,443 claims on this late claims report, CGLIC advised the Department that some of the 57,443 claims were not properly characterized as "late." In response to the CGLIC's concern, the Department reviewed 140 of the 57,443 claims on the late claims report. Through that review, the Department agreed that not all of the 57,443 claims were accurately characterized as late, finding that only 37 of the 140 claims were paid late. From this finding, the Department extrapolated a 26.4% late claims finding for the entire late claims report. This resulted in a late claim finding of 26.4% of 57,443 claims, representing 15,164 late claims.

As a result of the California Department of Insurance request to review Late Payment Interest ("LPI") of claim populations included in this market conduct examination, the Company provided direct feedback and the necessary coaching to the Claims Processors involved in the original review of the 190 claims identified during this examination. The Company's Management Team responsible for overseeing California claims processing also conducted discussions with their assigned teams to provide a refresher review of the processing guidelines for California LPI. Additionally, the Company's standard Operating Procedures ("SOPs") were reviewed and determined accurate against California time to process and late interest statutory requirements.

However, CGLIC will continue to closely monitor the processing of claims resulting in LPI payments to ensure they are processed timely and accurately. The Company states it works diligently to ensure compliance with all state regulations and will continue to do so in the future.

24. In 15,354 instances, the Company failed to pay interest on an uncontested claim after 30 working days. When the paid claim population was initially tested for the timeliness of payment parameters of CIC §10123.13(a), the electronic analysis identified 59,480 claims that were potentially paid beyond 30 working days from the date of receipt of the claim, and where the statutory interest was not paid. The Company performed a re-evaluation of these claims and identified 190 (147 group claims and 43 individual claims) that were not reimbursed as soon as practical, but no later than 30 working days of receipt of the claim, and the statutory interest was not paid. The Department alleges these acts are in violation of CIC §10123.13(b) and are unfair practices under CIC §790.03(h)(5).

Further analysis on the initial population identified 57,443 claims that initially appeared to be paid later than required by statute; the Company indicated it believed these were contested pending receipt of additional information. A sample of 140 claims from the 57,443 were randomly selected for review. The results of this testing, as described in section 25 below, revealed that in 37 instances (26.4% of the sample) the Company either did not require any further information to determine liability, or received additional information from the member, but failed to issue payments within 30 days; statutory was not included. After evaluating the Company's self-audit, the Department is alleging that liability was clear in a similar percentage (26.4%) of the population of 57,443 but that payment was not made within 30 days and interest was not included in the payment, resulting in violations on an additional 15,164 claims beyond those the Company identified.

Summary of the Company Response: The Company states, on July 27, 2011, it confirmed the requested claim count for the time period of December 1, 2009, through June 30, 2011. There were a total of 1,455,407 claims in scope for this examination.

The Department then generated contested claim reports from the 1,455,407 claims, and in one report captured only those claims that appeared to have been processed over 30 working days. This report identified a total of 57,443 claims.

After reviewing the 57,443 claims on this late claims report, CGLIC advised the Department that some of the 57,443 claims were not properly characterized as "late." In response to CGLIC's concern, the Department reviewed 140 of the 57,443 claims on the late claims report. Through that review, the Department agreed that not all of the 57,443 claims were accurately characterized as late, finding that only 37 of the 140 claims were paid late. From this finding, the Department extrapolated a 26.4% late claims finding for the entire late claims report. This resulted in a late claim finding of 26.4% of 57,443 claims, representing 15,164 late claims.

As a result of the CDI's request to review Late Payment Interest ("LPI") of claim populations included in this market conduct examination, the Company provided direct feedback and the necessary coaching to the Claims Processors involved in the original review of the 190 claims identified during this examination. The claims were reprocessed and additional payments reflecting the interest due were made totaling \$12,977.62. The Company's Management Team responsible for overseeing California claims processing, also conducted discussions with their aligned teams to provide a refresher review of the processing guidelines for California LPI. Additionally, the Company's standard Operating Procedures ("SOPs") were reviewed and determined accurate against California time to process and late interest statutory requirements. However, CGLIC will continue to closely monitor the processing of claims resulting in LPI payments to ensure they are processed timely and accurately. The Company states it works diligently to ensure compliance with all state regulations and will continue to do so in the future.

ACCIDENT AND DISABILITY (HEALTH) – CONTESTED CLAIM FILE REVIEW

25. In 37 instances the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The examination found in 30 instances clean claims were not reimbursed within 30 working days from received date. In four instances the requested additional information was received by the Company and the claims were not reimbursed within 30 working days, and in three instances additional information was requested when not needed to determine acceptance or denial of the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees in 36 instances claims were not reimbursed within regulatory guidelines. The Company took the following steps to ensure compliance with all state regulations: provided instruction to those who processed the claims identified as in violation during this examination; provided refresher reviews to all claims processors of the processing guidelines for California LPI; and reviewed the Company's Standard Operating Procedures ("SOPs") for accuracy with respect to California processing and statutory interest requirements.

The Company disagrees with the Department in one instance and states the claim was originally received on December 29, 2010 and processed on January 13, 2011, when additional information regarding pre-existing condition was requested.

Summary of Department's Evaluation of the Company's Response: The Company improperly conducted a pre-existing condition investigation which delayed payment of the claim. The claim was pended for additional pre-existing information on January 13, 2011. The claim was processed for payment on March 3, 2011 when it was determined the request for pre-existing information was unwarranted. This issue remains unresolved and may result in administrative action.

26. In 23 instances the Company failed to advise the insured of the right to an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. The Company failed to advise the insureds of their right to an independent medical review in these instances identified in the sample of contested claims. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company does not believe it violated the statutes when the IMR language was omitted from certain EOB and EOP statements. However, the Company acknowledges the Department's concerns and will incorporate the IMR language on California Member EOBs for all claims which have been modified, rejected, denied or delayed. The Company is scheduled to implement the addition of the updates to the IMR language to the Customer's Explanations of Benefits (EOBs) in May 2016. The EOB enhancement will apply to claim payments and billings for both CIGNA contracted and non-contracted providers.

27. In 17 instances the Company failed to include in its notice of a claim being contested or denied that either the insured or the provider may seek a review by the Department. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: "The Company has agreed to add the CDI right to a review language process to all member EOBs and provider EOPs for contracted and non-contracted providers when claims have been denied, modified, or delayed. The Company's previous position and understanding was that CIC §§ 10123.13(a) and 790.03(h)(3) applied to denied claims only and did not apply to paid claims based upon the provider's negotiated contract. Currently, CGLIC prints the CDI right to a review language on "denied" claims only for California-sitused plans. The Company will expand this to include providers located outside of California who rendered care to members of California-sitused plans. CGLIC will work diligently to enhance its EOBs/EOPs by implementing the addition of the CDI right to a review language on all EOBs/EOPs for claims denied, modified, or delayed, pursuant to CIC §§ 10123.13(a) and 790.03(h)(3)."

28. In 13 instances the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed. Specifically, the Company does not maintain copies of correspondence for additional information in its claim files. The examiners were unable to validate that the Company requested additional information from the claimant or the provider to perfect the claim. The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges it failed to retain copies of correspondence requesting additional information in the instances

cited. The Company also acknowledges that it was unable to provide copies of subsequent external pend requests as the process is strictly an internal function. The Proclaim system retained copies for a period of 90 days. Effective November 1, 2012, the Company implemented corrective action and worked with the Information Technology Department to make necessary updates to the Proclaim system to ensure correspondence and status letters are retained for a period of ten years.

29. In 13 instances, the Company failed to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date. In 13 instances the claim file reflects periods of inactivity as great as three months from the date of the first request for additional information. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings that claim files did not contain any follow-up or status letters. However, the Company respectfully submits that follow-up letters were mailed but not retained in the Proclaim processing system due to a letter retention issue during the timeline of the examination. The Proclaim system retained letters for up to 90 days. To ensure compliance, as of November 1, 2012, the Company worked with its Information Technology Department to make necessary updates so that all correspondence will be retained for a period of ten years.

30. In seven instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Department alleges these acts are in violation of CIC §790.03(h)(5). In five instances the Company failed to update the participating provider's contract prior to the submission of claims, and in two instances the Company failed to allow the contract rate for the procedure provided. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees with the findings and corrected the errors noted. The Company further acknowledges a provider's contract was improperly loaded resulting in five underpayments. The Company identified the error when the provider appealed a payment on May 23, 2011. Three of the five claims were adjusted prior to the examination. The Company processed the remaining two claims during the audit examination resulting in additional recoveries of \$222.43. The Company also corrected the portions of the provider's contract that was originally uploaded incorrectly. Additionally, claim reports were run to capture the provider's tax id, updated contract, the members' names and applicable claim numbers to ensure that every claim submitted was reprocessed per correct contract upload.

During the course of this examination the Company also implemented a system to "provide direct assistance to its contracted providers when late contract loading issues arise. CGLIC has a dedicated, specialty processing team, Research &

Reconciliation (R&R) Team, who works directly with the Company's Provider Relations Department to review and correct all claims associated with contract loading issues, including late loads, whether it's the result of an oversight by the Company or by the providers."

With regard to the failure to allow the contract rate, the Company states, "As part of the Company's checks and balances, when the National Appeal Organization ("NAO") identifies a discrepancy with a participating provider's contract, it is part of the quality assurance process to investigate the discrepancy and initiate all necessary corrections." Every claim processed prior to the updated contract undergoes a complete review for possible underpayment. Should an underpayment exist, the "R&R Team then adjusts the claims according to the updated contract while following normal adjustment processing guidelines (e.g. issuance of late payment interest, etc.)." CGLIC states once the adjustments have been completed an adjustment report is generated and sent to the Provider Service Partner (PSP) to review with the provider.

31. In seven instances, the Company failed to apply the time period specified by the code for any individual on the basis of a preexisting condition provision. In each of these instances the Company reviewed a look back period greater than six months. The Department alleges these acts are in violation of CIC §10198.7(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company agrees with the Department's findings and will provide feedback to the Claims Management Team to provide the training/coaching to the claims processor.

32. In six instances, the Company failed to pay interest on a contested claim after 30 working days. The Department alleges these acts are in violation of CIC §10123.13(c) and are unfair practices under CIC §790.03(h)(5)

Summary of the Company's Response: The Company acknowledges interest was not paid timely on contested claims. With regard to files reviewed in this section additional interest payments of \$ 163.30 were made between May 13, 2013 and June 22, 2013. The Claims Management Team will provide training/coaching to the claims processors to reinforce compliance with procedures.

33. In four instances the Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim. Specifically, the Explanation of Benefit Statement remark code stated "For Future Expansion" for those charges which were considered ineligible and disallowed for payment reimbursement. This remark code does not state the specific policy provision that is the basis for the denial and fails to provide an explanation of the application of the remark code to the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company agrees with the Department's findings and notified its Information Technology Division regarding the remark code issue to ensure compliance with requirements in future Explanation of Benefit (EOB) statements. The Company states, "For purposes of this examination, CGLIC requested all EOP copies via the reprint copy process. Since this specific EOP was processed over 15 months before the reprint was requested, the internal system (referred to as a "copybook") was used and incorrectly applied the old remark code text to the EOP reprint by displaying "For Future Expansion". The Company further states, the internal system, copybook logic, which caused this discrepancy was removed in November 2012. Following this date, the process of ordering EOP & EOB reprint copies was completed via the XNET system which used a Global Index to populate the accurate remark code literal texts. The previously mentioned copybook was no longer used by the Company after this date.

34. In two instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. In one instance a claim was denied on September 23, 2010 in error, and was re-adjudicated on January 18, 2011. On January 3, 2011, the Company received information that the service provided by a non-contracted provider was the result of a hospital confinement, which is a covered expense. In one instance the examiner failed to review the insured's eligibility information and denied the claim in error. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings and states these were claims processing errors. The Company re-adjusted the affected claims prior to the examination and has addressed the errors with the Claims Management Team who will provide training/coaching to the claims processors.

35. In one instance, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. The Department alleges this act is in violation of CCR § 2695.7(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges a duplicate request for information was inadvertently mailed in error as the claims processor failed to accurately update the claims system for information received. Feedback has been provided to the Claim Management Team to provide coaching/training to the claims processor.

36. In one instance, the Company failed to record the date the Company received, processed, transmitted or mailed every relevant document pertaining to the claim. The examination found that the Company mailed undated correspondence to the provider requesting additional information to perfect the claim. The Department alleges this act is in violation of CCR §2695.3(b)(2) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges a manual letter requesting additional information failed to contain the date the information was requested. This was a claims processor error. Feedback has been provided to the Claim Management Team to provide coaching/training to the claims processor.

37. In one instance the Company attempted to settle a claim by making a settlement offer that was unreasonably low. The Company recorded an incorrect date the claim was received in its calculation of late payment interest owed on the claim which resulted in the underpayment of applicable interest. The Department alleges this act is in violation of CCR §2695.7(g) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges this error and as a result of the examination, paid additional interest of \$12.11 on May 22, 2013. Feedback has been provided to the Claim Management Team to provide training to the claims processor.

38. In one instance, the Company failed to pay interest on an uncontested claim after 30 working days. The Company failed to pay late payment interest on a claim received November 9, 2010, and processed on February 23, 2011. Interest was paid on August 7, 2012 as result of the CDI examination. The Department alleges this act is in violation of CIC §10123.13(b) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: Connecticut General Life Insurance Company agrees with this finding and forwarded feedback to the Company's Claim Management Team, to provide coaching/training as necessary. As a result of the audit examination, additional interest was paid in the amount of \$13.16 on August 7, 2012.

39. In one instance, the Company failed to waive the pre-existing condition period when a certificate of creditable coverage had been presented to the Company. The Department alleges this act is in violation of CIC §10198.7(e) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees with the finding and states, "Based on the application, this member had previous COBRA coverage with CGLIC so the Certificate of Creditable Coverage was not required." As a result of the examination, the Company forwarded feedback to the Company's Claim Management Team, to provide coaching/training to the claims handling staff.