Illinois Department of Insurance

JB Pritzker
Governor

Robert H. Muriel
Director

VIA ELECTRONIC MAIL
VIA USPS CERTIFIED MAIL

July 14, 2020

Mr. Michael J. Phillips
President
CIGNA HealthCare of Illinois, Inc.
525 West Monroe Street, Suite 1650
Chicago, IL. 60661

Re: CIGNA HealthCare of Illinois, Inc., NAIC 95602
Market Conduct Examination Report Closing Letter

Dear Mr. Phillips:

The Department has received your Company's proof of compliance. 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,

Erica Weyhenmeyer

Erica Weyhenmeyer
Chief Market Conduct Examiner
Illinois Department of Insurance
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ILLINOIS DEPARTMENT OF INSURANCE
MENTAL HEALTH PARITY MARKET CONDUCT EXAMINATION REPORT OF

CIGNA HEALTHCARE OF ILLINOIS, INC.

MENTAL HEALTH PARITY MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	March 19, 2018 through August 31, 2018
EXAMINATION OF:	CIGNA HealthCare of Illinois, Inc. NAIC #95602
LOCATION:	1640 Dallas Parkway Plano, TX 75093
PERIOD COVERED BY EXAMINATION:	January 1, 2017 through December 31, 2017
EXAMINERS:	Lucinda Woods Elizabeth Harvey Phillip Chesson Art Kusserow Kirk Stephan June Coleman, Examiner-in-Charge Shelly Schuman, Supervisory Insurance Examiner

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I. SCOPE OF TARGETED EXAMINATION

Pursuant to the Director's authority as provided under Articles IX, XXIV, and XXVI, Sections 132, 401, 401.5, 402, 403, and 425 of the Illinois Insurance Code, a mental health parity targeted market conduct examination was called on CIGNA HealthCare of Illinois, Inc. (hereinafter referred to as the "Company" or "CIGNA").

The primary purpose of the examination was to verify the Company's compliance with Illinois insurance laws and Departmental regulations. The scope of the examination included, but was not limited to, activities as they pertained to parity in relation to mental health and substance use disorders (MH/SUD) within the Company's individual health insurance business. The examination encompassed the period from January 1, 2017 through December 31, 2017.

The objective of the examination was to evaluate if the Company designed, implemented, and managed MH/SUD benefits no less favorably than medical/surgical benefits. The objectives of the specific areas of review for the examination included but were not limited to the following:

1. Review the procedures and guidelines related to utilization review to ensure that such guidelines and utilization review processes on MH/SUD services are no more stringently applied than those applied to medical/surgical services.

2. Evaluate a sample of MH/SUD claims during the examination period to compare services to medical/surgical services and to ensure denials were appropriate based on medical necessity criteria.

3. Evaluate the universe of appeals during the examination period to determine if the appeal decisions were based on appropriate clinical criteria and policies.

4. Evaluate the medical necessity criteria, policies, and procedures to ensure the Company was not imposing more restrictive requirements and determinations for MH/SUD treatments and services than on medical/surgical treatments and services.

5. Determine that the MH/SUD benefits provided in the classifications identified by 45 CFR §146.136(c)(2)(ii)(A): inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs, are paid in parity with benefits in the same medical/surgical classifications.

6. Evaluate financial requirements and quantitative treatment limitations (QTL) to ensure that any such requirements and limitations were consistently applied through MH/SUD and medical/surgical benefits and that any financial requirements and

QTLs imposed meet the two-thirds threshold of the substantially all requirements outlined in 45 CFR § 146.136(c)(3)(i).

7. Evaluate non-quantitative treatment limitations (NQTL) to ensure that such limitations were consistently applied through MH/SUD and medical/surgical benefits and that the Company was not being more restrictive as outlined in 45 CFR § 146.136 (c)(4)(i) and 45 CFR § 146.136(c)(4)(ii).

8. Evaluate pre-certification/prior-authorization, step therapy policies, and procedural requirements for MH/SUD treatments were no more restrictive than the comparable medical/surgical policies and procedural requirements.

9. Determine that the policies and procedures for the selection, tier placement, and quantity limitations of MH/SUD treatment drugs on the formulary were no less favorable to the insured than policies and procedures used for the selection, placement, and limitations of medical/surgical drugs.

For this targeted examination, a MH/SUD subject matter expert and a pharmacist assisted in the interpretation of the documentation provided with respect to MH/SUD parity and pharmacy benefits.

II. SUMMARY OF FINDINGS

A targeted mental health parity market conduct examination was performed to determine compliance with Illinois statutes, the Illinois Administrative Code, as well as federal statutes and rules related to the Mental Health Parity and Addiction Equity Act of 2008. The following table represents general findings with specific details in each section of the report.

Table of Total Violations

Criticism Number	Statute/Rule	Description of Violations	Population	Files Reviewed	No. of Violations
01- Appeals	215 ILCS 5/370c(b)(3)	Failed to use only American Society of Addiction Medicine criteria to make medical necessity determinations for substance use disorders.	N/A	N/A	N/A
05- Individual Health Utilization Reviews	215 ILCS 5/370c(b)(3)	Failed to use only American Society of Addiction Medicine criteria to make medical necessity determinations for substance use disorders.	N/A	N/A	N/A
06- Pharmacy Utilization Review	215 ILCS 134/45.1(a), 215 ILCS 134/45.1(c)(2) and 215 ILCS 134/45.1(c)(3)	Failed to allow for clinically appropriate prescription drugs in accordance with the guidelines within 215 ILCS 134/45.1.	N/A	N/A	N/A
Interrelated Finding 3 - Appeals	215 ILCS 134/45(c)	Failed to render a decision on appeals within 15 business days after receipt of the required information.	N/A	N/A	N/A
Interrelated Finding 4 - Appeals	215 ILCS 134/45(c)	Failed to verbally contact any party of its appeal decision.	N/A	N/A	N/A
Interrelated Finding 7 - Individual Health Denied Claims	215 ILCS 5/154.6(c) and 215 ILCS 5/154.6(d)	Improperly denied the claim as out-of-network when, in fact, the claim was in-network.	2,925	104	34

III. METHODOLOGY

The targeted market conduct examination process placed emphasis on an insurer's systems and procedures used in dealing with insureds and claimants. The individual health business was reviewed in this examination.

The review of the MH/SUD operations included the following areas:

A. Company Operations and Management
B. Complaints
C. Appeals
D. Underwriting
E. Utilization Reviews
F. Claims
G. Substantially All/Predominant Cost-Sharing Testing in Health Plans
H. Formulary Designs

The review of these categories was accomplished through examination of material related to the Company's operations and management, plans, complaint files, claim files, as well as interviews with various Company personnel and Company responses to the coordinator's handbook, interrogatories, and criticisms.

The following method was used to obtain the required samples and to ensure a statistically sound selection. Surveys were developed from company-generated Excel spreadsheets. Random statistical file selections were generated by the examiners from these spreadsheets. In the event the number of files was too low for a random sample, the sample consisted of the universe of files.

Company Operations and Management

A review was conducted of the Company's underwriting and claims guidelines and procedures, policy forms, third party vendors, internal audits, certificate of authority, previous market conduct examinations, and annual statements. There were no exceptions noted.

Complaints

The Company was requested to identify MH/SUD consumer and Illinois Department of Insurance complaints received during the examination period and to provide copies of the complaint logs. The Company reported there were no MH/SUD complaints and provided all other complaints. All complaint files and logs were received. The files were reviewed for compliance with Illinois statutes and the Illinois Administrative Code.

Appeals

The Company was requested to identify MH/SUD appeals for the experience period. These appeal files were received and reviewed for compliance with Illinois statutes, the Illinois Administrative Code, and the Mental Health Parity and Addiction Equity Act of 2008.

Underwriting

The Company was requested to provide a sample individual accident and health policy including all disclosures for each plan written in Illinois. The policies were reviewed for compliance with Illinois statutes and the Illinois Administrative Code. There were no exceptions found.

Utilization Reviews

The Company was requested to provide a list of all utilization reviews for the experience period. The Company identified the universe of MH/SUD utilization reviews for individual health and pharmacy. Random samples of the files were made by the examiners and submitted to the Company. These utilization review files were received and reviewed for compliance with Illinois statutes, the Illinois Administrative Code, and the Mental Health Parity and Addiction Equity Act of 2008.

Claims

The Company was requested to provide a list of all claims during the examination period, to include paid and denied. The Company identified the universe of MH/SUD claims for individual health and pharmacy. Random samples of the files were made by the examiners and submitted to the Company. Due to various disqualifying factors, some individual files in the samples were replaced with another file. The files and responses to information requests and interrogatories were reviewed to ensure the claims were processed in compliance with the policy, Illinois statutes, the Illinois Administrative Code, the Mental Health Parity and Addiction Equity Act of 2008, and related regulations.

Substantially All/Predominant Cost-Sharing Testing in Health Plans

The Company was requested to provide the mental health parity testing of its health plans and the benefit classifications for medical/surgical and MH/SUD categories. The benefits, as classified accordingly, were evaluated for financial requirements and quantitative treatment limitations (QTL) compliance. The parity analyses of the health plans were reviewed for compliance with Illinois statutes, the Illinois Administrative Code, the Mental Health Parity and Addiction Equity Act of 2008, as well as the Mental Health Parity Addiction Equity Act (MHPAEA) and related regulations.

Formulary Designs

The Company was requested to identify and provide all formulary designs and pharmacy policies and procedures used during the experience period for MH/SUD requirements. In accordance with the requirements of the examination, the data and responses to follow up information requests were reviewed. The pharmacy documentation and responses to follow up information requests and interrogatories were reviewed for compliance with Illinois statutes, the Illinois Administrative Code, the Mental Health Parity and Addiction Equity Act of 2008, as well as the Mental Health Parity Addiction Equity Act (MHPAEA) and related regulations.

IV. SELECTION OF SAMPLES

Survey	Population	Number Reviewed	Percentage Reviewed
Complaints			
Consumer Complaint – ILDOI	10	10	100%
Consumer Complaints – Received by the Company	8	8	100%
Appeals			
Appeals	4	4	100%
Utilization Reviews			
Utilization Reviews – Individual Health	226	84	37%
Utilization Reviews – Pharmacy	121	79	65%
Claims			
Individual Health – Paid	13,071	109	<1%
Individual Health – Denied	2,925	104	3.6%
Pharmacy – Paid	32,653	109	<1%
Pharmacy – Denied	2,529	108	4.3%

V. COMPANY BACKGROUND

CIGNA HealthCare of Illinois, Inc. - NAIC #95602

CIGNA HealthCare of Illinois, Inc. (the Company) was incorporated as a for-profit organization on August 21, 1985 under the General Corporation Law of Delaware, and maintains its primary administrative office in Bloomfield, Connecticut. The Company was licensed as a Health Maintenance Organization in the State of Illinois on June 3, 1986, and in the State of Indiana on December 4, 1987, and received federal qualification on July 1, 1987.

Effective June 27, 2007, CIGNA HealthCare of Illinois, Inc. merged with CHC Merger, Inc., a newly formed Illinois domestic company. CIGNA HealthCare of Illinois, Inc. is the name that survived the merger. At the time of the merger, Healthsource, Inc. obtained all shares of the Company and the Company is a wholly owned subsidiary of Healthsource, Inc.

The Company's 2017 NAIC Annual Statement for Illinois reflects the following information for accident and health:

Direct Premiums Written	Direct Premiums Earned	Direct Losses Incurred	Pure Direct Loss Ratio
$48,413,143	$48,413,143	$36,992,034	100%

VI. MENTAL HEALTH PARITY FINDINGS

A. COMPLAINTS

1. Department of Insurance Consumer Complaints

   There were no criticisms in the Department of Insurance complaints survey.

2. Consumer Complaints Received Directly by the Company

   There were no criticisms in the consumer complaints survey.

B. APPEALS

The Company failed to use only American Society of Addiction Medicine criteria to make medical necessity determinations for substance use disorders. This is a violation of 215 ILCS 5/370c(b)(3).

C. UTILIZATION REVIEWS

1. Utilization Reviews - Individual Health

   The Company failed to use only American Society of Addiction Medicine criteria to make medical necessity determinations for substance use disorders as evidenced by the noted files. This is a violation of 215 ILCS 5/370c(b)(3).

2. Utilization Reviews – Pharmacy

   The Company failed to allow for clinically appropriate prescription drugs in accordance with the guidelines within 215 ILCS 134/45.1(a). In addition, the Company failed to approve step therapy requirement exception requests when the patient had tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submitted evidence of failure or intolerance; or the patient was stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan. This is a violation of 215 ILCS 134/45.1(a), 215 ILCS 134/45.1(c)(2) and 215 ILCS 134/45.1(c)(3).

D. CLAIMS

1. Individual Health – Paid

   There were no criticisms in the individual health paid claims survey.

2. Individual Health - Denied

   There were no criticisms in the individual health denied survey.

3. Pharmacy – Paid

   There were no criticisms in the pharmacy paid claims survey.

4. Pharmacy – Denied

   There were no criticisms in the pharmacy denied claims survey.

E. SUBSTANTIALLY ALL AND PREDOMINANT COST-SHARING TESTING IN HEALTH PLANS

   There were no criticisms in the substantially all and predominant cost-sharing testing review.

F. FORMULARY DESIGNS

   There were no criticisms in the formulary designs review.

G. ASSOCIATED MENTAL HEALTH/SUBSTANCE USE DISORDER FILES

A listing was compiled from the universe of claimants with multiple health and pharmacy claims, utilization reviews, appeals, and complaints. From this listing, five (5) top claimants were selected for a high-level review of the process and procedures involved in adjudicating the various submissions for each of these subscribers in order to receive the benefits of the health plan.

1. An adult subscriber was diagnosed with posttraumatic stress disorder, major depressive disorder, and alcohol dependence. The subscriber enrolled in an in-network only plan. The review for the subscriber included 16 pharmacy claims (11 paid and 5 denied) and five (5) health utilization reviews (4 approved and 1 denied). The pharmacy claims and health utilization reviews were appropriately paid or denied in a timely manner with no treatment limitations or restrictions. In addition, the review of the subscriber's health claims and an appeal were examined, and the following was noted:
   - Of the 22 health claims reviewed, 10 claims were paid and 12 claims were denied. Of the 12 denied health claims, one (1) laboratory testing claim was denied. It was determined that the denial of this claim resulted in the Company being in violation for imposing a NQTL with respect to MH/SUD benefits not in parity with medical/surgical benefits.

- One (1) appeal was submitted to the Company. The Company was in violation of MH/SUD parity because the Company utilized other criteria than the American Society of Addiction Medicine (ASAM) criteria in making the appeal decision.

2. An adult dependent of the subscriber was diagnosed with major depressive disorder and adjustment disorder. The subscriber enrolled in an in-network only plan. The review for the adult dependent included 12 pharmacy paid claims, 23 health claims (13 paid and 10 denied) and one (1) health utilization review that was approved. The pharmacy claims, health claims, and the utilization reviews were treated in parity and were no more restrictive than the handling of medical claims or utilization reviews. In addition, four (4) pharmacy utilization reviews were examined and the following was noted:
   - Of the four (4) pharmacy utilization reviews, three (3) reviews were approved and one (1) review was denied. The denied file was found to contain an violation for not being denied within the required 72 hours. The denial reason for step therapy protocol was determined to be in violation for failing to approve the pharmacy utilization review for a prescription drug, when the patient had tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submits evidence of failure or intolerance.

3. An adult subscriber was diagnosed with major depressive disorder and obstructive sleep apnea disorder. The subscriber enrolled in an in-network only plan. The review for the subscriber included 18 pharmacy claims (11 paid and 7 denied) and three (3) approved health utilization reviews. The pharmacy claims and health utilization reviews were appropriately paid or denied in a timely manner with no treatment limitations or restrictions. In addition, 15 health claims (10 paid and 5 denied) and an appeal were examined, and the following was noted:
   - Of the 15 health claims reviewed, one (1) denied health claim file was found to contain a violation for denying an in-network claim as an out-of-network claim.
   - The appeal file was found to contain two (2) violations for not rendering a decision on the appeal within 15 business days after receipt of the required information and for failing to verbally inform any party of the appeal decision.

4. An adult subscriber was diagnosed with bipolar disorder, major depressive disorder, and alcohol dependence. The subscriber enrolled in an in-network only plan. The review for the subscriber included 11 pharmacy paid claims, 12 health claims (10 paid and 2 denied), and seven (7) pharmacy utilization reviews (1 approved and 6 denied). These claims and utilization reviews were found to be treated in parity and were no more restrictive than the handling of medical/surgical claims or medical/surgical utilization reviews.

5. A child dependent of the subscriber was diagnosed with anorexia nervosa disorder. The subscriber enrolled in an in-network only plan. The review for the child dependent included 14 pharmacy claims (10 paid and 4 denied), 21 health claims (11 paid and 10 denied), and one (1) approved health utilization review. These claims and the utilization review were found to be treated in parity and were no more restrictive than the handling of medical/surgical claims or medical/surgical utilization reviews.

VII. INTERRELATED FINDINGS

1. During the review of the MH/SUD appeal files, it was determined that in two (2) instances of the four (4) appeal files reviewed, the Company failed to render a decision on appeals within 15 business days after receipt of the required information. This is a violation of 215 ILCS 134/45(c). Also, it was determined that in two (2) instances of the four (4) MH/SUD appeal files reviewed, the Company failed to verbally contact any party of its appeal decision. This is a violation of 215 ILCS 134/45(c).

2. During the review of the MH/SUD denied claim files, five (5) claim files were disqualified from the review for being paid claim files, leaving a total of 104 denied claims. In 34 instances of the 104 MH/SUD denied claim files reviewed, for an error percentage of 32.69%, the Company improperly denied the claim as out-of-network when, in fact, the claim was in-network. This is considered an improper claim practice and a violation of 215 ILCS 5/154.6(c) and 215 ILCS 5/154.6(d). An information request was issued asking the Company about an IOR project that appeared to be related to the number of in-network claims being denied as out-of-network. The Company responded that the IOR project was an "internal process that was very streamlined to support the correction of any claim processing errors identified by an internal source." The Company stated that the error of denying in-network claims as being out-of-network was discovered on November 8, 2017. The Company reported that there were a total of 327 claims identified with the same error and all were corrected through the IOR project.

EXAMINATION DRAFT REPORT SUBMISSION

The courtesy and cooperation of the officers and employees of the Company during the examination are acknowledged and appreciated.

Lucinda Woods
Elizabeth Harvey
Phillip Chesson
Art Kusserow
Kirk Stephan
June Coleman, Examiner-in-Charge
Shelly Schuman, Supervisory Insurance Examiner

Respectfully submitted,

June Coleman
JUNE COLEMAN
EXAMINER-IN-CHARGE

SHELLY SCHUMAN
SUPERVISING EXAMINER

STATE OF PENNSYLVANIA)
) ss
COUNTY OF LANCASTER)

JUNE COLEMAN, being first duly sworn upon her oath, deposes and says:

That she 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 Cigna HealthCare of Illinois, Inc., NAIC #95602, (the "Company").

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 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.

June A. Coleman
Examiner-In-Charge

Subscribed and sworn to before me this 10 day of September, 2018.

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
MICHAEL SHANE WERT
Notary Public
RAPHO TWP., LANCASTER COUNTY
My Commission Expires Jun 27, 2020

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

CIGNA HEALTHCARE OF ILLINOIS, INC.
1640 Dallas Parkway
Plano, TX 75093

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, CIGNA HealthCare of Illinois, Inc. ("the Company"), NAIC 95602, 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.*) 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 their 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, they waive 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 utilize patient placement criteria established by the American Society of Addiction Medicine when making medical necessity determinations for substance use disorders as required by 215 ILCS 5/370c(b)(3).

2. Institute and maintain policies and procedures whereby the Company shall establish and maintain a medical exception process that allows covered persons or authorized representatives to request any clinically appropriate prescription drug as required by 215 ILCS 134/45.1(a).

3. Institute and maintain policies and procedures whereby the Company shall adopt and implement a step therapy exception request process as required by 215 ILCS 134/45.1(c).

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 implement reasonable standards for the prompt investigation and settlement of claims as required by 215 ILCS 5/154.6(c).

6. Institute and maintain policies and procedures whereby the Company shall effectuate prompt, fair and equitable settlements when liability is reasonably clear as required by 215 ILCS 5/154.6(d).

7. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above six (6) orders within 30 days of execution of this Order.

8. Pay to the Director of Insurance, State of Illinois, a required contribution in the amount of $582,000 to the Parity Advancement Fund created under 215 ILCS 5/370c.1(i) to be paid within 10 days of receipt 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 CIGNA HealthCare of Illinois, Inc.

Signature

Brian P. Marcella

Name

President, Midwest Market

Title

Subscribed and sworn to before me this
29 day of April 2020.

Notary Public

SHIRLEY J. ROSS
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
October 20, 2023

DEPARTMENT OF INSURANCE of the
State of Illinois:

DATE 5/6/20

Robert Muriel mac

Robert H. Muriel
Director