

Consumer Affairs Group (CAG)

Complaint & Grievance Handling Procedure

CAG_PR_001

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1 Introduction

1.1 Policy

All HealthMarkets employees and appointed agents are responsible for identifying and properly routing verbal and written complaints and grievances to ensure that the Company appropriately records, acknowledges and responds to complaints and grievances.

All HealthMarkets employees and appointed agents are responsible for implementing complaint handling processes that are consistent with standards set by the National Association of Insurance Commissioners (NAIC).

Specifically, HealthMarkets must comply with the following standards:

- All complaints are recorded in the required format on the company complaint register.
- The company has adequate complaint handling procedures in place and communicates such procedures to policyholders.
- The company should take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language.
- The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations.
- Documentation of complaints is adequate and in accordance with applicable statutes, rules and regulations.
- In general, HealthMarkets makes no distinction between complaints and grievances, except to the extent that a state's requirements may be more restrictive with respect to handling either complaints or grievances. In the event a state's requirements are more restrictive for handling either complaints or grievances, the Company will adopt the more restrictive requirement.

EXAMPLE: if a state requires the Company to acknowledge a grievance within 3 business days and a complaint within 5 business days, the "3 business day rule" will apply to both complaints and grievances.

1.2 Scope

These policies and procedures apply to all departments of the Company with regular customer contact. This includes the Consumer Affairs Group (CAG) as well as the Company's other operational departments including Member Services, Benefit Confirmation, Underwriting and the Customer Retention Team. All other departments or persons within the Company and marketing affiliates who receive written or verbal complaints and grievances should forward such information to the Consumer Affairs Group for handling.

1.3 Accountability

Consumer Affairs management is accountable for:

- Monitoring the work of Consumer Affairs Group staff members
- Monitoring the level and aging of both the Company's and the Consumer Affairs Group's complaint inventory
- Maintaining these policies and procedures
- Developing, delivering, and maintaining records of Consumer Affairs staff training
- Ensuring that complaint handling processes, policies and procedures within other departments align with these policies and procedures.
- Preparing for Market Conduct Examinations and other audits specific to complaint handling
- Working with Corporate Compliance to respond to Market Conduct Examinations and other audits specific to complaint handling
- Analyzing complaint trends, conducting root cause analysis, and ensuring the Company addresses issues underlying complaints

The management of other departments in the Company that handle complaints (Member Services, Benefit Confirmation, Customer Retention, and Underwriting) is accountable for:

- Monitoring the complaint handling work of their specific departments' staff members
- Monitoring the level and aging of their departments' complaint inventory
- Maintaining their departments' complaint handling policies and procedures, including appropriate updates as advised by Consumer Affairs
- Analyzing complaint trends, conducting root cause analysis, and ensuring their departments address issues underlying complaints

2 Procedure

2.1 Complaint and Grievance Identification

A written or verbal communication is considered a complaint or grievance when:

The consumer expresses dissatisfaction regarding the Company's policies, procedures or services and/or

The consumer expresses an allegation of employee or agent misconduct.

Other identifiers of a complaint or grievance:

- The consumer threatens to take action as a result of his/her dissatisfaction.
- The consumer demands a response or action from the Company as a result of his/her dissatisfaction.
- The consumer has copied a regulatory agency, government office, Better Business Bureau, attorney on his/her dissatisfaction.

Please note: Coverage questions and requests for additional benefits or reconsideration of a Company decision are not considered to be complaints or grievances.

Complaint or grievance communications can be received by the Company through telephone, email, fax, and mail services, such as U.S. Postal Service, Federal Express.

2.2 Recording Complaints and Grievances

The Company must properly record complaints and grievances in a master complaint log.

The types of complaints recorded include:

- Department of Insurance (DOI) complaints,
- Written consumer complaints and grievances, and
- Verbal complaints and grievances (where required by statute or certificate)

Recording Department of Insurance Complaints

HealthMarkets is responsible for logging and maintaining procedures for recording all Department of Insurance complaints.

Department of Insurance complaints shall be logged by the Consumer Affairs Complaint Coordinator or designated staff. Detailed instructions on recording complaints and grievances are in the Complaint Handling System (CHS) Training.

Specifically, the Complaint Coordinator/designee ensures the following information is recorded:

The identity of the Complainant/Insured

If not an Insured or former Insured, the complainant type should be listed as "Prospective" rather than Insured

Whether the correspondence is a new complaint or a reopen of a previous Department of Insurance complaint

All data fields that identify the complainant and agent are completed

All data fields pertinent to appropriate handling of the complaint are completed (i.e. received date, due date, department, reason codes, assigned to, etc.)

Recording Written Consumer Complaints and Grievances

HealthMarkets is responsible for logging all written complaints and grievances from consumers, or their representatives, and for maintaining written complaint recording procedures.

Consumer complaints and grievances shall include written complaints and grievances received from an Insured or Prospective, or their personal representatives (other than the Department of Insurance). Consumer complaints and grievances may be categorized as the following complaint types in CHS:

Consumer: Written complaints and grievances received directly from consumers.

Attorney: Written complaints and grievances received from consumers represented by an attorney.

Attorney General: Written or verbal complaints and grievances received from a state's attorney general with respect to particular consumers.

Better Business Bureau: Written complaints and grievances received from the Better Business Bureau with respect to particular consumers.

President: Written or verbal complaints and grievances received from consumers directed to the Company's President or other executive officer.

Decision Review Form (DRF) – Complaint: Written complaints and grievances received directly from consumers on the company's Decision Review Form. The Company has renamed the form to "Request an Appeal Form", so either form variation can be received by the Company. Both forms will be logged as DRF Complaint.

Please note: Insureds may use either the Decision Review Form or the Request an Appeal Form to appeal a decision made by the Company. Appeal procedures are documented separately.

Written consumer complaints and grievances shall be logged by the Consumer Affairs Complaint Coordinator/designee, who is responsible for completing all data fields outlined in the CHS *Logging Written Complaints Procedure* using the instructions in the Complaint Handling System (CHS) Training. Specifically, the Complaint Coordinator/designee ensures the following information is recorded:

- The identity of the Complainant/Insured,
- If not an Insured or former Insured consumer, complainant type should be listed as "Prospective" rather than Insured
- Whether the correspondence is a new complaint, a reopen of a previous complaint, or an appeal of a previous complaint response rendering a decision
- All data fields that identify the complainant and agent
- All data fields pertinent to appropriate handling of the complaint (i.e. received date, due date, department, reason codes, assigned to, etc.)
- The Complaint Coordinator/designee also ensures letters acknowledging written complaints and grievances are sent to Complainants within the state's required timeframe.

Acknowledgement letter procedures are located in Section 2.3, below.

Recording Verbal Complaints, Grievances and Issues

For a period of time, the Company's policy was to record verbal complaints and grievances in all states, regardless of whether a particular state's law or certificate language required the Company to do so.

Effective 04/06/2009, the Company changed its policy to record verbal complaints and grievances only in states where required by law or certificate language. In states where verbal complaint and grievance recording is not required by law or by certificate language, the Company makes reasonable attempts to capture customer issues/concerns. The Company uses complaint, grievance and issue data to identify trends, conduct root cause analysis, and resolve issues underlying customer dissatisfaction.

Designated staff in the Company's call centers (Member Services, Customer Retention, Benefit Confirmation, and Underwriting) is responsible for identifying verbal complaints/grievances/issues and recording them in CHS.

Specifically, the Company's call center representatives will log verbal complaints/grievances/issues and ensure the following information is recorded:

- The identity of the Complainant/Insured
- If not an Insured or formerly Insured consumer, complainant type should be listed as "Prospective" rather than Insured

- Whether the complaint or grievance is a new complaint/grievance/issue, a reopen of a previous complaint/grievance/issue, or an appeal of a previous complaint/grievance/issue response in which the Company rendered a decision
- All data fields that identify the complainant and agent
- All data fields pertinent to appropriate handling of the complaint/grievance/issue (i.e. received date, due date, department, reason codes, assigned to, etc.)
- Staff members in the Company's call centers also ensure letters acknowledging verbal complaints and grievances are sent to Complainants within the state's required timeframe, as required.

See Acknowledgement letter procedures in Section 2.3.

Recording Discovered Complaints

From time to time an undocumented verbal or written complaint may be discovered within a customer's file. When discovered, we must:

- Log the complaint as of the date it was actually received
- Determine if any corrective action occurred as a result of the discovered complaint or any other related complaints logged by the customer, and then document the file
Note: Corrective action includes claim processing, refund/cancellation processing, disciplinary action/retraining.
- Close the complaint as of the date the corrective action was taken
- If no corrective action has been taken, send an Acknowledgement Letter if it is in a state that requires it
- Investigate the complaint and respond accordingly to the customer, after conferring with Consumer Affairs management if the complaint is more than three (3) months old
- Close the complaint as of the date of the response

In either case, notify Issues Resolution Team of the discovery so that it can be documented and forwarded to the management of the appropriate department who can then provide necessary coaching on complaint identification.

NOTE: If the complaint is over 3 months old, bring the complaint to the attention of Consumer Affairs management for guidance on appropriate corrective action and/or response.

Recording Complaint/Grievance-related Communications

All communications between the Insured/Prospective or their representatives (including Departments of Insurance) and the Company regarding the complaint, grievance or issue must be documented in CHS. Refer to Complaint Handling System (CHS) Training for specific steps.

2.3 Acknowledging Complaints and Grievances

Acknowledgement Letters – Department of Insurance

If requested, the Company sends acknowledgment letters upon the receipt of Department of Insurance complaints.

Acknowledgement Letters – Written Consumer Complaints and Grievances

In addition to responding to Department of Insurance complaints, the Company is responsible for acknowledging written complaints and grievances received from consumers or consumers' representatives.

When a written consumer complaint or grievance is received by the Company, a letter acknowledging the complaint or grievance must be sent to the Complainant, as required by most states.

- Acknowledgement letters are standardized and systematically ordered unless there are state regulations requiring more information than what is stated in the system-generated Acknowledgement Letter. In those cases, a state-specific template is available at W:/Consumer Affairs – Shared/Forms and Templates.

The Company provides a copy of its grievance procedures with its acknowledgement letters, where required.

Please note: The State of Oregon requires that a copy of the Company's grievance procedures are enclosed with the acknowledgment letter.

Acknowledgement Letters – Verbal Complaints and Grievances

The Company is responsible for acknowledging verbal complaints and grievances received from the consumer, or the consumer's representative, if the Company is required by state law or certificate/policy language to record verbal complaints and grievances.

When a verbal complaint/grievance is received, a letter acknowledging the complaint/ grievance must be sent to the Complainant in order to meet state requirements.

Standardized acknowledgement letters are ordered via CHS unless there are state regulations requiring more information than what is stated in the system-generated Acknowledgement Letter. In those cases, a state-specific template is available at W:/Consumer Affairs – Shared/Forms and Templates.

The call center assisting the complainant is responsible for generating the acknowledgement letter.

Please note:

The Commonwealth of Massachusetts requires a written summary of the verbal complaint within the body of the acknowledgement letter.

The States of Oregon and Michigan require that a copy of the Company's grievance procedures are enclosed with the acknowledgment letter.

Acknowledgement Letters – Issues

The Company records, trends, and analyzes issues raised by consumers in states where the Company is not required to record said issues as complaints/grievances. The Company sends acknowledgement letters for recorded consumer complaints; the Company does not send acknowledgement letters for recorded consumer issues.

Procedures for Ordering Acknowledgement Letters

Procedures for selecting, requesting and auditing a system-generated acknowledgement letter are in the document entitled Complaint Handling System (CHS) Training, which may be found in the CAG Documentation section of the INSIDER or the CAG Share Drive.

2.4 Responding to Complaints and Grievances

When responding in writing to a complainant, it is the responsibility of the Company to write in a clear and understandable manner, addressing all specific allegations with a complete and accurate explanation of the Company's investigation and position, and providing contact information should the complainant have questions or wish to submit additional information or appeal a decision.

Please note: When an investigator receives an inbound telephone call from or makes an outbound telephone call to an outside party, the investigator must disclose that the call is being recorded. Appropriate disclosure language includes: "This telephone call is being recorded for quality purposes."

Response Content – Department of Insurance Complaints

When responding in writing to a Department of Insurance complaint, investigators must focus on answering each and every specific question and address the specific needs expressed by the insurance department or consumer. Investigators with questions or concerns about the content of response letters should consult with Consumer Affairs management.

Response Content – Consumer and Verbal Complaints and Grievances

When responding in writing to consumer and verbal complaints and grievances, investigators must focus on answering the specific questions/concerns and addressing the specific needs of the consumer (or his/her representative). Investigators with questions or concerns about the content of a response letter should consult with Consumer Affairs management.

2.5 Timeliness of Responses to Complaints and Grievances

Each state imposes a specific response time frame for complaints and grievances.

DOI Complaints

The communication from the insurance department that accompanies the actual complaint will usually indicate the time in which the insurance department expects to receive a response.

Please review the letter from the DOI carefully to determine whether the DOI has directed the Company to respond by a certain date.

Please note: The response due date is always the EARLIER of the date the DOI has directed or the deadline as determined by statute.

If the due date does not fall on a regular business day, the due date is recorded as the immediately preceding regular business day.

The response must be *received* by the DOI on the due date specified.

Follow any special instructions in the letter as some states may require a more immediate response than specified by statute. The letter may also provide additional requirements relating to required documentation and method of response (email, fax, etc.).

Turnaround time can be stated in terms of business days or calendar days, and is usually counted from the date of the Company's receipt of the letter. (Day 1 = day of receipt).

If you are unable to comply with the due date for good reason, you must request an extension. See the [Extension Approval](#) process in Section 2.7.

Delays in responding to DOI complaints will be individually reviewed during the audit process.

Consumer Complaints and Grievances

Verbal or written communications from the consumer, or someone acting on behalf of the consumer, other than the Department of Insurance, will require a 30 calendar day turnaround time unless applicable state law, regulation, or regulatory directive requires a shorter turnaround time.

The due date will be counted from the date of receipt, *including* the date of receipt. (Example: Date of receipt = Day 1, the following day = Day 2, etc.)

If the due date does not fall on a regular business day, the due date is recorded as the immediately preceding regular business day.

If unable to respond within the timeframe allowed by the state, or within the 30 day turnaround time, the investigator must contact the consumer via telephone or written correspondence with the reason for the delay. See Section 2.7: Extension Approval Process.

Note: If contact is made with the customer by telephone, a recording of the call must be placed in the complaint file.

Delays in responding to verbal or written complaints and grievances will be individually reviewed during the audit process.

Review of Newly Assigned Files

Investigators must review newly assigned complaint and grievance files on a regular basis to:

Order information pertinent to the investigation of the complaint/grievance, which may include agent statements, rate increase information, claims histories, or policy print.

Verify that the file is actually a complaint, grievance, issue, request for information, DRF, appeal, or other type of correspondence/communication handled by Consumer Affairs, and re-route for appropriate handling where the matter is not a complaint/grievance/issue.

Please note: In some instances, complainants' attorneys submit new, unprocessed claims to the Company on law firm letterhead, and these claims are routed to Consumer Affairs for handling. In these instances, Consumer Affairs staff should contact the attorney, provide the correct address for claims submission, and re-route the items to the Claims Processing area. These claims will not be logged as complaints.

Information Requests from Complainant

Investigators may sometimes request additional information from Consumers regarding their complaints such as bank charges, medical authorizations, HIPAA authorizations, forgery affidavits, medical bills, etc. in order to further investigate the complaint. Other times, the Investigator may make an extra-contractual offer by sending the consumer a Settlement Agreement. In these instances, the Investigator should provide the consumer reasonable time in which to respond to the request or offer.

Timeline for making requests/offers:

Initial request/offer – allow 2 weeks and give deadline

Follow-up on request/offer – allow 2 weeks and give final deadline

Closing letter – send if customer does not respond to request/offer, address as much of the complaint as possible with the information available, and close the file.

Upon the Investigator's receipt of the requested information or executed agreement, the Investigator has 5 days, or up to the complaint due date, in which to formally respond to the Complainant and close the file.

Monitoring Department and Investigator Inventory Levels

Department management (or designees) uses the Open Item and Inventory reports to monitor inventory at the department and individual investigator level and re-allocate assigned files, as appropriate.

2.6 Supporting Documentation

File Completion

A complaint response is not considered completed (and should not be closed in CHS) until the Company has provided the DOI or consumer with all of the information requested or information promised.

File Documentation

A "completed file" contains the complaint and response, including all attachments and any information used to help in the research and resolution of the complaint. All file documentation is to be attached to the file by following the procedure to add Multiple Files in the Complaint Handling System (CHS) Training.

Please note: The Investigator responding to the complaint is ultimately accountable for the file documentation and should ensure that the documentation is complete and accurate, including documentation such as EOBs attached to the record by other Consumer Affairs staff.

File documentation could include, but is not limited to the following:

- Complaint
- Fax Confirmations
- Response
- Forgery Affidavit
- Acknowledgement Letter
- Explanation of Benefits
- All interim or extension correspondence
- Certificate or specific pages of the Certificate
- Emails
- Certified Mail Receipts
- Claim Spreadsheets
- Fed Express Receipts
- Premium Spreadsheets
- Notepads
- Application or any other signed document received with the application
- Previously archived correspondence received from or mailed to the consumer
- Refund Check
- Agent Statement
- Additional information requested/received from customer to support allegation
- Phone calls
- Underwriting Guidelines in the event of a rescission or exclusion/rate assessment complaint

System Documentation

When the Consumer Affairs Group makes an exception to general practices or certificate language and/or enters into a consumer settlement regarding a claim, the Claims processing system is updated as follows:

- Date of settlement release
- Who approved settlement (Appeals Team, Legal, Consumer Affairs Management, etc.)
- Detailed terms of settlement

Decision Tree – Root Cause Analysis of Complaint

Each investigator is required to validate and further complete the Decision Tree in order to document the root cause analysis conducted as part of the complaint investigation. The Decision Tree data is analyzed by the Company to identify trends so that appropriate corrective actions can be taken. Often, the Decision Tree information and the actual Reason Code for the complaint are not the same, because the Reason Code reflects why the consumer called (i.e. claims denial) and the Decision Tree information reflects the results of the Company's root cause analysis (i.e. system error).

Root causes of the complaint are recorded appropriately in the CHS using the instructions in the Complaint Handling System (CHS) Training.

Maintaining Documentation of Exceptions/Settlements

When an exception and/or settlement is made by CAG and does not go through the Appeals Team, documentation of the exception/settlement should be communicated to the Complaint Coordinator/designee for logging and trending (The Company's appeals process is documented separately.)

Provide the following information in an email to [Appeals Review](#) to support the exception:

- Copy of notarized settlement agreement
- Who approved settlement (Appeals Team, Legal, Consumer Affairs Management, other)
- Date the agreement was finalized by the Company

2.7 Extension Approvals for DOI Complaints

Written DOI Extension Approvals

If the Company is unable to respond to a DOI complaint within the timeframe specified, an extension must be requested from the DOI *in writing before* the due date, except as provided in Section 2.7.2.

Please note: All DOI extension requests are subject to Consumer Affairs management approval.

An extension may be requested from the DOI via written correspondence through U.S. mail or via fax. In situations where the DOI does not specifically bar electronic communications and an appropriate e-mail address is available, an electronic communication is acceptable.

1. Obtain approval for the extension from Consumer Affairs management.
2. Note the communication/request on the Complaint Handling System (CHS).
3. Insert a copy of the written or electronic request into the Complainant's file.
4. Insert a copy of the written or electronic approval into the Complainant's file, and update the CHS extension date field.

Verbal DOI Extension Approvals

In certain situations, a request for a deadline extension on a DOI complaint response is made and received verbally. If a *verbal* extension is requested, the file **MUST** be documented with the extension request and approval.

Please note: Verbal requests for extensions should rarely occur.

1. Obtain approval for the extension from Consumer Affairs management.
2. Note the verbal communication on the Complaint Handling System. In order to provide verification during an audit and confirm the extension in the response to the insurance department notation should include the date, time, extension due date, and the name of the DOI representative approving the extension.
3. Add the recording of the conversation to the complaint file.
4. Update the extension date field in CHS.
5. An email or letter must be sent to the DOI Investigator confirming the conversation and date of extension, as it has been agreed to

Written Consumer Complaints/Grievances Extensions Requests

If the investigator is unable to respond to a written consumer complaint/grievance/issue within the time frame specified, the investigator must contact the consumer and explain the reason for the delay in the Company's response.

To document the extension record the communication/request on the Complaint Handling System (CHS):

1. Obtain approval for the extension from Consumer Affairs Management.
2. Note the verbal communication on the Complaint Handling System. The notation should include the date, time, extension due date, and the name of the DOI representative approving the extension in order to provide verification during an audit and confirm the extension in the response to the insurance department.
3. Add the recording of the conversation to the complaint file.
4. Update the extension date field in CHS.

5. An email or letter must be sent to the customer confirming the conversation and date of extension as agreed.

2.8 Agent Statement Requests

An agent statement is requested where the Company receives a verbal or written consumer complaint/grievance/issue or a DOI complaint in which the consumer or DOI alleges agent misconduct, misrepresentation or mishandling. Statements should be obtained from all named agents of the complaint.

The Company must request an agent statement, even in cases where the DOI requests a statement directly from the agent and/or the agent is no longer with the Company.

The Investigator is responsible for requesting agent statements related to DOI complaints and verbal or written consumer complaints/grievances/issues; agent statements are requested within two (2) business days of being assigned the complaint/grievance.

Responses to agent statements should be reviewed immediately to determine if the agent has fully addressed the concerns and/or if additional information is required.

2.9 Confirmed Complaints

Complaints and grievances are considered **confirmed** when:

- The Company, its employees, or its agents committed an error, unintentionally or otherwise, including but not limited to:
 - Did not give accurate information
 - Did not follow the Company's own business rules
 - Did not adhere to the terms and conditions of the insurance policy/certificate, AND/OR
 - The Company, its employees, or its agents violated state or federal laws, regulations or requirements.

The investigator must update the Confirmed/Unconfirmed fields in CHS upon determination that a complaint/grievance is confirmed, and note in the "Comments" field the reason(s) for which the complaint is confirmed and who/what department is accountable.

Note: Effective March 2010, Confirmed/Unconfirmed should be selected for each Department/Reason.

Confirmed complaints are reviewed by management (Consumer Affairs, Member Services, Customer Retention, Benefit Confirmation, and Underwriting) to determine appropriate disciplinary action and/or to identify opportunities for additional training, process improvement, product changes, or policy modification

2.10 Legal Review

Complaint or Grievance

Any complaint or grievance requiring a legal opinion must be sent to the Corporate Legal Department for review. To request legal review, the investigator must:

1. Fully complete the CAG Legal Department Referral Form.
2. Print the complaint and all other pertinent information, including any previous complaint communications.
3. Place all documents in a file and deliver it to the Legal Department for logging and assignment.
4. Legal will review all documentation and then return to the investigator with opinion/comments.

Please note: The investigator must make every effort to meet response deadlines, even in cases where legal review is required.

Attorney Correspondence or Demand Letters

All responses to attorney correspondence and demand letters, including those from the Attorney General's Office, must be reviewed by the Corporate Legal Department.

To submit correspondence/demand letters to Legal for review, the investigator must:

1. Fully complete the CAG Legal Department Referral Form.
2. Print the complaint and all other pertinent information, including any previous complaint communications.
3. Attach the draft response to the file.
4. Place all documents in a file and deliver it to the Legal Department for logging and assignment.
5. Legal will review and return documents to the investigator with comments and/or approval.

Please note: All attorney correspondence and demand letters must be handled within the timeframes requested by the consumer's attorney. If a response date is not specified, a response should be provided within the confines of the state's requirements.

It is not necessary to obtain Legal opinion/review when:

- The attorney is representing the hospital and only needs status or explanation of a claim;
- The customer's attorney has only requested a certificate or EOBs;

To ensure this process is followed back-end audit will be performed to ensure legal consultation is appropriately sent and received. Failure to request a legal consultation at the appropriate juncture will invite Management notification and possible failure of an audit.

Settlements and Other

Settlements must be approved by the proper authorities. Please see Determining Settlement Authority Procedure.

All complaints and grievances for which a formal settlement offer is being made must be reviewed by the Corporate Legal Department. This requires front-end audit by Consumer Affairs' Auditor as well.

To submit settlement offers to Legal for review, the investigator must:

1. Fully complete the CAG Legal Department Referral Form.
2. Print the complaint and all other pertinent information, including any previous complaint communications.
3. Attach the draft response and settlement offer to the file.
4. Place all documents in a file and deliver it to the Legal Department for logging and assignment.
5. Legal will review and return documents to the investigator with comments and/or approval.

2.11 Unapproved Advertising

Any verbal or written complaint/grievance/issue that refers to an advertisement must be reviewed by the Corporate Compliance Department. To submit such correspondence to Corporate Compliance, an investigator must:

1. Forward a scanned copy of the complaint/grievance and advertisement via email to the Sales Compliance team of the Corporate Compliance Department.
2. Save a copy of the email into the complaint file.
3. Sales Compliance will advise the investigator whether or not the advertisement is/was an approved piece by the Company, and the investigator will continue with the complaint investigation.

Please Note: If during a verbal complaint call, or in a written consumer or DOI complaint, the consumer makes reference to emails or other written materials received from the agent or the Company, that information must be requested from the consumer for review. Upon receipt of the information, the above advertising verification process should be followed.

2.12 Cancellations

If the complainant requests cancellation of coverage (either within written correspondence or verbally as the investigator works the complaint), the investigator must advise the Customer Retention unit of the request for cancellation by notifying Retention via email. The investigator remains responsible for investigating and responding to the complaint or grievance, as appropriate.

2.12.1 Written Cancellation

If the cancellation request is in writing, to forward it to Customer Retention, the investigator must:

1. Scan a copy of the complaint, attach to an email, and forward it to Retention Supervisor for processing.
2. Notepad that a cancellation has been received and forwarded to the Retention Supervisor for processing.

Please note: The investigator must request that a copy of the refund check be routed to Consumer Affairs to complete the file documentation. If the check copy is not received by the time the response is ready to mail, a screen print of the Check Writer screen can be used in place of the check copy.

3. Save a copy of the email into the complaint file
4. Once notification from Retention that the coverage has been canceled is received, the investigator must inform the customer that the cancellation was processed.

2.12.2 Verbal Cancellation

If the cancellation request is received by the investigator during a phone call with the complainant, the investigator must:

1. Save the phone call into the complaint file.
2. Send an email to the Retention Supervisor advising of the verbal cancellation and ask that they send a cancellation letter to the customer and provide you with documentation upon completion.
3. Notepad the cancellation and that the request was forwarded to Retention for processing.
4. Save a copy of the email into the complaint file.
5. Once notification from Retention that the coverage has been canceled is received, the investigator must inform the customer that the cancellation was processed.

2.12.3 Refunds

Complaints regarding refund requests of more than 2 months must be reviewed by the Appeals Team. Provide the following information in an email to Appeals Review:

1. Fully completed Refund Review Form
2. Complaint or Appeal (verbal or written)
3. Supporting documents
4. Related phone calls

Approved refund requests require a formal settlement agreement between the Company and the Customer (see 2.10.3 Settlements and Other). Upon receipt of the notarized Refund and General Release, email the Agreement to NRH Refunds for processing. The complaint file should be documented with both the executed Agreement and a copy of the refund check.

2.13 Handling Allegations of Forgery

Allegations of forgery are investigated by Consumer Affairs Management or Senior Investigator (or designee, as necessary).

Consumers alleging forgery are asked to provide signed, notarized statements to substantiate the allegation.

Link to Forgery Affidavits Letter Template:

[Forgery Affidavit Letter](#)

Links to Forgery Affidavits by Company:

[Forgery Affidavit Chesapeake](#)

[Forgery Affidavit MEGA1](#)

[Forgery Affidavit Mid-West](#)

NOTE: The investigator should request the original application documents from Document Management as soon as possible. The original documents are retained by Document Management for a period of 60 days before the destruction of originals occurs.

An agent statement is requested in all cases where the consumer alleges forgery. Responses to agent statements should be reviewed immediately to determine if the agent has fully addressed the concerns and/or if additional information is required.

Upon receipt of the forgery affidavit, Consumer Affairs Management will review the agent's statement and compare the signatures throughout the original application packet, if available, to the signature on the forgery affidavit. There are instances in which the allegation is made after the destruction of the documents, and in that event, copies obtained from the Company's Imaging System will be used for signature comparison.

Should the agent admit to signing a customer's name, the complaint will be deemed "confirmed" and the matter will be promptly escalated to the Sales Practice Review Team for discipline. Should no significant variances be found, and the agent claims no wrongdoing, the complaint will be expedited through the Sales Practice Review Team (SPRT) for review. SPRT procedures are documented separately.

2.14 Fraud Procedures

The Consumer Affairs Group works with the Corporate Compliance Department and/or the Legal Department when allegations of fraud are made in a complaint. If the Company has evidence that fraud has been committed, the Consumer Affairs Department or Corporate Compliance Department may refer the matter to the appropriate regulatory agency. Corporate Compliance Department procedures are documented separately.

2.14.1 Agent Reporting Suspected Fraud of Another Agent

Operation Agent Outreach (OAO) provides assistance to agents inquiring about business or customer related matters. In the event that OAO receives a verbal or written accusation from an agent with regard to the suspected fraud activity of another agent, OAO will send an email and/or documentation to consumeraffairs@healthmarkets.com.

Consumer Affairs will:

- Log the fraud allegation as an Inquiry
- Assign the fraud allegation case to Corporate Compliance
- Corporate Compliance will investigate and document their findings in CHS
- Corporate Compliance will report cases of suspected (where required) or confirmed fraud to Regulatory Affairs who reports fraudulent activity to the proper regulatory agency, who also maintains a report of all fraudulent activity submitted to state agencies on behalf of the company.

2.15 Settlements

Extra-Contractual Agreements made by Consumer Affairs

Once a file has been thoroughly investigated, and there is evidence that inaccurate information was provided to the customer, it may be necessary to offer extra-contractual benefits in order to resolve the matter.

Consumer Affairs has authorization to settle complaints where there is supporting evidence (confirmation) that the Company or the agent has provided inaccurate information, within the designated spending authority of the highest-ranking officer with direct management responsibility over the department (currently the Senior Director of Operations Strategy and \$10,000).

Approvals

- All extra-contractual settlements must have management approval, as outlined in the Company's Corporate Purchasing Policy.
- Refund settlements of more than two months must have management approval.
- Extra-contractual settlements over \$5,000 are also approved by one or more of the following:
 - Claims Risk
 - Claims Processing
 - Legal
 - The Appeals Team

Settlement Offers

Settlements under \$1,000 are made on the Appeal Response Template.

Settlements over \$1,000 must be made through a Compromise Agreement. These Agreements must be sent for Legal Review. See procedure 2.10.3 for more information.

System Documentation

1. Supporting documents, including documentation of management approval, must be inserted into the file.
2. Upon receipt of a notarized settlement agreement, an extra-contractual claim benefit must be processed in Processor 1 and the Diary Comments screen of Processor 1 must be updated to indicate reason for settlement.
3. Upon receipt of a notarized Rescission and General Release Agreement, the refund must be processed through the Accounting Department.
4. Upon completion of a settlement CAG has made without the Appeals Team, notification must be provided to Appeal Coordinator or designated staff for tracking.

Lawsuit Settlements

Lawsuit settlement checks are requested by the Legal Department and are generally dispersed through a manual check or wire transfer by Accounting. Accounting will notify the CAG Manager when monies have been paid on a lawsuit. CAG enters the manual check/wire transfer on Processor 1 and notifies Actuarial via email upon completion.

2.16 Market Conduct Exams

Consumer Affairs is responsible for preparing and providing complaint data and complaint files to the Corporate Compliance Department for delivery to market conduct examiners. Please see the Market Conduct Procedures document for more information.

2.17 Trend Analysis and Issues Resolution

Consumer Affairs management works closely with the Operations Strategy team to analyze trends in complaints and resolve issues identified via complaints and trend analysis. Trend analysis and issues tracking/resolution procedures are documented separately.

2.18 Tools & Templates

The Complaint Handling System (CHS) is the primary workflow tool utilized by the Company to record, track and handle complaints and grievances.

- Appeals and Complaints Process
- Agent Statement Request Process
- Daily Reports
- Consumer Affairs Open Item Reports
- Consumer Affairs Inventory Reports
- Member Services Open Item Report
- Customer Retention Open Item Report
- Underwriting Open Item Report
- Weekly Reports
- Medicare Agent Complaint Weekly
- Monthly Reports
- YTD Memo Report
- DOI Timeliness Report
- High Complaint Reports
- Complaint to PIF Analysis
- Complaint Exposure Report
- Monthly Complaint Review
- Quarterly Reports
- Board Report (Produced by Corporate Compliance)

Forms and Letters

Listed in the order of appearance in the procedure:

- Decision Review Form
- Request an Appeal Form

Acknowledgement Letters
Affidavit of Forgery
Agent Statement Request Form
Legal Referral Form
Audit Forms
Appeal Review Form (formerly CRT Form)
Procedure Audit & Training

2.19 Auditing

Consumer Affairs Group (CAG) Investigators, who respond to consumer complaints, grievances and issues, and to various state insurance departments and governmental agencies concerning complaints and grievances filed with the insurance departments by insureds, agents, prospective insureds, etc. are audited by the CAG Auditor. Additionally, Complaint Coordinators/designees who are responsible for coordinating the above mentioned complaints and grievances are audited by the CAG Auditor.

The following Measurement of Effectiveness is applicable to these procedures.

Consumer Affairs management regularly reviews quality audit reports (weekly, monthly). As complaint handling trends are identified management takes corrective action, including revising procedures as warranted. In addition to the regular reviews, management will also do the following in order to validate that the above documented process is being followed and measurements of success are stated:

- Each calendar quarter, prior quarter quality audit results will be reviewed to identify problem trends, such as timeliness failures, re-opened complaints, and/or failure to use Required Practices or otherwise adhere to procedural requirements. (Required Practices, which may change based on business needs, are housed on the Consumer Affairs shared drive W:/Consumer Affairs – Shared/CAD/Complaint Procedures.)
- Annual reviews of quality results will also be conducted to identify problem trends and to monitor the effectiveness of corrective actions, Required Practices or procedural modifications implemented to resolve problem trends.
- As Market Conduct Exams and internal/external audits are conducted, management will review exam/audit findings to determine procedural or employee weaknesses leading to those findings.
- Results of the reviews are documented.

Audit Guidelines

New Employees – Trainees are front-end audited on 100% of their complaints and grievances until such time that they are able to consistently meet all audit criteria.

Seasoned Employees – All tenured employees are back-end audited on 25% of their completed work. If a pattern of poor responses is detected corrective actions are taken which include, but are not limited to, increase in the percentage of completed responses audited up to 100%, retraining, and/or disciplinary action.

Timeliness – All complaints are reviewed to ensure the matter was addressed within the timeframes dictated by the state.

States – Consumer and/or DOI complaints and grievances may be audited as issues, volume, or other indicators emerge in a particular state. In these cases, complaint responses are audited, regardless of tenure.

One hundred percent (100%) audits are conducted in the following situations:

- Department of Insurance complaints
- **Confirmed Complaints** (effective March 2010).
- **Attorney Demand/Settlements**– CAG audit before the response is sent to the Legal Department for review. Provider attorney letters do not require Legal Department review.
- **State of Massachusetts, regardless of complaint type**
- **Reopens, regardless of complaint type**

Audit Criteria

All complaint responses are audited for the following criteria:

Timeliness - The investigator responded to the complaint or grievance within the required timeline.

Format - The format of the response is reviewed to determine that it contains all the necessary items in the address and reference line. The closing should include use of the correct email address and telephone number. All enclosures, if being provided, are listed at the bottom of the response. Also, within the body of the letter, the order of the paragraphs is important to accurately and clearly tell the story or answer the concern.

Content - The content of the response is reviewed to determine that it contains all the necessary information relative to the issues presented in the complaint. The information provided is also complete and accurate.

Grammar - The grammar of the response is reviewed to determine that it contains all the necessary information relative to punctuation, spelling, correct word usage etc.

Accuracy and Tone - The response is reviewed for accuracy and tone. Accurate information should be provided to the consumer regarding their concerns. The tone of the response should also be appropriate.

Resolution - Did the investigator provide a resolution or disposition for the complaint? This could be a resolution in the complainant's favor or it could also be that the original decision was upheld.

Responsiveness - The response is reviewed to determine if all issues are addressed and if the appropriate research was conducted.

System Documentation – Ensure the claims processing system has been updated (as per section 2.14 Settlements – System Documentation) and telephone calls have been logged in Notepad.

2.20 Failure of an Audit

There are some instances when a file automatically fails an audit and receives a zero (0) for the entire file. These instances are listed below:

- All issues within the complaint not addressed
- Inaccurate information provided
- Harsh Tone / Rudeness (effective Jan 1, 2008)
- Response time exceeds state or Company timeframe
- Incomplete information to the DOI, consumer or other representative

2.21 Training

New employees for Consumer Affairs shall receive Policy and Procedure training. An email documenting completion of the training will be sent to Consumer Affairs management and shall serve as documentation that the training of a new employee was completed.

New or updated Policies or Procedures are communicated in a training session with a sign-in sheet, or via email. If by email, Consumer Affairs staff is instructed to email the Quality Assurance Auditor to indicate their acknowledgement of the new procedure or change to procedure.

2.22 Training Maintenance

The Management of Consumer Affairs shall conduct Policy and Procedure training with the Consumer Affairs Staff on an annual basis.

A sign-in sheet will be completed at each session to document those who attended the annual training.

3 Administrative Information

3.1 Document Location

This original document is housed in The HealthMarkets Insider where access is controlled by Consumer Affairs management. All revisions to or convenience copies from this document must stem from this location:

HealthMarkets employees are able to access these procedures via the Company's intranet: [HealthMarkets INSIDER](#). Appointed agents of HealthMarkets are able to access these procedures via the Agency website.

3.2 Document Refresh Rate

This document is reviewed for validity every 12 to 18 months. Changes must be noted in Revision History.

3.3 Revision History

The Revisions Table is used to track changes that occur during the documentation process.

Revision Date	Version	Description of Revision	Modified by	Approved by
05/01/2009	01	<p>This document replaces:</p> <p>CAG-EN-PO-001 Policy Overview 01.10.08</p> <p>CAG-EN-PO-002 Recording Complaints Policy</p> <p>CAG-EN-PO-003 Complaint and Grievance Handling Policy</p> <p>CAG-EN-PO-004 Timely Acknowledgement Letter Policy</p> <p>CAG-EN-PO-005 Supporting Documents Policy</p> <p>CAG-EN-PR-001 Logging Communications Procedure</p> <p>CAG-EN-PR-002 Recording Complaint Procedure</p> <p>CAG-EN-PR-002a CHS Logging Verbal Complaint *</p> <p>CAG-EN-PR-002b CHS Logging Written Complaint *</p> <p>CAG-EN-PR-002c CHS QA *</p> <p>CAG-EN-PR-002d CHS Written Complaints *</p> <p>CAG-EN-PR-002e CHS How to Add Multiple Files *</p> <p>CAG-EN-PR-003 Verbal Complaint Identification Procedures</p> <p>CAG-EN-PR-004 Timeliness ProcedureV3</p> <p>CAG-EN-PR-005 Supporting Documents Procedure</p> <p>CAG-EN-PR-006 Acknowledgement Letter Procedures</p> <p>CAG-EN-PR-007 DOI Extension Request Procedure</p> <p>CAG-EN-PR-009 Legal Review Procedure</p> <p>CAG-EN-PR-010 Response Letter Procedure</p> <p>CAG-EN-PR-011 Unapproved Advertising Procedure</p> <p>CAG-EN-PR-012 Cancellation Procedure</p> <p>CAG-EN-PR-014 Consumer Affairs Training Procedure</p> <p>* Now documented separately in Complaint Handling System (CHS) Training located on HealthMarkets INSIDER.</p>	Kristi Colbert	Rhonda Sayles
10/15/2009	02	Remove direct references to the Grievance Matrix	Rhonda	Kristi

Revision Date	Version	Description of Revision	Modified by	Approved by
05/24/2010	03	Replaced the role of the Complaint Action Team	Sayles	Colbert
		Clarified Trend Analysis and Issues Resolution		
		Clarified the manner in which the Company handles complaints v. grievances		
05/24/2010	03	Further explanation of Allegations of Forgery	Kristi Colbert	Rhonda Sayles
		Improved definition of Confirmed complaints		
		2.2.4: Added section on Recording Discovered Complaints		
05/24/2010	03	2.3.3: Added Michigan grievance procedure documentation with acknowledgement letter in Acknowledgement Letter Section	Kristi Colbert	Rhonda Sayles
		2.4: Added Note re telephone recording of CAG to Customer contact in Consumer Complaints & Grievances section		
		2.6.2: Added Underwriting Guidelines to File Documentation List section		
05/24/2010	03	2.9: Added required Confirmed/Unconfirmed selection in CHS in Confirmed Complaints section	Kristi Colbert	Rhonda Sayles
		2.10.2: Added details as to when it is NOT necessary to obtain Legal opinion/review on a complaint in Attorney Correspondence section		
		2.12.2: Added recording a phoned-in request for cancellation to the Verbal Cancellation section		
05/24/2010	03	2.13: Added admission of signing a customer's name as Confirmed to Allegations of Forgery section	Kristi Colbert	Rhonda Sayles
		2.19.1: Added Timeliness to Audit Guidelines section		
		2.19.1 Added details re when Audits are conducted		
8/25/2010	04	Added Section 2.12.3: Refunds	Kristi Colbert	
1/20/2011	05	Added Section 2-14-1: Agent Reporting Suspected Fraud of Another Agent	Kristi Colbert	
		Updated Section 3.5 Approval/Authorizations from		

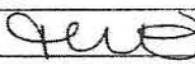
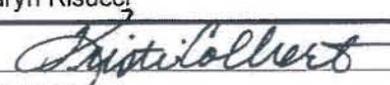
Revision Date	Version	Description of Revision	Modified by	Approved by
		Rhonda Sayles to Taryn Risucci Updated 2.19.1 Audit Guidelines / Attorney Demand/Settlements: Provider attorney letters do not require Legal Department review.		

3.4 Acronyms/Definitions

Acronym / Term	Definition	Link Back
Acknowledgement Letter	Letter sent to a complainant to acknowledge receipt of complaint or grievance	Return to Section
Affidavit	A written declaration made under oath before a notary public or other authorized officer	Return to Section
Agent Statements	Narratives provided by agents in response to allegations of agent misconduct.	Return to Section
BBB	Better Business Bureau	N/A
Benefit Confirmation	Unit making outbound calls to customers to review coverage shortly after the coverage is issued	Return to Section
CHS	Complaint Handling System	N.A
Complaint Coordinator	Consumer Affairs staff person whose responsibilities include recording complaints	Return to Section
Customer Retention	Operations call center focused on retaining customers through benefit and base plan changes	Return to Section
DOI	Department of Insurance	N/A
EOB	Explanation of Benefits	N/A
Front-End Audited	Front-end audited means the investigation/response is reviewed /audited prior to being finalized.	Return to Section
HealthMarkets Insider	Company Intranet Portal	N/A
Management of Consumer Affairs	Includes Senior Director, Manager, Business Analyst, and Auditor	Return to Section
Member Services	Company customer call center	Return to Section
NAIC	National Association of Insurance Commissioners	N.A
Open Item Report	Daily inventory of work in progress	Return to Section
PHI	Personal Health Information, sensitive health or insurance related information from a client's files	Return to Section
Quality Assurance Auditor	Consumer Affairs staff person whose responsibilities include measuring accuracy and timeliness of production	Return to Section
Root Cause	A root cause is an initiating cause of a causal chain which leads to an outcome or effect of interest.	Return to Section
Sales Compliance	Corporate Compliance staff focused on monitoring the Company's sales and advertising compliance	Return to Section

Senior Investigator	Consumer Affairs investigator charged with specialized processing and with providing support to rest of investigator team	N/A
SIU	Special Investigations Unit	Return to Section
SPRT	Sales Practice Review Team is a cross-functional group charged with overseeing agent discipline	N/A

3.5 Approvals/Authorizations

Signature	Title	Date
 Taryn Risucci	Vice President, Supplemental Operations/Network Management	1/25/11
 Kristi Colbert	Manager, Consumer Affairs Group	1/25/11