CONNECTICUT HEALTH INSURANCE EXCHANGE
d/b/a Access Health CT (the "Exchange")

PROCEDURE: EXCHANGE ASSESSMENTS AND FEES

Operating Funding Authorization

38a-1083(c)(7) of Connecticut General Statutes authorizes the Exchange to "charge assessments or user fees to health carriers that are capable of offering a qualified health plan through the exchange or otherwise generate funding necessary to support the operations of the exchange." Pursuant to this authority, the Board of Directors of the Exchange (the "Board") adopted the Policy: Acquiring Operating Funding (the "Policy") through which the Exchange, acting through its Chief Executive Officer or another duly authorized officer, shall charge such assessments or user fees to health and dental carriers capable of offering qualified health plans through the Exchange or otherwise generate funding necessary to support the operations of the Exchange and carry out its purposes as set forth under Connecticut law. Provided any assessment or fee has been duly authorized by the Board, the Exchange shall implement the following procedure.

Definitions:

The phrase "capable of offering qualified health plans through the Exchange" means:

(a) the plan is licensed as either an A&H company or a health care center pursuant to Conn. Gen. Stat. §38a-41;

(b) the plan is in good standing in Connecticut; and,

(c) the plan has not notified the Insurance Commissioner that it has withdrawn from either the individual or small group market in Connecticut in compliance with requirements of the sections 2742 and 2712 of the Public Health Service act, as set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any company that has submitted a withdrawal notice to the Insurance Commissioner may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed". (See 42USC §300gg-2(c)(2) and 45 CFR 147.106(d)(2)). If the plan is within the 5-year period, it is not capable of offering qualified health plans through the Exchange. Notwithstanding the foregoing, the plan may in the discretion of the Exchange be subject to assessment for all premium earned prior to the notice to the Insurance Commissioner and effective date of withdrawal.

Procedure:

Regular assessments and fees will be determined based on the amount reasonably and prudently needed to operate the Exchange as set forth in the annual budget reviewed and approved by the Board. Such assessments and fees will be charged no less frequently than annually. Final determinations as to the terms, conditions, basis, amount, frequency, and methodology, including any modifications thereto, of any assessments or fees to be charged shall rest in the sole discretion of the Board acting in accordance with applicable law.

Assessments:

Health Carriers:

Assessments for health carriers will be calculated as a percentage of earned premiums that carriers report for their individual and small group businesses for the previous calendar year on their Medical Loss Ratio Reports (the "MLR Reports") to the Health Insurance Oversight System of the Centers for Medicare and Medicaid Services. Subject to final approval and adjustment by the Board, the assessment base for health insurance business will be the sum of small group, individual, and expatriate health insurance business reported in the carriers' MLR Reports.

Dental Carriers:

Subject to final approval and adjustment by the Board, assessments for carriers in the dental business only (i.e., not also in the health business) will be calculated as a percentage of earned premiums in the State of Connecticut for the previous calendar year as reported in Annual Statements and/or Exhibits filed with the Connecticut Insurance Department (the "Annual Statements") for both dental insurance products and dental maintenance organization products. Carriers who have not specifically reported the amount of premium dollars for dental insurance products and dental maintenance organization products attributable to Connecticut or to the individual or small group market may, in a separate report and attestation to the Exchange, identify such premiums for use by the Exchange in calculating their assessment. In the absence of a timely response acceptable to the Exchange, the Exchange will base its assessment for such business for such carrier on its best available approximation or use other reasonable methodology in its sole discretion.

New Market Entrants:

For all new Connecticut market entrants capable of offering a qualified health plan through the Exchange, an assessment will be imposed for the first year of operations. Such assessment will be calculated as a percentage of projected premiums that carriers will charge in their first year of operation in the Connecticut market as set forth in such carrier's plan of operation approved by the Insurance Commissioner as part of the licensing process. At the end of the first year of operations, the Exchange will verify actual premium revenues and adjust the assessment as necessary to reflect the carrier's actual experience in its first year of operation in the Connecticut market. For health carriers such adjustment shall be calculated based on data reported on the carrier's MLR Report to the Health Insurance Oversight System of the Centers for Medicare and Medicaid Services. For dental carriers such adjustment shall be calculated based on data reported in the Annual Statement filed with the

Connecticut Insurance Department. Such adjustments may be made by separate billing or by credit to amounts owed in the discretion of the exchange.

Sources of Premium Information for Assessment Purposes

The Exchange intends to use the best available source of premium information for calculating the assessment. The Exchange reserves the right to use other sources of premium information that may become available or brought to its attention if, in the judgment of the Chief Executive Officer or the Chief Financial Officer of the Exchange, these sources provide more accurate premium information for the State of Connecticut.

User Fees

User fees on health and dental carriers participating on the Exchange may be charged as a flat fee, percentage of premium for qualified plans sold on the Exchange, or based on any other per sale charge method.

Notice Date for Assessments and User Fees:

MLR Reports are filed between May 1 and June 1 annually and Annual Statements are filed March 1. As a result, the determination of the assessment rate and user fees will be completed and approved by the Board as soon as practicable but no later than July, 1.

Special Assessments

In addition to regular assessments and fees, the Exchange reserves the right to impose special assessments and fees that it determines are necessary and prudent to carry out the operations of the Exchange.

Invoicing, Payment and Collections:

Acting at the direction of the Chief Executive Officer or the Chief Financial Officer, the Exchange shall invoice carriers for assessments and fees. The invoice will include a payment schedule stipulating when the amount due on invoice shall be periodically paid to the Exchange. Invoices, including the payment schedule may be delivered by physical or electronic transmission. Assessments or fees are payable by check or electronic fund transfer with payment instructions as directed by the Exchange.

If payment of an assessment or fee or any part thereof is not received by the Exchange within thirty (30) days from the payment schedule due date, the carrier shall be subject to interest from the billing date at the rate of six (6) percent per annum simple interest on the outstanding principal balance. If payment is not received within ninety (90) days from the billing date, the Exchange shall, in addition to interest, charge a late fee of one (1) percent per month on the outstanding principal balance. The Chief Executive Officer of the Exchange shall provide the name of any carrier that fails to pay the assessment to the

Commissioner of Insurance to begin enforcement actions using powers granted under title 38a and all further powers that are reasonable and necessary.

The Exchange may employ such internal or external resources as it deems necessary to enforce collection of delinquent amounts. Any costs of collection shall be borne by the delinquent carrier.

The Exchange reserves the right to take such further enforcement actions as are available to it at law. The Exchange further reserves the right, acting through the Board, to settle or waive any amounts due that it deems *de minimus* or for other good cause.