STATE OF ARIZONA
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DEPT OF INSURANCE
BY

STATE OF ARIZONA

DEPARTMENT OF INSURANCE

In the Matter of:	Docket No. 04A-175-INS
CONNECTICUT GENERAL LIFE INSURANCE COMPANY, NAIC # 62308, Respondent.	**CONSENT ORDER**

Examiners for the Department of Insurance (the "Department") conducted a market conduct examination of Connecticut General Life Insurance Company ("CGLIC"). In the Report of Examination of the Market Conduct Affairs of CGLIC, the Examiners allege that CGLIC violated A.R.S. §§20-461, 20-466.03, 20-1402, 20-1403, 20-2106, 20-2301, 20-2304, 20-2307, 20-2309, 20-2310, 20-2534, 20-2535, 20-2536, and A.A.C. R20-6-801.

CGLIC wishes to resolve this matter without formal proceedings, admits that the following Findings of Fact are true, and consents to the entry of the following Conclusions of Law and Order.

FINDINGS OF FACT

1. CGLIC is authorized to transact life and disability insurance pursuant to a Certificate of Authority issued by the Director.

2. The Examiners were authorized by the Director to conduct a market conduct examination of CGLIC. The on-site examination covered the time period from July 1, 2001 to June 30, 2002, commenced on October 28, 2002, and was concluded on February 27, 2003. Based on their findings, the Examiners prepared the "Report of Examination of the Market Conduct Affairs of Connecticut General Life Insurance Company" dated February 27, 2003.

3. The Examiners reviewed all of the forms used by the Company during the time frame of the examination and found as follows:

a. CGLIC used one large group health policy form [GM6000] that contained certain modifying pages [definitions-DEF7, definitions-DEF8, eligibility-EL1, eligibility-EF2, medical management not covered-MM5, prescription drugs-PD2, and rider-R7] that violated the following Arizona insurance statutes as indicated on the following table:

Statute	Definitions DEF7	Definitions DEF8	Eligibility EL1	Eligibility EF2	Medical Mgt. N/C MM5	Prescription Drugs PD2	Rider R7
20-2301 (A)(15) Legal Separation	X	X					
20-2301(B) Late Enrollment	X		X	X			
20-1402(F) Coverage for Prescription Drugs Used for Cancer Treatment						X	
20-1402(H), (I), (J), & (K) Coverage for Prescribed Foods to Treat Inherited Metabolic Disorders					X	X	
20-2310(E)(2) Maximum Gap in Coverage 63 days							X
20-2301(A)(15) & (B) Incomplete Definition of Late Entrant							X

b. CGLIC used a large group health insurance policy form [GM6000] that utilized two modifying pages [definitions-DEF3 and eligibility-EL2] that contained language establishing eligibility requirements for covered employees. These pages were used in connection with CGLIC's indemnity, PPO, EPP (exclusive provider), and DPP (designated provider/point of service) forms.

c. CGLIC used an insert page for group health coverage that stated preexisting condition limitations and exclusions may not be imposed for newborn and newly adopted children if covered within 30 days of birth, adoption, or placement for

adoption, instead of the required 31 days.

d. CGLIC used four forms [31939-5-96; 557790b Rev.6-99; 561479c Rev. 10-99; and 587994 4-02] that contained a disclosure authorization notice that failed to state:

i. The authorization is valid for no more than 30 months.

ii. The individual or the individual's authorized representative is entitled to receive a copy of the authorization.

e. CGLIC used 18 claim forms [FORM 00123 REV 10/99, CL 500919 Rev 4-98, CL 503919 2-96, CL 427526 10-93, CL 427526 Rev 4-96 PDF, CL 503919 4-98, FORM 00123 REV 12-97, FORM 00123 REV 11-94, CL 421283 11-94, CL 427526 Rev. 4-98, 77144 Rev. 5-2000, CL 506608 7-94, CL 503919 4-96, CL 505517 Rev. 4-98, CL_44476 Rev. 4-98, CL_44476 Rev. 10-98, 077211 12-99, and CL 244475 10-99] that failed to contain:

i. The fraud warning notice printed in at least 12-point type.

ii. A statement that would notify the insured that the authorization remains valid for the term of coverage of the policy.

f. CGLIC used one form [MCC Behavioral Care Coordination Form] that contained a disclosure authorization notice that failed to state that the individual or the individual's authorized representative is entitled to receive a copy of the authorization.

4. The Examiners reviewed all of the advertising materials used by the Company during the time frame of the examination and found a handbook explaining the benefits of CGLIC's Exclusive Provider Plan. This handbook was included in the materials provided to the Examiners by the Company as an example of explanatory information provided to Arizona policyholders covered under the Exclusive Provider

Plan. The examiners determined that CGLIC had nine EPP plans in force in Arizona during the time frame of the examination. By offering a plan that requires services be rendered by a particular hospital or provider, CGLIC offered and administered a health benefits plan that is beyond the scope of its certificate of authority. These plans are no longer in force.

5. The Examiners reviewed six of six Expedited Appeals reviewed by the Company during the time frame of the examination and found as follows:

a. CGLIC failed to include the criteria used for the decision in the notice to three members.

b. CGLIC failed to provide notice telephonically and by mail of the adverse decision and of the member's option to proceed to an expedited review to two members and the members' treating providers.

6. The Examiners reviewed 22 of 22 Informal Reconsiderations reviewed by the Company during the time frame of the Examination and found as follows:

a. CGLIC failed to acknowledge nine requests for Informal Reconsideration within five business days of receipt of the request.

b. CGLIC failed to provide six members and the members' treating providers with the clinical reason and the criteria used for making the decision.

c. CGLIC failed to provide two members and the members' treating providers with notice of the right to proceed to an External Independent Review, following the denial of an Informal Reconsideration.

7. The Examiners reviewed two of two Formal Appeals reviewed by the Company during the time frame of the Examination and found that CGLIC failed to send a written acknowledgement, including the information packet, to two members and the members' treating providers within five business days of receipt of the notice.

8. The Examiners reviewed the Company's underwriting procedures to verify compliance with the Accountable Health Plan/HIPAA statutes and found that CGLIC did not offer at least one health benefits plan on a guaranteed issue basis to small employers during the examination period.

9. The Examiners reviewed 41 of 41 large group renewal notices sent by the Company during the time frame of the examination and found as follows:

a. CGLIC sent 30 renewal notices to the producer, and not the insured.

b. CGLIC sent 29 notices that failed to contain an explanation of the extent to which any increase in premium was due to the actual or expected claims experience of the group insured under the plan.

10. The Examiners reviewed 489 of 7,922 insured Non-ERISA paid and denied behavioral health, dental, and disability claims processed by the Company during the time frame of the examination and found as follows:

a. CGLIC failed to notify 103 insureds of the receipt of the claim within ten working days.

b. CGLIC failed to accept or deny 35 first-party claims within 15 working days of receipt of an acceptable proof of loss.

CONCLUSIONS OF LAW

1. CGLIC violated A.R.S §20-1403 by issuing and administering a group disability policy that required the service be rendered by a particular hospital or person.

2. CGLIC violated A.R.S §20-2301(B) by using policy form pages that contained language stating that a person must request enrollment within 30 days of becoming a dependent, to not be considered a late enrollee.

3. CGLIC violated A.R.S §20-2301(A)(15)(ii) by using policy form pages that

failed to contain language stating that legal separation was a criterion for exception for not being considered a late enrollee.

4. CGLIC violated A.R.S §20-1402(F) by failing to include language in a policy form page and certificates of coverage that provided benefits for off-label use of prescription drugs related to cancer treatment.

5. CGLIC violated A.R.S §20-1402(H), (I), (J), and (K) by using policy form pages that provided for prescription drug coverage but failed to offer coverage for prescribed medical foods to treat inherited metabolic disorders.

6. CGLIC violated A.R.S §20-2310(E)(2) by using a policy form page that stated an incorrect maximum number of days between coverages to determine creditable coverage.

7. CGLIC violated A.R.S §20-2301(A)(15) and (B) by using a policy form page that contained an incomplete definition of late entrant.

8. CGLIC violated A.R.S §20-2307(A) by establishing eligibility requirements for employees enrolled in a health benefits plan.

9. CGLIC violated A.R.S §20-2310(E)(7) by using policy form pages stating that preexisting condition limitations and exclusions may not be imposed on newborn and newly adopted children if covered within 30 days of birth, adoption, or placement for adoption.

10. CGLIC violated A.R.S §20-2106(9) by using a disclosure authorization notice that failed to include notice that the individual or the individual's authorized representative is entitled to receive a copy of the authorization.

11. CGLIC violated A.R.S §20-2106(7)(a) by using a disclosure authorization notice that failed to include notice that the authorization can be valid for no more than 30 months.

12. CGLIC violated A.R.S §20-2106(8)(a) by using claim forms that failed to include notice that the authorization would be valid for the term of coverage.

13. CGLIC violated A.R.S §20-466.03 by using claim forms that contained the compliant fraud warning notice printed in a font smaller than 12-point type.

14. CGLIC violated A.R.S §20-2534(B) by failing to include language in its notice to the member and the member's treating provider concerning the denial of an expedited medical review, regarding the criteria used and the clinical reasons for the decision.

15. CGLIC violated A.R.S §20-2534(C) by failing to telephonically provide and mail to the member and the member's treating provider a notice of the adverse decision and of the member's option to immediately proceed to an expedited appeal pursuant to subsection E of this section.

16. CGLIC violated A.R.S §20-2535(B) by failing to mail a written acknowledgement to the member and the member's treating provider within five business days after the utilization review agent receives the request for informal reconsideration.

17. CGLIC violated A.R.S §20-2535(D) by failing to mail to the member and the member's treating provider within thirty days after receipt of the request for reconsideration, a notice of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.

18. CGLIC violated A.R.S §20-2535(F) by failing to provide the member and the member's treating provider with a written statement of the utilization review agent's decision and the criteria used and the clinical reasons for that decision, including any references to any supporting documentation and a notice of the option to proceed after the formal appeal process to an external independent review.

19. CGLIC violated A.R.S §20-2536(B) by failing to mail a written acknowledgment to the member and the member's treating provider within five business days after the agent receives the formal appeal.

20. CGLIC violated A.R.S §20-2304(A) by failing to offer at least one health benefits plan on a guaranteed issuance basis to small employers.

21. CGLIC violated A.R.S §20-2309(A) by:

a. Mailing a renewal notice to the producer, and not the insured.

b. Mailing a renewal notice that failed to include language explaining the extent to which the actual or expected claims experience of the group covered under the health benefits plan affected any increase in premium.

22. CGLIC violated A.R.S §20-461(A)(2) and A.A.C. R20-6-801(E)(1) by failing to acknowledge the receipt of a first-party claim within ten working days.

23. CGLIC violated A.R.S §20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a) by failing to accept or deny a first-party claim within 15 working days of receipt of an acceptable proof of loss.

24. Grounds exist for the entry of the following Order in accordance with A.R.S. §§20-220, 20-456, 20-2117, and 20-2508.

ORDER

IT IS HEREBY ORDERED THAT:

1. CGLIC shall cease and desist from:

a. Marketing, selling and administering a health benefits plan that requires the insured to receive treatment from a particular hospital or provider.

b. Using large group health insurance policy forms that:

i. Fail to state that the applicant needs to request enrollment within 31 days of becoming eligible to avoid being considered a late enrollee.

ii. Fail to state that legal separation is an exemption from being considered a late enrollee.

iii. Fail to allow coverage for prescription drugs used for cancer treatment.

iv. Fail to allow coverage for prescribed foods to treat inherited metabolic disorders.

v. Fail to state that the maximum allowable gap for continuous coverage is 63 days.

vi. Fail to provide the insured with a compliant definition of a late enrollee.

c. Using large group health insurance policy certificates that:

i. Establish eligibility requirements [full time status and hours worked weekly] for employees enrolled in a health benefits plan.

ii. Fail to state that preexisting condition exclusions may not be imposed for newborn or newly adopted children if covered within 31 days of birth, adoption, or placement for adoption.

d. Using a disclosure authorization notices that:

i. Fail to state that the authorization is valid for no more than 30 months.

ii. Fail to state that the individual or the individual's authorized representative is entitled to receive a copy of the authorization.

e. Using claim forms that:

i. Fail to contain a compliant fraud warning notice.

ii. Fail to state that the authorization remains valid for the term of coverage of the policy.

f. Failing to include the criteria used for the decision in the notice regarding Expedited Appeals.

g. Failing to provide notice telephonically and by mail of the adverse decision and of the member's option to proceed to an expedited review to two members and the member's treating provider regarding Expedited Appeals.

h. Failing to acknowledge requests for Informal Reconsiderations within five business days of receipt.

i. Failing to provide the member and the member's treating provider with the clinical reason and the criteria used for making the decision regarding Informal Reconsiderations.

j. Failing to provide the member and the member's treating provider with notice of the right to proceed to an External Independent Review.

k. Failing to send a written acknowledgment to the member and the member's treating provider within five business days of receipt.

l. Failing to offer, market, and administer a small group health benefits plan on a guaranteed issuance basis, as required of all accountable health plans.

m. Sending large group health insurance renewal notices to the producer and not the insured where there is no specific direction from the employer that the producer was the delegated agent for this purpose.

n. Using a large group health insurance renewal notice that fails to include notice of the extent to which the actual or expected claims experience of the group affects any increase in premium.

o. Failing to acknowledge the receipt of a first-party claim within ten working days.

p. Failing to accept or deny a first-party claim within 15 working days of receipt of an acceptable proof of loss.

2. Within 90 days of the filed date of this Order, CGLIC shall submit to the Arizona Department of Insurance, for approval, evidence that corrections have been implemented and communicated to the appropriate personnel, regarding the issues outlined in Paragraph 1 of the Order section of this Consent Order. Evidence of corrective action and communication thereof includes, but is not limited to, memos, bulletins, E-mails, correspondence, procedures manuals, print screens, and training materials.

3. The Department shall be permitted, through authorized representatives, to verify that CGLIC has complied with all provisions of this Order.

4. CGLIC shall pay a civil penalty of $105,000.00 to the Director for remission to the State Treasurer for deposit in the State General Fund in accordance with A.R.S. §§ 20-220(B) and 20-456. The civil penalty shall be provided to the Market Oversight Division of the Department prior to the filing of this Order.

5. The Report of Examination of the Market Conduct Affairs of Connecticut General Life Insurance Company as of February 27, 2003, including the letter of objection to the Report of Examination, shall be filed with the Department upon the filing of this Order.

DATED at Phoenix, AZ this 16th day of November, 2004.

Christina Urias
Director of Insurance

CONSENT TO ORDER

1. Connecticut General Life Insurance Company has reviewed the foregoing Order.

2. Connecticut General Life Insurance Company admits the jurisdiction of the Director of Insurance, State of Arizona, admits the foregoing Findings of Fact, and consents to the entry of the Conclusions of Law and Order.

3. Connecticut General Life Insurance Company is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. Connecticut General Life Insurance Company irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.

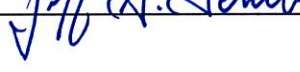
4. Connecticut General Life Insurance Company states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.

5. Connecticut General Life Insurance Company acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter and does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future.

6. Jeff S. Terrill, who holds the office of Vice President of Connecticut General Life Insurance Company, is authorized to enter into this Order for them and on their behalf.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

November 12, 2004
Date

By 

COPY of the foregoing mailed/delivered
this 16th day of November , 2004, to:

Gerrie Marks
Deputy Director
Mary Butterfield
Assistant Director
Consumer Affairs Division
Paul J. Hogan
Market Oversight Administrator
Market Oversight Division
Deloris E. Williamson
Assistant Director
Rates & Regulations Division
Steve Ferguson
Assistant Director
Financial Affairs Division
Alan Griffieth
Chief Financial Examiner
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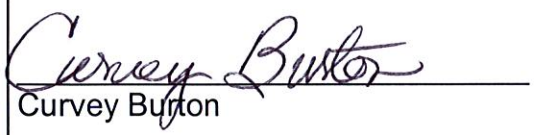

Curvey Burton