STATE OF CONNECTICUT

INSURANCE DEPARTMENT

In the Matter of:	:	
	:	
JOHN ALDEN LIFE INSURANCE COMPANY, TIME INSURANCE COMPANY, AND UNION SECURITY INSURANCE COMPANY	:	**Docket No. MC 07-32**
	:	
Respondents.	:	

SETTLEMENT AGREEMENT

WHEREAS, John Alden Insurance Company ("John Alden"), Time Insurance Company ("Time," formerly known as Fortis Insurance Company), and Union Security Insurance Company ("Union") (collectively the "Insurers") are licensed by the Insurance Commissioner of the State of Connecticut (the "Commissioner") to transact the business of insurance in the State of Connecticut and are part of Assurant Health Group; and

WHEREAS, the Commissioner and the Insurance Department of the State of Connecticut (the "Department") have conducted an investigation into the market practices of the Insurers relating to short-term health insurance covering the period January 1, 2000 to December 31, 2005 (the Investigation") and,

WHEREAS, on March 28, 2007, the Department and the Insurers entered into a Stipulation and Consent Order (the "Stipulation") under which the Insurers agreed to send a notice to Connecticut insureds who had claims denied for pre-existing conditions under short-term health policies and certificates for the years 2001 through 2007, with such notice offering to reconsider such claim determinations upon the written request of the insureds, and in total 305 policyholders requested reconsideration of their claims, and the Examiners (as defined below) proposed to overturn all or part of the Insurer's decisions to deny claims on 112 such policies; and

WHEREAS, in June 2007 the Department elected, consistent with the Stipulation, to enlarge the review to include all policyholders who had claims denied for pre-existing conditions under short-term health policies and certificates for the years 2001 through 2007, through a market conduct examination of the Insurers (the "Examination"), which was conducted on behalf of the Department for the period January 1, 2001 to April 30, 2007 by RSM McGladrey, Inc. (the "Examiners"), and of 515 policyholders who had not previously requested reconsideration of their claims, the Examiners proposed to overturn all or part of the Insurer's decisions to deny one or more claims on 79 such policies (17 of which totaled less than $100); and

WHEREAS, John Alden and Time, but not Union Security, sold or had short-term health insurance policies in-force for Connecticut residents during the review period; and

WHEREAS, the Investigation and Examination focused on the manner in which the Insurers investigated, evaluated, and adjudicated short-term health insurance claims of Connecticut residents that were denied in relation to the policy's pre-existing condition exclusion, and investigated the Insurers' policies, practices, and procedures relating to policy rescissions; and

WHEREAS, the Department alleges that two of the Insurers during the period of review in the Examination engaged in certain unfair or deceptive acts or practices defined in Conn. Gen. Stat. § 38a-816 and committed violations of other Connecticut insurance laws and regulations arising under short-term health insurance policies, including but limited to: failing to adopt and implement reasonable standards for the prompt investigation of claims, failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed, failing to promptly provide the policyholder and/or provider a reasonable explanation of the basis for claim denial; and failing to pay the required interest payments when the claim was not paid within the timeframes prescribed by law; and

WHEREAS, the Insurers have responded and objected to the Department's allegations, asserting that the claim and other reviews purportedly forming the basis of the violations identified by the Department were incorrectly decided, and that the procedures, standards and conclusions by the Department and the Examiners were based on incorrect factual and legal determinations; and

WHEREAS, the Insurers do not admit or concede any actual or potential violation, fault, wrongdoing, or liability in connection with any facts or claims which have been or could have been alleged against them by the Department as of the date of this Settlement Agreement; and

WHEREAS, notwithstanding the detailed responses and objections submitted by the Insurers to the Department directed to the issues raised by the Investigation and Examination, the Insurers nonetheless consider it desirable for this administrative dispute to be settled and resolved, because the contemplated regulatory settlement will (i) provide substantial benefits to the Insurers' former, current and future policyholders; (ii) avoid further expense and disruption of the management and operation of the Insurers' business due to the pendency of the Investigation and Examination; (iii) put the Department's allegations and the matters underlying those allegations to rest; and (iv) avoid the substantial expense, burdens, and uncertainties associated with a continuation of the Investigation and Examination and the Insurers' response thereto; and

WHEREAS, no report of the Examination has been finalized as of the effective date of this Agreement; and

WHEREAS, with respect to regulatory concerns raised by the Department, the Insurers have agreed to a plan of corrective action to address those concerns for the benefit of the

Insurers' former, current and future policyholders and insureds, and a means of enforcement of such a plan; and

WHEREAS, the Insurers have cooperated with the Investigation and the Examination; and

WHEREAS, the Department and the Insurers wish to enter into this Settlement Agreement (the "Agreement") to resolve all issues related to the Investigation, Examination and allegations in this Agreement; and

WHEREAS, the Insurers voluntarily waive: (1) any right to a hearing; (2) any requirement that the Commissioner's decision contain a statement of findings of fact and conclusions of law; and (3) any and all rights to object to or challenge before the Commissioner or in any judicial or administrative proceeding any aspect of the Investigation and Examination as of the date of this Settlement Agreement; and

WHEREAS, the Department and Commissioner find the relief and agreements contained in this Agreement appropriate and in the public interest, and are willing to accept this Agreement in settlement of the Investigation and Examination;

NOW, THEREFORE, upon consent of the Commissioner, the Department and the Insurers, it is hereby agreed and ordered:

1. The foregoing recitals are hereby adopted, incorporated into and made a part of this Agreement.

2. The Insurers shall pay or cause to be paid the Examiner's fees and costs in connection with the Department's Examination as conducted by the Examiners. No later than forty-five (45) days following execution of this Agreement, the Insurers shall be presented with a final invoice for payment of the cost of the Examination. The Insurers shall not be obligated to reimburse the Department for any other costs incurred by the Department in connection with the Investigation. Upon execution of this Agreement, the Examiners shall not longer participate in the Investigation or the Examination.

3. Pursuant to the Stipulation, the Insurers have paid and shall continue to pay restitution on all claims plus interest to claimants or health care providers in instances where claimants have had their claims reviewed as part of the Examination and the Examiners have determined that claims were improperly denied in relation to policy pre-existing condition exclusions, or that short-term health insurance policies were improperly rescinded, cancelled or limited, and shall pay interest on claims that were paid late in violation of Conn. Gen. Stat. § 38a-815 and § 38a-816(15). In addition, the Insurers shall promptly process and make payment as appropriate, including interest, with respect to all of the closed claims identified in the Corrective Action Plan. The Insurers shall identify as denied any closed claims that they deem not payable. The Insurers shall report to the Department the results of this processing - identifying claims that have been paid and providing a complete record of all claims that have been denied. The Department staff shall conduct a review of all denied closed claims and determine whether such claims were properly denied. The Department shall notify Insurers of all claims it has determined

to have been improperly denied. Insurers agree to be bound by all such Department determinations and shall make prompt payment including any applicable interest on all closed claims determined by the Department to have been improperly denied.

4. If, upon review by the Insurance Department Consumer Affairs Division of consumer complaints presently being evaluated, or received in the future, the Department determines that a policy or certificate was improperly rescinded, cancelled or limited, or that a claim thereunder was improperly denied, the Department shall notify the Insurers of its determination as to such consumer complaint. Thereafter, the Insurers' shall either make restitution and/or all other appropriate adjustments on such claim, including the payment of interest as required by the laws of Connecticut, within a reasonable time following the Insurers review of the consumer complaint, or exercise all applicable statutory and other rights of appeal or review.

5. Within thirty (30) days following execution of this Agreement, Alden and Time shall pay or cause to be paid the aggregate amount of $2,100,000 as a monetary penalty (representing $1,050,000 for each of Alden and Time), by wire transfer or certified check to the Department.

6. By entering into this Agreement, the Department intends to resolve all matters involving medical insurance as of the effective date of this Agreement, including those addressed in the Examination, and with respect to the time period subject to the Examination, and except as provided herein, the Department shall not engage in any further investigative or examination activities as to the Insurers relating to medical insurance, including the issues that were the subject of the Investigation or Examination, and will not impose a monetary assessment, fine, injunction or any other remedy on the Insurers for any of the potential violations relating to medical insurance asserted by the Department, including those that are the subjects of the Investigation or Examination. By entering into this Agreement, the Department and Insurers intend to resolve all issues relating to medical insurance, including the subjects and concerns addressed by the Investigation and Examination, including any alleged violations of laws and regulations, and this Agreement shall be deemed a complete settlement and full and final resolution, and is in lieu of any disciplinary, legal, regulatory or enforcement action(s) that could have been taken by the Department, relating to all potential violations relating to medical insurance, including the subjects and concerns addressed in the Investigation and Examination, and arising out of any alleged violations of any laws, regulations or administrative orders issued or which could have been issued by the Department, including those relating to the Investigation and Examination, but such release will not be final until the Insurers have paid all amounts as specified in Sections 2, 3 and 5, respectively. Provided however, notwithstanding the foregoing, the Department may take any and all appropriate actions should the Insurers in the future violate any provision of the insurance laws and regulations of Connecticut not otherwise subject to this Agreement, as well as with respect to individual consumer complaints as otherwise provided for herein, and except as expressly addressed in this Section 6, nothing in this Agreement shall relieve the Insurer's obligations imposed by any applicable state insurance law or regulations or other applicable law.

7. The Insurers shall commence implementation of the Corrective Action Plan attached as Exhibit A to this Agreement (the "Corrective Action Plan") within thirty (30) days of the effective date of this Agreement. The Department shall assess performance and compliance

with the Corrective Action Plan regarding short term products in accordance with the compliance requirement measurements specified in the Corrective Action Plan. The Insurers acknowledge that compliance with the Corrective Action Plan will be measured against the standards contained therein. The Department acknowledges that compliance with the Corrective Action Plan will be measured from the commencement of implementation through the term thereof. Notwithstanding the provisions of paragraph 6 above, in the event the Insurers fail to comply with the terms and conditions of the Corrective Action Plan, the Department may take appropriate regulatory action with respect to such non-compliance.

8. The Department shall conduct a future market conduct examination of the Insurers' individual medical and small group medical (non-six month coverages), commencing no sooner than twelve (12) months after the effective date of this Agreement and covering a period of four (4) prior years including the year of the examination, with such examination to be conducted by the market conduct staff of the Department, pursuant to Conn. Gen. Stat. § 38a-15 and procedures established by the *NAIC Market Regulation Handbook.*

9. Nothing in the Agreement or any of its terms and conditions shall be interpreted to alter in any way the contractual terms of any insurance policy, certificate or health benefit plan issued or acquired by the Insurers or by the parties to such contract.

10. Except in a proceeding to enforce the terms hereof, neither this Agreement nor any related negotiations, statements, reports or court proceedings shall be offered by the Insurers or the Department as evidence of or an admission, denial or concession of any liability or wrongdoing whatsoever on the part of any person or entity, including but not limited to the Insurers, or as a waiver by the Insurers of any applicable defense, including without limitation any applicable statute of limitations or statute of frauds.

11. Nothing contained herein shall limit the authority of the Department from dealing with specific instances of consumer complaints, licensing changes, rate and form filings, or conducting other regulatory functions. Such regulatory functions shall not be deemed within the scope of this Agreement.

12. This Agreement may be signed in multiple counterparts, each of which shall constitute a duplicate original, but which taken together shall constitute but one and the same instrument.

13. This Agreement shall be binding on and inure to the benefit of the Commissioner, the Department and the Insurers, and their legal representatives, successors and assigns. Nothing in this Agreement shall confer rights upon any persons or entities other than the Commissioner and/or Department and the Insurers. This Agreement sets forth the entire agreement among the parties with respect to its subject matter and supersedes all prior agreements, arrangements, understandings (whether in written or oral form) between the Commissioner and/or Department and the Insurers. No modification or amendment of this Agreement shall be of any force or effect unless in writing executed by both the Commissioner and/or Department and the Insurers.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of this 15th day of May, 2008.

JOHN ALDEN INSURANCE COMPANY
TIME INSURANCE COMPANY and UNION
SECURITY INSURANCE COMPANY

By: _____
John B. Euwema
Senior Vice President, Regulatory Compliance

I, John B. Euwema, hereby affirm that I am the Senior Vice President, Regulatory Compliance of Assurant, Inc. and have the authority to execute this Agreement on behalf of John Alden Insurance Company, Time Insurance Company and Union Security Insurance Company.

AGREED AND ORDERED this 16th day of May, 2008.

_____
Thomas R. Sullivan
Insurance Commissioner

EXHIBIT A

Corrective Action Plan

CORRECTIVE ACTION PLAN

Corrective Action	Standard to be Met	Compliance Requirements//Measurements[1]
		Overall Annual Accuracy Requirement • Claim Processing = 95% overall claim processing accuracy • Timeliness = 95% of all processing within required timeframes
1. Insurers[2] shall maintain procedures to ensure compliance with the requirements of Conn. Gen. Stat. Sections 38a-815 and 38a-816 (6)(e) and 38a-816(15)(B) and Conn. Gen. Stat. Section 38a-477		
	1. Insurers shall evaluate a short term claimant's proof of loss form or a heath care provider's request for payment within 15 business days of receipt and conduct a relevant investigation so that they may affirm or deny coverage within forty-five (45) days after receipt, except when there is a deficiency in the information needed for processing a claim in accordance with Conn. Gen. Stat. Section 38a-816(15)(B) and Conn. Gen. Stat. Section 38a-477. An investigation will include review of all available information which is defined to include, but is not limited to: medical records and reports, underwriting	An acceptable sample = 3-5% of all claims received during the prior quarter. Standard = 95% compliance Audit for a three year period Note: Relevancy is defined as information being unique to the particular facts and circumstances of the claim being investigated, logically connected and tending to prove or disprove a material matter in issue/question.

[1] All compliance and reporting obligations under this Corrective Action Plan for short term health policies shall be applied for a period of three (3) years following the effective date of the regulatory Settlement Agreement.

[2] Insurers is the collective reference for John Alden Insurance Company, Time Insurance Company, and Union Security Insurance Company.

Corrective Action	Standard to be Met	Compliance Requirements//Measurements[1]
	materials, claims history, insured provided details, conversation with treating physicians and any other relevant materials.	
	2. A "deficiency" will be defined as a missing data element as itemized in Conn. Gen. Stat. Section 38a-477. In the event there is a deficiency in the information needed for processing a claim as described above, Insurers shall send written notice to the claimant and health care provider not later than thirty (30) days after Insurers receives a claim for payment or reimbursement under the policy or certificate and every 10 business days thereafter until information is obtained. Once this information is obtained, Insurers shall promptly affirm or deny coverage and make any required payment not later than thirty (30) days after Insurers receives the information requested.	An acceptable sample – 3-5% of all claims processed during the prior quarter. Standard is 95% compliance.
2. Insurers shall maintain procedures to ensure compliance with the requirements of Conn. Gen. Stat. Sections 38a-815 and 38a-816(15)(A).	1. A "legitimate dispute" will be defined pursuant to the forthcoming guidelines to be issued by the Connecticut Insurance Department. Claims will be processed in accordance with timeliness required by statute unless a legitimate dispute is identified. Insurers will continue to follow their current procedure regarding legitimate disputes, submitted to the Connecticut Insurance Department on January 22, 2008, and at	An acceptable sample = 3-5% of all claims processed during the prior quarter. Standard is 95% compliance 1. Within 90 days from the date of settlement, Insurers are required to review the list of 1688 Connecticut closed claims identified through the

Corrective Action	Standard to be Met	Compliance Requirements/Measurements
	such time as guidance is published by the Insurance Department, Insurers will follow such guidance.	Examination and process all identified claims which were closed but the file contained the necessary information to process the claim; Insurers are required to provide confirmation to the Department that all such identified claims have been appropriately processed for payment; Insurers will also provide a list of the outcome determination, including an indication of any interest payable pursuant to C.G.S.§38a-816(15) (15% per annum) for each claim on the list. The Insurers shall identify as denied any closed claims that they deem not payable. The Insurers shall report to the Department the results of this processing - identifying claims that have been paid and providing a complete record of all claims that have been denied. The Department staff shall conduct a review of all denied closed claims and determine whether such claims were properly denied. The Department shall notify Insurers of all claims it has determined to have been improperly denied. Insurers shall be bound by all such Department determinations and shall make prompt payment including any applicable interest on all closed claims determined by the Department to have been improperly denied.
	2. Should Insurers fail to pay a claim within forty-five (45) days after receipt	An acceptable sample = 3-5% of all claims processed during the prior

Corrective Action	Standard to be Met	Compliance Requirements//Measurements
	of the claimant's proof of loss form or the health care provider's request for payment in which no deficiency exists as provided in Conn. Gen. Stat. Section 38a-816(15)(B) and Conn. Gen. Stat. Section 38a-477, or a legitimate dispute pursuant to Conn. Gen. Stat. Section 38a-816(15)(A), the Insurers shall pay the claimant or health care provider the amount of such claim plus interest at the rate of fifteen (15%) percent per annum.	quarter. Standard is 95% compliance
	3. Insurers shall provide to claim representatives training on the statutory prompt pay requirements for claims settlement practices, including, but not limited to, the requirement that claims with no deficiencies be settled within forty-five (45) days from receipt as required by Conn. Gen. Stat. Section 38a-816(15)(B) and Conn. Gen. Stat. Section 38a-477.	1. Insurers shall develop and provide copies of all prompt pay training materials for Connecticut claims to the Department no later than 30 days following execution of any settlement agreement. 2. Insurers shall conduct prompt pay training for all employees in the claims area no later than 60 days following execution of settlement agreement. 3. Upon completion of the initial prompt pay training, Insurers shall provide a list of all the Insurers' Departments that have completed the prompt pay training. 4. Insurers will include these prompt pay training materials in the training provided new employees in the claims area.
	4. Insurers shall continuously monitor and communicate new regulatory	

Corrective Action	Standard to be Met	Compliance Requirements//Measurements
	requirements to personnel handling claims for Insurers. When new laws or regulations are enacted, Insurers's implementation team will ensure that notification for all impacted areas occurs the later of 60 days after publication or 30 days before the effective date of the new law or regulation and that all written materials are updated to reflect any necessary changes resulting from the new laws/regulations including claims workflows and manuals, sales brochures, applications and policies.	
	5. Insurers shall provide a list of Compliance and Legal contacts for the Insurance Department.	The list should be updated as necessary and verified quarterly.
3. Insurers shall maintain procedures to ensure that any claim denial based upon a pre existing condition exclusion shall be based upon the specific policy or certificate language at issue, which language shall be in accordance with the laws and Regulations of the State of Connecticut, and shall include medical involvement by trained medical personnel.		
	1. After receipt of a claimant's proof of loss form or a health care provider's request for payment, Insurers shall review and evaluate all information available and if such information is adequate to affirm coverage, payment shall be effectuated within forty-five (45)	1. Within 30 days of execution of the settlement agreement, Insurers shall provide copies of procedures/process materials dealing with processing of pre existing claims. 2. Insurers shall conduct short term pre

Corrective Action	Standard to be Met	Compliance Requirements/Measurements
	days from receipt as required by Conn. Gen. Stat. Section 38a-816(15)(B) and Conn. Gen. Stat. Section 38a-477.	existing condition exclusion training no later than 60 days following execution of settlement agreement. 3. All short term pre-ex claims will be subjected to a 3-5% sample audit, on a quarterly basis, for 3 years. 4. Acceptable performance is an error rate of 5% or less as identified by audit. 5. All overturns identified through the audit will be reprocessed and paid, including applicable interest, within 30 calendar days of overturn determination.
	2. A claims reviewer will review the submitted claim, the request for pre-certification or a pre-determination of benefits to determine if a pre-existing condition investigation will occur. In making that decision, the reviewer will be instructed to base the decision on the specific language of the policy or certificate at issue, (consistent with state law), the effective date of the policy or certificate, the nature of the condition, whether the claimant received medical treatment or advice with respect to the condition within the 24 months prior to the issuance of coverage, and other reasonable and appropriate information that may indicate a condition is pre-existing as defined by the policy or certificate at issue. For consecutive	1. Insurers are required to submit, within 30 days of execution of the settlement agreement, copies of processes and procedures reflecting claim review and examination process. 2. Insurers shall conduct training no later than 60 days following execution of settlement agreement. 3. Insurers are required to provide confirmation that claims reviewers have been trained on new processes and procedures. 3. All Connecticut short term pre-ex claims will be subjected to a 3-5% sample audit, on a quarterly basis, for 3 years.

Corrective Action	Standard to be Met	Compliance Requirements/Measurements
	policies, the reviewer will also determine whether the insured is entitled to reduction or elimination of his/her pre-existing condition exclusion period pursuant to Section 38a-476(g) as amended by Public Act 07-113. The process described in this corrective action must be followed even if the amount of the claim is less than the deductible.	4. Acceptable performance is an error rate of 5% or less as identified by audit. 5. All overturns identified through the audit will be reprocessed and paid, including applicable interest, within 30 calendar days of overturn determination.
	3. If a pre-existing condition investigation is undertaken due to the factors above, Insurers, shall seek information within 15 business days of the claim being submitted from the insured or the insured's health care providers to ascertain whether the condition at issue constitutes a pre-existing condition excluded by the language of the policy or certificate at issue. Insurers shall follow-up on the outstanding responses no less than every 10 business days. If a response is not received following 3 follow-up requests, Insurers may close the file by issuing a denial notice to the claimant and the affected medical providers indicating the claim is denied due to lack of information. Upon receipt of any outstanding information, the claim shall be immediately re-opened and processing resumed.	1. Insurers are required to submit, within 30 days of execution of the settlement agreement, copies of processes and procedures reflecting pre existing condition claim review and examination process, including investigation triggers. 3. Insurers shall conduct training no later than 60 days following execution of settlement agreement. 4. Insurers are required to provide confirmation that claims reviewers have been trained on new processes and procedures. 5. All short term pre-ex claims will be subjected to a 3-5% sample audit, on a quarterly basis, for 3 years. 6. Acceptable performance is an overturn

Corrective Action	Standard to be Met	Compliance Requirements//Measurements
		rate of 5% or less as identified by audit. 7. All Connecticut claim overturns identified through the audit will be reprocessed and paid, including applicable interest, within 30 calendar days of overturn determination.
	4. Any investigation by Insurers of a claim to determine whether a pre-existing condition existed at inception of the policy or certificate under which the claim is being made shall have medical involvement and thorough review prior to denying the claim because of a pre-existing condition.	1. Insurers are required to submit, within 30 days of execution of the settlement agreement copies of processes and procedures reflecting pre existing condition claim review and examination process, including investigation triggers. 2. Insurers shall conduct training no later than 60 days following execution of settlement agreement. 3. Insurers are required to provide confirmation that claims reviewers have been trained on new processes and procedures. 4. All short term pre-ex claims will be subjected to a 3-5% sample audit, on a quarterly basis, for 3 years. 5. Acceptable performance is determination that 95% of the claims denied for medical review had required medical intervention.

Corrective Action	Standard to be Met	Compliance Requirements//Measurements
	5. Trained medical personnel shall consist of physicians, nurses, and chiropractors both on Insurers's staff and under contract. The trained medical personnel must have broad knowledge of medical conditions and symptomatology. Where necessary, specialists will be utilized or retained to make determinations. All staff or contracted physicians shall be licensed to practice medicine in at least one state in the United States of America.	1. Insurers are required to submit, within 30 days of execution of the settlement agreement, copies of processes and procedures reflecting pre existing condition medical investigation and review process, in which trained medical personnel utilize nationally recognized evidence based treatment protocols (as available through the National Guideline Clearinghouse, www.guidelines.gov), current editions of standard textbooks, peer reviewed medical literature and general medical knowledge and experience, and then base their decisions upon the contract language in force. 2. Insurers shall conduct training no later than 60 days following execution of settlement agreement. 3. Insurers are required to provide confirm that medical personnel have been trained on new processes and procedures. 4. Insurers are required to submit on an annual basis a listing of credentials and specialties of the medical personnel used to conduct medical investigations. 5. All pre-ex claims will be subjected to a 3-5% sample audit, on a quarterly basis, for 3 years.

Corrective Action	Standard to be Met	Compliance Requirements/Measurements
		6. Acceptable performance is an error rate of 5% or less as identified by audit. 7.All Connecticut claim overturns identified through the audit will be reprocessed and paid, including applicable interest, within 30 calendar days of overturn determination
4. Insurers shall maintain procedures to ensure that all communications with insureds are handled in accordance with applicable laws and regulations, are properly documented and made available to the Department consistent with their statutory authority.		
	1. Written and verbal communications material regarding the claim between the Insurers and the insureds shall be documented.	1. Insurers will develop internal and external documentation standards, procedures and processes. 2. Insurers are required to submit to the Department, within 30 days of execution of the settlement agreement, standards and processes 3. Insurers shall conduct training no later than 60 days following execution of settlement agreement. 4. Insurers are required to provide confirmation that claims reviewers have been trained on new processes and

Corrective Action	Standard to be Met	Compliance Requirements//Measurements[1]
		procedures.
	2. Documents received by Insurers shall identify the date received with a calendar date.	
	3. Insurers shall provide written notification of the claim determinations to insureds through Explanations of Benefits (EOB's) or letter.	An acceptable sample = 3-5% of all claims processed during the prior quarter. Standard for performance is 95% compliance rate with published standard.
	4. Insurers shall communicate denials of coverage through Explanations of Benefits (EOB) or letter. Insurers shall maintain copies of the EOB's or letters consistent with retention standards required by this Corrective Action Plan.	
	5. Insurers shall respond to communications from the Connecticut Insurance Department within fifteen (15) calendar days and shall maintain claim documentation to facilitate Department review.	
5. Improvement of document management and retention processes.	2. Insurers will develop new processes for Connecticut policies and Connecticut insureds which will (i) facilitate document control number consistency, and (ii) facilitate a consistent, reasonable, and accurate process for tracking the received date of claims.	1. Insurers are required to submit, within 60 days of execution of the settlement agreement, copies of processes and procedures reflecting document management and retention processes. 2. Insurers shall conduct training no later than 60 days following execution of settlement agreement.

Corrective Action	Standard to be Met	Compliance Requirements//Measurements[1]
		3. Insurers are required to provide evidence that claims reviewers have been trained on new processes and procedures.
6. Disclosure of information to insureds concerning pre-existing conditions, as required under Connecticut laws and regulations, and clearly indicate the name of the underwriting Insurers, in materials provided to the insured, consistent with Connecticut laws and regulations and bulletins.		
	1. For any new short term business in Connnecticut, Insurers will be required to review their practices for compliance with Section 38a-505 and Section 38a-505-5 of the Regulation of the Connecticut State Agencies and clearly explain to insureds how pre-existing conditions are handled, particularly where there are consecutive policies.	
	2. For any new short term business, Insurers need to fully comply with Public Act 07-113 and Bulletin HC-66. In addition to other requirements, specified in the Act and Bulletin, Insurers need to provide notice to any applicants for insurance who are accepted for enrollment as to what medical conditions, as noted on their application,	Insurers are required to submit to Department for its approval a sample of the notice to be provided pursuant to Bulletin HC-66 Once approved, Insurers must issue notice in compliance with Bulletin directives.

Corrective Action	Standard to be Met	Compliance Requirements/Measurements
	will be subject to, and claims denied under, the pre-existing condition limitation (as described in the Bulletin).	
	3. Insurers are required to review and make changes as necessary to their telephone practices to ensure that insureds and providers are clearly informed that confirmation of an insured's eligibility does not imply that a claim may be later denied for a pre-existing condition.	At least 30 days prior to the selling a new short term plan Insurers are required to submit to Department for its review a sample of telephone scripts for sales, preauthorization, eligibility to reflect warnings about pre-existing condition limitations. With respect to new short term sales, all calls must be recorded for quality control and audit purposes.
	4. Insurers are required to review their short term application forms in Connecticut and ensure that the underwriting Insurer's name is shown somewhere on the form.	1. Following the review contemplated in this standard, if short term policy forms and applications are found to be deficient, Insurers shall refile and receive approval for short term policy forms and applications found to be deficient prior to marketing or issuing policies using deficient forms. 2. For a period of 3 years from the execution of the settlement agreement, Insurers are required to submit, at least 30 days prior to planned use, for review all short term marketing and sales materials to be used in Connecticut, including internet screens, telephone scripts and advertising. 3. Insurers will be restricted to marketing only approved short term

Corrective Action	Standard to be Met	Compliance Requirements//Measurements
		forms and applications.
	5. Insurers are required to review all of their short term rates and rate discounts used in Connecticut and to confirm that Insurers have received approval by the Department before use of such rates and rate discounts.	1. Following the review contemplated in this standard, for all non-complying rates or rate discounts, Insurers are required to refile and receive approval for non-complying short term individual rates and rate discounts (including those used in connection with Internet sales) prior to marketing or issuing new policies.
7. Insurers shall maintain procedures to accurately log complaints, in accordance with laws and regulations of the State of Connecticut.		
	Maintain an accurate record of all written complaints from all Connecticut residents, related to Connecticut Insurance Products, since the last examination of record by the Connecticut Insurance Department.	Insurers shall be required within 30 days of execution of the settlement agreement to submit to Department proposed format/structure of complaint log to determine if acceptable and in compliance with Conn. Agencies Reg. Section 38a-819-51, et seq. Audit will be based on 3-5% sample audit in comparison with complaints received during that same period, on a quarterly basis, for 3 years. Standard for performance is 95% compliance rate.
8. Insurers shall maintain all information related to Connecticut files for 6 years.		
	1. Information systems must be able to reproduce, with accuracy, all data	

Corrective Action	Standard to be Met	Compliance Requirements/Measurements
	necessary for validating compliance with Connecticut Insurance statutes and regulations.	
	2. Policies and procedures must be implemented to provide documentation of accurate policy issuance.	
9. Insurers shall ensure that all persons effecting coverage are properly licensed and appointed consistent with all laws and regulations of the State of Connecticut.		
	1. Insurers must correct coding procedures to allow applications to be submitted only by properly licensed and appointed agents.	