Illinois Department of Insurance

BRUCE RAUNER
Governor

JENNIFER HAMMER
Director

July 3, 2017

Mr. Thomas Bertolini
President
Aetna Life Insurance Company
151 Farmington Ave
Hartford, CT 06156

Re: Aetna Life Insurance Company, NAIC 60054
Market Conduct Examination Report Closing Letter

Dear Mr. Bertolini:

The Department has reviewed your Company's proof of compliance and deems it adequate and sufficient. Therefore, the Department is closing its file on this exam.

I intend to ask the Director to make the Examination Report and Stipulation and Consent Order available for public inspection as authorized by 215 ILCS 5/132. At the Department's discretion, specific content of the report may be subject to redaction for private, personal, or trade secret information prior to making the report public. However, any redacted information will be made available to other regulators upon request.

Please contact me if you have any questions.

Sincerely,

Jack Engle, MCM
Assistant Deputy Director-Market Conduct and Analysis
Illinois Department of Insurance
320 West Washington- 5th Floor
Springfield, IL 62767
217-558-1058
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ILLINOIS DEPARTMENT OF INSURANCE
MARKET CONDUCT EXAMINATION OF

Aetna Life Insurance Company

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	July 15, 2013 through September 12, 2014
EXAMINATION OF:	Aetna Life Insurance Company
LOCATION:	One South Wacker Drive Chicago, Illinois 60606
PERIOD COVERED BY EXAMINATION:	04/01/12 through 03/31/13 – Claims 04/01/11 through 06/15/13 – Complaints
EXAMINERS:	David Bradbury Examiner-in-Charge

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I. FOREWORD

This is a comprehensive market conduct examination report of the Aetna Life Insurance Company. (NAIC Code #60054). This examination was conducted at the offices of Aetna Life Insurance Company ("Company or ALIC"), located at One South Wacker Drive in Chicago, Illinois.

This examination report is generally a report by exception. However, failure to criticize specific practices, procedures or files does not constitute approval thereof by the Illinois Department of Insurance ("Department").

During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

II. SCOPE OF THE EXAMINATION

The Department has the authority to conduct this examination pursuant to, but not limited to, 215 ILCS 5/132.

The purpose of the examination was to determine if the Company complied with Illinois statutes and the Illinois Administrative Code and to consider whether the Company's operations are consistent with the public interest. The primary period covered by this review is April 4, 2012 through March 31, 2013, for claims and April 1, 2011 through June 15, 2013, for complaints and appeals unless otherwise noted. Errors outside of this time period discovered during the course of the examination may also be included in the report.

The examination was a comprehensive examination involving the following business functions and lines of business; claims handling practices, policy forms and advertising in use, producer licensing and the handling of consumer complaints, appeals and Department complaints for all lines of business.

In performing this examination, the examiners reviewed a sample of the Company's practices, procedures, products, forms, advertising, extra-contractual claim adjudication guidelines and files. Therefore, some noncompliant events may not have been discovered. As such, this report may not fully reflect all of the practices and procedures of the Company. As indicated previously, failure to identify or criticize improper or noncompliant business practices in this state or other jurisdiction does not constitute acceptance of such practices.

III. COMPANY PROFILE

The following company profile was provided to the examiner by the Company.

Aetna Life Insurance Company was incorporated in Connecticut in June, 1853. ALIC was a publicly held corporation until 1967, when all outstanding shares of its stock were acquired by

Aetna Life & Casualty Company (AL&C) in a share exchange. In 1996, AL&C changed its name to Aetna Services, Inc. ("ASI") and became a wholly owned subsidiary of Aetna Inc., a Connecticut corporation ("Old Aetna"). On October 31, 2000, ASI merged into Old Aetna, and on November 3, 2000, ALIC became a wholly owned subsidiary of Aetna U.S. Healthcare Inc., a Pennsylvania corporation ("New Aetna") which was a wholly owned subsidiary of Old Aetna at such time. On December 13, 2000, Old Aetna sold its financial services and international businesses and simultaneously spun-off New Aetna to its shareholders. On the same date, New Aetna was renamed Aetna Inc. Shares of Aetna Inc. are traded on the New York Stock Exchange. ALIC is a for profit stock corporation.

ALIC is licensed as a life, accident and health insurer in all states and the District of Columbia. ALIC is also licensed in Guam, Puerto Rico and the U.S. Virgin Islands.

IV. SUMMARY

1. The Company was criticized under 50 Ill. Adm. Code 919.50(a)(1) for failing to pay or deny claims within 30 days after the claim file was complete.

2. The Company was criticized under 215 ILCS 5/368a(c) for the underpayment of interest when a health claim remains unpaid for more than 30 days.

3. The Company was criticized under 50 Ill. Adm. Code 2051.280(b) for the underpayment of claims when the insured was referred out of network.

4. The Company was criticized under 50 Ill. Adm. Code 919.70(a)(2) for failure to provide notice of the availability of the Department in 45-day delay letters when a claim remained unpaid.

5. The Company was criticized under 215 ILCS 5/154.6(f) for engaging in activity which results in a disproportionate number of meritorious complaints against the insurer received by the Department.

6. The Company was criticized under 215 ILCS 5/123.1, 215 ILCS 5/149(1), and 50 Ill. Adm. Code 2002.60 for use of false and misleading advertising stating that an external review is only available if the member's responsibility for a claim exceeds a specified dollar amount.

7. The Company was criticized under 50 Ill. Adm. Code 2002.70(b)(1) Appendix A, Illustration O for failing to disclose exceptions, reductions and limitations for health related insurance.

8. The Company was criticized under 50 Ill. Adm. Code 2002.70(a)(1) Appendix A, Illustration I for omitting the word "covered" when referring to hospitalization for health related insurance where certain sicknesses or injuries were excluded in the policy.

9. The Company was criticized under 50 Ill. Adm. Code 2002.70(a)(2) Appendix A, Illustration J, for use of deceptive words, phrases or illustrations in video, PowerPoint presentations and accompanying presentation materials stating the plan can replace "loss of income," and using the phrases "financial protection," "financial security," and/or "peace of mind," in an advertisement for health related insurance.

10. The Company was criticized under 215 ILCS 180/25 for stating in the benefit plan documents that an external review request must be submitted to ALIC.

11. The Company was criticized under 215 ILCS 180/35(a) for stating in the benefit plan documents that the external review request must be submitted within 60 calendar days.

12. The Company was criticized under 215 ILCS 180/30 for stating in the benefit plan documents that internal appeal processes must be exhausted before a request for an external review may be made.

13. The Company was criticized under 215 ILCS 180 for stating in the benefit plan documents that there is a minimum threshold on the cost of treatment or service with regard to the insured's cost sharing before a request can be made for an external review.

14. The Company was criticized under 215 ILCS 180/25 for stating in the benefit plan documents language limiting an external review request to claim denials by ALIC when it determines the care was not medically necessary.

15. The Company was criticized under 215 ILCS 180/75 for failure to provide in the benefit plan documents a statement that informs the covered person of their right to request an external review following an adverse determination or final adverse determination with the Director that includes the toll-free telephone number and address of the Office of Consumer Health Insurance with the Department of Insurance.

16. The Company was criticized under 215 ILCS 134/45(a) and 134/50(a)(1) for excluding and limiting the Department of Insurance from investigation of complaints by preventing a claimant from contacting the Department of Insurance to request an investigation of a complaint or appeal by use of the Exhaustion of Process language in filed policy forms.

17. The Company was criticized under 215 ILCS 134/45(c) for failure to provide a written notice of determination on appeals within 15 business days after receipt of the required information from the appellant.

18. The Company was criticized under 215 ILCS 134/45(c) for failure to notify the party filing the appeal, the enrollee, the enrollee's primary care physician and any health care provider who recommended the health care service involved in the appeal of all information needed within three (3) business days.

19. The Company was criticized under 215 ILCS 134/45(c) for failure to provide oral notification of its decision on appeals within 15 days, if at all.

20. The Company was criticized under 215 ILCS 180/20 and 215 ILCS 134/45(d) & (e) for failure to provide notice of the right to an external review upon adverse determination as a result of an appeal.

21. The Company was criticized under 215 ILCS 5/234.1 for failure to provide a complete "Notice of Enactment of Non-Forfeiture Option" that contains a reference to the availability of the cash value of the policy and subsequent surrender.

V. METHODOLOGY

The market conduct examination places emphasis on evaluating an insurer's systems and procedures used in dealing with insureds and claimants. The following categories are the general areas examined:

1. Producer Licensing and Production Analysis
2. Policy Forms and Advertising Material Analysis
3. Claims
4. Consumer and Insurance Department Complaints

The review of these categories is accomplished through examination of producer files, application files, cash surrendered policy files, extended term and reduced paid-up policy files, claim files, Department complaint files, policy forms and advertising material. Each of these categories is examined for compliance with Department regulations and applicable state laws.

The following methods were used to obtain the required samples and to assure a methodical selection:

Producer Licensing and Production Analysis

Populations for the producer file reviews were determined by whether or not the producers were licensed by the State of Illinois. New business listings were retrieved from Company records selecting newly solicited insurance applications which reflected Illinois addresses for the applicants.

Policy Forms and Advertising Material Analysis

The Company was requested to provide specimen copies of all policy forms and samples of all advertising material in use during the survey period.

Claims

Claim surveys were selected using the following criteria:

1. Paid Claims - Payment for coverage made during the examination period.
2. Denied Claims - Denial of benefits for losses not covered by policy provisions.
3. Individual or Franchise Claims - Determine whether the contracts were issued on an individual or franchise basis.

All claims were reviewed for compliance with policy contracts and endorsements under the Illinois Insurance Code (215 ILCS 5/1 *et. seq.*), the Managed Care Reform and Patient Rights Act (215 ILCS 134/1 *et. seq.*), the Health Carrier External Review Act (215 ILCS 180/1 *et. seq.*) and the Illinois Administrative Code (50 Ill. Adm. Code 101 *et. seq.*).

All median payment periods were measured from the date necessary proofs of loss were received to the date of payment or denial to the insured or the beneficiary.

The examination period for the claims review was April 1, 2012 through March 31, 2013.

Consumer and Department of Insurance Complaints

The Company was requested to provide all files relating to complaints which had been received via the Department as well as those received directly by the Company from the insured or his/her representative. A copy of the Company's complaint register was also reviewed.

Median periods were measured from the date of notification of the complaint to the date of response to the Department.

An emphasis was placed upon review of Appeals and the Company's handling pursuant to 215 ILCS 134/45 of the Managed Care Reform and Patient Rights Act.

The examination period for Department of Insurance complaints was April 1, 2011 through June 15, 2013.

VI. SELECTION OF SAMPLE

	Population	Sample	% Reviewed
CLAIMS ANALYSIS			
Paid Group Life	1466	56	4%
Denied Group Life	10	10	100%
Paid Individual Life	395	55	14%
Denied Individual Life	0	0	0%
Paid Group Major Medical	377,684	120	.03%
Denied Group Major Medical	31,473	120	.38%
Paid Group Short Term Disability	565	55	10%
Denied Short Term Group Disability	358	55	15%
Paid Long Term Care	32	32	100%
Denied Long Term Care	5	5	100%
Paid Student Health	59823	120	.2%
Denied Student Health	19932	120	.6%
Paid Accidental Death and Dismemberment	16	16	100%
Denied Accidental Death and Dismemberment	11	11	100%
Paid Medicare Supplement	8343	120	1.4%
Denied Medicare Supplement	1054	55	5%
Approved Waiver of Premium	38	38	100%
Rejected Waiver of Premium	202	52	26%
COMPLAINTS			
Department of Insurance Complaints	62	62	100%
Consumer Complaints	3498	3498	100%
POLICY FORMS & ADVERTISING			
Advertising	416	416	100%
Policy Forms	63	63	100%
PRODUCER ANALYSIS			
Producer Licensing	1508	1508	100%
UNDERWRITING			
Medicare Supplement New Issues	298	55	18%
Extended Term/Reduced Paid Up	5	5	100%
Life Cash Surrenders – Group	16	16	100%
Life Cash Surrenders – Individual	97	55	57%

VII. FINDINGS

A. CLAIMS PRACTICES

The examiners reviewed the Company's claim practices in order to determine its efficiency of handling, accuracy of payment, adherence to contract provisions and compliance with Illinois laws and regulations.

1. Paid Group Life

   A review of 56 of the paid group life claims produced one (1) criticism or an error rate of 2%, written under 50 Ill. Adm. Code 919.50(a)(1) for failure to pay claims within 30 days after the claim file was complete.

   The median for payment was seven (7) days.

2. Denied Group Life

   A review of 10 denied group life claims produced three (3) criticisms or an error rate of 30%, written under 50 Ill. Adm. Code 919.50(a)(1) for failing to pay or deny claims within 30 days after the claim file was complete.

   The median for denial was one (1) day.

3. Paid Individual Life

   A review of 66 paid individual life files produced no criticisms.

   The median for payment was one (1) day.

4. Denied Individual Life

   No such claims were identified during the period under review.

5. Paid Group Major Medical

   A review of 120 paid group major medical claims produced no criticisms.

   The median for payment was eight (8) days.

6. Denied Group Major Medical

   A review of 120 denied group major medical claims produced one (1) criticism or an error rate of less than 1%, written under 215 ILCS 5/368a(c) for the underpayment of interest when a claim remains unpaid for more than 30 days.

DRB 33 115 $ 3.78

ALIC agreed and made the payment prior to completion of the examination.

The median for denial was ten (10) days.

7. Paid Group Short Term Disability

   A review of 55 paid group short term disability claims produced no criticisms.

   The median for payment was nine (9) days.

8. Denied Group Short Term Disability

   A review of 55 denied group health claims produced no criticisms.

   The median for denial was two (2) days.

9. Paid Long Term Care

   A review of 32 paid long term care claims produced no criticisms.

   The median for payment was eight (8) days.

10. Denied Long Term Care

    A review of five (5) denied long term care claims produced no criticisms.

    The median for approval was eight (8) days.

11. Paid Student Health

    A review of 120 paid student health claims produced no criticisms.

    The median payment was one (1) day.

12. Denied Student Health

    A review of 120 denied student health claims produced no criticisms.

    The median for denial was six (6) days.

13. Paid Accidental Death and Dismemberment

    A review of 16 paid accidental death and dismemberment claims produced eight (8) criticisms or an error rate of 50%, for failure to provide notice of availability of the

Department in a delay letter when a claim remained opened beyond 45 days pursuant to 50 Ill. Adm. Code 919.70(a)(2).

The median for payment was 16 days.

14. Denied Accidental Death and Dismemberment

A review of 11 denied accidental death and dismemberment claims produced two (2) criticisms or an error rate of 18%, for failure to provide notice of availability of the Department in a delay letter when a claim remained open for 45 days pursuant to 50 Ill. Adm. Code 919.70(a)(2).

The median for denial was nine (9) days.

15. Paid Medicare Supplement

A review of 120 paid Medicare supplement claims produced no criticisms.

The median for payment was four (4) days.

16. Denied Medicare Supplement

A review of 55 denied Medicare supplement claims produced no criticisms.

The median for payment was two (2) days.

17. Approved Group Waiver of Premium

A review of 38 approved life waivers produced 24 criticisms.

24 criticisms, or an error rate of 63%, were written under 50 Ill. Adm. Code 919.50(a)(1) for failing to pay claims within 30 days after the claim file was complete.

The median for approval was 69 days.

18. Rejected Group Waiver of Premium

A review of 52 rejected life waiver claims produced no criticisms.

The median for rejection was one (1) day.

B. COMPLAINTS AND APPEALS

1. Department of Insurance Complaints

A review of 62 Department of Insurance complaint files produced 2 criticisms.

One (1) criticism, was written under 215 ILCS 5/154.6(f) for engaging in activity which results in a disproportionate number of meritorious complaints against the insurer.

One (1) criticism, for an error rate of 2%, was written under 215 ILCS 5/368a(c) for the underpayment of interest when a claim remains unpaid for more than 30 days.

DB 87 82	$	249.69

ALIC agreed and made the payment prior to completion of the examination.

The median for response to the Department of Insurance was 21 days.

2. Health Appeals

A review of 3,498 appeal files produced 845 criticisms. ALIC sought clarification on a number of the appeals issues examined prior to the examination, but had not received a response from the Department by the time the examination was called. Their prior attempt to clarify the issues to come into compliance with Illinois law and regulations was noted during the examination.

In 267 appeal files (7.63% of the 3,498 files reviewed) the Company was criticized under 215 ILCS 134/45(c) for failure to notify the party filing the appeal, the enrollee, the enrollee's primary care physician and any health care provider who recommended the health care service involved in the appeal of all information needed within three (3) business days.

In 166 appeal files (4.75% of the 3,498 files reviewed) the Company was criticized under 215 ILCS 134/45(c) for failure to provide a written notice of determination on appeals within 15 business days after receipt of the required information.

In 317 appeal files (9.06% of the 3,498 files reviewed) the Company was criticized under 215 ILCS 134/45(c) for failure to provide oral notification to the party filing the appeal, the enrollee, the enrollee's primary care physician and any health care provider who recommended the health care service involved in the appeal.

In 15 appeal files (.43% of the 3,498 files reviewed) the Company was criticized under 215 ILCS 180/20 and 215 ILCS 134/45(d) & (e) for failure to provide notice of the right of external review upon adverse determination on an appeal of denial for payment of medical service.

One (1) criticism was written under 50 Ill. Adm. Code 2051.280(b) for underpayment of a claim in the amount of $3815.43, Whenever a preferred provider finds it medically necessary to refer a beneficiary to a non-preferred provider, the

payor shall ensure that the beneficiary so referred shall incur no greater out of pocket than had the beneficiary received services from a preferred provider. ALIC agreed and made payment.

79 individual criticisms, or an error rate of 2% of the 3,498 files reviewed, were written under 215 ILCS 5/368a(c) for the underpayment of interest totaling $3,228.51.

Control Number			A/D	Into U/p
JR	1O	20	A	$ 1.16
JR	1O	24	A	$ 2.84
JR	1O	44	A	$ 3.18
JR	1O	59	A	$ 4.74
JR	1O	69	A	$ 34.86
JR	1O	85	A	$ 5.15
JR	1O	175	A	$ 8.88
JR	1O	193	A	$ 26.03
JR	1O	224	A	$ 9.10
JR	1O	250	A	$ 2.50
DB	1O	270	A	$ 2.15
JR	1O	289	A	$ 2.94
JR	1O	293	A	$ 3.61
JR	1O	305	A	$ 4.39
DB	1O	311	A	$ 15.09
DB	1O	324	A	$ 84.55
JR	1O	338	A	$ 10.27
DB	1O	362	A	$ 54.01
DB	1O	471	A	$ 39.50
DRB	1O	502	A	$ 11.87
DB	1O	517	A	$ 6.92
JR	1O	531	A	$ 506.40
DB	1O	548	A	$ 42.64
JR	1O	557	A	$ 8.82
DB	1O	561	A	$ 4.80
DRB	1O	578	A	$ 129.17
JR	1O	587	A	$ 1.42
JR	1O	590	A	$ 1.21
JR	1O	592	A	$ 50.14
JR	1O	619	A	$ 1.93
DB	1O	716	A	$ 11.84
DB	1O	737	A	$ 1.73
JR	1O	782	A	$ 10.07
DB	1O	789	A	$ 85.24

DB	1O	800	A	$	80.54
JR	1O	879	A	$	1.46
JR	1O	912	A	$	28.98
DB	1O	923	A	$	1.22
JR	1O	955	A	$	97.13
DB	1O	984	A	$	570.86
JR	1O	986	A	$	9.91
JR	1O	999	A	$	8.38
DB	1O	1004	A	$	10.11
DB	1O	1006	A	$	13.64
DB	1O	1047	A	$	7.94
JR	1O	1062	A	$	30.54
DB	1O	1068	A	$	7.94
JR	1O	1094	A	$	4.13
DRB	1O	1102	A	$	10.32
JR	1O	1118	A	$	1.50
JR	1O	1266	A	$	86.52
JR	1O	1271	A	$	53.52
JR	1O	1285	A	$	71.47
JR	1O	1297	A	$	242.53
JR	1O	1331	A	$	19.16
JR	1O	1363	A	$	64.23
JR	1O	1386	A	$	12.82
JR	1O	1455	A	$	1.02
DB	1O	1480	A	$	19.87
JR	1O	1592	A	$	9.09
JR	1O	1699	A	$	129.72
JR	1O	1722	A	$	2.94
JR	1O	1952	A	$	10.59
JR	1O	2050	A	$	4.20
JR	1O	2107	A	$	46.92
JR	1O	2117	A	$	14.76
JR	1O	2178	A	$	42.93
JR	1O	2216	A	$	35.01
DB	1O	2232	A	$	4.85
JR	1O	2260	A	$	268.90
JR	1O	2261	A	$	1.51
JR	1O	2268	A	$	7.37
JR	1O	2280	A	$	4.83
		73		$	3,228.51

C. POLICY FORMS AND ADVERTISING

A review of the policy forms, applications and membership materials produced four (4) advertising form criticisms and seven (7) policy form criticisms.

ALIC contends that the policy forms criticized were filed on 06/06/2012 and approved by the Department on 07/03/2012. The forms criticized were in use from 12/07/2006 until the updated forms were used at renewal sometime after the 07/03/2012 date. For an annual policy, the forms not in compliance would have been in use up to 07/02/2013. The Health Carrier External Review Act had an effective date of 07/01/2010. The basis for the criticisms noting the violations is the three year period ALIC used forms that were not in compliance with this Act. In summary, forms were in violation and in use for the period under review, however corrections were made to the forms before the examination. The Company has represented it is complying with post-09/01/2015 external review rules currently in effect.

ALIC was criticized under 50 Ill. Adm. Code 2002.70(b)(1) Appendix A, Illustration O(a) for failing to disclose exceptions, reductions and limitations for health related insurance. A presentation related to Voluntary Plans directed to plan sponsors did not contain exceptions, reductions and limitations.

The Company was criticized under 50 Ill. Adm. Code 2002.70(a)(1) Appendix A, Illustration I (p, q, r,) for omitting the word "covered" when referring to hospitalization for health related insurance in a telephone welcome call script, where the policy excluded certain sicknesses or injuries.

ALIC was criticized for four (4) violations under 50 Ill. Adm. Code 2002.70(a)(2), Illustration J of the Illinois Administrative Code for use of deceptive words, phrases and illustrations in a video and accompanying presentation, advertising forms in use and as a standard heading in advertisements that the plan can replace "loss of income," use of the phrases "financial protection," "financial security," and "peace of mind" for health related insurance. ALIC's prior and continuing use of the phrase "financial well-being" was reviewed and determined to be permissible only in ALIC general brand identification.

ALIC was criticized under 215 ILCS 5/123.1, 215 ILCS 5/149(1) and 50 Ill. Adm. Code 2002.60 for placing false and misleading information in its disclosure form stating that an external review is only available if the insured's responsibility for a claim exceeds $500 for health related insurance.

ALIC was criticized under Section 25 of the Health Carrier External Review Act (215 ILCS 180/25) for providing in the policy that the external review request must be submitted to ALIC. The Act clearly states that the external review request is to be made to the Director of Insurance.

ALIC was criticized under Section 35(a) of the Health Carrier External Review Act (215 ILCS 180/35(a)) for indicating in the benefit policy plan that the external review request must be filed within 60 calendar days following the date the final claim denial letter is received. The Act clearly states that an external review request may be filed within four (4) months after receipt of a notice of adverse determination or final adverse determination.

ALIC was criticized under Section 30 of the Health Carrier External Review Act (215 ILCS 180/30) for indicating in the benefit policy plan that the internal appeal processes must be exhausted before a request for an external review may be made. The Act clearly provides exceptions to the requirement and is not absolute.

ALIC was criticized under the Health Carrier External Review Act (215 ILCS 180) for placing a threshold on the cost of service or treatment before a request can be made for an external review. The Act places no threshold on the service or treatment cost before an insured may request an external review.

ALIC was criticized under Section 25 of the Health Carrier External Review Act (215 ILCS 180/25) for limiting an external review request to claim denials by ALIC when the Company determines that the care was not necessary and/or was experimental or investigational. The Act does not limit it to those specific instances and it is not ALIC's sole discretion to make this determination. All demands for reimbursement relating to the insured's medical service and demand for subsequent payment are eligible.

ALIC was criticized under Section 75 of the Health Carrier External Review Act (215 ILCS 180/75) for failure to provide a statement in the benefit plan policy that informs the covered person of their right to request an external review following an adverse determination or final adverse determination with the Director that include the toll-free telephone number and address of the Office of Consumer Health Insurance with the Department of Insurance.

ALIC was criticized under Section 45(a) and 50(a)(1) of the Managed Care and Patient Rights Act (215 ILCS 134/45(a) and 134/50(a)) for excluding and limiting the Illinois Department of Insurance from investigating complaints by preventing a claimant from contacting the Illinois Department of Insurance to request an investigation of a complaint or appeal. Use of any exhaustion of process provision is contrary to the law. The forms stated –

"You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Illinois Department of Insurance to request an investigation of a complaint or appeal; or

- File a complaint or appeal with the Illinois Department of Insurance; or
- Establish any :
  - Litigation;
  - Arbitration; or
  - Administrative proceeding;

  Regarding an alleged breach of the policy terms by ALIC or any matter within the scope of the Appeals Procedure."

D. PRODUCER ANALYSIS

Review of the producer licensing files and first year commissions produced no exceptions.

E. UNDERWRITING

1. Medicare Supplement New Issues

A review of 55 Medicare supplement new issues produced no exceptions.

2. Extended Term / Reduced Paid Up

A review of five (5) extended term / reduced paid-up Insurance non-forfeiture files resulted in five (5) criticisms under 215 ILCS 5/234.1 for failure to include all available options in the notice of the non-forfeiture to the policy owner/insured. The surrender option was not included in the notices.

3. Life Cash Surrenders – Group

A review of 16 group cash surrender life files resulted in no criticisms.

The median for surrender was five (5) days.

4. Life Cash Surrenders – Individual

A review of 55 individual life cash surrenders resulted in no criticisms.

The median for surrender was eight (8) days.

STATE OF ILLINOIS)
) ss
COUNTY OF COOK)

David Bradbury, being first duly sworn upon his/her oath, deposes and says:

That he was appointed by the Director of Insurance of the State of Illinois (the "Director") as Examiner-In Charge to examine the insurance business and affairs of Aetna Life Insurance Company NAIC#60054;

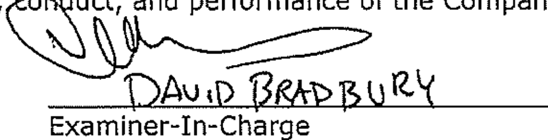
That the Examiner-In-Charge was directed to make a full and true report to the Director of the examination with a full statement of the condition and operation of the business and affairs of the Company with any other information as shall in the opinion of the Examiner-In-Charge be requisite to furnish the Director with a statement of the condition and operation of the Company's business and affairs and the manner in which the Company conducts its business;

That neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is an officer of, connected with, or financially interested in the Company nor any of the Company's affiliates other than as a policyholder or claimant under a policy or as an owner of shares in a regulated diversified investment company, and that neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is financially interested in any other corporation or person affected by the examination;

That an examination was made of the affairs of the Company pursuant to the authority vested in the Examiner-In-Charge by the Director of Insurance of the State of Illinois;

That she/he was the Examiner-in-Charge of said examination and the attached report of examination is a full and true statement of the condition and operation of the insurance business and affairs of the Company for the period covered by the Report as determined by the examiners;

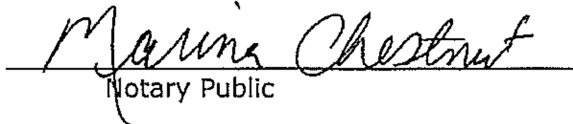
That the Report contains only facts ascertained from the books, papers, records, or documents, and other evidence obtained by investigation and examined or ascertained from the testimony of officers or agents or other persons examined under oath concerning the business, affairs, conduct, and performance of the Company.



DAVID BRADBURY
Examiner-In-Charge

Subscribed and sworn to before me

this 29th day of October, 2014.



Notary Public

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

AETNA LIFE INSURANCE COMPANY
151 FARMINGTON AVE
HARTFORD, CT 06156

STIPULATION AND CONSENT ORDER

WHEREAS, the Director of the Illinois Department of Insurance ("Department") is a duly authorized and appointed official of the State of Illinois, having authority and responsibility for the enforcement of the insurance laws of this State; and

WHEREAS, Aetna Life Insurance Company ("the Company"), NAIC 60054, is authorized under the insurance laws of this State and by the Director to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS, a Market Conduct Examination of the Company was conducted by a duly qualified examiner of the Department pursuant to Sections 132, 401, 402, 403, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402, 5/403, and 5/425); and

WHEREAS, as a result of the Market Conduct Examination, the Department examiner filed a Market Conduct Examination Report which is an official document of the Department; and

WHEREAS, the Market Conduct Examination Report cited various areas in which the Company was not in compliance with the Illinois Insurance Code (215 ILCS 5/1 *et seq.*), the Managed Care Reform and Patient Rights Act (215 ILCS 134/1 *et seq.*), the Health Carrier External Review Act (215 ILCS 180/1 *et seq.*) and Department Regulations (50 Ill. Adm. Code 101 *et seq.*); and

WHEREAS, nothing herein contained, nor any action taken by the Company in connection with this Stipulation and Consent Order, shall constitute, or be construed as, an admission of fault, liability or wrongdoing of any kind whatsoever by the Company; and

WHEREAS, the Company is aware of and understands its various rights in connection with the examination and report, including the right to counsel, notice, hearing and appeal under Sections 132, 401, 402, 407, and 407.2 of the Illinois Insurance Code and 50 Ill. Adm. Code 2402; and

WHEREAS, the Company understands and agrees that by entering into this Stipulation and Consent Order, it waives any and all rights to notice and hearing; and

WHEREAS, the Company and the Director, for the purpose of resolving all matters raised by the report and in order to avoid any further administrative action, hereby enter into this Stipulation and Consent Order.

NOW, THEREFORE, IT IS AGREED by and between the Company and the Director as follows:

1. The Market Conduct Examination indicated various areas in which the Company was not in compliance with provisions of the Illinois Insurance Code and Department Regulations; and

2. The Director and the Company consent to this Order requiring the Company to take certain actions to come into compliance with provisions of the Illinois Insurance Code and Department Regulations.

THEREFORE, IT IS HEREBY ORDERED by the undersigned Director that the Company shall:

1. Institute and maintain policies and procedures whereby the Company shall affirm or deny liability on claims within a reasonable time after proof of loss statements have been completed and offer payment within 30 days after affirmation of liability as required by 50 Ill. Adm. Code 919.50(a)(1).

2. Institute and maintain policies and procedures whereby the Company shall provide the insured, or beneficiary when applicable, a Notice of Availability of the Department of Insurance in delay letters when a claim remains unresolved for forty-five (45) days from the date it is reported as required by 50 Ill. Adm. Code 919.70(a)(2).

3. Institute and maintain policies and procedures whereby the Company shall no longer engage in activity which results in a disproportionate number of meritorious complaints as required by 215 ILCS 5/154.6(f).

4. Institute and maintain policies and procedures whereby the Company shall notify the party filing the appeal and all other necessary parties of all the information required to evaluate the appeal within three (3) business days and shall orally notify all parties involved in the appeal of its decision as required by 215 ILCS 134/45(c).

5. Institute and maintain policies and procedures whereby the Company shall discontinue use of misleading information in its disclosure form, stating External Review is only available if the member's responsibility exceeds a specified dollar amount, as required by 215 ILCS 5/123.1, 215 ILCS 5/149(1) and 50 Ill. Adm. Code 2002.60.

6. Institute and maintain policies and procedures whereby the Company shall discontinue the use of benefit plan documents that state the insured may request an external review of an adverse determination to the Company. A request for external review shall be made in writing to the Director of Insurance as required by 215 ILCS 180/25.

7. Institute and maintain policies and procedures whereby the Company shall discontinue the use of benefit plan documents that state a request for an external review must be submitted within 60 days. The request for an external review can be submitted within four (4) months after receipt of a notice of adverse determination as required by 215 ILCS 180/35(a).

8. Institute and maintain policies and procedures whereby the Company shall discontinue the use of benefit plan documents that state all internal appeal processes must be exhausted before request of an external review may be made as required by 215 ILCS 180/30.

9. Institute and maintain policies and procedures whereby the Company shall discontinue the use of benefit plan documents that state there is a minimum threshold on the cost of treatment or service with regard to the insured's cost sharing. No threshold limitation must be met before a request can be made for an external review as required by 215 ILCS 180.

10. Institute and maintain policies and procedures whereby the Company shall discontinue the use of plan documents that fail to include notice of availability of the Director with a toll free number and the address of the Office of Consumer Health Insurance within the Illinois Department of Insurance as required by 215 ILCS 180/75.

11. Institute and maintain policies and procedures whereby the Company shall discontinue the use of benefit plan documents that exclude and limit the Illinois Department of Insurance from an investigation of complaints by preventing a claimant from contacting the Illinois Department of Insurance to request an investigation of a complaint or appeal by use of the Exhaustion of Process language in filed policy forms as required by 215 ILCS 134/45(a) and 215 ILCS 134/50(a)(1).

12. Institute and maintain policies and procedures whereby the Company shall provide policy owners with a Notice of Enactment of Non-Forfeiture Option prior to enactment of the non-forfeiture option, that notifies the policy owners of the other available options under the provisions of the policy as required by 215 ILCS 5/234.1.

13. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above 12 orders within 30 days of execution of this Order.

14. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $74,000 to be paid within 30 days of execution of this Order.

NOTHING contained herein shall prohibit the Director from taking any and all appropriate regulatory action as set forth in the Illinois Insurance Code, including but not limited to, levying additional forfeitures, should the Company violate any of the provisions of this Stipulation and Consent Order or any provisions of the Illinois Insurance Code or Department Regulations.

On behalf of **AETNA LIFE INSURANCE COMPANY**

Kristin M Peng
Signature

Kristin Myers Peng
Name

Market President, Great Lakes
Title

Subscribed and sworn to before me this
18 day of May 2017.

Anette Szkwarla
Notary Public

DEPARTMENT OF INSURANCE of the
State of Illinois:

DATE 5/24/17

JL Hammer
Jennifer Hammer
Director