Column 5 – Plan Characteristics

Means one or more of the following identifiers of the features of a policy or certificate form (all applicable identifiers must be shown).

- "1" Means inclusion of new or innovative benefits.
- "2" Means direct response solicited.
- "3" Means agent solicited.
- "4" Means underwritten policy or certificate.
- "5" Means the policy or certificate is guaranteed issued to all applicants.
- "6" Means the policy is offered to individuals eligible for Medicare by reason of disability.
- "7" Means the policy or certificate was assumed from another carrier.

Column 6 – Date Approved

Means the date the policy form was approved for sale in the state by the insurance department.

Column 7 – Date Approval Withdrawn

Means the date the policy form approval was withdrawn by the insurance department.

Column 8 – Date Last Amended

Means the date of approval of a rider or endorsement for this policy form. Do not reflect the date of optional riders added to an individual policy.

Column 9 – Date Closed

Means the date when the policy form is no longer actively marketed or offered for sale in this state.

Column 10 – Policy Marketing Trade Name

Means the title or name under which a policy is (was) marketed.

Columns 12 & 16 – Incurred Claims

Incurred claims equal paid claims plus the change in claim reserves. Claim reserves include only those unpaid liabilities for claims that have been incurred. Incurred claims in this exhibit do not include policy (additional) reserves.

The sum of Columns 11 and 15, and the sum of Columns 12 and 16, Lines 0199999 and 0299999 for all states should equal the amounts disclosed in the General Interrogatories, Part 2, Line 1.2 minus Line 1.3 and Line 1.5, respectively.

Columns 14 & 18 – Number of Covered Lives

Means the number of individuals covered under the policy form as of December 31 of the reporting year.

Not for Distribution

TRUSTEED SURPLUS STATEMENT

The Trusteed Surplus Statement must be completed by each United States branch of a non-U.S. insurer licensed to do any insurance business in any state. The Trusteed Surplus Statement shall be submitted together with its accompanying schedules and the inventory(ies) of trusteed assets. The Trusteed Surplus Statement shall be submitted together with the annual statement (showing business transacted by the U.S. branch of the non-U.S. insurer in the United States) on or before March 1.

Page 1

Affidavit of U.S. Managers, General Agents, or Attorneys

1. The Trusteed Surplus Statement shall be signed and verified by the United States Manager, attorney-in-fact or a duly empowered assistant United States manager of the non-U.S. insurer.

2. In the case of a Canadian life insurance company, the title United States Manager shall refer to the president, vice-president, secretary, or treasurer of the company at its home office in Canada.

Affidavit of Trustee

Each trustee must execute an Affidavit of Trustee.

Page 2

Schedule A – Deposits with State Officers

1. Include only securities deposited with insurance departments or officers of the various states and territories of the United States for the protection of all of the society's certificate holders, or certificate holders and creditors within the United States. For each state and territory, provide a complete and accurate description of each of the assets deposited therein.

2. Exclude special state deposits that are deposited with officers of any state in trust for the security of the certificate holders, or certificate holders and creditors in that particular state.

3. Line 1.99, minus Line 1.98 where appropriate should agree with the total of special deposits held for the benefit of all certificate holders, claimants and creditors in Schedule E, Part 3 of the annual statement.

Schedules B, C, and D – Deposits With United States Trustees

1. List in Schedules B, C, and D, totals of the assets held by the categories pre-printed therein.

2. A U.S. Branch having deposits with two or more U.S. trustees should list the assets deposited with one trustee in Schedule B and the assets deposited with other trustees in Schedules C and D. The trustee holding the assets listed under Schedule B should execute the first Affidavit of Trustee and the trustees holding the assets listed in Schedule C and D should execute the respective affidavit.

   In the event that there are more than three separate trusts, attach additional affidavits and corresponding schedules.

3. Each trustee shall submit to the U.S. Manager for inclusion with the Trusteed Surplus Statement, an inventory of each asset held by that trustee. Such inventory shall include the location of the assets (if there is more than one location, indicate which assets are at which location), the complete and accurate description of each asset, the information required to be provided in the Columns 3 through 5 of Schedules B, C, and D of this supplement, and as much additional information as is available (e.g., number of shares of stocks). The subtotal of each category of assets should agree with the amounts shown on Page 2 and Schedules B, C, and D.

4. If market or admitted asset values are not known by the trustee, such information shall be inserted on the inventory by the U.S. Manager.

Not for Distribution

Page 3

Liabilities and Trusteed Surplus

Line 1 – Total Liabilities

Should agree with the amount reported on Annual Statement Page 3, Line 25 of the annual statement.

Additions to Liabilities –

Liabilities used to offset admitted assets in the annual statement.

Line 2 – Aggregate Write-ins for Additions to Liabilities

Enter the total of write-ins listed in schedule "Detail of Write-ins Aggregated at Line 2 for Additions to Liabilities."

Deductions From Liabilities –

No item of deduction should exceed the net asset value thereof allowed in the annual statement of the United States branch.

Line 4 – Amounts Recoverable From Reinsurers

Line 4.1 – Authorized Companies

Include: Any reinsurance recoverable on paid losses from authorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 4.2 – Unauthorized Companies

Include: Any reinsurance recoverables on paid losses from unauthorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 4.3 – Certified Companies

Include: Any reinsurance recoverable on paid losses from certified companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 7 – Accident and Health Premiums Due and Unpaid

The sum of Lines 6 and 7 should agree with the amount reported on Page 2, Line 15.1 plus Line 15.2, Column 3 of the annual statement.

Line 8 – Contract Loans and Premium Notes

Line 8.1 – Contract Loans not Exceeding Reserves Carried on Such Policies

Should agree with the amount included on Page 2, Line 6, Column 3 of the annual statement.

Line 8.2 – Premium Notes

Not applicable to Fraternals.

Not for Distribution

Line 9 – Aggregate Write-ins for Other Deductions From Liabilities

Enter the total of write-ins listed in schedule "Detail of Write-ins Aggregated at Line 9 for Other Deductions From Liabilities."

Line 12 – Trusteed Surplus

The excess of Total Gross Assets and the Total Adjusted Liabilities reported on Line 11 of this page. Total Gross Assets are the Total Trusteed Assets reported in Schedules A, B, C and D on Page 2 of the Trusteed Surplus Statement.

Details of Write-ins Aggregated at Line 2 for Additions to Liabilities

List separately each category of additions to liabilities for which there is no pre-printed line on Page 3.

Include: Any credit balances included in deductions from assets in the annual statement.

Details of Write-ins Aggregated at Line 9 for Other Deductions From Liabilities

List separately each category of other deductions from liabilities for which there is no pre-printed line on Page 3.

Include: Commissions and Expense Allowances Due, Experience Rating and Other Refunds Due, and other receivables on reinsurance ceded to authorized insurers that was not included in Line 4.1 above. Amounts receivable from unauthorized insurance companies may be included but only to the extent that a liability for such unauthorized recoverables is included in Line 1 above.

Amounts if any, on Page [illegible], Line 22, Column 3 of the annual statement as "Net adjustment in assets and liabilities due to foreign exchange rates" which are attributable to trusteed assets.

Not for Distribution

MEDICARE PART D COVERAGE SUPPLEMENT

NET OF REINSURANCE

The federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created a prescription drug coverage, referred to as "Part D" coverage. This form is intended to capture information about the coverage net of reinsurance.

The form applies to the following **stand-alone** Medicare Part D coverage:

Stand-alone Part D coverage written through individual contracts;

Stand-alone Part D coverage written through group contracts and certificates; and

Part D coverage written on employer groups where the reporting entity is responsible for reporting claims to the Centers for Medicare & Medicaid Services (CMS).

The form does not apply to:

Part D coverage that is provided through a Medicare Advantage plan (referred to as MA-PD); and

Employer coverage that is part of the employer's comprehensive medical coverage and where the reporting entity does **not** provide claim data directly to CMS including instances where the employer and the medical provider are one and the same but the administration and reporting to CMS is handled by a third party vendor.

The statutory accounting treatment of Medicare Part D coverage is addressed by Interpretation 05-05 in the *Accounting Practices and Procedures Manual* (INT 05-05). Although most of the coverage is treated as an insured plan, a portion is treated as uninsured. Refer to INT 05-05 for specifics of the accounting treatment, as well as for definitions of many of the capitalized terms used below.

Group "Uninsured" would be only the aspects of any Group coverage for which the entity has federal payments that are to be considered "Uninsured" per INT 05-05, e.g., payments for low income subsidy (cost-sharing portion) and the group plan is an insured plan. Group coverage where the basic coverage is uninsured is not reported in this supplement.

Since a reporting entity may offer multiple prescription drug plans (PDPs) with varying benefits, it is possible for a portion of the entity's coverage to be subject to reinsurance coverage and another portion to be part of the Part D Payment Demonstration, where no reinsurance coverage is provided. Where there is reinsurance coverage, the corresponding funds received or receivable are reported in Lines 12.1 through 12.3.

Columns 1 – Individual Coverage Insured and
Columns 2 – Individual Coverage Uninsured

Report here the amounts for coverage written through individual contracts. Amounts treated as insured business pursuant to INT 05-05 should be reported in column 1. Amounts treated as uninsured business pursuant to INT 05-05 should be reported in column 2.

Columns 3 – Group Coverage Insured and
Columns 4 – Group Coverage Uninsured

Report here the amounts for coverage written through group contracts and certificates, including coverage of employer groups as described above. Amounts treated as insured business pursuant to INT 05-05 should be reported in column 3. Amounts treated as uninsured business pursuant to INT 05-05 should be reported in column 4.

Column 5 – Total Cash

Report here the totals of Columns 1 through 4 for the indicated lines. This column is intended to measure the cash flow impact of the Part D coverage on the reporting entity (i.e., including both insured and uninsured business).

Not for Distribution

Line 1 – Premiums Collected

Line 1.11 – Standard Coverage with Reinsurance Coverage

Report the Beneficiary Premium (Standard Coverage Portion), Low-Income Subsidy (Premium Portion) and Direct Subsidy amounts received for PDPs that are subject to Reinsurance Coverage. These amounts represent the premium as approved by CMS (including the effect of the "health status risk adjustments") for the Part D coverages that qualify as Standard Coverage. Note that the actual coverage does not have to be identical to the "standard coverage" as defined by the MMA, but may instead be coverage approved as actuarially equivalent by CMS.

Line 1.12 – Standard Coverage without Reinsurance Coverage

Report the Beneficiary Premium (Standard Coverage Portion), Low-Income Subsidy (Premium Portion), Direct Subsidy and Part D Payment Demonstration amounts received for PDPs that are not subject to Reinsurance Coverage. These amounts represent the premium as approved by CMS (including the effect of the "health status risk adjustments") for the Part D coverages that qualify as Standard Coverage. Note that the actual coverage does not have to be identical to the "standard coverage" as defined by the MMA, but may instead be coverage approved as actuarially equivalent by CMS.

Line 1.13 – Standard Coverage, Risk Corridor Payment Adjustments

Report any amounts paid to or received from CMS as Risk Corridor Payment Adjustments (based on where actual loss experience falls within the various MMA-defined risk corridors). Amounts paid to CMS should be reported as negative amounts; amounts received from CMS should be reported as positive amounts.

Line 1.2 – Supplemental Benefits

Report all other premiums received for Part D coverage. These will be the additional premiums that the PDP requires participants to pay for Supplemental Benefits.

Line 2 – Premiums Due and Uncollected – Change

Exclude any receivable or payable for Risk Corridor Payment Adjustments, which should be reported on Lines 4.1 and 4.2. Note that, per the reference in INT 05-05 to SSAP No. 84, receivables from CMS are not subject to the 90-day rule for non-admission.

Line 4 – Risk Corridor Payment Adjustments – Change

The reporting entity will need to estimate the Risk Corridor Payment Adjustment that is receivable (Line 4.1) or payable (Line 4.2) at year-end for each PDP, consistent with the reported experience through year-end. The receivable or payable should exclude any amounts already settled in cash, which should be reported in Line 1.13. An increase in a receivable or a decrease in a payable should be reported as a positive amount; a decrease in a receivable or an increase in a payable should be reported as a negative amount.

Line 5 – Earned Premiums

Earned premium = Premiums Collected +
Change in Due and Uncollected –
Change in Unearned and Advance Premium +
Change in Risk Corridor Payment Adjustments Payable/Receivable.

Note that Lines 5.11, 5.12, and 5.2 will exclude any amounts associated with the Risk Corridor Payment Adjustments, whereas Line 5.13 relates solely to the Risk Corridor Payment Adjustments.

Not for Distribution

Line 6 – Total Premiums

Sum of Lines 5.11 through 5.2 (Columns 1 and 3) and Sum of Lines 1.11 through 1.2 (Column 5).

Line 7 – Claims Paid

Follow similar rules as for premiums above.

Line 8 – Claims Reserves and Liabilities – Change

Follow similar rules as for premiums above.

Line 9 – Health Care Receivables – Change

For Lines 9.1 and 9.2, report the portion of Health Care Receivables (pharmacy rebates, loans to providers, etc.) that relate to the Part D coverage that is included in this supplement. This does not include any amounts receivable for the Risk Corridor Payment Adjustments, which are reported on Line 4.1.

Line 10 – Claims Incurred

Claims Incurred = Claims Paid +
Change in Claim Reserves and Liabilities –
Change in Health Care Receivables

Line 11 – Total Claims

Sum of Lines 10.11 through 10.2 (Columns 1 and 3) and Sum of Lines 7.11 through 7.2 (Column 5).

Line 12 – Reinsurance Coverage and Low-Income Cost-Sharing

Line 12.1 – Claims Paid Net of Reimbursements Applied

Report claims paid less amounts received for the following portions of any Part D coverage that is included in the supplement. These amounts are considered payments under an uninsured plan.

Low-Income Subsidy (Cost-Sharing Portion).

Reinsurance Coverage.

Line 12.2 – Reimbursements Received but Not Applied – Change

Report the change during the year in the liability for amounts received from CMS that are in anticipation of future uninsured claim payments by the PDP sponsor.

Line 12.3 – Reimbursements Receivable – Change

Report the change during the year for amounts due from CMS for uninsured claim payments already made by the PDP Sponsor. This will exclude amounts that are already reported on Line 12.2.

Line 12.4 – Health Care Receivables – Change

Report any portion of Health Care Receivables (pharmacy rebates, loans to providers, etc.) that relate to uninsured Part D coverage that is included in this supplement.

Not for Distribution

Line 13 – Aggregate Policy Reserves – Change

Report the change during the year in any policy reserves, including any premium deficiency reserves, established for Part D coverage included in this supplement.

Line 14 – Expenses Paid and
Line 15 – Expenses Incurred

Report the allocated expenses relating to Part D coverage included in this supplement. The allocated expenses will be treated as relating entirely to the insured portion, to avoid the necessity of a separate allocation to the uninsured portion.

Line 16 – Underwriting Gain or Loss

Line 6 – Line 11 – Line 13 – Line 15.

Line 17 – Cash Flow Result (Column 5 only)

Sum of Lines 1– sum of (Lines 7 – Line 12.1 + Line 12.2 – Line 14).

Not for Distribution

VM-20 RESERVES SUPPLEMENT – PART 1

Life Insurance Reserves by Product Type

($000 Omitted Except for Number of Policies)

This Supplement provides information on the reserves required to be calculated by Section VM-20 of the *Valuation Manual*. This includes the Net Premium Reserve and, as applicable, the Deterministic Reserve and the Stochastic Reserve. This Supplement also provides information regarding business where VM-20 of the *Valuation Manual* is not required to be applied. Only business issued on or after Jan. 1, 2017, valued by the requirements of VM-20 should be reported in Part 1. Companies that elect the three-year transition for some of their policies should not report those policies in this part. Companies that elect the three-year transition period for all of their business or are otherwise exempted from the requirements of Section VM-20 are not required to complete Part 1 of this Supplement pursuant to the instructions in Part 2 of this Supplement.

Part 1 of this Supplement breaks out, by product type, the prior year and current year reported reserves on a Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded basis as defined in Section 8.D of Section VM-20 of the *Valuation Manual*. In addition, Part 1 of this Supplement shows, by product type for the current year, the Deferred Premium Asset, the Net Premium Reserve (NPR), the Deterministic Reserve (DR) and the Stochastic Reserve (SR), where the NPR, DR and SR are as defined in Section VM-20 of the *Valuation Manual*. This Supplement is intended to aid regulators in the analysis of reserves as determined under Section VM-20 of the *Valuation Manual* for both the prior and current year.

Section VM-20 of the *Valuation Manual* requires that the Post-Reinsurance-Ceded Reserve be determined by three product groups – Term Insurance, Universal Life with Secondary Guarantees and all other. The Term Insurance and ULSG should be reported on lines 1.1 and 1.2, respectively. Each of the other products reported on lines 1.3 – 1.8 should be determined as the sum of the policy reserves using the policy reserves determined following the allocation process of VM-20 Section 2. A similar process should be used for each of the pre-reinsurance-ceded reserves.

Section A: Columns 4 through 8 are to be completed if each of the reserves in Columns 4 through 6 (NPR, DR, SR) is calculated according to the requirements of Section VM-20 of the *Valuation Manual*.

Section B: Columns 9 through 12 are to be completed only if the reserves in Columns 9 and 10 (NPR, DR) are calculated according to the requirements of Section VM-20 of the *Valuation Manual*.

Section C: Columns 13 through 15 are to be completed only if the reserve in Column 13 (NPR) is calculated according to the requirements of Section VM-20 of the *Valuation Manual*.

Column 1 & 2 – Reported Reserve

Provide the reported reserve for the prior year and current year for each line item. Post-Reinsurance-Ceded is net of reinsurance ceded, and Pre-Reinsurance-Ceded includes reinsurance assumed and excludes any reinsurance ceded. Sections 2 and 8 in the *Valuation Manual* further describe the required reserve and treatment of reinsurance.

Column 4, 9 & 13 – Net Premium Reserve (NPR)

Report the Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded Net Premium Reserve for the each product type. The Net Premium Reserve is defined in Section 3 in VM-20 of the *Valuation Manual*.

Column 5 & 10 – Deterministic Reserve

Report the Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded Deterministic Reserve for each product type. The Deterministic Reserve calculation is defined in Section 4 in VM-20 of the *Valuation Manual*.

Not for Distribution

Column 6 – Stochastic Reserve

Report the Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded Stochastic Reserve for each product type. The Stochastic Reserve calculation is defined in Section 5 in VM-20 of the *Valuation Manual.*

Column 7, 11 &14 – Number of Policies

Report the number of individual life insurance policies by product type and by the required VM-20 methodology used as described in Section A, Section B and Section C above. The number of policies should be prior to any reinsurance ceded and include reinsurance assumed.

Column 8, 12 & 15 – Face Amount

Report the face amount of individual life insurance by product type and by the required VM-20 methodology used as described in Section A, Section B and Section C above. The face amount should be prior to any reinsurance ceded and include reinsurance assumed.

VM-20 RESERVES SUPPLEMENT – PART 2

Three Year-Transition Period

($000 Omitted Except for Number of Policies)

This section of the Supplement should be completed when a reporting entity has elected to apply the three-year transition provided in Section II, Sub-section C under Life Insurance Products of the *Valuation Manual* to some or all of its business. This Part 2 should include the values requested for the business for which the three-year transition has been elected and should not include values for any policies valued based on VM-20. This Part 2 allows the company to establish minimum reserves according to applicable requirements stated in Appendix A (VM-A) and Appendix C (VM-C), in the *Valuation Manual*, for business otherwise subject to VM-20 requirements and issued during the first three years following the Operative Date of the *Valuation Manual*. If a company does not elect this three-year transition, but elects to apply VM-20 to a block of business issued on and after the Operative Date, then such company must continue to apply the requirements of VM-20 to this block of business, as well as future new issues of this type of business.

A company that elects to apply the three-year transition for all of its products within the scope of VM-20 does not have to complete Part 1 of the VM-20 Supplement. If a company applies VM-20 to a product or products, then Part 1 of this VM-20 Supplement will need to be completed.

VM-20 RESERVES SUPPLEMENT – PART 3

Life PBR Exemption

This section of the Supplement should be completed by a company that has filed and been granted a Life PBR Exemption from its state of domicile.

If a company has been granted a Life PBR Exemption, the company must indicate the source of the Life PBR Exemption, which could be defined in a state statute, a state regulation or in the NAIC-adopted *Valuation Manual*. If the source of the granted Life PBR Exemption is not the NAIC-adopted *Valuation Manual*, the company must disclose the criteria of the state's Life PBR Exemption that the company has met, and the company must disclose the minimum reserve requirements that are required by the state of domicile. If the minimum reserve requirements of the state of domicile are the same as those specified in the NAIC-adopted *Valuation Manual*, the company may indicate: "Same as NAIC VM".

Companies whose individual ordinary life business is exempted from the requirements of VM-20 pursuant to a Life PBR Exemption are not required to complete Part 1 of this VM-20 Supplement.

Not for Distribution

VM-20 RESERVES SUPPLEMENT – PART 4

Other Exclusions from Life PBR

Questions 1 and 2 of this section of the Supplement should be completed by a company that has filed and been granted a Single State Exemption from the reserve requirements of VM-20 by its state of domicile pursuant to requirements similar to the optional Section 15 of the NAIC *Standard Valuation Law* (# 820). The response to question 2 should be "Yes" if the company has any business assumed that relates to issues outside the state of domicile.

Question 3 of this section of the Supplement should be completed by a company if all its life business is excluded from the requirements of VM-20 pursuant to Section II.B of the *Valuation Manual*.

Companies responding "Yes" to question 1 are not required to complete Part 1 of this VM-20 Supplement if all of their individual ordinary life business was covered under the Single State Exemption. Companies responding "YES" to question 3 are not required to complete Part 1 of this VM-20 Supplement.

Not for Distribution

LONG-TERM CARE INSURANCE EXPERIENCE REPORTING FORMS 1 THROUGH 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are "incidental" regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue). If a policy form has had no policies in force and all claims on the policy form have been settled for more than one year, then the policy form is no longer reported on Forms 1, 2 and 4.

Form 1 focuses on the critical assumptions of morbidity and persistency while still presenting loss ratio data (without the level of detail in the original forms). As noted in the instructions specific to the form, prior-year values will be filled in over time. Only information as of 2009 and subsequent years is required on the forms unless it was required on the previous Long-Term Care Insurance Experience Reporting Forms. Companies are not required to supply information for spaces on the forms corresponding to any year prior to adoption of the forms, unless that information was previously reported. Form 2 focuses on the developing level of funds from the issue age premium basis and compares this to the active life reserve. As noted in the instructions specific to the form, prior-year values will be filled in over time. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 is to include life and annuity products that are not exempt as outlined in the Long-Term Care Insurance Model Regulation. Form 5, which replaces the LTC Experience Form C, requires information at the state level. In addition to the considerable changes in the structure and purpose of the forms, the new forms are based on adding additional calendar years of experience to prior results. To more appropriately compare the actual results with expectations, the expected values are based on the exposure at the beginning of that year, *not* the original assumed sales distribution used when completing the original forms.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident and health annual statement. The list of the various annual statements is: life, accident and health, property/casualty, fraternal and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.

Not for Distribution

Experience for LTC insurance should be reported separately by stand-alone LTC policy form or by rider where experience is to be reported by form. Reporting by rider is applicable only to riders having distinct premiums for LTC coverage that are attached to products other than stand-alone LTC policies. Experience under forms that provide substantially similar coverage and provisions, that are issued to substantially similar risk classes and that are issued under similar underwriting standards, may be combined. If this option is utilized, the forms combined should be identified in the column captioned "Policy Form."

Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse's benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods. If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve and experience fund would be the paid-up value and future incurred claims will be only for LTC benefits. If the assumption is that future premiums (gross or net) will be considered as "paid by waiver," the reserve and experience fund will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.

Not for Distribution

INSTRUCTIONS FOR FORM 1

OVERVIEW

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual claims and persistency against expected on a nationwide basis. Certain group business is reported separately from individual and some group business. (See Section 4(E) of the Long-Term Care Insurance Model Act.) Policy forms are grouped into three categories: comprehensive, institutional only or non-institutional. Yearly and cumulative comparisons are exhibited. Even though only policy form groupings are displayed, policy form level information should be kept. It may facilitate rating reviews by the regulators. If a policy form has had no policies in force and all claims on the policy form have been settled for more than one year, then the policy form is no longer reported on this form.

DEFINITIONS AND FORMULAS

Comprehensive

Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only

Policy forms that provide institutional coverage only.

Non-Institutional Only

Policy forms that provide only non-institutional coverage.

Current

Current calendar year of reporting.

Example: For a specific policy form category, the first year of issue was 2001. This Form 1 is required starting for the year 2009 and the reporting year is 2011. The current year would be 2011.

Prior

The year immediately prior to the year of reporting.

Example: 2010

2nd Prior

Two years prior to the year of reporting.

Example: 2009

3rd Prior

Three years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

Not for Distribution

4th Prior

Four years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

5th Prior

Five years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

Form Inception-to-Date

Aggregate experience data since the adoption of this Form 1.

Example: Data from 2009 through 2011.

Actual and expected in force counts are sums of counts for all years since adoption of Form 1.

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Example: Data from 2001 through 2011.

Column 1 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Column 2 – Incurred Claims

If

iy	=	Incurred year
T	=	Report year – incurred year
V	=	Discount rate
${}_t$Paid Claims$_{iy}$	=	Paid claims during claim duration t from claims incurred in year iy, t = 0, 1, 2, 3, . . . T
${}_T$Case Reserve$_{iy}$	=	Case reserve at end of report year from claims incurred in iy

Incurred claims for incurred year iy :

For T=0

$${}_0\text{Paid Claims}_{iy} \times v^{1/4} + {}_0\text{Case Reserve}_{iy} \times v^{1/2} + {}_0\text{IBNR}_{iy} \times v^{1/2}.$$

For T>0

$${}_0\text{Paid Claims}_{iy} \times v^{1/4} + {}_1\text{Paid Claims}_{iy} \times v^{1} + {}_2\text{Paid Claims}_{iy} \times v^{2} + \ldots + {}_T\text{Paid Claims}_{iy} \times v^{T} + {}_T\text{Case Reserve}_{iy} \times v^{T+1/2} + ({}_T\text{IBNR}_{iy} \times v^{T+1/2})$$

Not for Distribution

This is the developed claim amounts for claims incurred during the specific calendar year. For each claim, the incurred claim equals the present values of all claim payments and the present value of any outstanding case reserve. This will be different from the reported financial incurred claims. The financial incurred claims, including the change in claim reserves that contains gain or loss due to reserve estimation different from actual payments for claims incurred in prior years.

For purposes of the present value calculation, assume all payments are made in the middle of the calendar year and the case reserve is at the end of the calendar year. The discount rate is the statutory valuation interest rate for case reserve. For the current calendar year, an Incurred But Not Reported (IBNR) reserve should be assigned. If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the direct liability attributable to long-term care business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only. This amount includes accrued and unaccrued claims liabilities, which are incurred but not yet paid, both reported and not reported.

The incurred claims should be consistent with the claims exhibited on Form 3.

Column 3 – Valuation Expected Incurred Claims

The expected claim cost for an individual covered under a policy in force[1] at the beginning of the calendar year based on statutory active life reserve morbidity assumption. This is the interpolation of successive policy year expected claim cost for all coverages in force at the beginning of the year. Simple averaging is acceptable.

An acceptable approximation is the expected claim cost multiplied by an exposure adjustment, where expected claim cost is the sum of claim costs during the year based on the valuation morbidity assumption of each life in force at the beginning of the year. The valuation claim cost during the year is an interpolation of successive claim costs by policy year. Other approximations may also be acceptable. Any changes in method should be disclosed on the form.

The exposure adjustment is:

> [Actual Number of Lives In Force at Beginning of Year – (Expected Deaths + Expected Lapses) / 2] / Actual Number of Lives In Force at Beginning of Year,

where Expected Deaths and Expected Lapses are based on valuation assumptions. They can be derived from a single average decrement rate combining deaths and lapses, or specific decrement rates applying to actual exposures. If there is no in force at the beginning of the year, the expected claim cost can be zero.

Column 4 – Actual to Expected Incurred Claims

Actual incurred claims as a percentage of valuation expected incurred claims.

Column 5 – Open Claim Count

Number of claims that have at least one benefit payment made during the year after the elimination period. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. Examples are payments of caregiver training benefits and optional care coordination benefits. For these examples, if the amounts paid are included as benefits under the policy, they should be included in the claim amounts but excluded from the claim counts. A claim should be included in the count, even though it has terminated by the end of the year.

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[1] If active life reserves are not held for claimants, then exclude the claimants.

Column 6 – New Claim Count

Number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A new claim should be included in the count even though it has terminated by the end of the year.

Column 7 – Lives In Force End of Year

Actual number of lives in force at the end of the year. Joint policies should be counted by number of lives.

Column 8 – Expected Lives In Force End of Year

Expected number of lives in force at the end of the year:

> Actual Number of Lives In Force at Beginning of Year + New Issue Lives – Expected Deaths – Expected Lapses,
>
> where Expected Deaths and Expected Lapses are based on valuation assumptions. They can be derived from a single average decrement rate combining deaths and lapses or specific decrement rates applying to actual exposures. Joint policies should be counted by number of lives.

Column 9 – Actual to Expected Lives In Force

Actual number of lives in force as a percentage of expected number of lives in force at the end of the year.

NOTES

1. Form 1 applies to direct business only.

2. Prior years' figures, except for incurred claims, should be the same as the figures from prior years' Form 1.

3. Form Inception-to-Date figures, except for incurred claims, should be the corresponding figures from prior-year Form 1 plus the figures for the current year. No interest discounting is required to determine Form Inception-to-Date and Total Inception-to-Date figures.

4. If Incurred But Not Reported reserves must be allocated by policy form, the allocation should be based on paid claims and change in claim reserves.

5. Use the valuation assumptions corresponding to the current reserves being held. They are not necessarily the original reserve assumptions if strengthening or release of reserves has been made in the past. The assumptions for each year should be applied to the actual in-force (age, gender, plan distribution), not the distribution originally expected or issued.

6. An insurance company may use more refined methods in determining the required information than those described in the definitions and instructions. Methods must be consistent from report year to report year.

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INSTRUCTIONS FOR FORM 2

OVERVIEW

The purpose of Form 2 is to calculate a ratio of an experience reserve to the reported reserve by calendar year on a nationwide basis. Summary data by policy form is to be reported. Data for the current reporting year, as well as that reported in each of the prior two reporting years, is to be shown on Form 2.

The following formulae specify data by calendar duration (t) and calendar year of issue (n). Data at this detail is required for the calculation of the experience reserve, although only totals by policy form are illustrated. Experience data is notated by a superscript E to distinguish from valuation assumptions. The experience reserve reported in column 13 is developed from: 1) the experience reserve at the end of the prior reporting year (t-1); 2) valuation net premiums and interest rates; and 3) experience incurred claims, earned premiums, and actual persistency. The valuation net premiums used are the actual net premiums used for that reporting year. *As an example, if a factor file method is used, the valuation net premiums used to calculate the reserve factors would be used for Form 2.*

For 2009, the experience reserve (column 13) was calculated using the reported reserves as of the end of 2008 as the prior year's reserve. Similarly, for acquired business, the experience reserve as of the year-end following acquisition is set equal to the reported reserve as of that date. The experience reserve as of subsequent periods is developed from the first experience reserve reported in this form. If a policy form has had no policies in force and all claims on the policy form have been settled for more than one year, then the policy form is no longer reported on this form.

Experience and valuation data are reported by base policy form. Rider forms will be reported with the base forms to which they are attached.

Only summary data by reporting year is illustrated. *The reporting company should have detail by calendar duration available upon request.*

DEFINITIONS AND FORMULAS

Column 3 – Last Year Issue

For closed blocks of business, report the last year a policy was issued for the policy form. For open blocks of business, leave blank.

Column 4 – Earned Premiums

$_tEP_n$ = The direct earned premium in calendar duration t for all business of Calendar Year of Issue (CYI) n. Include earned premiums only for the reporting year. Total direct earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2 for life, accident & health, fraternal and property/casualty only.

Column 5 – Incurred Claims

$_tIC^E_n$ = The experience incurred claims of all business of CYI n in calendar duration t for the reporting year.

$_tIC^E_n$ = $[_t(\text{Paid Claims})_n] + [_tCLiab^E_n \times (1+i_n)^{-1/2} - (_{t-1}CLiab^E_n) \times (1+i_n)^{1/2}]$

Where:

$_t(\text{Paid Claims})_n$ = The paid claims of all business of CYI n in calendar duration t for the reporting year. Paid claims is the total direct paid claims for LTC business from Exhibit 8, Part 2, Line 1.1 for life, accident & health and fraternal only.

i_n = The valuation interest rate for CYI n.

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$_{t}CLiab^{E}{}_{n}$ = The claim liability of all business of CYI n in calendar duration t for the reporting year. $_{t}CLiab^{E}$ is the portion of the total direct claim liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health, and fraternal only. This amount includes accrued and unaccrued claims liabilities, which are incurred but not yet paid, both reported and not reported.

$_{t-1}CLiab^{E}{}_{n}$ = The claim liability of all business of CYI n in calendar duration t-1 for the prior reporting year. $_{t-1}CLiab^{E}{}_{n}$ is the total direct claim liability for LTC business from Exhibit 8, Part 2, Line 4.1 (life, accident & health and fraternal) of the current year's annual statement plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business on the prior year's annual statement for life, accident & health and fraternal only. This amount includes accrued and unaccrued claims liabilities that were incurred but not paid at the prior year-end, both reported and not reported.

Column 6 – Loss Ratio

$_{t}LR_{n}$ = The incurred claims loss ratio in calendar duration t for all business of CYI n.

$_{t}LR_{n}$ = $_{t}IC^{E}{}_{n} / {}_{t}EP_{n}$

Column 6 = Column 5 / Column 4 x 100

Column 7 – Annual Net Premium/Annual Gross Premium

The ratio of annual net premium to annualized gross premium.

Annual Net Premium = ∑ (annual valuation net premiums for policies issued in calendar year n at the start of calendar duration t). Companies may report zero (0) for the net premiums during the Preliminary Term period.

Annual Gross Premium = ∑ (Annualized Premium In Force, including mode loadings for policies issued in calendar year n at the start of calendar duration t).

For calendar duration 0, the net premiums and gross premiums at issue should be used.

Column 8 – Current Year Net Premiums

$_{t}P_{n}$ = The annual valuation net premium for all business of CYI n in calendar duration t.

$_{t}P_{n}$ = $_{t}EP_{n}$ x ∑ (annual valuation net premiums for policies issued in calendar year n at the start of calendar duration t)/ ∑ (Annualized Premium In Force for policies issued in calendar year n at the start of calendar duration t). At the detail level of CYI n and calendar duration t, Column 8 = Column 4 x Column 7.

Column 9 – In Force Count Beginning of Year

$_{t-1}IF_{n}$ = The in force count in calendar duration t-1 for all business of CYI n at the end of the calendar year preceding the reporting year. In force Count Beginning of Years should equal in force end of prior year from the Exhibit of Number of Policies (Accident and Health Insurance, Line 1) for LTC business for life, accident & health and fraternal only.

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Column 10 – New Issues Current Year

The new issues count during the reporting year. New Issues Current Year should equal issued during year from the Exhibit of Number of Policies (Accident and Health Insurance, Line 2) for LTC business for life, accident & health and fraternal only.

Column 11 – In Force Count End of Year

$_{t}IF_{n}$ = The in force count in calendar duration t for all business of CYI n at the end of the reporting year. In Force Count End of Years should equal in force end of year from the Exhibit of Number of Policies (Accident and Health Insurance, Line 9) for LTC business for life, accident & health and fraternal only.

Column 12 – Persistency Rate

(Column 11 – .5 x Column 10) / (Column 9 + .5 x Column 10)

Column 13 – Experience Policy Reserves

$$_{t}V^{E}_{\ n} = [({}_{t-1}V^{E}_{\ n}) + {}_{t}P_{n}] \times (1+i_{n}) - {}_{t}IC^{\ E}_{\ n} \times (1+i_{n})^{1/2}$$

Where:

$_{t}V^{E}_{\ n}$ = The experience reserve as of the end of the reporting year for calendar duration t, and CYI n.

$_{t-1}V^{E}_{\ n}$ = The experience reserve as of the end of the prior reporting year for calendar duration t-1, and CYI n. For the first filing of this form, the experience reserve as of the second prior year is set equal to the reported reserve as of that date.

$_{t}P_{n}$ = The annual valuation net premium for all business of CYI n in calendar duration t. The total for the reporting year is the amount reported in Column (8).

i_{n} = The valuation interest rate for CYI n.

$_{t}IC^{\ E}_{\ n}$ = The experience incurred claims for all business of CYI n in calendar duration t. The total amount for the reporting year is reported in Column (5).

Column 14 – Reported Policy Reserves

The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health and fraternal only.

Column 15 – Experience/Reported Ratio

Column 15 = Column 13 / Column 14 x 100

Section C – Summary

Line 1 –	Total Current - Individual	=	Sum of each Section A, Line 1 (all policy forms)
Line 2 –	Total Prior - Individual	=	Sum of each Section A, Line 2 (all policy forms)
Line 3 –	Total 2nd Prior - Individual	=	Sum of each Section A, Line 3 (all policy forms)
Line 4 –	Total Current - Group	=	Sum of each Section B, Line 1 (all policy forms)
Line 5 –	Total Prior - Group	=	Sum of each Section B, Line 2 (all policy forms)
Line 6 –	Total 2nd Prior - Group	=	Sum of each Section B, Line 3 (all policy forms)
Line 7 –	Current Year Total	=	Section C, Line 1 + Section C, Line 4

Not for Distribution

INSTRUCTIONS FOR FORM 3

The purpose of this form is to test the adequacy of reserves held on long-term care policies. This form allows for the development of a seven-year trend of losses incurred by a specific year group of claimants. This form is to be prepared on a nationwide basis.

Report all dollar amounts in thousands ($000 omitted).

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The "Prior" values in these sections will not be directly comparable to prior statements, as the current year's statement will include an additional incurred year's values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurral year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y for claims incurred in year X.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Line 1, Columns 1 through 8.

The "Prior" values in these sections will not be directly comparable to prior statements, as the current year's statement will include an additional incurred year's values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for ***transfer claims (acquired or sold)*** are shown here, by claim incurred year, starting from the year of transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.

Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading to the extent interest income on claim reserves is material. To show consistent values; paid claims; transferred reserves and claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year).

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

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If			
	iy	=	Incurred year
	T	=	Report year – incurred year
	v	=	Discount rate
	${}_{t}\text{Paid Claims}_{iy}$	=	Paid claims during current or prior calendar year t from claims incurred in year iy
	${}_{t}\text{Case Reserve}_{iy}$	=	Case reserve at end of calendar year t from claims incurred in iy
	${}_{t}\text{Transferred Reserve}_{iy}$	=	Transferred reserve at end of calendar year t from claims incurred in iy and
	t	=	iy, iy+1, iy+2, . . . , iy + T

then the Present Value of Incurred Claims for incurred year iy:

For T=0

$$ {}_{iy}\text{Paid Claims}_{iy} \times v^{1/4} + {}_{iy}\text{Case Reserve}_{iy} \times v^{1/2} + {}_{iy}\text{IBNR}_{iy} \times v^{1/2} + {}_{iy}\text{Transferred Reserve}_{iy} \times v^{1/2} $$

For T>0

$$ {}_{iy}\text{Paid Claims}_{iy} \times v^{1/4} + {}_{iy+1}\text{Paid Claims}_{iy} \times v^{1} + {}_{iy+2}\text{Paid Claims}_{iy} \times v^{2} + \ldots + {}_{iy+T}\text{Paid Claims}_{iy} \times v^{T} + {}_{iy+T}\text{Case Reserve}_{iy} \times v^{T+1/2} + \left({}_{iy+T}\text{IBNR}_{iy} \times v^{T+1/2}\right) + {}_{iy+T}\text{Transferred Reserve}_{iy} \times v^{T+1/2} $$

If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the total direct liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only. This amount includes accrued and unaccrued claims liabilities that are incurred but not yet paid, both reported and not reported.

Not for Distribution

INSTRUCTIONS FOR FORM 4

OVERVIEW

Long-Term Care Insurance Experience Reporting Form 4 is intended to track life insurance and annuity products that have long-term care benefits provided by acceleration of certain benefits within these products. Include only the products that are not exempt as outlined in the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio, and premium rate increases also defined as "incidental" at the beginning of these experience forms instructions). This form is not to include stand-alone LTC products. Individual and group business is separated in this form.

DEFINITIONS AND FORMULAS

Current

Current calendar year of reporting.

Example: For a specific policy form category, the first year of issue was 2001. This Form 4 is required starting for the year 2009 and the reporting year is 2010. The current year would be 2010.

Prior

The year immediately prior to the year of reporting.

Example: 2009

2nd Prior

Two years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Example: Data from 2001 through 2010.

Column 1 – Number of Policies In Force

The total number of policies in force as of end of calendar year.

Column 2 – Number of Certificates

The total number of certificates as of end of calendar year.

Column 3 – Death Claims

The total number of death claims for a calendar year.

Column 4 – Long-Term Care Accelerated Claims

The total number of long-term care accelerated claims for a calendar year. Only the long-term claims that have been triggered due to acceleration should be totaled.

Column 5 – Total Reserves

The total amount of non-claim reserves for these life insurance or annuity products.

Not for Distribution

INSTRUCTIONS FOR FORM 5

OVERVIEW

For long-term care insurance reported in the Long-Term Care Insurance Experience Reporting Form 1, Form 2 and Form 3, these lines are the state's portion of the earned premium, incurred claims and number of in force count of lives at end of the year. A schedule must be prepared for each jurisdiction in which the company has long-term care direct earned premiums and/or has direct incurred claims. In addition, a schedule must be prepared that contains the grand total (GT) for the company.

DEFINITIONS AND FORMULAS

Policy forms should be grouped by individual and group and reported on Lines 1 and 2, respectively. The subtotals for these two classes (i.e., individual and group) must be provided. Line 3 is the sum of Lines 1 and 2.

Column 1 – Earned Premiums

Earned premiums reported should be the state amount that is included in the current year of Form 2, Part C, Column 4.

Grand Total Page:

Line 1 should equal the amount in Form 2, Part C, Column 4, Line 1.

Line 2 should equal the amount in Form 2, Part C, Column 4, Line 4.

Line 3 should equal the amount in Form 2, Part C, Column 4, Line 7.

For Line 4 "Actual total reported experience through prior year", the amount will be Line 5 from the previous year's report.

For Line 5 "Actual total reported experience through statement year": should be the state's allocated earned premium for the current year (as reported on Line 3) added to the state's cumulative experience through prior year (as reported on Line 4).

Column 2 – Incurred Claims

Incurred claims reported should be the state amount that is included in the current year of Form 2, Part C, Column 5. Incurred claims should be paid claims in the state plus a reasonable allocation of claim reserves less the reported allocated portion of the prior year's claim reserve. The allocation method should be consistent from year-to-year when estimating reserves for each state.

Grand Total Page:

Line 1 should equal the amount in Form 2, Part C, Column 5, Line 1.

Line 2 should equal the amount in Form 2, Part C, Column 5, Line 4.

Line 3 should equal the amount in Form 2, Part C, Column 5, Line 7.

For Line 4 "Actual total reported experience through prior year", the amount will be Line 5 from the previous year's form.

For Line 5 "Actual total reported experience through statement year": This should be the state's allocated incurred claims for the current year (as reported on Line 3) added to the state's cumulative experience through prior year (as reported on Line 4).

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Column 3 – In Force Count End of Year

The In Force Count End of Year should be the state total used in calculating the In Force Count End of Year in Form 2, Part C, Column 11.

Grand Total Page:

Line 1 should equal the amount in Form 2, Part C, Column 11, Line 1.

Line 2 should equal the amount in Form 2, Part C, Column 11, Line 4.

Line 3 should equal the amount in Form 2, Part C, Column 11, Line 7.

Column 4 – Lives In force End of Year

Actual number of lives in force at the end of the year. Joint policies should be counted by number of lives. Once the state forms are completed, the Lives In force End of Year for all states (Grand Total State Page) LTC Form 5, Column 4, Line 01 should equal LTC Form 1, Column 7, Line A01 + A09 + A17 and Form 5, Line 02 should equal Form 1, Line B01 + B09 + B17. The number of lives for each state for individual policies should be based on the policies that were issued in that state. The number of lives for each state in group policies should be based on the certificates that were issued in that state.

Not for Distribution

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS
INTEREST SENSITIVE LIFE INSURANCE PRODUCTS REPORT

Filing date: This exhibit is to be filed no later than April 1.

This exhibit shows Lines 1 through 29 of the Fraternal Blank, Summary of Operations by Line of Business, for interest and non-interest sensitive life insurance products. The purpose of this exhibit is to reflect the amount of revenue and expense attributable to each of these classifications.

An interest sensitive life insurance product is any product under the provisions of which separately identified interest credits are made to the product. They are distinguished by the existence of an indeterminate product value from which specified periodic charges are deducted and to which specified periodic interest is credited at a rate not determined at issue.

For purposes of the classification of products between interest and non-interest sensitive products, apply the definition to the base certificate. The allocation of amounts not directly allocable should follow the instructions for Analysis of Operations by Lines of Business (Page 6). Allocation of receipts and expenses between interest and non-interest sensitive products should be consistent with the primary line of business allocations.

The columns on the Interest Sensitive Life Insurance Products Report for the Summary of Operations by Lines of Business are labeled as follows:

(References to present annual statement page totals are listed as needed.)

			Page	Column
Ordinary Life	–	Interest Sensitive	6s	1
	–	Non-Interest Sensitive	[illegible]	2
	–	Total (Page 6, Column 2)	6s	3

Not for Distribution

ANALYSIS OF INCREASE IN RESERVES
INTEREST SENSITIVE LIFE INSURANCE PRODUCTS REPORT

Filing date: This exhibit is to be filed no later than April 1.

This exhibit analyzes the development of life insurance certificate reserves for interest and non-interest sensitive products by showing how the reserve may be traced mathematically from one year-end to the next.

An interest sensitive life insurance product is any product under the provisions of which separately identified interest credits are made to the product. They are distinguished by the existence of an indeterminate product value from which specified periodic charges are deducted and to which specified periodic interest is credited at a rate not determined at issue.

For purposes of the classification of products between interest and non-interest sensitive life insurance products, apply the definition to the base certificate. The allocation of amounts not directly allocable should follow the instructions from Analysis of Increase in Reserves During the Year (Page 7).

The columns on the Interest Sensitive Life Insurance Products Report for the Analysis of Increase in Reserves are labeled as follows:

(References to annual statement page totals are listed as needed.)

			Column
Ordinary Life	–	Interest Sensitive	1
	–	Non-Interest Sensitive	2
	–	Total (Page 7, Column 2)	3

Lines 2 through 6 and Lines 9 through 11 do not include amounts related to the VM-20 Deterministic/Stochastic portion of the reserves, which are reported on Line 6.1.

Line 6 – Increase in Reserve on Account of Change in Valuation Basis

Enter appropriate amounts from Part A of Exhibit 5A, Changes in Bases of Valuation During the Year.

Line 6.1 – Change in Excess of VM-20 Deterministic/Stochastic Reserve over Net Premium Reserve

As the line item describes, this is the change in excess of any Deterministic/Stochastic reserve over the amount of the VM-20 Net Premium Reserve.

Line 10 – Reserves Released by Death

Entries should be made only in the columns involving life insurance. Enter terminal reserves released.

Exclude Deterministic/Stochastic Reserves from the reporting of Reserves Released by Death

Line 11 – Reserves Released by Other Terminations (Net)

Enter reserves released by all causes in and other than by death in. The computation should be on a net basis so as to take account of revivals, increases, changes, etc.

Exclude Deterministic/Stochastic Reserves from the reporting of Reserves Released by Other Terminations (Net)

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ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT

This exhibit is required to be filed no later than April 1.

1. The name of the society must be clearly shown at the top of each page or pages.

2. The Exhibit will show information concerning direct business written on policy forms approved for use in the United States with a final total for all policy forms (including non-U.S. policy forms) on the bottom line of the Exhibit.

   The Exhibit will show information for each listed product for Individual, Group, and Other business categories. Subtotals by product within the individual category are required for all columns.

3. A Summary Page shows a reconciliation with Schedule H for Individual, Group and Credit policies separately and in total for companies filing the Life, Accident and Health, Fraternal and Property/Casualty Annual Statement, and a reconciliation of these policies in total only with the specified exhibits of the Health Annual Statement for companies filing that statement.

4. This Exhibit should not include any data pertaining to double indemnity, waiver of premiums and other disability benefits embodied in life contracts.

5. Include membership charges, modal loadings, and policy fees, if any, with premiums earned (Column 1).

DEFINITIONS

Accident Only or AD&D

Policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents. Types of coverage include student accident, sports accident, travel accident, blanket accident, specific accident or accidental death and dismemberment (AD&D).

Administrative Services Only (ASO) and Administrative Services Contract (ASC)

An uninsured accident and health plan is where an administrator performs administrative services for a third party that is at risk, but has not issued an insurance policy. The health plan bears all of the insurance risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. Under an ASO plan, claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the administrator, but only after receiving funds from the plan sponsor that are adequate to fully cover the claim payments. Under an ASC plan, the administrator pays claims from its own bank accounts, and only subsequently receives reimbursement from the plan sponsor.

Comprehensive/Major Medical

Policies that provide fully insured indemnity, HMO, PPO, or Fee for Service coverage for hospital, medical, and surgical expenses. This category excludes Short-Term Medical Insurance, the Federal Employees Health Benefit Program and non-comprehensive coverage such as basic hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage as well as any other coverage described in the other categories of this exhibit.

Not for Distribution

Group business is further segmented under this category as follows (please note there is a separate category for Administrative Services Only/Administrative Services Contract business):

Single Employer:

Group policies issued to one employer for the benefit of its employees. This would include affiliated companies that have common ownership.

Small Employer: Group policies issued to single employers that are subject to the definition of Small Employer business, when so defined, in the group's state of situs.

Other Employer: Group policies issued to single employers that are not defined as Small Employer business.

Multiple Employer Associations and Trusts:

Group policies that are issued to an association or to a trust. This category also includes policies issued to one or more trustees of a fund established or adopted by two or more employers, or by one or more labor unions or similar employee organizations. The organizations include those that are exempt and also those that are non-exempt from statewide community rating. This category does not exclude policies providing coverage to employees of small employers, as defined in the employer's state of situs.

Other Associations and Discretionary Trusts:

Group policies issued to associations and trusts that are not included in the Small Employer, Other Employer or Multiple Employer Associations and Trusts group categories. This category does not exclude insurance providing coverage to employees of small employers, as defined in the employer's state of situs. This category does include blanket and franchise accident and sickness insurance, and insurance for any group that includes members other than employees, such as an association that has both employees of participating employers and also individuals as members.

Other Comprehensive/Major Medical:

Group policies providing comprehensive or major medical benefits that are not included in any of the categories listed above.

Contract Reserves

Reserves set up when, due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim and premium reserves.

Credit

Individual or group policies that provide benefits to a debtor for full or partial repayment of debt associated with a specific loan or other credit transaction upon disability or involuntary unemployment of debtor, except in connection with first mortgage loans. In some states, involuntary unemployment credit insurance is not included in health insurance. This category should not include that type of credit insurance in those states.

Dental

Policies providing only dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw. If dental benefits are part of a comprehensive medical plan, then include data under comprehensive/major medical category.

Not for Distribution

Disability Income – Long-Term

Policies that provide a weekly or monthly income benefit for more than five years for individual coverage and more than one year for group coverage for full or partial disability arising from accident and/or sickness. Include policies that provide Overhead Expense Benefits. Does not include credit disability.

Disability Income – Short-Term

Policies that provide a weekly or monthly income benefit for up to five years for individual coverage and up to one year for group coverage for full or partial disability arising from accident and/or sickness. Include policies that provide Overhead Expense Benefits. Does not include credit disability.

Federal Employees Health Benefits Program (FEHBP)

Coverage provided to Federal employees, retirees and their survivors and administered by the Office of Personnel Management.

Group Business

Health insurance where the policy issued to employers, associations, trusts, or other groups covering employees or members and/or their dependents, to whom a certificate of coverage may be provided.

Individual Business

Health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes conversions from group policies.

Limited Benefit

Policies that provide coverage for vision, prescription drug and/or any other single service plan or program. Also include short-term care policies that provide coverage for less than one year for medical and other services provided in a setting other than an acute care unit of the hospital.

Long-Term Care

Policies that provide coverage for not less than one year for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, including policies that provide benefits for cognitive impairment or loss of functional capacity. This includes policies providing only nursing home care, home health care, community based care, or any combination. Do not include coverage provided under comprehensive/major medical policies, Medicare Advantage, or for accelerated death benefit-type products.

Medicaid

Policies issued in association with the Federal/State entitlement program created by Title XIX of the Social Security Act of 1965 that pays for medical assistance for certain individuals and families with low incomes and resources.

Medicare

Policies issued as Medicare Advantage Plans providing Medicare benefits to Medicare eligible beneficiaries created by title XVIII of the Social Security Act of 1965. This includes Medicare Managed Care Plans (i.e., HMO and PPO) and Medicare Private Fee-for-Service Plans. This also includes all Medicare Part D Prescription Drug Coverage through a Medicare Advantage product and whether sold directly to an individual or through a group.

Medicare Part D – Stand-Alone

Stand-alone Part D coverage written through individual contracts; stand-alone Part D coverage written through group contracts and certificates; and Part D coverage written on employer groups where the reporting entity is responsible for reporting claims to the Centers for Medicare & Medicaid Services (CMS).

Not for Distribution

Medicare Supplement

Policies that qualify as Medicare Supplement policy forms as defined in the NAIC Medicare Supplement Insurance Minimum Standards Model Act. This includes standardized plans, pre-standardized plans and Medicare select.

Other Business

Any business that is not included in the Individual Business or Group Business listed above, including credit insurance, stop loss/excess loss, administrative services only and administrative services contract.

Other Group Business

Group policies providing health insurance benefits that are not included in any other group business category of this exhibit should be reported as other group business.

Other Individual Business

Individual policies providing health insurance benefits that are not included in any other individual business category of this exhibit should be reported as other individual business.

Other Medical (Non-Comprehensive)

Policies such as hospital only, hospital confinement, surgical, outpatient indemnity, intensive care, mental health/substance abuse, and organ and tissue transplant (including scheduled type policies), etc. Expense reimbursement and indemnity plans should be included. This category does not include TRICARE/CHAMPUS Supplement, Medicare Supplement, or Federal Employee Health Benefit Program coverage.

Short-Term Medical

Policies that provide major medical coverage for a short period of time, typically 30 to 180 days. These policies may be renewable for multiple periods.

Specified/Named Disease

Policies that provide benefits only for the diagnosis and/or treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem or as a principal sum.

State Children's Health Insurance Program

Policies issued in association with the Federal/State partnership created by title XXI of the Social Security Act.

Stop Loss/Excess Loss

Individual or group policies providing coverage to a health plan, a self-insured employer plan, or a medical provider providing coverage to insure against the risk that any one claim or an entire plan's losses will exceed a specified dollar amount.

Student

Policies that cover students for both accident and health benefits while they are enrolled and attending school or college. These can be either individual policies or group policies sponsored by the school or college.

TRICARE

Policies issued in association with the Department of Defense's health care program for active-duty military, active-duty service families, retirees and their families, and other beneficiaries.

Not for Distribution

CROSS REFERENCES AND OTHER INSTRUCTIONS

The Exhibit

Column 1 – Premiums Earned

Fractional premium loadings and policy fees must be included in the Earned Premiums.

The Policy Experience Exhibit requires that the Premiums Earned should be on a direct basis such that the grand total reported should equal:

A. Premiums Collected During the Year

Exhibit 1, Part 1, Lines (6.1+10.1+16.1), Column 4

B. Plus the Change in Deferred and Uncollected

Exhibit 1, Part 1, Lines (3.1+13.1), Column 4

C. Minus the Increase in Premium Reserves on Direct Business Only Included in:

1. Unearned Premium Reserve

Exhibit 6, Line 1, Column 1

2. Advance Premiums

Exhibit 1, Part 1, Lines (4+1[illegible]), Column 4

3. Reserves for Rate Credits

Exhibit 6, Line 5, Column 1

Column 2 – Incurred Claims Amount

This column does not include the "Increase in Policy Reserves."

The Policy Experience Exhibit requires that the Incurred Claims should be on a direct basis such that the grand total reported should equal:

A. Incurred Claims

Exhibit 8, Part 2, Line 6.1, Columns (9+10+11)

B. Plus the Change in Claim Reserves on Direct Business Only Included in:

Exhibit 6, Line 13, Column 1

Column 3 – Change in Contract Reserves

The Policy Experience Exhibit requires that the change in contract reserves should be on a direct basis. This is the direct basis included in the sum of:

Line 2, Grand Total Individual, Group and Other Business of "D" Total Business should equal:

A. The Change in Additional Reserves

Exhibit 6, Lines 2 + 3, Column 1. Current year minus prior year.

Not for Distribution

B. Plus the Change in the Reserve for Future Contingent Benefits

Exhibit 6, Line 4, Column 1. Current year minus prior year.

C. Less the Change in the Premium Deficiency Reserve

Footnote (a) Schedule H Part 2. Current year minus prior year.

Column 4 – Loss Ratio

This is the ratio of the Incurred Claims (Column 2) plus the Change in Contract Reserves (Column 3) to Earned Premiums (Column 1).

Column 5 – Number of Policies or Certificates as of Dec. 31

This is the number of individual policies or group certificates issued to individuals covered under a group policy in force as of December 31 of the reporting year. It is not the number of persons covered under individual policies or group certificates. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Column 6 – Number of Covered Lives

This is the total number of lives insured, including dependents, under individual policies and group certificates as of December 31 of the reporting year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Column 7 – Member Months

The sum of total number of lives insured on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

SUMMARY

Part 1

Columns 1 and 2 should agree to Schedule H – Part 1, Column 1 Lines 2 and 3, respectively.

Not for Distribution

ANALYSIS OF ANNUITY OPERATIONS BY LINES OF BUSINESS

This exhibit is required to be filed no later than April 1.

This exhibit shows Lines 1 through 29 of the Analysis of Operations by Lines of Business. Column 3 of the Analysis of Operations by Lines of Business is segregated on this schedule into fixed annuities, indexed annuities, variable annuities general account, variable annuities separate account, and other annuities.

A company shall not omit the columns for any lines of business in which it is not engaged.

Include in the premium, benefit, withdrawal or other appropriate captioned lines of this analysis of operations by lines of business, all separate accounts premiums, benefit, withdrawal or other types of transactions that are transferred to or from the Separate Accounts Statement on Line 24. Such transactions are also to be reported as premiums, benefits, withdrawals or other types of transactions in the analysis of operations by lines of business of the Separate Accounts Statement.

Definitions:

Fixed Annuity:	A fixed annuity is a policy or contract that has a specified crediting rate periodically and unilaterally adjusted by the company not below minimum contract rate. Include market value adjusted annuities. A market value adjusted annuity is a fixed annuity with a provision that changes in the interest environment are taken into account if the annuity is surrendered.
Variable Annuity:	A variable annuity is a policy or contract that provides for annuity benefits that vary according to the investment experience of a separate account or accounts maintained by the insurer as to the policy or contract.
Indexed Annuity:	An indexed annuity is a policy or contract that is not a variable annuity and that contains a benefit in which the value of the benefit is determined using an interest crediting based on the performance of an index and contract parameters.
Other Annuity:	An annuity not included in the definition of fixed, variable or indexed above.

Column 1 – Total

The lines in this column are to agree with Analysis of Operations by Lines of Business, Column 3 and the sum of Columns 2 through 6 of this exhibit.

Column 2 – Fixed Annuities

Include: Market Value Adjusted Annuities

Column 6 – Other Annuities

Exclude: Market Value Adjusted Annuities

Line 29 – Net gain from operations after refunds to members and federal income taxes and before realized capital gains or (losses)

The sum of Columns 2 through 6 for Line 29 should equal Line 29, Column 3 of the Analysis of Operations by Lines of Business.

Not for Distribution

Line 30 – Policies in force end of year

In force refers to number of policies

Column 1 should equal Line 9, Columns 3 the Exhibit of Number of Certificates for Supplementary Contracts, Annuities and Accident & Health Insurance.

NOTE: Line 10 is not applicable to annuities but is presented on the schedule for consistency with Analysis of Increase in Reserves During the Year.

Not for Distribution

ANALYSIS OF INCREASE IN ANNUITY RESERVES DURING THE YEAR

This exhibit is required to be filed no later than April 1.

This exhibit shows Lines 1 through 15 of the Analysis of Increase in Reserves During the Year. Column 3 of the Analysis of Increase in Reserves During the Year is segregated on this schedule into fixed annuities, indexed annuities, variable annuities general account, variable annuities separate account, and other annuities.

This exhibit analyzes the development of life certificate and contract reserves by showing how the reserve may be traced mathematically from one year-end to the next by taking account of its various theoretical components.

A company shall not omit the columns for any lines of business in which it is not engaged.

Definitions:

Fixed Annuity: A fixed annuity is a policy or contract that has a specified crediting rate periodically and unilaterally adjusted by the company not below minimum contract rate. Include market value adjusted annuities.

A market value adjusted annuity is a fixed annuity with a provision that changes in the interest environment are taken into account if the annuity is surrendered.

Variable Annuity: A variable annuity is a policy or contract that provides for annuity benefits that vary according to the investment experience of a separate account or accounts maintained by the insurer as to the policy or contract.

Indexed Annuity: An indexed annuity is a policy or contract that is not a variable annuity and that contains a benefit in which the value of the benefit is determined using an interest crediting based on the performance of an index and contract parameters.

Other Annuity: An annuity not included in the definition of fixed, variable or indexed above.

Column 1 – Total

The lines in this column are to agree with Analysis of Increase in Reserves During the Year, Column 3 and the sum of Columns 2 through 6 of this exhibit.

Column 2 – Fixed Annuities

Include: Market Value Adjusted Annuities

Column 6 – Other Annuities

Exclude: Market Value Adjusted Annuities

Line 15 – Reserves December 31, Current Year

The sum of Columns 2 through 6 for Line 15 should equal Line 15, Column 3 of the Analysis of Increase in Reserves During the Year.

Not for Distribution

X-FACTORS ACTUARIAL OPINION

For all reporting entities that are required to submit an actuarial opinion on X-Factors per Appendix A-830 of the *Accounting Practices and Procedures Manual*, such document shall be filed with the state of domicile and electronically with the NAIC no later than March 1. The actuarial opinion should be filed in the same manner as the annual statement opinion.

SEPARATE ACCOUNTS FUNDING GUARANTEED MINIMUM BENEFIT ACTUARIAL OPINION

A reporting entity that maintains any separate accounts governed by Model #200 shall submit an actuarial opinion rendered by the valuation actuary with the state of domicile and electronically with the NAIC annually by March 1 showing the status of the accounts as of the preceding December 31. The actuarial opinion shall be supported by a confidential actuarial memorandum prepared by the valuation actuary rendering the opinion and submitted to the commissioner. The valuation actuary may be either the appointed actuary of the company or a qualified actuary designated by the appointed actuary to be the valuation actuary.

SYNTHETIC GUARANTEED INVESTMENT CONTRACTS ACTUARIAL OPINION

A reporting entity that issues a synthetic guaranteed investment contract subject to Model #695 shall submit an actuarial opinion with the state of domicile and electronically with the NAIC and, upon request, a memorandum to the commissioner annually by March 1 following the December 31 valuation date showing the status of the accounts as of the prior December 31. The actuarial opinion and memorandum shall be in form and substance satisfactory to the commissioner.

REASONABLENESS OF ASSUMPTIONS CERTIFICATION REQUIRED BY ACTUARIAL GUIDELINE XXXV

For all reporting entities that are required to submit this certification, such document shall be filed with the state of domicile and electronically with the NAIC no later than March 1. An example for a certification can be found in the Appendices of AG 35.

Not for Distribution

REASONABLENESS AND CONSISTENCY OF ASSUMPTIONS CERTIFICATION REQUIRED BY ACTUARIAL GUIDELINE XXXV

For all reporting entities that are required to submit this certification, such document shall be filed with the state of domicile and electronically with the NAIC no later than March 1. An example for a certification can be found in the Appendices of AG 35.

REASONABLENESS OF ASSUMPTIONS CERTIFICATION FOR IMPLIED GUARANTEED RATE METHOD REQUIRED BY ACTUARIAL GUIDELINE XXXVI

For all reporting entities that are required to submit this certification, such document shall be filed with the state of domicile and electronically with the NAIC no later than March 1. An example for a certification can be found in the Appendices of AG 36.

REASONABLENESS AND CONSISTENCY OF ASSUMPTIONS CERTIFICATION REQUIRED BY ACTUARIAL GUIDELINE XXXVI (UPDATED AVERAGE MARKET VALUE)

For all reporting entities that are required to submit this certification, such document shall be filed with the state of domicile and electronically with the NAIC no later than March 1. An example for a certification can be found in the Appendices of AG 36.

REASONABLENESS AND CONSISTENCY OF ASSUMPTIONS CERTIFICATION REQUIRED BY ACTUARIAL GUIDELINE XXXVI (UPDATED MARKET VALUE)

For all reporting entities that are required to submit this certification, such document shall be filed with the state of domicile and electronically with the NAIC no later than March 1. An example for a certification can be found in the Appendices of AG 36.

Not for Distribution

C-3 RBC CERTIFICATIONS REQUIRED UNDER C-3 PHASE I

Instructions for C-3 RBC Certifications state: "The risk-based capital submission is to be accompanied by a statement from the appointed actuary certifying that in his or her opinion the assumptions used for these calculations are not unreasonable for the products, scenarios and purpose being tested. This C-3 assumption Statement is required from the appointed actuary even if the cash flow testing for C-3 RBC is done by a different actuary."

This certification should be submitted with the state of domicile no later than March 1.

C-3 RBC CERTIFICATIONS REQUIRED UNDER C-3 PHASE II

The C-3 Phase II RBC instructions state the following: "Certification of the work done to set the RBC level will be required to be submitted with the RBC filing. Refer to Appendices 10 and 11 of the AAA LCAS C-3 Phase II RBC Report (June 2005) for further details of the certification requirements. The certification should specify that the actuary is not opining on the adequacy of the company's surplus or its future financial condition. The actuary will also note any material change in the model or assumptions from that used previously and the impact of such changes (excluding changes due to a change in these NAIC instructions. Changes will require regulatory disclosure and may be subject to regulatory review and approval."

The certification(s) should be submitted with the state of domicile a[illegible] no later than March 1.

ACTUARIAL CERTIFICATIONS RELATED TO ANNUITY NONFORFEITURE ONGOING COMPLIANCE

For all reporting entities that are required to submit a Actuarial Certification Related to Annuity Nonforfeiture Reductions and Compliance for equity indexed annuities, such document shall be filed with the state of domicile and electronically with the NAIC no later than March 1. An example for a certification can be found in the appendix of Model #806.

ACTUARIAL OPINION REQUIRED BY MODIFIED GUARANTEED ANNUITY MODEL REGULATION

A reporting entity that issues a modified guaranteed annuity subject to Model #255 shall submit an actuarial opinion with the state of domicile and electronically with the NAIC by March 1 following the December 31 valuation date, showing the status of the accounts as of the prior December 31. In the actuarial opinion the valuation actuary shall indicate whether the assets in the separate account are adequate to provide all future benefits that are guaranteed.

Not for Distribution

ACTUARIAL CERTIFICATIONS RELATED TO HEDGING
REQUIRED BY ACTUARIAL GUIDELINE XLIII

For all reporting entities that are required to submit an Actuarial Certification related to hedging required by Actuarial Guideline XLIII.

FINANCIAL OFFICER CERTIFICATION RELATED TO CLEARLY DEFINED HEDGING STRATEGY
REQUIRED BY ACTUARIAL GUIDELINE XLIII

For all reporting entities that are required to submit a certification by a financial officer related to clearly defined hedging strategy required by Actuarial Guideline XLIII.

MANAGEMENT CERTIFICATION THAT THE VALUATION REFLECTS MANAGEMENT'S INTENT
REQUIRED BY ACTUARIAL GUIDELINE XLIII

For all reporting entities that are required to submit a certification by management required by Actuarial Guideline XLIII.

ACTUARIAL CERTIFICATION RELATED TO THE RESERVES
REQUIRED BY ACTUARIAL GUIDELINE XLIII

For all reporting entities that are required to submit an actuarial certification of reserves required by Actuarial Guideline XLIII.

Not for Distribution

ACTUARIAL CERTIFICATION RELATED TO THE USE OF 2001 PREFERRED CLASS TABLES
REQUIRED BY THE MODEL REGULATION PERMITTING THE RECOGNITION OF PREFERRED
MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES

For all reporting entities that use the 2001 Preferred Class Tables permitted by the *Model Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities (#815).*

SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1, 2 AND 3

The purpose of this supplemental exhibit is to assist state and federal regulators in identifying and defining elements that make up the medical loss ratio as described in Section 2718(b) of the Public Health Service Act (PHSA) and for purposes of submitting a report to the HHS Secretary, as required by Section 2718(a) of the PHSA. The supplemental exhibit is also intended to track and compare financial results of health care business as reported in the annual financial statements. Thus, the numbers included in this supplemental exhibit are not the exact numbers that will be utilized for rebate purposes due to possible revisions for claim reserve run-off subsequent to year-end, statistical credibility concerns and other defined adjustments. (See Cautionary Statement at *www.naic.org/cmte_e_app_blanks.htm*.)

A schedule must be prepared and submitted for each jurisdiction in which the company has written direct comprehensive major medical health business, or has direct amounts paid, incurred or unpaid for provisions of health care services. In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company. However, insurers that have no business that would be included in Columns 1 through 9 or 12 of Part 1 for ANY of the states are not required to complete this supplement at all. If an insurer is required to file the supplement, then the insurer must complete Parts 1 and 2 for each state in which the insurer has any health business, even if a particular state will show $0 earned premiums reported in Columns 1 through 9 or 12 of Part 1. Also, Part 3 must be completed for any state in which there are non-zero amounts in Columns 1 through 9 of Part 1. Companies should contact their domiciliary regulator to obtain a waiver of the filing if the only reportable business in Columns 1 through 9 are comprised of closed blocks of small group, large group or individual business that, if totaled across all states, does not equal 1,000 lives in total.

Run-Off and Reinsurance Business

Similarly, insurers in run-off (major medical claims incurred with zero major medical earned premiums) or that only has assumed and no direct written major medical business in any of the states are not required to complete this supplement. However, 100% assumption reinsurance with novation (or 100% indemnity reinsurance for administration of a block of business entered into prior to March 23, 2010 – see HHS Reg. 158.130 (a)(3)) is treated as direct business for purposes of this supplement (included as direct business for the assuming reinsurer and excluded from direct business for the ceding insurer). Otherwise, the reinsurance data required in this supplement is only for use if an insurer writes direct major medical business and also assumes and/or cedes such insurance.

If an insurer has direct earned premiums to include in Columns 1 through 9 or 12 of Part 1, but also has some business in run-off (major medical claims incurred for 2018 policy year and prior, with zero major medical earned premiums or no coverage in place), the run-off claims and expenses results should be reported in Part 1, Columns 1 through 9 or 12. (If an insurer files the supplement and has a state in which the only Columns 1 through 9 or 12 business is run-off business as defined above, the insurer can report the run-off business for that state as if it was other health business; i.e., because the MLR is meaningless for that state, report zero for Columns 1 through 9 or 12 and include the run-off business along with any other health insurance reported in the Other Health Business columns of Parts 1 and 2.)

The allocation of premium and claims between jurisdictions should be based upon situs of the contract. For purpose of this exhibit, situs of the contract is defined as "the jurisdiction in which the contract is issued or delivered as stated in the contract." For individual business sold through an association, the allocation shall be based on the issue state of the certificate of coverage. When the association is made up of employers, it should be reported as large group or small group depending on the size of each employer. For employer business issued through a group trust, the allocation shall be based on the location of each employer. For employer business issued through a multiple employer welfare association the allocation should be based on the location of each employer.

Include only in this schedule the business issued by this reporting entity. Business that is written by an unaffiliated entity as part of a package provided to the consumer (e.g., inpatient written by this legal entity, outpatient written by unaffiliated separate entity) should not be included in this exhibit. Similarly, business written by an affiliated legal entity as part of a package provided as an option to the group employer (e.g., out of network coverage written by an affiliated entity and in-network coverage written via this legal entity) should not be included in this exhibit.

Not for Distribution

Comprehensive health coverage, Columns 1 through 3, includes business that provides for medical coverages including hospital, surgical and major medical. Include risk contracts and Federal Employees Health Benefit Plan (FEHBP), stand-alone plan and any other comprehensive plan addressed in PPACA and not excluded. Exclude mini-med plans, expatriate plans and student health plans, as these are reported in Columns 4 through 9. Stand-alone plans (e.g., stand-alone pharmacy) excluding Medicare Part D stand-alone addressed in PPACA and not excluded should be reported in the appropriate column that corresponds to the details of the plan.

Do not include business specifically identified in other columns (e.g., uninsured business, Medicare Title XVIII, Medicaid Title XIX, vision only, dental only business, Insurance Program (SCHIP), Medicaid Program Title XXI risk contracts and short-term limited duration insurance). Stop-loss coverage for self-insured groups should be reported in Part 1, Column 11 (Other Health Business).

Not for Distribution

COLUMN DEFINITIONS FOR SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1 AND 2

Where specifically stated, the reporting instructions and definitions contained in the supplement should be used. When not specifically stated, use the annual statement instructions and definitions. Amounts reported in the columns below are mutually exclusive to each other and should not be duplicated in another column.

Column 1 – Comprehensive Health Coverage – Individual

Include: Health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes group conversion policies.

Column 2 – Comprehensive Health Coverage – Small Group Employer

All policies issued to small group employers.

Include small group health plans. "Small group health plan" means a health plan offered in the small group market as such term is defined in state law, consistent with the group's state of situs reporting, in accordance with the Public Health Service Act.

Column 3 – Comprehensive Health Coverage – Large Group Employer

All policies issued to large group employers (including Federal Employees Health Benefit Plan and similar insured state and local fully insured programs).

Include: TRICARE plans.

Column 4 – Mini-med plans – Individual
Column 5 – Mini-med plans – Small Group Employer
Column 6 – Mini-med plans – Large Group Employer

Include "mini-med" plans also referred to as "limited benefit indemnity health insurance plans" in Section 158.120(d)(3) of the MLR Interim Final Rule for policies that have a total annual limit of $250,000 or less.

The definition of individual, small group employer and large group employer is the same definition as used for Comprehensive Health Coverage (Columns 1 through 3) above.

Column 7 – Expatriate plans – Small Group
Column 8 – Expatriate plans – Large Group

Include expatriate plans referenced in Section 158.120(d)(4) of the MLR Interim Final Rule as policies that provide coverage for employees, substantially all of whom are: working outside their country of citizenship, working outside of their country of citizenship and outside the employer's country of domicile, or non-U.S. citizens working in their home country.

These policies can be reported on a nationwide, aggregated basis, in the respective small group/large group columns. The amounts should be reported on the appropriate, domiciliary state page.

Column 9 – Student Health Plans

Include student health plans referenced in Section 147.145(a) of the MLR Interim Final Rule

These policies can be reported on a nationwide, aggregated basis. The amounts should be reported on the appropriate, domiciliary state page.

Not for Distribution

Column 10 – Government Business (Excluded by Statute)

Include government programs that are excluded by statute, such as Medicaid Title XIX, State Children's Health Insurance Program (SCHIP), Medicaid Program Title XXI risk contracts and other federal or state government-sponsored coverage. Exclude Medicare Advantage Part C and Medicare Part D stand-alone plans subject to the ACA reported in Column 12.

Column 11 – Other Health Business

Other Business (Excluded by Statute):

Health plan arrangements that do not provide comprehensive coverage as defined by statute.

Include short-term limited duration insurance and Medicare supplemental health coverage as defined under Section 1882(g)(1) of the Social Security Act, if offered as a separate policy, including student health plans meeting this criteria. Include coverage supplemental to the coverage provided under chapter 55 of title 10, United State Code, and similar supplemental coverage provided under a group health plan, hospital or other fixed indemnity coverage, specified disease or illness coverage and other limited benefit plans as specified by regulations promulgated by HHS in consultation with the NAIC.

All other health care business included in the Accident and Health Experience Exhibit that is not reported in Columns 1 through 10 or 12, including the stand-alone dental and vision coverages, long-term care, disability income, etc.

For insurers that assume health business via aggregate stop-loss reinsurance or other reinsurance that applied to a reinsured entity's or group of entities' entire business that would not be allocable to comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student plans in Columns 1 through 9 of Parts 1 and 2 of the supplement: report such assumed reinsurance on Line 1.1 (premiums) and Line 5.1 (claims) in Column 11 (Other Health Business) for the state page corresponding to the **ceding** insurer's state of domicile.

Column 12 – Medicare Advantage Part C and Medicare Part D Stand-Alone Plans Subject to ACA

Include Medicare Advantage Part C plans as referenced in Section 1103 of Title 1, Subpart B of the federal Reconciliation Act, and Medicare Part D plans as referenced in Section 1860D-12(b)(3)(D) of the federal Affordable Care Act.

These policies can be reported on an aggregated basis on the domiciliary state page.

Not for Distribution

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1

(To Be Filed By April 1 – Not for Rebate Purposes – See Cautionary Statement at *www.naic.org/cmte_e_app_blanks.htm*.)

Column 14 – Uninsured Plans

Refer to *SSAP No. 47—Uninsured Plans* for additional guidance.

Line 1.1 – Health Premiums Earned

Include: Direct written premium plus the change in unearned premium reserves.

Premiums earned on novated policies and on 100% assumption reinsurance where policyholders have consented (via opt-in or failure to opt-out) to the replacement of the original policy issuer (including cases where full servicing of premiums and claims have been transferred) by the assuming reinsurer.

Columns 1 through 13 should equal Part 2, Line 1.11, Columns 1 through 13, respectively.

Line 1.2 – Federal High-Risk Pools

Include: Subsidies received or (assessments paid) under federal high-risk pools as provided in PPACA of 2010 [HR 3590 – cite sections for initial high-risk and future-risk adjustment mechanisms].

Line 1.3 – State High-Risk Pools

Include: Subsidies received or (assessments paid) under state high-risk pools.

Exclude: Items included on Line 2.4.

Line 1.5 – Federal Taxes and Federal Assessments

Refer to *SSAP No. 101—Income Taxes* for "current income taxes incurred."

Include: All federal taxes and assessments allocated to health insurance coverage reported under Section 2718 of the federal Public Health Service Act. Risk adjustment user fees shall be treated as government assessments.

Federal reinsurance contributions required under Section 1341 of the federal Affordable Care Act, including the assessments payable for administration expenses and U.S. Treasury assessments.

Exclude: Federal income taxes on investment income and capital gains.

Not for Distribution

Line 1.6 – State Insurance, Premium and Other Taxes and Assessments

Include: Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the state directly; premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the state; or market stabilization redistributions, or cost transfers for the purpose of rate subsidies, not directly tied to claims and that are authorized by state law.

Guaranty fund assessments.

Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states.

Advertising required by law, regulation or ruling, except advertising associated with investments.

State income, excise and business taxes other than premium taxes.

State premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes.

In lieu of reporting state premium taxes the reporting entity may choose to report payment for community benefit expenditures** limited to the highest premium tax rate in the state for which the report is being submitted, **but not both**.

Exclude: State sales taxes, if company does not exercise the option of including such taxes with the cost of goods and services purchased.

Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes.

Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

Line 1.6a – Community Benefit Expenditures (informational only)

Include: Allowed Community Benefit Expenditures described below and included here and on Line 1.6, limited to premiums earned on comprehensive health policies (individual, small group and large group business), mini-med plans (individual, small group and large group business) and expatriate plans. (small group and large group business) multiplied by the highest state premium tax rate applicable to entities subject to premium tax.

EITHER*:

a. Payments to a state, by health plans, of premium tax exemption values in lieu of state premium taxes;

b. Payments by health plans for community benefit expenditures.** These payments must be state-based requirements to qualify for inclusion in this line item;

OR

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c. Payments made by (federal income) tax-exempt health plans for community benefit expenditures.** (NOTE: If the instruction for Line 1.5 above is revised to exclude federal income taxes, then tax-exempt health plans may NOT include community benefit expenditures in this line.)

Exclude: Any community benefit expenses in excess of the tax rate limitation. Such excess expenses will be reported on line 10.4a (informational) and included in line 10.4.

* These expenditures may not be double-counted between this category; the federal or state assessments for similar purposes included in Lines 1.5 or 1.6; or the quality improvement expenses reported in Lines 6.1 through 6.4.

** Community benefit expenditures are for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes activities that:

- Are available broadly to the public and serve low-income consumers;
- Reduce geographic, financial or cultural barriers to accessing health services, and if ceased to exist would result in access problems (e.g., longer wait times or increased travel distances);
- Address federal, state or local public health priorities, such as advancing health care knowledge through education or research that benefits the public;
- Leverage or enhance public health department activities, such as childhood immunization efforts; or
- Otherwise would become the responsibility of government or another tax-exempt organization.

Line 1.7 – Regulatory Authority Licenses and Fees

Include: Statutory assessments to defray operating expenses of any state insurance department. Examination fees in lieu of premium taxes as specified by state law.

Exclude: Fines and penalties of regulatory authorities.

Fees for examinations by state departments other than as referenced above.

Line 1.9 – Net Assumed Less Ceded Reinsurance Premiums Earned

The amount to net against the assumed reinsurance premiums earned is the ceded reinsurance premiums written plus the change in unearned premium reserve that is transferred to the company assuming the risk plus the change in reserve credit taken other than for unearned premiums.

Should agree with Supplemental Health Care Exhibit, Part 2, Line 1.12 plus Line 1.13 less Line 1.14 for each column.

Line 1.10 – Other Adjustments Due to MLR Calculations – Premiums

Any amounts excluded from premiums in Part 2 for MLR calculation purposes. Should agree with Supplemental Health Care Exhibit, Part 2, Line 1.15.

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Line 1.11 – Risk Revenue

Include: Amounts charged by the reporting entity as a provider or intermediary for specified medical services (e.g., full professional, dental, radiology, etc.) provided to the policyholders or members of another insurer or reporting entity.

Unlike premiums that are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payment, made by another insurer or reporting entity to the reporting entity in exchange for services to be provided or offered by such organization.

Health Statement:

Column 13 should equal Statement of Revenue and Expense, Line 5, Column 2.

Line 2 – Claims

Health Statement:

Column 13, Lines 2.2 minus 2.3 should equal Statement of Revenue and Expense, Line 13, Column 2.

Line 2.1 – Incurred Claims Excluding Prescription Drugs

Include: Direct Paid Claims during the Year

Report payments before ceded reinsurance, but net of risk-share amount collected.

Change in Unpaid Claims

Report the change between prior year and current year unpaid claims reserves including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation.

Change in Incurred but not Reported

Report the change in claims incurred but not reported from prior year to current year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure, claim frequency or severity.

Change in Contract & Other Claims Related Reserves (including the Change in Reserve for Rate Credits).

Exclude: MLR rebates paid during the year.

Prescription drugs reported in Line 2.2.

Pharmaceutical rebates received during the year, reported in Line 2.3.

Medical incentive pools and bonuses.

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Line 2.2 – Prescription Drugs

Include: Expenses for prescription drugs and other pharmacy benefits covered by the reporting entity.

Exclude: Prescription drug charges that are included in a hospital billing that should be classified as Hospital/Medical Benefits on Line 2.1.

Line 2.3 – Pharmaceutical Rebates

Refer to *SSAP No. 84—Health Care and Government Insured Plan Receivables* for accounting guidance.

Line 2.4 – State Stop Loss, Market Stabilization and Claim/Census Based Assessments (Informational Only)

Any market stabilization payments or receipts by insurers that are directly tied to claims incurred and other claims based or census based assessments.

State subsidies based on a stop-loss payment methodology.

Unsubsidized state programs designed to address distribution of health risks across health insurers via charges to low risk-carriers that are distributed to high risk carriers.

Refer to *SSAP No. 35R—Guaranty Fund and Other Assessments* for accounting guidance.

Line 3 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk-sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments to providers to promote quality improvements as defined in the PHSA (Section 2717).

Should agree to Supplemental Health Care Exhibit, Part 2, Line 2.11, for each column.

Health Statement:

Column 15 should equal Underwriting and Investment Exhibit, Part 2, Line 13, Column 1 minus 10.

Line 4 – Deductible Fraud and Abuse Detection/Recovery Expenses

This amount is the lesser of the expense reported in Part 3, Column 7, Lines 1.11, 2.11, 3.11, 4.11, 5.11, 6.11, 7.11, 8.11 and 9.11, and the fraud and abuse recoveries reported in Part 2, Line 3, Columns 1, 2, 3, 4, 5, 6, 7, 8 and 9, respectively.

Line 5.0 – Total Incurred Claims (Lines 2.1 + 2.2 – 2.3 + 3)

Should agree with Supplemental Health Care Exhibit, Part 2, Line 2.15.

Line 5.1 – Net Assumed Less Ceded Reinsurance Claims Incurred

Assumed reinsurance claims paid plus the change in the assumed reinsurance claims liability and aggregate assumed reinsurance claims reserve less the ceded reinsurance claims paid plus the change in the ceded reinsurance claims liability and aggregate ceded reinsurance claims reserve less the change in claims related reinsurance recoverables.

Should agree with Supplemental Health Care Exhibit, Part 2, Line 2.16 plus Line 2.17, less Line 2.18, for each column.

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Line 5.2 – Other Adjustments Due to MLR Calculation – Claims

Any amounts excluded from claims in Part 2 for MLR calculation purposes.

Deduct: MLR rebated incurred included in Line 5.0

Line 5.3 – Rebates Paid

MLR Rebates paid during the year.

Columns 1 through 3 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(8), Columns 1 through 3, respectively.

Sum of Columns 4 through 9 plus 12 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(8), Column 4.

Line 5.4 – Estimated Rebates Unpaid at the End of the Prior Year

Should equal Line 5.5 from the prior year.

Columns 1 through 3 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(3), Columns 1 through 3, respectively.

Sum of Columns 4 through 9 plus 12 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(3), Column 4.

Line 5.5 – Estimated Rebates Unpaid at the End of the Current Year

MLR rebates estimated but unpaid as of reporting period.

Columns 1 through 3 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(9), Columns 1 through 3, respectively.

Sum of Columns 4 through 9 plus 12 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(9), Column 4.

This cross-check is for the year-end annual statement accrual for the Public Health Service Act rebates to Supplemental Health Care Exhibit, Part 1 April 1 filing. This amount may differ from the final payment made in accordance with the HHS filing.

Line 5.6 – Fee-for-Service and Co-Pay Revenue (net of expenses)

Include: Revenue recognized by the reporting entity for collection of co-payments from members and revenue derived from health services rendered by reporting entity providers that are not included in member policies.

Deduct: Medical expenses associated with fee-for-service business.

Not for Distribution

Line 6.1 – Improve Health Outcomes

Include expenses meeting the definition of Improve Health Outcomes in Part 3, Column 1 that are not health information technology expenses.

Part 1, Column 1, Line 6.1 should tie to Part 3, Column 1, Line 1.10

Part 1, Column 2, Line 6.1 should tie to Part 3, Column 1, Line 2.10

Part 1, Column 3, Line 6.1 should tie to Part 3, Column 1, Line 3.10

Part 1, Column 4, Line 6.1 should tie to Part 3, Column 1, Line 4.10

Part 1, Column 5, Line 6.1 should tie to Part 3, Column 1, Line 5.10

Part 1, Column 6, Line 6.1 should tie to Part 3, Column 1, Line 6.10

Part 1, Column 7, Line 6.1 should tie to Part 3, Column 1, Line 7.10

Part 1, Column 8, Line 6.1 should tie to Part 3, Column 1, Line 8.10

Part 1, Column 9, Line 6.1 should tie to Part 3, Column 1, Line 9.10

Line 6.2 – Activities to Prevent Hospital Readmissions

Include expenses meeting the definition of Improving Activities to Prevent Hospital Readmissions in Part 3, Column 2 that are not health information technology expenses.

Part 1, Column 1, Line 6.2 should tie to Part 3, Column 2, Line 1.10

Part 1, Column 2, Line 6.2 should tie to Part 3, Column 2, Line 2.10

Part 1, Column 3, Line 6.2 should tie to Part 3, Column 2, Line 3.10

Part 1, Column 4, Line 6.2 should tie to Part 3, Column 2, Line 4.10

Part 1, Column 5, Line 6.2 should tie to Part 3, Column 2, Line 5.10

Part 1, Column 6, Line 6.2 should tie to Part 3, Column 2, Line 6.10

Part 1, Column 7, Line 6.2 should tie to Part 3, Column 2, Line 7.10

Part 1, Column 8, Line 6.2 should tie to Part 3, Column 2, Line 8.10

Part 1, Column 9, Line 6.2 should tie to Part 3, Column 2, Line 9.10

Line 6.3 – Improve Patient Safety and Reduce Medical Errors

Include expenses meeting the definition of Improve Patient Safety and Reduce Medical Errors in Part 3, Column 3 that are not health information technology expenses.

Part 1, Column 1, Line 6.3 should tie to Part 3, Column 3, Line 1.10

Part 1, Column 2, Line 6.3 should tie to Part 3, Column 3, Line 2.10

Part 1, Column 3, Line 6.3 should tie to Part 3, Column 3, Line 3.10

Part 1, Column 4, Line 6.3 should tie to Part 3, Column 3, Line 4.10

Part 1, Column 5, Line 6.3 should tie to Part 3, Column 3, Line 5.10

Part 1, Column 6, Line 6.3 should tie to Part 3, Column 3, Line 6.10

Part 1, Column 7, Line 6.3 should tie to Part 3, Column 3, Line 7.10

Part 1, Column 8, Line 6.3 should tie to Part 3, Column 3, Line 8.10

Part 1, Column 9, Line 6.3 should tie to Part 3, Column 3, Line 9.10

Not for Distribution

Line 6.4 – Wellness and Health Promotion Activities

Include expenses meeting the definition of Wellness and Health Promotion Activities in Part 3, Column 4 that are not health information technology expenses.

Part 1, Column 1, Line 6.4 should tie to Part 3, Column 4, Line 1.10

Part 1, Column 2, Line 6.4 should tie to Part 3, Column 4, Line 2.10

Part 1, Column 3, Line 6.4 should tie to Part 3, Column 4, Line 3.10

Part 1, Column 4, Line 6.4 should tie to Part 3, Column 4, Line 4.10

Part 1, Column 5, Line 6.4 should tie to Part 3, Column 4, Line 5.10

Part 1, Column 6, Line 6.4 should tie to Part 3, Column 4, Line 6.10

Part 1, Column 7, Line 6.4 should tie to Part 3, Column 4, Line 7.10

Part 1, Column 8, Line 6.4 should tie to Part 3, Column 4, Line 8.10

Part 1, Column 9, Line 6.4 should tie to Part 3, Column 4, Line 9.10

Line 6.5 – Health Information Technology Expenses related to Health Improvement

Include expenses meeting the definition of HIT Expenses for Health Care Quality Improvements in Part 3, Column 5 that are health information technology expenses. Include ICD-10 conversion costs incurred up to .3% of earned premium related to quality improvement. (Refer to 45 CFR 158.150 of PPACA.) Exclude ICD-10 expenses related to claims adjudication or maintenance.

Part 1, Column 1, Line 6.5 should tie to Part 3, Column 5, Line 1.10

Part 1, Column 2, Line 6.5 should tie to Part 3, Column 5, Line 2.10

Part 1, Column 3, Line 6.5 should tie to Part 3, Column 5, Line 3.10

Part 1, Column 4, Line 6.5 should tie to Part 3, Column 5, Line 4.10

Part 1, Column 5, Line 6.5 should tie to Part 3, Column 5, Line 5.10

Part 1, Column 6, Line 6.5 should tie to Part 3, Column 5, Line 6.10

Part 1, Column 7, Line 6.5 should tie to Part 3, Column 5, Line 7.10

Part 1, Column 8, Line 6.5 should tie to Part 3, Column 5, Line 8.10

Part 1, Column 9, Line 6.5 should tie to Part 3, Column 5, Line 9.10

Not for Distribution

Line 8.1 – Cost Containment Expenses not Included in Quality of Care Expenses in Line 6.6

Include: Expenses that actually serve to reduce the number of health services provided or the cost of such services. Exclude cost containment expenses that improve the quality of health care (reported in Line 6.6). The following are examples of items that shall be considered "cost containment expenses" only if they result in reduced levels of costs or services (see the instructions for Part 3 of this supplement for items that qualify for Quality Improvement instead of "cost containment"):

Post and concurrent claim case management activities associated with past or ongoing specific care;

Utilization review;

Detection and prevention of payment for fraudulent requests for reimbursement;

Expenses for internal and external appeals processes; and

Network access fees to preferred provider organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting.

Line 8.2 – All Other Claims Adjustment Expenses

All Other Claims Adjustment Expenses not Included in Quality of Care Expenses in Line 6.6.

Include: Costs expected to be incurred in connection with the adjustment and recording of accident and health claims defined in *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*. Further, Claim Adjustment Expenses for Managed Care Reporting Entities are those costs expected to be incurred in connection with the adjustment and recording of managed care claims defined in *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*.

Examples of other claim adjustment expenses are:

Estimating the amounts of losses and disbursing loss payments;

Maintaining records, general clerical and secretarial;

Office maintenance, occupancy costs, utilities and computer maintenance;

Supervisory and executive duties; and

Supplies and postage.

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Line 10 – General and Administrative Expenses

General and Administrative Expenses not Included in Line 6.6 or Line 8.3.

Line 10.1 – Direct Sales Salaries and Benefits

Compensation (including, but not limited, to salaries and benefits) to employees of the company engaged in the activity of soliciting and generating sales to policyholders for the company.

Line 10.2 – Agents and Brokers Fees and Commissions

All expenses incurred by the company payable to a licensed agent, broker or producer who is not an employee of the issuer in relation to the sale and solicitation of policies for the company.

Line 10.3 – Other Taxes (Excluding Taxes on Lines 1.5 through 1.7 above and Line 14 below)

Include: Taxes of Canada or of any other foreign country not specifically provided for elsewhere.

Sales taxes, other than state sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

Line 10.4a – Community Benefit Expenditures (informational only; already reported in line 10.4)

Community benefit expenditures excluded from line 1.6a due to tax rate limitation.

Line 16 – ICD-10 Implementation Expenses (Informational only; already included in Line 8.2 and Line 6.5)

Costs associated the implementation of ICD-10, including the total cost of conversion, claims adjudication, maintenance and quality improvement allowance.

Line 16a – ICD-10 Implementation Expenses (Informational only, already included in Line 6.5)

Include: Quality improvement ICD-10 conversion costs incurred up to .3% of earned premium in the relevant state market. (Refer to 45 CFR 158.150 of PPACA.)

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OTHER INDICATORS

These should be allocated to jurisdictions in the same manner as premium.

Line 1 – Number of Certificates / Policies

This is the number of individual policies (for individual business) or certificates issued to individuals covered under a group policy in force as of end of the reporting period. It is not the number of persons covered under individual policies or group certificates. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Column 15 should equal Accident and Health Policy Experience Exhibit Column [illegible], Line D2 – D1.

Line 2 – Number of Covered Lives

This is the total number of lives insured, including dependents, under individual policies and group certificates as of the reporting period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Column 15 should equal Accident and Health Policy Experience Exhibit Column 6, Line D2 – D1.

Line 3 – Number of Groups

This is the total number of insurance groups issued as of the end of the reporting period.

Line 4 – Member Months

The sum of total number of lives insured on a pre-specified day of each month of the reported period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Column 15 should equal Accident and Health Policy Experience Exhibit Column 7, Line D2 – D1.

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ACA RECEIPTS, PAYMENTS, RECEIVABLES and PAYABLES TABLE

Permanent ACA Risk Adjustment Program

The amounts from the lines below for Column 1, Individual Plans and Column 2, Small Group Employer Plans, are included in the amount reported on Line 1.1 of Part 2:

Line 1.0	Premium adjustments receivable/(payable)
Line 4.0	Premium adjustments receipts/(payments)

Transitional ACA Reinsurance Program

The amounts from the lines below for Column 1, Individual Plans, are included in the amount reported on Line 2.17 and Line 2.18 of Part 2:

Line 2.0	Amounts recoverable for claims (paid & unpaid)
Line 5.0	Amounts received for claims

Temporary ACA Risk Corridors Program

The amounts from the lines below for Column 1, Individual Plans and Column 2, Small Group Employer Plans, are included in the amount reported on Line 1.6 of Part 2:

Line 3.1	Accrued retrospective premium
Line 3.2	Reserve for rate credits or policy experience refunds

The amounts from the lines below for Column 1, Individual Plans and Column 2, Small Group Employer Plans, are included in the amount reported on Line [illegible].5 of Part 2:

Line 6.1	Retrospective premium received
Line 6.2	Rate credits or policy experience refunds paid

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Column 13 – Total

For Part 2, the GT (Grand Total) page:

- Column 13, Line 1.16 (Net Premiums Earned) should equal the Accident and Health Policy Experience Exhibit, Part 4, Column 1, Line 6 (Total) minus Line 2 (Other Forms Direct Business).
- Column 13, Line 1.11 (Total Direct Premiums Earned) minus Line 1.5 (Paid Rate Credits) minus Line 1.8 (Change in Reserve for Rate Credits) plus Line 1.15 (Other Adjustments Due to MLR Calculation – Premiums) should equal the Accident and Health Policy Experience Exhibit, Part 4, Column 1, Line 1 (U.S. Forms Direct Business).
- Column 13, Line 2.20 (Net Incurred Claims) minus Line 2.11 (Incurred Medical Incentive Pools and Bonuses) should equal the Accident and Health Policy Experience Exhibit, Part 4, Columns 2 plus 3, Line 6 (Total) minus Line 2 (Other Forms Direct Business).
- Column 13, Line 2.15 (Total Incurred Claims) minus Line 2.8 (Paid Rate Credits) minus Line 2.9 (Reserve for Rate Credits Current Year) plus Line 2.10 (Reserve for Rate Credits Prior Year) minus Line 2.11 (Incurred Medical Incentive Pools and Bonuses) plus Line 2.19 (Other Adjustments Due to MLR Calculation – Claims) should equal the Accident and Health Policy Experience Exhibit, Part 4, Columns 2 plus 3, Line 1 (U.S. Forms Direct Business).

NOTE: If the reporting entity has a Premium Deficiency Reserve, they will fail the crosschecks above due to the Accident and Health Policy Experience Exhibit excluding Premium Deficiency Reserve. The reporting entity should provide that explanation for the crosscheck failure.

Lines 1.1 – Direct Premiums Written

Include: Premium adjustments for contracts subject to redetermination where premium adjustments are based on the risk scores (health status) of covered enrollees, rather than the actual loss experience of the policy (e.g., Medicare Advantage risk adjustment and ACA risk adjustment). See *SSAP No. 54R—Individual and Group Accident and Health Contracts* and *SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act* for accounting guidance.

Exclude: Amounts for rate credits paid. Premium adjustments related to retrospectively rated contracts are reported on Part 2 Line 1.5 through Line 1.8.

Line 1.5 – Paid Rate Credits

Report experience-rated premium refunds paid or received during the reporting year for retrospectively rated contracts.

Include: MLR rebates paid, risk corridor premiums paid or received, and all other premium refunds paid or received related to retrospectively rated contracts. See *SSAP No. 66—Retrospectively Rated Contracts* and *SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act* for accounting guidance.

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Line 1.6 – Reserve for Rate Credits Current Year

Report experience-rated refund liabilities less receivables under retrospectively rated contracts.

Include: MLR rebates accrued, premium stabilization reserves and risk corridor liabilities less receivables.

Line 1.9 – Premium Balances Written Off

Include: Agents' or premium balances determined to be uncollectible and written off as losses. Also include recoveries during the current year on balances previously written off. Include actual write offs, not reserves for bad debt or statutory nonadmitted amounts.

Line 1.10 – Group Conversion Charges

If Line 1.1 has been reduced or increased by the amount of any conversion charges associated with group conversion privileges between group and individual lines of business in the annual statement accounting, enter the reverse of these charges on this line in the appropriate columns.

Line 1.11 – Total Direct Health Premiums Earned

Include: Direct written premium plus the change in unearned premium reserves.

Line 1.12 – Assumed Premium Earned from Non-affiliates

Include: Premiums assumed from ceding entity per *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance.*

Line 1.13 – Net Assumed Less Ceded Premiums Earned from Affiliates

Include: Premiums received from ceding entity and ceded premium per *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance*.

Line 1.14 – Ceded Premium Earned to Non-affiliates

Include: Assessments payable for reinsurance for issuers of individual policies per *SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act* and ceded premium per *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance*.

Line 1.15 – Other Adjustments Due to MLR Calculation – Premiums

Include: Any amounts excluded from premium for MLR calculation purposes that are normally included in premiums for financial statement purposes.

Do Not Include: MLR rebates or any other premium adjustment related to retrospectively rated contracts as those amounts are to be reported on Part 2 Line 1.5 through Line 1.8.

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Line 2 – Direct Claims Incurred:

Hospital/Medical Benefits

Include: Expenses for physician services provided under contractual arrangement to the reporting entity.

Salaries, including fringe benefits, paid to physicians for delivery of medical services. Capitation payments by the reporting entity to physicians for delivery of medical services to reporting entity subscribers.

Fees paid by the reporting entity to physicians on a fee-for-service basis for delivery of medical services to reporting entity subscribers. This includes capitated referrals.

Inpatient hospital costs of routine and ancillary services for reporting entity members while confined to an acute care hospital.

Charges for non-reporting entity physician services provided in a hospital are included in this line item only if included as an undefined portion of charges by a hospital to the reporting entity. (If separately itemized or billed, physician charges should be included in outside referrals, below.)

The cost of utilizing skilled nursing and intermediate care facilities.

Routine hospital service includes regular room and board (including intensive care units, coronary care units and other special inpatient hospital units), dietary and nursing services, medical-surgical supplies, medical social services and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.

Ancillary services may also include laboratory, radiology, drugs, delivery room, physical therapy services, other special items and services for which charges are customarily made in addition to a routine service charge.

Skilled nursing facilities are primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation service.

Intermediate care facilities are for individuals who do not require the degree of care and treatment that a hospital or skilled nursing-care facility provides, but that do require care and services above the level of room and board.

Other Professional Services

Include: Expenses for other professional providers under contractual arrangement to the reporting entity.

Salaries, as well as fringe benefits, paid by the reporting entity to non-physician providers licensed, accredited or certified to perform specified clinical health services, consistent with state law, engaged in the delivery of medical services to reporting entity enrollees. Capitation payments by the reporting entity to such clinical service

Compensation to personnel engaged in activities in direct support of the provision of medical services.

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Exclude: Professional services not meeting this definition. Report these services as administrative expenses. For example, exclude compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks.

Outside Referrals

Include: Expenses for providers not under arrangement with the reporting entity to provide services, such as consultations or out-of-network providers.

Emergency Room and Out-of-Area

Include: Expenses for other health delivery services, including emergency room costs incurred by members for which the reporting entity is responsible and out-of-area service costs for emergency physician and hospital.

In the event a member is admitted to the health care facility immediately after seeking emergency room service, emergency service expenses are reported in this line, the expenses after admission are reported in the hospital/medical line, provided the member is seeking services in the service area. Out-of-area expenses incurred, whether emergency or hospital, are reported in this line.

Aggregate Write-ins for Other Hospital and Medical

Include: Other hospital and medical expenses not covered in the other claims accounts.

Line 2.1 Paid Claims during the Year

Report payments net of risk share amount collected.

Line 2.2 – Direct Claim Liability Current Year

Report the outstanding liabilities for health care services related to claims in the process of adjustment, incurred but not reported, amounts withheld from paid claims and capitations.

Include: Unpaid Claims

Report the current year unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation.

Incurred but not Reported

Report the claims incurred but not reported in the current year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure, claim frequency or severity.

The direct claims related portion of lawsuit liability as reported on the Liabilities Page 3, Line 4.2 (Life Statement), Line 1, (Health Statement) and Line 1 (Property Statement).

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Line 2.4 – Direct Claim Reserves Current Year

Report reserves related to health care services for present value of amounts not yet due on claims and the claims related portion for reserve for future contingent benefits.

Include: Amounts for the reserve for rate credits for the current year.

The direct claims related portion of lawsuit reserves as reported on the Liabilities Page 3, Line 2 (Life Statement), Line 7 (Health Statement) and Line 1 (Property Statement).

Line 2.6 – Direct Contract Reserve Current Year

Report the amount of reserves required when due to the gross premium structure the future benefits exceed the future net premium. Contract reserves are in addition to claim liabilities and claim reserves. Refer to *SSAP No. 54R—Individual and Group Accident and Health Contracts* for guidance.

Include: Contract reserves and other claims related reserves.

Exclude: Premium deficiency reserves.

Line 2.8 – Paid Rate Credits

Report experience-rated premium refunds paid or received during the reporting year for retrospectively rated contracts.

Include: MLR rebates paid, risk corridor premiums paid or received, and all other premium refunds paid or received related to retrospectively rated contracts.

Line 2.9 – Reserve for Rate Credits Current Year

Report experience-rated refund liabilities less receivables under retrospectively rated contracts.

Include: MLR rebates accrued, premium stabilization reserves, and risk corridor liabilities less receivables.

Line 2.11 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk-sharing arrangements whereby the reporting entity agrees to share savings with contracted providers.

Line 2.12 – Net Health Care Receivables

Report the change between prior year health care receivables and current year health care receivables. The amounts on this line are the gross health care receivable assets, not just the admitted portion. This amount should not include those health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

Line 2.13 – Group Conversion Charges

If Line 1.1 has been reduced or increased by the amount of any conversion charges associated with group conversion privileges between group and individual lines of business in the annual statement accounting, enter the reverse of these charges on this line. Otherwise, if group conversion charges were reported separately from premiums and claims on the annual statement, enter these charges on this line in the appropriate columns.

Not for Distribution

Line 2.14 – Multi-option Coverage Blended Rate Adjustment

If multi-option coverage is provided to a single employer at blended rates, which are defined as cross-subsidized rates charged for coverage provided by a single employer through two or more affiliates, the reporting entity may make an adjustment to bring each affiliate's ratio of incurred claims to earned premium to equal the ratio calculated for that employer group in aggregate for the MLR reporting year. If the reporting entity chooses to make this adjustment, it must be made for a minimum of three years. (This does NOT include dual contract amounts for in network and out of network coverage.)

Line 2.15 – Total Incurred Claims

Should agree to Supplemental Health Care Exhibit, Part 1, Line 5.0.

Line 2.19 – Other Adjustments Due to MLR Calculation – Claims

Include: Any amounts excluded from claims for MLR calculation purposes that are normally included in claims for financial statement purposes. For example, premium deficiency reserves are excluded from contract reserves for MLR purposes in Part 2; thus, premium deficiency reserves would be included on this Line. Include the adjustment for multi-option coverage amounts (if offsetting line 2.14, report as a negative amount).

Do Not Include MLR rebates or any other premium adjustment related to retrospectively rated contracts as those amounts are to be reported on Part 2 Line 2.8 through Line 2.10.

Line 3 – Fraud and Abuse Recoveries that Reduced PAID Claims in Line 2.1 above (informational only)

Include collected recoveries on paid claims only.

Footnote (a)

Report the amount of direct written premium included in Column 13, Line 1.1 for stand-alone dental and vision policies.

Not for Distribution

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

This exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student health plans.

This exhibit also shows the amount of qualifying HIT expenses, reported separately for the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student health plans, broken down into the four categories of Quality Improvement expenses (see below); similarly, the Other than HIT qualifying Quality Improvement expenses are disclosed for each of the four categories of Quality Improvement expenses.

The definitions of Individual, Small Group and Large Group are found in the instructions for Part 1 and 2 of this supplement exhibit.

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage, as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self-insured plans.

Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

They should not be designed primarily to control or contain cost, although they may have cost-reducing or cost-neutral benefits, as long as the primary focus is to improve quality.

Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;
- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency and outcomes.

NOTE: Expenses that otherwise meet the definitions for QI but were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

Not for Distribution

Column 1 – Improve Health Outcomes

Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, Web-based interactions or other means of communication) to improve health outcomes as defined above.

This category can include costs for associated activities such as:

- Effective case management, care coordination and chronic disease management, including:
  - Patient-centered intervention, such as:
    - Making/verifying appointments;
    - Medication and care compliance initiatives;
    - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center);
    - Programs to support shared decision-making with patients, their families and the patient's representatives; and
    - Reminding insured of physician appointments, lab tests or other appropriate contact with specific providers;
  - Incorporating feedback from the insured to effectively monitor compliance;
  - Providing coaching or other support to encourage compliance with evidence-based medicine;
  - Activities to identify and encourage evidence-based medicine;
  - Use of the medical homes model as defined for purposes of Section 3602 of PPACA;
  - Activities to prevent avoidable hospital admissions;
  - Education and participation in self-management programs; and
  - Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;
- Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in Columns 1 through 5;
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine;
- Quality reporting and documentation of care in non-electronic format; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above; and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.

Not for Distribution

Column 2 – Activities to Prevent Hospital Readmission

Expenses for implementing activities to prevent hospital readmissions as defined above, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help ensure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Personalized post-discharge counseling by an appropriate health care professional;
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above; and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.

Column 3 – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities to improve patient safety and reduce medical errors (as defined above) through:

- The appropriate identification and use of best clinical practices to avoid harm;
- Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;
- Activities to lower risk of facility acquired infections;
- Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions;
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions), including:
  - Data extraction, analysis and transmission in support of the activities described above; and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.

Column 4 – Wellness & Health Promotion Activities

Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or Web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition; and
- Public health education campaigns that are performed in conjunction with state or local health departments.

Not for Distribution

- Actual rewards/incentives/bonuses/reductions in co-pays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:
  - Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit;
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and
- Health information technology expenses to support these activities (Report 1, Column 5 – See instructions).

Column 5 – HIT Expenses for Health Care Quality Improvements

The PPACA also contemplates "Health Information Technology" as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers or enrollees for the electronic creation, maintenance, access or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements, in the following ways:

1. Monitoring, measuring or reporting clinical effectiveness, including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations, such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law;
2. Advancing the ability of enrollees, providers, insurers or other systems to communicate patient-centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic health records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history;
3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
4. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease; or
5. Provision of electronic health records and patient portals.
6. ICD-10 conversion costs incurred up to .3% of earned premium related to quality improvement. (Refer to 45 CFR 158.150 of PPACA).

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the ICD-10 conversion costs not related to quality improvement and ICD-10 conversion costs incurred that are in excess of .3% of earned premium that are related to quality improvement.

Not for Distribution

NOTE: a. Health Care Professional Hotlines: Expenses for health care professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.

b. Prospective Utilization Review: Expenses for prospective utilization review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

The following items are broadly excluded as not meeting the definitions above:

- All retrospective and concurrent utilization review;
- Fraud prevention activities (all are reported as cost containment, but Part 1, Line [illegible] includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider credentialing;
- Marketing expenses;
- Any accreditation fees that are not directly related to activities included in Columns 1 through 5;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.

NOTE: The NAIC will review requests to include expenses for broadly excluded activities and activities not described under Columns 1 through 5 above. Upon an adequate showing that the activity's costs support the definitions and purposes therein, or otherwise support monitoring, measuring, or reporting health care quality improvement, the NAIC may recommend that the HHS Secretary certify those expenses as Quality Improvement.

The sections for comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business) and expatriate plans (small group and large group business) are defined as per the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student health plans columns in Parts 1 and 2 of this supplement.

For questions on definitions, refer to the instructions for the Annual Statement Expenses Schedule (i.e., the Underwriting and Investment Exhibit, Part [illegible] for P/C and Health, and Exhibit 2 for Life and Fraternal), for the line references provided below. **DIFFERENT FROM A/S EXPENSE REPORTING**: For non-affiliated management agreements/outsourced services, report all amounts in the supplement's Line 1.2, 2.2, 3.2, 4.2, 5.2, 6.2, 7.2 , 8.2 or 9.2 for Outsourced Services (not just those amounts less than 10% of total expenses). Continue to allocate all affiliated management agreements/outsourced services to the appropriate expense lines as if the costs had been borne directly by the insurer.

Not for Distribution

Lines 1.1, 2.1,
3.1, 4.1, 5.1,
6.1, 7.1, 8.1
& 9.1 – Salaries

Life/Fraternal Statement:

Exhibit 2, Line 2 Salaries and wages

Exhibit 2, Line 3.11 Contributions for benefit plans for employees

Exhibit 2, Line 3.12 Contributions for benefit plans for agents

Exhibit 2, Line 3.21 Payments to employees under non-funded benefit plans

Exhibit 2, Line 3.22 Payments to agents under non-funded benefit plans

Exhibit 2, Line 3.31 Other employee welfare

Exhibit 2, Line 3.32 Other agent welfare

Health Statement:

U&I Part 3, Line 2 Salaries, wages and other benefits

P/C Statement:

U&I Part 3, Line 8.1 Salaries

U&I Part 3, Line 9 Employee relations and welfare

U&I Part 3, Line 11 Directors' fees

Lines 1.2, 2.2,
3.2, 4.2, 5.2,
6.2, 7.2, 8.2
& 9.2 – Outsourced Services

Include: All non-affiliated expenses for administrative services, claim management services, EDP programming, membership services, and other similar services, regardless of amount. Thus, non-affiliated amounts greater than the 10% threshold that are reported in the various expense categories (e.g., salaries, rent) for A/S Expense Exhibit reporting will be backed out of the expense categories and reported in Outsourced Services in the Supplemental Health Care Exhibit, Part 3. In addition, the non-affiliated amounts less than the 10% threshold will be included in Outsourced Services (reported as follows in the A/S Expense Exhibit):

Life/Fraternal Statement:

Exhibit 2, Line 4.5 Expense of investigation and settlement of policy claims

Outsourced portion of Exhibit 2, Line 7.1 Agency expense allowance

Health Statement:

U&I Part 3, Line 14 Outsourced services including EDP, claims, and other services

P/C Statement:

Outsourced portion of U&I Part 3, Line 1.4 Net claim adjustment services

Outsourced portion of U&I Part 3, Line 2.8 Net commission/brokerage

Outsourced portion of U&I Part 3, Line 3 Allowances to manager and agents

Exclude: Services provided by affiliates under management agreements.

Not for Distribution

Lines 1.3, 2.3, 3.3, 4.3, 5.3, 6.3, 7.3, 8.3 & 9.3 – EDP Equipment and Software

Life/Fraternal Statement:

Exhibit 2, Line 5.7 Cost or depreciation of EDP equipment and software

Health Statement:

U&I Part 3, Line 13 Cost or depreciation of EDP equipment and software

P/C Statement:

U&I Part 3, Line 15 Cost or depreciation of EDP equipment and software

Lines 1.4, 2.4, 3.4, 4.4, 5.4, 6.4, 7.4, 8.4 & 9.4 – Other Equipment (excluding EDP)

Life/Fraternal Statement:

Exhibit 2, Line 5.6 Rental of equipment

Equipment amounts from Exhibit 2, Line 5.5 Cost or depreciation of furniture/equipment

Health Statement:

U&I Part 3, Line 12 Equipment

P/C Statement:

U&I Part 3, Line 14 Equipment

Lines 1.5, 2.5, 3.5, 4.5, 5.5, 6.5, 7.5, 8.5 & 9.5 – Accreditation and Certification

Include: Fees associated with the certification and accreditation of a health plan, including but not limited to: fees paid to Joint Commission on Accreditation of Health Care Organizations (JCAHO), National Committee on Quality Assurance (NCQA), and American Accreditation Health Care Commission (URAC).

Life/Fraternal Statement:

Applicable portion of Exhibit 2, Line 6.2 Bureau and association fees

Health Statement:

U&I Part 3, Line 5 Certification and Accreditation

P/C Statement:

Applicable portion of U&I Part 3, Line 5 Boards, bureaus and associations

Exclude: Rating agencies and other similar organizations.

Not for Distribution

Lines 1.6, 2.6, 3.6, 4.6, 5.6, 6.6, 7.6, 8.6 & 9.6 – Other Expenses

Include: Any additional expenses not included in another category.

Life/Fraternal Statement:

Exhibit 2, Line 1 Rent

Exhibit 2, Line 4.1 Legal fees and expenses

Exhibit 2, Line 4.2 Medical examination fees

Exhibit 2, Line 4.3 Inspection report fees

Exhibit 2, Line 4.4 Fees of public accountants and consulting actuaries

Exhibit 2, Line 5.1 Traveling expenses

Exhibit 2, Line 5.2 Advertising

Exhibit 2, Line 5.3 Postage, express, telegraph and telephone

Exhibit 2, Line 5.4 Printing and stationery

Furniture portion of Exhibit 2, Line 5.5 Cost or depreciation of furniture/equipment

Exhibit 2, Line 6.1 Books and periodicals

Non-accreditation portion of Exhibit 2, Line 6.2 Bureau and association fees

Exhibit 2, Line 6.3 Insurance, except on real estate

Exhibit 2, Line 6.4 Miscellaneous losses

Exhibit 2, Line 6.5 Collection and bank service charges

Exhibit 2, Line 6.6 Sundry general expenses

In house portion of Exhibit 2, Line 7.1 Agency expense allowance

Exhibit 2, Line 7.2 Agents' balances charged off (less $__ recovered)

Exhibit 2, Line 7.3 Agency conferences other than local meetings

Exhibit 2, Line 9.1 Real estate expenses

Exhibit 2, Line 9.2 Investment expenses not included elsewhere

Exhibit 2, Line 9.3 Aggregate write-ins for expenses

Not for Distribution

Health Statement:

U&I Part 3, Line 1 Rent

U&I Part 3, Line 3 Commissions

U&I Part 3, Line 4 Legal fees

U&I Part 3, Line 6 Auditing, actuarial and other consulting

U&I Part 3, Line 7 Traveling expenses

U&I Part 3, Line 8 Marketing and advertising

U&I Part 3, Line 9 Postage, express and telephone

U&I Part 3, Line 10 Printing and office supplies

U&I Part 3, Line 11 Occupancy, depreciation and amortization

U&I Part 3, Line 15 Boards, bureaus and association fees

U&I Part 3, Line 16 Insurance, except on real estate

U&I Part 3, Line 17 Collection and bank service charges

U&I Part 3, Line 18 Group service and administration fees

U&I Part 3, Line 21 Real estate expenses

U&I Part 3, Line 24 Investment expenses not included elsewhere

U&I Part 3, Line 25 Aggregate write-ins

P/C Statement:

In house portion of U&I Part 3, Line 1.4 Net claim adjustment services

In house portion of U&I Part 3, Line 2.8 Net commission/brokerage

In house portion of U&I Part 3, Line 3 Allowances to manager and agents

U&I Part 3, Line 4 Advertising

Non-accreditation portion of U&I Part 3, Line 5 Boards, bureaus and associations

U&I Part 3, Line 6 Surveys and underwriting reports

U&I Part 3, Line 7 Audit of assured's records

U&I Part 3, Line 10 Insurance

U&I Part 3, Line 12 Travel and travel items

U&I Part 3, Line 13 Rent and rent items

U&I Part 3, Line 16 Printing and stationery

U&I Part 3, Line 17 Postage, telephone and telegraph, exchange and express

U&I Part 3, Line 18 Legal and auditing

U&I Part 3, Line 21 Real estate expenses

U&I Part 3, Line 24 Aggregate write-ins

Not for Distribution

Lines 1.8, 2.8, 3.8, 4.8, 5.8, 6.8, 7.8, 8.8 & 9.8 – Reimbursement by uninsured plans and fiscal intermediaries

Life Statement:

Exhibit 2, Line 6.7 Group service and administration fees

Exhibit 2, Line 6.8 Reimbursements by uninsured plans

Health Statement:

U&I Part 3, Line 19 Reimbursements by uninsured plans

U&I Part 3, Line 20 Reimbursements from fiscal intermediaries (e.g., Medicare, CHAMPUS, other governmental)

P/C Statement:

U&I Part 3, Line 23 Reimbursements by uninsured plans

Lines 1.9, 2.9, 3.9, 4.9, 5.9, 6.9, 7.9, 8.9 & 9.9 – Taxes, Licenses and Fees

Life Statement:

Exhibit 3, Line 1 Real estate taxes

Exhibit 3, Line 2 State insurance department licenses and fees

Exhibit 3, Line 3 State taxes on premiums

Exhibit 3, Line 4 Other state taxes, incl $__ for employee benefits

Exhibit 3, Line 5 U.S. Social Security taxes

Exhibit 3, Line 6 All other taxes

Fraternal Statement:

Exhibit 3, Line 1 Real estate taxes

Exhibit 3, Line 2 State insurance department licenses and fees

Exhibit 3, Line 3 Other state taxes, incl $__ for employee benefits

Exhibit 3, Line 4 U.S. Social Security taxes

Exhibit 3, Line 5 All other taxes

Health Statement:

U&I Part 3, Line 22 Real Estate Taxes

U&I Part 3, Line 23.1 State and local insurance taxes

U&I Part 3, Line 23.2 State premium taxes

U&I Part 3, Line 23.3 Regulatory authority licenses and fees

U&I Part 3, Line 23.4 Payroll taxes

U&I Part 3, Line 23.5 Other (excluding federal income and real estate)

Not for Distribution

P/C Statement:

U&I Part 3, Line 8.2 Payroll taxes

U&I Part 3, Line 20.1 State and local insurance taxes, deducting guaranty association credits of $___

U&I Part 3, Line 20.2 Insurance department licenses and fees

U&I Part 3, Line 20.3 Gross guaranty association assessments

U&I Part 3, Line 20.4 All other taxes, licenses and fees (excluding federal and foreign income and real estate)

U&I Part 3, Line 22 Real estate taxes

Lines 1.11, 2.11, 3.11, 4.11, 5.11, 6.11, 7.11, 8.11 & 9.11 – Total Fraud and Abuse Detection/Recovery Expenses Included in Column 7 (Informational Only)

Include: Fraud and abuse detection and recovery expenses as well as prevention expenses.

Not for Distribution

EXPENSE ALLOCATION SUPPLEMENTAL FILING

A single (not state-by-state), separate, regulator-only supplemental filing must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each state and to each line and column on Part 3.

Additionally, companies reporting QI expenses in Part 3, Columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above.

The definitions established in the Supplemental Health Care Exhibit apply to this supplemental filing, as well. For a **new initiative** that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an "X" in the "New" column of the supplement and include in the description the expected time frame for the activity to accomplish the objective, verifiable results.

Expenses for prospective utilization review and the costs of reward or bonuses associated with wellness and health promotion that are included in QI should include an "E" in the "New" column. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

Expense Type from Part 3	Line Number
Improve Health Outcomes	1.0001 – 1.9999
Activities to Prevent Hospital Readmission	2.0001 – 2.9999
Improve Patient Safety and Reduce Medical Errors	3.0001 – 3.9999
Wellness & Health Promotion Activities	4.0001 – 4.9999
HIT Expenses for Health Care Quality Improvements	5.0001 – 5.9999

Not for Distribution

SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 1 – ALL CESSIONS OF TERM AND UNIVERSAL LIFE INSURANCE WITH SECONDARY GUARANTEES

This exhibit is required to be filed no later than April 1.

Part 1 applies to all cessions of life insurance policies containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees, regardless of the effective date of the cession or the issue date of the policies, excepting only reinsurance of:

(1) Policies that satisfy the criteria for exemption set forth in Section 6F or 6G of the NAIC *Valuation of Life Insurance Policies Model Regulation* (#830), and which are issued before the later of:

  (a) The effective date of the NAIC *Term And Universal Life Insurance Reserve Financing Model Regulation* (#787) in the reporting entity's state of domicile, and

  (b) The date on which the reporting entity begins to apply the provisions of VM-20 (as defined below) to establish the ceded policies' statutory reserves, but in no event later than Jan 1, 2020;

(2) Portions of policies that satisfy the criteria for exemption set forth in Section 6E of Model #830, and which are issued before the later of:

  (a) The effective date of Model #787 in the reporting entity's state of domicile, and

  (b) The date on which the reporting entity begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than Jan. 1, 2020;

(3) Any universal life policy that meets all of the following requirements:

  (a) Secondary guarantee period, if any, is five (5) years or less;

  (b) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the Commissioners Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy; and

  (c) The initial surrender charge is not less than one hundred percent (100%) of the first-year annualized specified premium for the secondary guarantee period;

  NOTE: For purposes of this Exhibit, the term "universal life with secondary guarantees" shall not include the policies described in (3) above.

(4) Credit life insurance;

(5) Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; or

(6) Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

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A cession described above shall be reported in Part 1, even if one or more of the following circumstances exist:

1. The domiciliary regulator of the reporting entity has issued a waiver of compliance with *Actuarial Guideline XLVIII–Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830)* (AG48) to the reporting entity.

2. Regulation substantially similar to Model #787 has not been adopted by the domiciliary regulator of the reporting entity.

3. The risks ceded arise under policies that meet the definition of "Grandfathered Policies" (as defined below).

4. The risks ceded qualify for an exemption from AG48 pursuant to Section 3 thereof or from Model #787 pursuant to Section 4 thereof.

Cessions shall be reported on a treaty-by-treaty basis.

NOTE: Cessions reported on this exhibit should be reported on Schedule S, Part 3, Section 1 using only the codes XXXL (XXX Life) or AXXX (AXXX Life) as the type of business ceded in Column 6 of that schedule.

The terms below shall have the following definitions for the purposes of this Part 1:

A. **Actuarial Method:** The methodology used to determine the Required Level of Primary Security, as described in Section 6 of Model #787.

B. **Covered Policies:** Subject to the exemptions described in Section 4 of Model #787, Covered Policies are those policies, other than Grandfathered Policies, of the following policy types:

   1. Life insurance policies with guaranteed non-level gross premiums and/or guaranteed non-level benefits, except for flexible premium universal life insurance policies; or

   2. Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

C. **Grandfathered Policies:** Policies of the types described in Subsections B1 and B2 above that were:

   1. Issued prior to Jan. 1, 2015; and

   2. Ceded, as of Dec. 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in Section 4 of Model #787 had that section then been in effect.

D. **Required Level of Primary Security:** The dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies but not more than the total reserve ceded.

E. **Primary Security:** The following forms of security:

   1. Cash meeting the requirements of Section 3A of the NAIC *Credit for Reinsurance Model Law* (#785);

   2. Securities listed by the Securities Valuation Office meeting the requirements of Section 3B of Model #785, but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and

Not for Distribution

3. For security held in connection with funds withheld and modified coinsurance reinsurance arrangements:

   a. Commercial loans in good standing of CM3 quality and higher;

   b. Policy loans; and

   c. Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance arrangement.

F. **Other Security:** Any asset, including any asset meeting the definition of Primary Security, acceptable to the commissioner of the ceding insurer's domiciliary state.

G. **Valuation Manual:** The *Valuation Manual* adopted by the NAIC as described in Section 11B(1) of the NAIC *Standard Valuation Law* (#820), with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.

H. **VM-20:** "Requirements for Principle-Based Reserves for Life Products," including all relevant definitions, from the *Valuation Manual*.

Column 1 – NAIC Company Code

Provide the NAIC code of the assuming insurer.

Column 2 – ID Number

Enter one of the following as appropriate for the assuming insurer reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

Federal Employer Identification Number	(FEIN)
Alien Insurer Identification Number	(AIIN)
Certified Reinsurer Identification Number	(CRIN)

Column 3 – Name of Company

Provide the name of the assuming insurer.

Column 4 – Reinsurer that is Licensed, Accredited or Domiciled in Another State and that Meets Certain Additional Statutory Accounting and RBC Requirements (YES/NO)

Enter "YES" if the reinsurance was ceded to an assuming insurer that meets the applicable requirements of Section 2A, Section 2B or Section 2C of Model #785, as adopted in the reporting entity's state of domicile, and in addition:

1. Prepares its statutory financial statements in compliance with the *NAIC Accounting Practices and Procedures Manual*, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer's reported surplus and are material enough that they would need to be disclosed in the financial statement of the assuming insurer pursuant to *SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures*; and

2. Is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in the NAIC *Risk-Based Capital (RBC) for Insurers Model Act* (#312) when its RBC is calculated in accordance with the life RBC report, including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation.

Not for Distribution

Column 5 – Reinsurer that is Licensed, Accredited or Domiciled in Another State and that Meets Certain Additional Non-affiliation, Statutory Accounting, Licensing, and RBC Requirements (YES/NO)

Enter "YES" if the reinsurance was ceded to an assuming insurer that meets the applicable requirements of Section 2A, Section 2B or Section 2C of Model #785, as adopted in the reporting entity's state of domicile, and that, in addition:

1. Is not an affiliate, as that term is defined in Section 1A of the NAIC *Insurance Holding Company System Regulatory Act* (#440), of:

    (a) The insurer ceding the business to the assuming insurer; or

    (b) Any insurer that directly or indirectly ceded the business to that ceding insurer;

2. Prepares statutory financial statements in compliance with the NAIC *Accounting Practices and Procedures Manual*;

3. Is both:

    (a) Licensed or accredited in at least 10 states (including its state of domicile): and

    (b) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary or any other similar licensing regime; and

4. Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in NAIC *Risk-Based Capital (RBC) for Insurers Model Act* (#312) when its risk-based capital (RBC) is calculated in accordance with the life RBC report, including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer's reported surplus.

Column 6 – Certified Reinsurer (YES/NO)

Enter "YES" if the reinsurance was ceded to an assuming insurer that meets the applicable requirements of Section 2E of the NAIC *Credit for Reinsurance Model Law* (#785) and has been certified in the ceding insurer's domiciliary state or, if that state has not adopted a provision equivalent to Section 2E, in a minimum of five states.

Column 7 – Reinsurer Meeting Certain Size and Licensing Requirements (YES/NO)

Enter "YES" if the reinsurance was ceded to an assuming insurer that maintains at least $250 million in capital and surplus when determined in accordance with the NAIC *Accounting Practices and Procedures Manual*, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is:

1. Licensed in at least 26 states; or

2. Licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

Column 8 Reinsurer Maintaining Trust Fund (YES/NO)

Enter "YES" if the reinsurance was ceded to an assuming insurer that meets the applicable requirements of Section 2D of the NAIC *Credit for Reinsurance Model Law* (#785), as adopted in the reporting entity's state of domicile.

Not for Distribution

Column 9 – Special Exemption by Domestic Regulator (YES/NO)

Enter "YES" if the ceding insurer's domiciliary regulator, after consulting with the NAIC Financial Analysis (E) Working Group or other group of regulators designated by the NAIC, as applicable, has determined under all the facts and circumstances that all of the following apply: (1) the risks are clearly outside of the intent and purpose of Model #787; and (2) such risks are included within the scope of Model #787 only as a technicality; and (3) the application of Model #787 to such risks is not necessary to provide appropriate protection to policyholders.

Column 10 – Affiliate (YES/NO)

Enter "YES" if the assuming insurer identified in Column 3 is an affiliate.

Column 11 – Effective Date

Provide the effective date of the reinsurance ceding arrangement.

Column 12 -- Statutory Reserve

State the dollar amount of the statutory reserve for the life insurance products containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees included in the ceded reinsurance contract.

Column 13 – Statutory Reserve Credit Taken

State the dollar amount of the total statutory reserve credit taken for life insurance products containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees included in the ceded reinsurance contract. For reserves subject to modified coinsurance, report the modified coinsurance reserve.

Column 13 should equal the sum of Column 14 and Column 15.

Column 14 – Term Life Statutory Policy Reserve Credit Taken

State the dollar amount of statutory policy reserve credit taken (include the impact of any liability established as a result of Primary Security being less than the Required Level of Primary Security offset) for life insurance products containing guaranteed non-level gross premiums or guaranteed non-level benefits. For reserves subject to modified coinsurance, report the modified coinsurance reserve.

Column 15 – Universal Life Statutory Policy Reserve Credit Taken

State the dollar amount of statutory policy reserve credit taken for universal life insurance policies with secondary guarantees. For reserves subject to modified coinsurance, report the modified coinsurance reserve.

Not for Distribution

SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 2 – TRANSACTIONS SUBJECT TO PART 2A OR PART 2B DISCLOSURE
(GENERAL INSTRUCTIONS)

This exhibit is required to be filed no later than April 1. All capitalized terms used in Part 2 shall have the meanings ascribed to them in Part 1.

Part 2 applies to all cessions identified in Part 1 except cessions as to which Column 4, 5, 6, 7 or 8 is reported as "YES."

A cession to which Part 2 applies shall be reported in Part 2A if:

a. Column 9 in Part 1 is reported as "YES" with respect to such cession; or

b. The cession is of risks under policies that meet the definition of "Grandfathered Policies."

All other cessions to which Part 2 applies shall be reported in Part 2B. In the event that a cession contains both risks required to be reported in Part 2A according to the instructions above, and risks to be reported in Part 2B according to the instructions above, the reporting of the cession shall be bi-furcated accordingly between Part 2A and 2B under the same Cession ID.

For purposes of Part 2, the word "collateral" shall mean assets retained by the ceding company through a modified coinsurance or funds withheld basis and assets held in trust by the assuming insurer for the benefit of the ceding company, or, if the case of a letter of credit, in the possession of the ceding company or held in trust for the benefit of the ceding company. Collateral also includes parental guarantees made payable to the ceding company.

For assets that would be admitted under the NAIC *Accounting Practices and Procedures Manual* if they were held by the reporting entity and without taking into consideration any prescribed or permitted practices, and including assets held in trust, the values are to be determined according to statutory accounting procedures the NAIC *Accounting Practices and Procedures Manual* as if such assets were held in the reporting entity's general account. If the ceding company cannot determine the statutory accounting value of certain assets under the NAIC *Accounting Practices and Procedures Manual* after making a diligent effort to do so, the ceding company can report that asset using the value assigned to the asset for the purpose of determining the amount of reserve credit taken; provided, however, any such assets must be reported on a line separate from those assets valued in accordance with the NAIC *Accounting Practices and Procedures Manual* and the reporting entity shall provide a note indicating the basis for the valuation used.

For all other assets, the values are to be those that were assigned to the collateral in the reporting entity's Schedule S for the purpose of determining the amount of reserve credit allowed.

Not for Distribution

SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 2A – TRANSACTIONS SUBJECT TO PART 2 DISCLOSURE (GRANDFATHERED OR SPECIAL EXEMPTION)

Column 1 – Cession ID

Enter a unique Cession ID for each line (01 – 99).

Column 2 – NAIC Company Code

Provide the NAIC code of the assuming insurer.

Column 3 – ID Number

Enter one of the following as appropriate for the assuming insurer being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

Federal Employer Identification Number	(FEIN)
Alien Insurer Identification Number	(AIIN)
Certified Reinsurer Identification Number	(CRIN)

Column 4 – Name of Company

Provide the name of the assuming insurer.

Column 5 – Effective Date or Prior Year Annual Statement Date

Provide the later of the effective date of the cession or the annual statement date immediately preceding the current annual statement date.

As of Effective Date or Prior Year's Annual Statement

Column 6 – Statutory Reserve

State the dollar amount of the statutory reserve for the life insurance products containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees included in the ceded reinsurance contract.

Column 7 – Statutory Reserve Credit Taken

State the dollar amount of the statutory reserve credit taken by the reporting entity for the life insurance products containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees included in the ceded reinsurance contract as of the date reported in Column 5. For reserves subject to modified coinsurance, report the modified coinsurance reserve.

Not for Distribution

Column 8A – "Economic Reserve" Level

State the value as of the date reported in Column 5 of:

(A) That portion of the statutory reserve credit that the reporting entity and the reporting entity's domestic regulator have agreed must be supported by assets admissible per the NAIC *Accounting Practices and Procedures Manual* and that cannot be financed; or

(B) If no such agreement exists, the reserves calculated by the method required under the Generally Accepted Accounting Principles (GAAP) for the jurisdiction in which the reinsurer's affiliated group prepares GAAP financial statements; or

(C) If the agreement referenced in (A) does not exist and (B) does not apply, that portion of the reserve established by the reinsurer that the reinsurer and reinsurer's domestic regulator have agreed must be supported by assets admissible per the NAIC *Accounting Practices and Procedures Manual* and that cannot be financed; or

(D) If (A), (B) or (C) does not apply, the reserve required by the regulator in the jurisdiction of the reinsurer.

Column 8B – "Economic Reserve" Level (Method Used)

Indicate the method used to calculate the amount stated in Column 8A by inserting (A), (B), (C) or (D) after the stated value.

Column 9 – Primary Security

State the value as of the date reported in Column 5 of the Primary Security received by the reporting entity as collateral.

Column 10 – Other Security

State the value as of the date reported in Column 5 of all collateral that is not reported in Column 9.

As of Current Year's Annual Statement

Column 11 – Statutory Reserve

State the dollar amount of the statutory reserve for the life insurance products containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees included in the ceded reinsurance contract.

Column 12 – Statutory Reserve Credit Taken

State the dollar amount of the statutory reserve credit taken by the reporting entity (include the impact of any liability established as a result of Primary Security being less than the Required Level of Primary Security offset) for the life insurance products containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees included in the ceded reinsurance contract as of the current annual statement date. For reserves subject to modified coinsurance, report the modified coinsurance reserve.

Not for Distribution

Column 13A – "Economic Reserve" Level

State the value as of the current annual statement date of:

(A) That portion of the statutory reserve credit that the reporting entity and the reporting entity's domestic regulator have agreed must be supported by assets admissible per the NAIC *Accounting Practices and Procedures Manual* and that cannot be financed; or

(B) If no such agreement exists, the reserves calculated by the method required under the Generally Accepted Accounting Principles (GAAP) for the jurisdiction in which the reinsurer's affiliated group prepares GAAP financial statements; or

(C) If the agreement referenced in (A) does not exist and (B) does not apply, that portion of the reserve established by the reinsurer that the reinsurer and reinsurer's domestic regulator have agreed must be supported by assets admissible per the NAIC *Accounting Practices and Procedures Manual* and that cannot be financed; or

(D) If (A), (B) or (C) does not apply, the reserve required by the regulator in the jurisdiction of the reinsurer.

Column 13B – "Economic Reserve" Level (Method Used)

Indicate the method used to calculate the amount stated in Column 13A by inserting (A), (B), (C) or (D) after the stated value.

Column 14 – Primary Security

State the value as of the current annual statement date of the Primary Security received by the reporting entity as collateral.

Column 15 – Primary Security – Trust

State the value as of the current annual statement date of any part of the collateral reported in Column 14 that is held in trust for the benefit of the reporting entity.

Column 16 – Primary Security – Funds Withheld or Modified Coinsurance

State the value as of the current annual statement date of any part of the collateral reported in Column 14 that is held by the reporting entity on a funds withheld basis or on a modified coinsurance basis.

Column 17 – Other Security

State the value as of the current annual statement date of all collateral that is not reported in Column 14.

Not for Distribution

SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 2B – TRANSACTIONS SUBJECT TO PART 2 DISCLOSURE (NON-GRANDFATHERED)

Column 1 – Cession ID

Enter a unique Cession ID for each line (01 – 99).

To differentiate between cessions that contain risks subject to the provisions of AG 48 and those that contain risks subject to the provisions of a state regulation equivalent to Model #787, append an A or B after the cession ID.

In the event that a cession contains risks subject to both the provisions of AG 48 and the provisions of a state regulation equivalent to Model #787, the reporting of the cession shall be bifurcated accordingly and listed on two distinct lines.

Use "A" for cessions that contain risks subject to the provisions of AG 48.

Use "B" for cessions that contain risks subject to the provisions of state regulation.

Column 2 – NAIC Company Code

Provide the NAIC code of the assuming insurer.

Column 3 – ID Number

Enter one of the following as appropriate for the assuming insurer being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

Federal Employer Identification Number	(FEIN)
Alien Insurer Identification Number	(AIIN)
Certified Reinsurer Identification Number	(CRIN)

Column 4 – Name of Company

Provide the name of the assuming insurer.

Column 5 – Effective Date or Prior Year Annual Statement Date

Provide the later of the effective date of the cession or the annual statement date immediately preceding the current annual statement date.

As of Effective Date or Prior Year's Annual Statement

Column 6 – Statutory Reserve

State the dollar amount of the statutory reserve for the life insurance products containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees included in the ceded reinsurance contract.

Not for Distribution

Column 7 – Statutory Reserve Credit Taken

State the dollar amount of the statutory reserve credit taken by the reporting entity for the life insurance products containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees included in the ceded reinsurance contract as of the date reported in Column 5. For reserves subject to modified coinsurance, report the modified coinsurance reserve.

Column 8 – Required Level of Primary Security

State the Required Level of Primary Security applicable to the covered policies as of date reported in Column 5.

Column 9 – Primary Security

State the value of the Primary Security received by the reporting entity as collateral as of the date reported in Column 5.

Column 10 – Other Security

State the value as of the date reported in Column 5 of all collateral that is not reported in Column 8.

As of Current Year's Annual Statement

Column 11 – Statutory Reserve

State the dollar amount of the statutory reserve for the life insurance products containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees included in the ceded reinsurance contract as of the current annual statement date.

Column 12 – Statutory Reserve Credit Taken

State the dollar amount of the statutory reserve credit taken by the reporting entity (include the impact of any liability established as a result of Primary Security being less than the Required Level of Primary Security offset) for the life insurance products containing guaranteed non-level gross premiums, guaranteed non-level benefits and universal life insurance policies with secondary guarantees included in the ceded reinsurance contract as of the current annual statement date. For reserves subject to modified coinsurance, report the modified coinsurance reserve.

Column 13 – Required Level of Primary Security

State the Required Level of Primary Security applicable to the covered policies as of the current annual statement date.

Should not be zero if an amount is reported in Column 12.

Column 14 – Primary Security

State the value of the Primary Security received by the reporting entity as collateral as of the current annual statement date.

Should not be zero if an amount is reported in Column 12.

Not for Distribution

Column 15 – Primary Security Remediation Adjustment

If Column 13 is greater than Column 14, state the value as of the current annual statement date of any additional Primary Security received by the reporting entity after the as of date of the current annual statement as collateral to cover the difference.

Column 16 – Primary Security – Trust

State the value as of the current annual statement date of any part of the collateral reported in Column 14 and Column 15 that is held in trust by the assuming insurer for the benefit of the reporting entity.

Column 17 – Primary Security – Funds Withheld or Modified Coinsurance

State the value as of the current annual statement date of any part of the collateral reported in Column 14 and Column 15 that is held by the reporting entity on a funds withheld basis or on a modified coinsurance basis.

Column 18 – Other Security

State the value as of the current annual statement date of any collateral that is not reported in Columns 14 and 15.

**** Columns 19 through 20 will be electronic only. ****

Column 19 – Primary Security Shortfall

If Column 12 is greater than Column 14 and if Column 13 is greater than the sum of Column 14 and Column 15, state the difference between Column 13 and the sum of Column 14 and Column 15.

If Column 12 is equal to or less than Column 14 or if Column 13 is less than or equal to the sum of Column 14 and Column 15, leave this column blank.

Column 20 – Other Security Shortfall

If Column 12 is greater than Column 14 and if Column 12 minus the sum of Column 14 and Column 15 is greater than Column 18, state the difference between Column 12 and the sum of Column 14 and Column 15.

If Column 12 is equal to or less than Column 14 or if Column 12 minus the sum of Column 14 and Column 15 is less than or equal to Column 18, leave this column blank.

Not for Distribution

SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 3 – COLLATERAL FOR ALL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE TRANSACTIONS REPORTED ON PART 2A OR PART 2B

This exhibit is required to be filed no later than April 1. All capitalized terms used in Part 3 shall have the meanings ascribed to them in Part 1.

Part 3 applies to all the cessions identified in Part 2A or Part 2B; provided, however, that if the reporting entity has not received any collateral in connection with a cession identified in Part 2A, the only information required is the Cession ID number, Name of Company, NAIC Company Code and ID Number. The reporting entity should prepare a separate page for each Cession ID reported in Part 2. The reporting entity should also provide a Grand Total page.

For each Cession ID, the information regarding the Name of the Company, the NAIC Company Code, the ID Number and the inception date or prior year annual statement date should match what was reported for those columns in Part 2. Note: Only the numeric portion of the Cession ID is used. The identifiers ("A" and "B") provided for Part 2B are aggregated together for the purpose of this Exhibit.

For purposes of Part 3, the word "collateral" shall mean assets retained by the ceding company through a modified-coinsurance or funds withheld basis and assets held in trust by the assuming insurer for the benefit of the ceding company; or, if the case of a letter of credit, in the possession of the ceding company or held in trust for the benefit of the ceding company. Collateral also includes parental guarantees made payable to the ceding company.

For assets that would be admitted under the NAIC *Accounting Practices and Procedures Manual* if they were held by the reporting entity and without taking into consideration any prescribed or permitted practices, and including assets held in trust, the values are to be determined according to statutory accounting procedures under the NAIC *Accounting Practices and Procedures Manual* as if such assets were held in the reporting entity's general account. If the ceding company cannot determine the statutory accounting value of certain assets under the NAIC *Accounting Practices and Procedures Manual* after making a diligent effort to do so, the ceding company can report that asset using the value assigned to the asset for the purpose of determining the amount of reserve credit taken, provided, however, any such assets must be reported on a line separate from those assets valued in accordance with the NAIC *Accounting Practices and Procedures Manual* and the reporting entity shall provide a note indicating the basis for the valuation used.

For all other assets, the values are to be those that were assigned to the collateral in the reporting entity's Schedule S for the purpose of determining the amount of reserve credit allowed.

As of Effective Date or Prior Year's Annual Statement

Column 1 – Assets

State the value as of the latter of the effective date of the cession or the annual statement date immediately preceding the current annual statement date for collateral held in each category identified.

For the Grand Total page, the total for Column 1 should equal the sum of Column 9 (Primary Security) plus Column 10 (Other Security) from Parts 2A and 2B

Column 2 – Affiliate or Parental Guarantee (YES/NO)

Enter "YES" if any asset identified in Column 1 as to which an affiliate of the reporting entity has issued a guarantee.

Not for Distribution

As of Current Year's Annual Statement

Column 3 – Assets

State the value as of the current annual statement date for collateral held in each category identified.

For the Grand Total page, the total for Column 3 should equal Column 14 (Primary Security) from Parts 2A and 2B plus Column 17 (Other Security) from Part 2A plus Column 15 (Primary Security Remediation Adjustment) from Part 2B plus Column 18 (Other Security) from Part 2B.

Column 4 – Affiliate or Parental Guarantee (YES/NO)

Enter "YES" if any asset identified in Column 3 as to which an affiliate of the reporting entity has issued a guarantee.

For Lines 1 through 20, the reporting entity shall report the amount of assets in which collateral supporting the cession was held corresponding to the categories shown below.

Primary Security

Line 1 – Cash

Cash meeting the definition of Primary Security found in the instructions for Part 1.

Line 2 – NAIC 1 SVO-Listed Securities

NAIC 1 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 3 – NAIC 2 SVO-Listed Securities

NAIC 2 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 4 – NAIC 3 SVO-Listed Securities

NAIC 3 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 5 – NAIC 4 SVO-Listed Securities

NAIC 4 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 6 – NAIC 5 SVO-Listed Securities

NAIC 5 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Not for Distribution

Line 7 – NAIC 6 SVO-Listed Securities

NAIC 6 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 8 – Commercial Loans

Commercial loans meeting the definition of Primary Security found in the instructions for Part 1.

Line 9 – Policy Loans

Policy Loans meeting the definition of Primary Security found in the instructions for Part 1.

Line 10 – Derivatives Acquired in the Normal Course

Derivatives acquired in the normal course meeting the definition of Primary Security found in the instructions for Part 1.

Other Security

Line 12 – Other Investments Admissible per the NAIC AP&P Manual

Other investments admissible per the NAIC *Accounting Practices and Procedures Manual.*

Line 13 – Evergreen, Unconditional LOCs

Evergreen, unconditional letters of credit.

Line 14 – Other LOCs

Conditional letters of credit issued by qualified U.S. banks.

Line 15 – Affiliate or Parental Guarantees

Affiliate or parental guarantees.

Line 16 – LOC-Like Assets

Synthetic letters of credit, contingent notes, credit-linked notes or other similar securities that operate in a manner similar to letters of credit.

Line 17 – Excess of Loss Reinsurance

Excess of loss reinsurance.

Line 18 – All Other Assets

All other assets.

Not for Distribution

SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 4 – NON-COLLATERAL ASSETS SUPPORTING RESERVES FOR ALL AFFILIATE TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE TRANSACTIONS REPORTED ON PART 2A OR PART 2B

This exhibit is required to be filed no later than April 1. All capitalized terms used in Part 4 shall have the meanings ascribed to them in Part 1.

Part 4 applies to all the cessions identified in Part 2A or Part 2B in which the assuming insurer is an affiliate of the reporting entity. The reporting entity should prepare a separate page for each Cession ID required to be reported in Part 4. The reporting entity should also provide a Grand Total page.

For each Cession ID, the information regarding the Name of the Company, the NAIC Company Code, the ID Number and the inception date or prior year annual statement date should match what was reported for those columns in Part 2. Note: Only the numeric portion of the Cession ID is used. The identifiers ("A" and "B") provided for Part 2B are aggregated together for the purpose of this Exhibit.

For assets that would be admitted under the NAIC *Accounting Practices and Procedures Manual* if they were held by the reporting entity and without taking into consideration any prescribed or permitted practices, and including assets held in trust, the values are to be determined according to statutory accounting procedures under the NAIC *Accounting Practices and Procedures Manual* as if such assets were held in the reporting entity's general account. If the ceding company cannot determine the statutory accounting value of certain assets under the NAIC *Accounting Practices and Procedures Manual* after making a diligent effort to do so, the ceding company can report the asset using the value assigned to the asset for the purpose of determining the amount of reserve credit taken; provided, however, any such assets must be reported on a line separate from those assets valued in accordance with the NAIC *Accounting Practices and Procedures Manual* and the reporting entity shall provide a note indicating the basis for the valuation used. For all other assets, the values are to be those that were assigned to the assets on the financial statements of the assuming insurer.

As of Effective Date or Prior Year's Annual Statement

Column 1 – Non-Collateral Assets Supporting Reserves – Affiliate Transactions

In each category identified, state the value, as of the later of the effective date of the cession or the annual statement date immediately preceding the current annual statement date, for all assets held by the assuming insurer in support of the cession and not held as collateral, but not including assets supporting liabilities not covered by the cession. If the assuming insurer holds assets supporting the cession and other liabilities, the assuming insurer, for purposes of this Part 4, should make an allocation of assets by liability and should report here only the assets allocated to the cession. Do not include any asset reported in Part 3.

Column 2 – Affiliate or Parental Guarantee (YES/NO)

Indicate as to any asset identified in Column 1 as to which an affiliate of the reporting entity has issued a guarantee.

As of Current Year's Annual Statement

Column 3 – Non-Collateral Assets Supporting Reserves – Affiliate Transactions

In each category identified, state the value, as of the current annual statement date, for all assets held by the assuming insurer in support of the cession and not held as collateral, but not including assets supporting liabilities not covered by the cession. If the assuming insurer holds assets supporting the cession and other liabilities, the assuming insurer, for purposes of this Part 4, should make an allocation of assets by liability and should report here only the assets allocated to the cession. Do not include any asset reported in Part 3.

Not for Distribution

Column 4 – Affiliate or Parental Guarantee (YES/NO)

Enter "YES" if any asset identified in Column 3 as to which an affiliate of the reporting entity has issued a guarantee.

For Lines 1 through 17, the reporting entity shall report the amount of assets corresponding to the categories shown below.

Line 1 – Cash

Cash meeting the definition of Primary Security found in the instructions for Part 1.

Line 2 – NAIC 1 SVO-Listed Securities

NAIC 1 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 3 – NAIC 2 SVO-Listed Securities

NAIC 2 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 4 – NAIC 3 SVO-Listed Securities

NAIC 3 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 5 – NAIC 4 SVO-Listed Securities

NAIC 4 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 6 – NAIC 5 SVO-Listed Securities

NAIC 5 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 7 – NAIC 6 SVO-Listed Securities

NAIC 6 SVO-Listed Securities meeting the definition of Primary Security found in the instructions for Part 1.

Line 8 – Commercial Loans

Commercial loans meeting the definition of Primary Security found in the instructions for Part 1.

Line 9 – Policy Loans

Policy Loans meeting the definition of Primary Security found in the instructions for Part 1.

Line 10 – Derivatives Acquired in the Normal Course

Derivatives acquired in the normal course meeting the definition of Primary Security found in the instructions for Part 1.

Line 11 – Other Investments Admissible per the NAIC AP&P Manual

Other Investments Admissible per the NAIC *Accounting Practices and Procedures Manual.*

Not for Distribution

Line 12 – Evergreen, Unconditional LOCs

Evergreen, unconditional letters of credit.

Line 13 – Other LOCs

Conditional letters of credit issued by qualified U.S. banks.

Line 14 – Affiliate or Parental Guarantees

Affiliate or parental guarantees.

Line 15 – LOC-like Assets

Synthetic letters of credit, contingent notes, credit-linked notes or other similar securities that operate in a manner similar to letters of credit.

Line 16 – Excess of Loss Reinsurance

Excess of loss reinsurance.

Line 17 – All Other Assets

All other Assets.

Not for Distribution

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Not for Distribution

Separate Accounts
Statement

Not for Distribution

INSTRUCTIONS

For Completing Separate Accounts Annual Statement Blank

INDEX

The annual statement shall contain an alphabetized index on the last page of the hard copy statement which references the title and page number of all of the pages that are required to be included in that filing. The NAIC shall maintain, and place on its Website at *www.naic.org/cmte_e_app_blanks.htm*, the alphabetized index for all statement types that is required to be included in the hard copy of the statement. The above is only required on the March 1 filing, and specifically excludes any supplements.

GENERAL

The instructions for completing the general account are to be followed to the extent applicable. This supplement provides additional instructions that are unique to the Separate Accounts Blank as well as some that differ from those for the Fraternal Blank. Where there is a conflict with the Fraternal Blank's instructions, use these instructions. The reporting date must be plainly written or stamped at the top of all pages, exhibits and schedules (and duplicate schedules) and also upon all inserted schedules and loose sheets.

Reinsurance of separate accounts business is subject to the same Transfer of Risk requirements for reinsurance accounting treatment as general account business. All reinsurance transactions involving separate accounts business, if any, must be reported as reinsurance transactions in the general account annual statement, including reinsurance premiums, deposits, benefits, withdrawals, Schedule S (for separate accounts modified coinsurance reserves), Schedule T and where applicable, the Notes to Financial Statements and Schedule Y, Part 2.

If the assuming company does not receive funds to be invested, such as with modified coinsurance or coinsurance with funds withheld, the assuming company must account for such reinsurance in its general account statement. If the assuming company receives funds to be invested in support of the reinsured variable benefit reserves, the assuming company must use its separate accounts statement for such reinsurance assumed.

The separate accounts statement reports only the operations of the separate accounts themselves. It assumes that the administration of the contracts is reflected in the general account statement – hence, administrative expense does not appear in the Separate Accounts Statement, premiums and considerations are net of loading, and the expenses and taxes are those associated with the separate account investment operations.

A separate distinct filing should be made for separate account products that are insulated from the general creditors of the general account and for separate account products that are not insulated (i.e., an insurance company with both insulated and non-insulated products in the separate account would submit two complete and different filings). Seed money and unsettled fees and expenses are allowed to be reported with the corresponding product (insulated or non-insulated).

When completing the insulated blank, a reporting entity should only include those assets that are legally insulated by state law or statute. Legally insulated assets shall be equal to the reserves and supporting contract liabilities of the separate account. Such assets provide legal protection to the separate account contract holder from the general account liabilities. All other assets within the separate account that are not legally insulated by state law or statute shall be included in the non-insulated blank.

Not for Distribution

Examples:

Scenario	Insulated S/A Blank	Non-insulated S/A Blank
Scenario 1: Separate Account Insulated Assets = Separate Account Liabilities (For example, 100% of investment proceeds, net fees is attributed to the contract holder.) 40 bonds at $100 par value = $4,000	The $4,000 issue is associated with an insulated product; thus, the entire $4,000 would be reported in the insulated blank.	No amount.
Scenario 2: Separate Account Assets > Separate Account Liabilities resulting in a "due to" the General Account (For example, the contract specifies a ceiling on the investment return to contractholder; excess investment returns are retained by the reporting entity; the portion then retained by the General Account is considered non-insulated.) 40 bonds at $100 par value = $4,000 Max to contractholder is $3,990	$3,990 of the issue is associated with an insulated product; thus, this amount would be included in the insulated blank.	The remaining $10 is due to the General Account; the $10 would then be reported under the non-insulated blank.
Scenario 3: Separate Account Non-insulated Assets = Separate Account Liabilities (For example, the asset supporting the contract was not approved by the state as a legally insulated product.) The reporting entity owns 15 bonds at $100 par value that do not support an insulated product. 15 bonds at $100 par value = $1,500	No amount.	The $1,500 issue would be reported under the non-insulated blank.

Not for Distribution

Receipts other than income from investments are handled as a transfer from the general account. Similarly, amounts providing for the payment of benefits including surrender benefits and various other payments, appear as transfers from the separate account to the general account. When eventually paid, these items are reported in the general account statement. The assets and liabilities are strictly those which arise from the operations of the separate accounts themselves, i.e., policy and contract reserves and items related to the making of investments, including investment expenses and taxes due or accrued. Unpaid transfers due the general account, such as surplus, contractual benefits, or contractual charges, would also appear on the liability page.

The format of the annual statement has been designed to facilitate data capture. Therefore, do not change the captions for pre-printed items, lines, or columns and do not insert write-ins between pre-printed items, lines, or columns (however, these requirements do not apply to the signature lines on the Jurat Page). An entry for which there is no specific pre-printed line title must be reported with an identifying title (for example, Deferred option income) in the appropriate schedule for each applicable page or section thereof entitled Details Of Write-Ins Aggregated At Item (Or On Line) ______ For ______________. These write-in lines should be reported in descending order. The statement provides a limited number of lines for write-ins in each applicable section. These pre-printed write-in detail schedules should not be modified.

If there is not sufficient room in a write-in detail schedule to accommodate all write-ins to be reported therein, companies shall report the write-in detail overflow on pages sequentially numbered beginning with Page 21, followed by 21.1, 21.2, etc. In such instances, companies shall carry the summary of write-in overflow lines from this page to the prescribed line in the original write-in detail section.

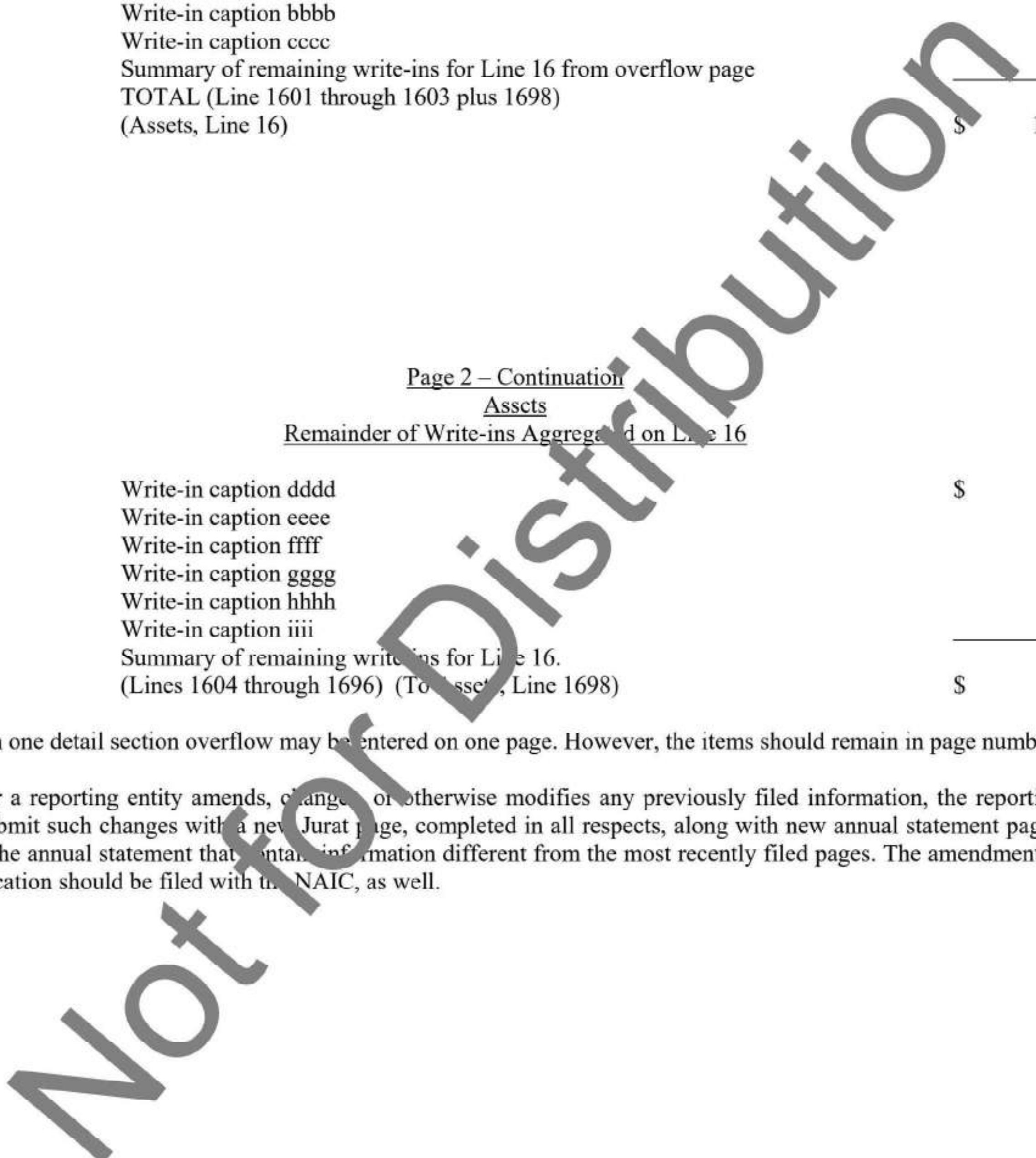
Each overflow write-in section should adhere to the following example:

Page 2

ASSETS

DETAILS OF WRITE-INS AGGREGATED ON LINE 16 FOR OTHER-THAN-INVESTED-ASSETS

1601	Write-in caption aaaa	$	500,000
1602	Write-in caption bbbb		350,000
1603	Write-in caption cccc		250,000
1698	Summary of remaining write-ins for Line 16 from overflow page		300,000
1699	TOTAL (Line 1601 through 1603 plus 1698) (Assets, Line 16)	$	1,400,000


Not for Distribution

Page 2 – Continuation
Assets
Remainder of Write-ins Aggregated on Line 16

1604	Write-in caption dddd	$	100,000
1605	Write-in caption eeee		75,000
1606	Write-in caption ffff		50,000
1607	Write-in caption gggg		50,000
1608	Write-in caption hhhh		20,000
1609	Write-in caption iiii		5,000
1697	Summary of remaining write-ins for Line 16. (Lines 1604 through 1696) (To Assets, Line 1698)	$	300,000

More than one detail section overflow may be entered on one page. However, the items should remain in page number order.

Whenever a reporting entity amends, changes, or otherwise modifies any previously filed information, the reporting entity should submit such changes with a new Jurat page, completed in all respects, along with new annual statement pages for all pages of the annual statement that contain information different from the most recently filed pages. The amendment, change, or modification should be filed with the NAIC, as well.

JURAT PAGE

Enter all information completely as indicated by the format of the page.

NAIC Group Code

Current Period

Enter the NAIC Group Code for the filing being processed.

Prior Period

Enter the NAIC Group Code for the prior quarter.

State of Domicile or Port of Entry

Alien companies doing business in the United States through a port of entry should complete this line with the appropriate state. U.S. insurance entities should enter the state of domicile.

Country of Domicile

U.S. branches of alien insurers should enter the three-character identifier for the reporting company's country of domicile from the Appendix of Abbreviations. Domestic insurers should enter "US" in this field.

Type of Separate Accounts

Indicate the type of separate accounts reported in the filing by choosing "insulated" or "non-insulated", but not both.

Commenced Business

Enter the date when the reporting entity first became obligated for any insurance risk via the issuance of policies and/or entering into a reinsurance agreement.

Statutory Home Office

As identified with the Certificate of Authority in domiciled state.

Main Administrative Office

Location of the reporting entity's main administrative office.

Mail Address

Reporting entity's mailing address, if other than the main administrative office address. May be a P.O. Box and the associated ZIP code.

Primary Location of Books and Records

Location where examiners may review records during an examination.

Internet Website Address

Include the Internet Website address of the reporting entity. If none, and information relating to the reporting entity is contained in a related entity's Website, include that Website.

Not for Distribution

Statutory Statement Contact

Name & Email

Name and email address of the person responsible for preparing and filing all statutory filings with the reporting entity's regulators and the NAIC. The person should be able to respond to questions and concerns for the Separate Accounts.

Telephone Number & Fax Number

Telephone and fax number should include area code and extension.

To be filed in electronic format only:

Policyowner Relations Contact

Name

List person able to respond to calls regarding policies, premium payments, etc. on individual policies.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the policyowner relations contact person as described above.

Government Relations Contact

Name

The government relations contact represents the person the company designates to receive information from state insurance departments regarding new bulletins, company and producer licensing information, changes in departmental procedures and other general communication regarding non-financial information.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the government contact person as described above.

Not for Distribution

Market Conduct Contact

Name

The market conduct contact represents the person the reporting entity designates to receive information from state insurance departments regarding market conduct activities. Such information would include (but not be limited to) data call letters, filing instructions, report cards, and inquires/questions about the reporting entity's market conduct.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the market conduct contact person as described above.

Cybersecurity Contact

Name

The cybersecurity contact represents the person the reporting entity designates to receive information from regulatory agencies on active, developing and potential cybersecurity threats.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the cybersecurity contact person as described above.

Life Insurance Policy Locator Contact

Name

List person able to respond to calls regarding locating policies on lost or forgotten life insurance policies.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the policy locator contact person as described above.

Not for Distribution

ASSETS

Receivables from the General Account Statement must be excluded from the assets of the Separate Accounts Statement to eliminate the need for consolidating adjustments in the General Account Statement. Such receivables must be reported as a negative liability and netted against payables to the General Account Statement (see instructions for Page 3, Line 10, Other Transfers to General Account Due or Accrued (Net)).

Columns 1 & 2 – General Account Basis and Fair Value Basis

Report in the General Account Basis column, Column 1, the assets of those separate accounts whose assets are carried at the same basis as the general account. Include all separate accounts whose assets support fund accumulation contracts (GICs), which do not participate in underlying portfolio experience, with fixed interest rate guarantee, purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer. Such assets must be valued as if the assets were held in the general account.

Report in the Fair Value Basis column, Column 2, the assets of those separate accounts whose assets are carried at market value. Include separate account whose assets support all other policies and contracts and those liabilities being recorded at current interest rates.

Contracts with assets held in a separate account where the separate account's plan of operations was filed and approved prior to codification's effective date that are continuing to be valued on the approved basis shall be reported in the General Account or Fair Value basis columns.

Further instruction in the determination of appropriate valuation basis for amounts that are to be reported in the assets can be located in *SSAP No. 56—Separate Accounts*.

Column 3 – Total

The amount to be reported equals the sum of Columns 1 and 2.

Not for Distribution

LIABILITIES AND SURPLUS

Columns 1 & 2 – General Account Basis and Fair Value Basis

Report in the General Account Basis column, Column 1, the liabilities and, if any, surplus of those separate accounts whose assets are carried at the general account valuation basis, consistent with the reporting of general account basis assets of Page 2.

Report in the Fair Value Basis column, Column 2, the liabilities and, if any, surplus of those separate accounts whose assets are carried at fair value, consistent with the reporting of fair value basis assets on Page 2.

Further instructions in the determination of appropriate valuation basis for amounts that are to be reported in the liabilities can be located in *SSAP No. 56—Separate Accounts*.

Column 3 – Total

The amount to be reported equals the sum of Columns 1 and 2.

Line 1 – Aggregate Reserve for Life, Annuity and Accident and Health Contracts

If the company uses a modified reserving method, such as CARVM or CRVM, for business in the Separate Accounts Statement, the modified reserve must be reported as a liability in the Separate Account Statement.

Line 2 – Liability for Deposit-Type Contracts (Exhibit 4, Deposit-Type Contracts, Line 9, Column 1)

Include: Liabilities for contracts that have no mortality or morbidity risk. Refer to *SSAP No. 52—Deposit-Type Contracts* for accounting guidance.

Line 10 – Other Transfers to General Account Due or Accrued (Net) (including $________ accrued for expense allowances recognized in reserves)

Include: Receivables from the General Account as a negative amount.

The excess, if any as of the statement date, of policyholder account values as appropriate, over modified reserves used in the Separate Accounts Statement, such as the expense allowance provided by the use of CARVM or CRVM. Such excess or expense allowance must be reported as a transfer to the general account in this line. All other forms of surplus covered by assets in the Separate Accounts Statement, such as asset values in excess of account values, seed monies and retention of other profits, must be reported as surplus in the Separate Accounts Statement until such time as the surplus is withdrawn from the separate account and paid to the general account.

In the parenthetical, report the amount of such excess or expense allowance, if any, included in Line 10. Exclude from the parenthetical disclosure all other types of accruals, such as accruals for fees and charges.

The inside amount for this line should equal the amount reported on Page 3, Transfers to Separate Accounts Due or Accrued Line, of the general account statement.

Not for Distribution

Line 12 – Derivatives

Include: Derivative liability amounts shown as credit balances on Schedule DB, Parts A and B, if any.

Line 13 – Payable for Securities

Include: Amounts that are due to brokers when a security has been purchased, but have not yet been paid.

Line 14 – Payable for Securities Lending

Include Liability for securities lending collateral received by the reporting entity that can be reinvested or repledged.

Line 18 – Contributed Surplus

Include: Only surplus transferred from the general account to establish a separate account, less any portion of such surplus subsequently returned to the general account.

Line 19 – Aggregate Write-ins for Special Surplus Funds

Enter the excess, if any, of the aggregate benefit base over the aggregate reserve.

Line 21 – Surplus

Exclude: Surplus derived from the excess of policyholder account values as appropriate, over modified reserves, such as the expense allowance provided by the use of CARVM or CRVM (see instructions for Line 10).

Include All other forms of surplus covered by assets in the Separate Accounts Statement, such as asset values in excess of account values, seed monies and retention of other profits.

Not for Distribution

SUMMARY OF OPERATIONS

Line 1.1 – Net Premiums and Annuity Considerations for Life and Accident and Health Contracts

Report premium and annuity considerations for life and accident and health contracts. Refer to *SSAP No. 50—Classifications of Insurance or Managed Care Contracts* for life, accident and health deposit-type contract definitions and *SSAP No. 51R—Life Contracts* and *SSAP No. 52—Deposit-Type Contracts*.

Include: Accrued net premiums required to maintain the larger of the aggregate reserves or the aggregate benefit base. All considerations for annuity products, including pension products, for which purchases have been made for individuals or individual certificateholders.

Experience rating refunds received.

Deduct: Premiums and annuity considerations returned (other than cash surrender values) including amounts returned during the year due to recession of contracts not taken, "free-look" provision, reformation or contract, other contractual return premium provisions, erroneously computed premiums or similar returns.

Experience rating refunds paid.

Exclude: Deposits to deposit-type contract funds. Refer to *SSAP No. 51R—Life Contracts* and *SSAP No. 52—Deposit-Type Contracts* for accounting guidance.

Line 2 – Transfers on Account of Deposit-type Contracts

Include: Net amount of deposits, withdrawals and fund balance transferred to the Separate Accounts Statement.

Line 7 – Transfers on Account of Policy Loans

Enter the net amount transferred if policy loan assets are maintained in the general account.

Line 8 – Net Transfer of Reserves From or (to) Separate Accounts

Exclude: Transfers related to the payment of contract benefits.

Line 9.2 – Change in Expense Allowances Recognized in Reserves

Report the amount of increase or (decrease), if any, in the excess of policyholder account values as appropriate, over modified reserves such as the expense allowance provided by the use of CARVM or CRVM, excluding the portion reported in Exhibit 3A, if any. Such excess or expense allowance must be reported as a transfer to the general account.

Line 11 – Fees Associated with Charges for Investment Management, Administration and Contract Guarantees

Enter the gross amount of accrued transfers of fees and charges to the general account, exclusive of amounts deducted in determining net investment income and of charges for taxes attributable to investment gains and income. Exclude any fees or charges otherwise includable in Line 9.1 that were payable to an entity other than the general account. Report such amounts as "Other fees associated with charges for investment management, administration and contract guarantees" in Line 9.3, Aggregate Write-ins for other Transfers from Separate Accounts.

Not for Distribution

Line 12 – Increase in Aggregate Reserve for Life and Health Contracts

Exclude: Any increase or (decrease) in reserves on account of change in valuation basis.

Line 17 – Net Gain from Operations (Including $__________ Unrealized Capital Gains)

In determining the unrealized capital gains or losses for disclosure in the caption, include only that portion of total unrealized gains or losses included in net gain from operations. This excludes the portion allocated and credited to separate account contract holders or policyholders. Disclose net unrealized losses as a negative amount.

Example:

a.	Total unrealized capital gains included in Line 3	$	10,000
b.	Unrealized capital gains credited to reserves included in Lines 12, 13 and 15		9,750
c.	Amount of unrealized capital gains included in Lines 17 (a-b)	$	250

SURPLUS ACCOUNT

Line 22 – Transfer from Separate Accounts of the Change in Expense Allowances Recognized in Line 21

Report the amount of decrease or (increase), if any, in the excess of policyholder account values as appropriate, over modified reserves such as the expense allowance provided by the use of CARVM or CRVM, reported in Exhibit 3A and Line 22. Such excess or expense allowance must be reported as a transfer to the general account.

Not for Distribution

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

A company which is engaged in one or more insurance businesses which cannot be reported in Columns 2 through 8 on Page 5, shall add the amounts for each additional line of business and shall enter the total in Column 9 (All Other Lines of Business).

Not for Distribution

ANALYSIS OF INCREASE IN RESERVES DURING THE YEAR

This exhibit shows how the reserve may be traced mathematically from one year-end to the next by taking account of its various theoretical components.

Lines 2 through 6 and Lines 8 through 11 do not include amounts related to the VM-20 Deterministic/Stochastic portion of the reserves, which are reported on Line 6.1.

Line 1 – Reserve December 31 of Prior Year

Enter total reserves from Line 16 of the prior year's Separate Accounts Statement.

Line 2 – Tabular Net Premiums and Considerations for Annuities and Supplementary Contracts With Life Contingencies

Enter accrued transfers of tabular net premiums from the general account as determined by the valuation basis employed.

Lines 3, 4 & 9 – Increase or Decrease from Investment Results, Tabular Less Actual Reserve Released and Tabular Cost

Show the increase or decrease before charges for investment management, administration and contract guarantees.

If Line 3 is not available from accounting records, the formulas indicated below may be used.

(1) On Life Insurance

Tabular Cost Minus Increase (or Decrease) From Investment Results on Life Insurance (C–I):

Reserve Dec. 31 of prior year	________
Tabular premiums	________
Other increases	________
Total	________

DEDUCT:

Reserve Dec. 31 of current year	________
Terminal reserves released by death	________
Net reserves released by other terminations	________
Total deduction	________
Balance (C–I)	________

Increase (or Decrease) from Investment Results (I):

One-half of reserve Dec. 31 of prior year	________
One-half of reserve Dec. 31 of current year	________
One-half of (C–I)	________
One-half of terminal reserves released by death	________
Total	________
Total multiplied by net investment return equals increase (if positive) or decrease (if negative) from investment results	________

Tabular Cost (C):

C–I	________
Add I	________
Total equals tabular cost	________

Not for Distribution

(2) On Annuities and Supplementary Contracts with Life Contingencies

Tabular Less Actual Reserve Released Plus Increase (or Minus Decrease) From Investment Results (T–A+I):

Reserve Dec. 31 of current year
Charges for investment management, administration and contract guarantees
Transfers incurred during year on account of annuity, supplementary contract and disability payments
Net Transfer of reserves to general account during year
    Total

DEDUCT:

Reserve Dec. 31 of prior year
Tabular considerations for annuities and supplementary contracts
Other increases
Total Deductions
Balance (T–A+I)

Increase (or Decrease) from Investment Results (I):

One-half of reserve Dec. 31 of prior year
One-half of reserve Dec. 31 of current year
    Subtotal

Deduct one-half of (T–A+I)
    Total
    Total multiplied by net investment return equals increase (if positive) or decrease (if negative) from investment results

Tabular Less Actual Reserve Released (T–A):

T–A+I
Deduct I
    Balance equals tabular less actual reserve released

Line 6.1 – Change in Excess of VM-20 Deterministic/Stochastic Reserve over Net Premium Reserve

As the line item describes, this is the change in excess of any Deterministic/Stochastic reserve over the amount of the VM-20 Net Premium Reserve.

Line 8 – Net Transfer of Reserves from or (to) Separate Accounts

Exclude: Transfers related to the payment of contract benefits.

Line 10 – Reserves Released By Death

Enter terminal reserves released.

Exclude: Deterministic/Stochastic Reserves from the reporting of Reserves Released by Death

Not for Distribution

Line 11 – Reserves Released By Other Terminations (Net)

Enter reserves released by all causes other than death. The computation should be on a net basis so as to take account of revivals, increases, changes etc.

Exclude — Deterministic/Stochastic Reserves from the reporting of Reserves Released by Other Terminations (Net)

Line 16 – Reserve December 31 of Current Year

Enter total reserves minus the accident and health reserves from Exhibit 3 of the current year's Separate Accounts Statement.

Not for Distribution

EXHIBIT OF CAPITAL GAINS (LOSSES)

Capital gains and losses, realized and unrealized, are to be calculated on the basis of original cost adjusted, as appropriate, for accrual of discount or amortization of premium and for depreciation.

Not for Distribution

EXHIBIT 3 – AGGREGATE RESERVE FOR LIFE, ANNUITY AND ACCIDENT AND HEALTH CONTRACTS

Column 1 – Description of Valuation Basis

State the valuation basis used for the reserve(s) in each separate account or each group of separate accounts for which the same valuation basis applies. Indicate whether the assets supporting the reserves are on a market value (MV) or an amortized cost/book value (BV) basis. Where applicable, state the table of mortality and the interest rate or range of rates as well as the valuation method. For annuities, indicate whether immediate, deferred or both.

If necessary, companies may add lines to report each reserve basis used.

The valuation assumption and valuation method abbreviations presented in the NAIC *Annual Statement Instructions* for Exhibit 5 of the Fraternal Annual Statement should be used.

For any reserves valued under VM-20, include the entire CRVM reserve required by VM-20 split into the following components, with each component on a separate line:

VM-20 Net Premium reserve identifying the valuation basis

The balance of the reserve labeled "VM-20 Deterministic and/or Stochastic (Excess over Net Premium)"

In addition, the following valuation methods and abbreviations may be used:

NAV Net Asset Value –

Reserves determined by the value of the separate account's assets, such as traditional variable account business, not reduced for surrender charge, if any.

IAV Indexed Account Value –

Reserve determined by performance of an index, such as S&P 500, not reduced for surrender charge, if any.

CSV Cash Surrender Value –

Reserves at cash surrender value other than NAV or IAV above.

OCAV Other Current Account Value

EXAMPLES:

Life Insurance:

1. Variable NAV MV
2. VM-20 Net Premium: 2017 CSO @ 3.5%
3. VM-20 Net Premium: 2017 CSO @ 4%
4. VM-20 Deterministic and/or Stochastic (Excess over Net Premium)

Not for Distribution

Annuities (excluding supplementary contracts)

1. Deferred Variable NAV MV

2. Deferred Mod Var IAV MV

3. Deferred X.X%–X.X% CARVM BV

4. Deferred X.X%–X.X% CSV BV

5. Deferred X.X%–X.X% OCAV MV

6. Immediate 1971 GAM XX% MV

Miscellaneous Reserves

Include: Surrender values in excess of reserves otherwise required and carried in this schedule.

Not for Distribution

EXHIBIT 4 – DEPOSIT-TYPE CONTRACTS

This exhibit is intended to capture information about the activity for deposit-type contracts as defined in *SSAP No. 52—Deposit-Type Contracts*.

Column 2 – Guaranteed Interest Contracts (without life contingencies)

Include: Contracts that do not subject the reporting entity to any mortality or morbidity risk.

Column 3 – Annuities Certain

Include: Amounts settled under contracts without any mortality or morbidity risk, e.g., certain immediate annuity contracts; amounts associated with lottery payouts, structured settlements, income settlement options or other amounts where payments are for a fixed period or amount.

Exclude: Amounts reported in Column 2 or 4.

Column 4 – Supplemental Contracts (without life contingencies)

Include: Amounts resulting from proceeds settled under a settlement option provision of life or annuity contract without any mortality or morbidity risk.

Column 5 – Dividend Accumulations or Refunds

Include: Amounts held on account related to contracts with any mortality or morbidity risk.

Column 6 – Premium and Other Deposit Funds

Include: Amounts not reported elsewhere in this exhibit for contracts that do not incorporate any mortality or morbidity risk.

Line 2 – Deposits Received During the Year

Include: Considerations or amounts from policy or contract holders that increased the fund balance.

Line 3 – Investment Earnings Credited to Account

Include: Investment income and capital gains and losses credited to accounts.

Line 4 – Other Net Change in Reserves

Include: The net difference between periods when the reserve amount held differs from the accumulated account balance, including income accumulations less withdrawal and applicable surrender charges. Enter appropriate amount for Deposit-type Contract reserves from Exhibit 3A, Changes in Bases of Valuation During the Year.

Increase (Decrease) by Foreign Currency Adjustment
Report amounts needed to adjust from the spot rate to a periodic rate. Refer to *SSAP No. 23—Foreign Currency Transactions and Translation* for accounting guidance.

Exclude: Investment earnings credited to accounts reported in Line 3.

Not for Distribution

Line 5 – Fees and Other Charges Assessed

Include: Any fees or assessments to the account that reduce the balance and are reported as income by the reporting entity.

Line 6 – Surrender Charges

Include: Charges assessed for contract surrenders or withdrawals, e.g., early withdrawal penalties.

Line 7 – Net Surrender or Withdrawal Payments

Include: The net proceeds paid or payable (after deduction for surrender charges) to the contract holder.

Line 8 – Other Net Transfers To Or (From) General Account

Include: Net transfer of liabilities for deposit-type contracts to or (from) the general account where such transfers are not due to deposits or withdrawals.

Not for Distribution

EXHIBIT 5 – RECONCILIATION OF CASH AND INVESTED ASSETS

Line 9.7 – Policy Loans (Net)

Enter the net amount disbursed to the general account if policy loan assets are maintained in the general account.

Line 12.1 – Fees associated with Investment Management, Administration and Contract Guarantees

Enter the gross amount of fees and charges paid, exclusive of charges for taxes attributable to investment gains and income.

Line 27 – Increase in Policy Loans

Enter the net increase in policy loan assets maintained in separate accounts.

Not for Distribution

EXHIBIT 6 – GUARANTEED INSURANCE AND ANNUITY PRODUCTS

Lines 1 through 4 – Liabilities Associated with Guarantees

Include: Separate account liabilities for products where:

1. The separate account benefits are guaranteed as to dollar amount and duration or

2. The policyholder's or contractholder's separate account funds are guaranteed as to principal amount or stated rate of interest or stated index.

Those separate account liabilities for any guarantee features in variable benefit products that are held in a separate account.* The liability for the variable benefit portion of such products should be reported in Line 5.

Exclude: The separate account liabilities for guaranteed benefit features offered with variable benefit products which are minimal, such are annuity purchase rates.*

Line 5 – Total Liabilities Not Associated With Guarantees

Include: Separate account liabilities for products where:

1. The separate account benefits available to the policyholder or contractholder are determined by the non-guaranteed investment performance and/or market value of the investments held in the separate account, (i.e., the benefits are variable).

2. The benefits are variable but the product contains minimal guarantee features such as annuity purchase rates.*

The separate account liabilities for the variable benefit portion of products that contain guarantee features. Where the liabilities for such features are held in a separate account,* then the liability for the guaranteed benefit portion of such products should be reported in Lines 1 thru 4.

* NOTE: Although the NAIC Model Variable Contract Law generally requires reserves for guaranteed benefits to be held in the general account, there may be circumstances where the liability for guaranteed benefits offered with variable products is held in a separate account. For example, an actuarial guideline is currently being developed that will interpret the application of the NAIC Model Standard Valuation Law to variable annuities with guaranteed living benefits. It has not yet been determined whether the guideline will specify that reserves for these living benefits be held in the general account (as is required for minimum guaranteed death benefits according to Actuarial Guideline XXXIV) or in a separate account. All such reserves for guaranteed living benefits that are held in a separate account should be reported in Lines 1 thru 4, even if minimal.

Not for Distribution

INTEREST MAINTENANCE RESERVE

Interest Maintenance Reserve (IMR) requirements for investments reported in the Separate Accounts Statement are applied on an account-by-account basis. If an IMR is required for a separate account, all of the investments in that separate account are subject to the requirement. If an IMR is not required for a separate account, none of the investments in that separate account are subject to the requirement.

An IMR is required for separate accounts valued at book but is not required for separate accounts valued at market. For example, separate accounts for traditional variable annuities, or variable life insurance do not require an IMR because assets and liabilities are valued at market.

If an IMR is required for investments in the Separate Accounts Statement, it is kept separate from the General Account IMR and accounted for in the Separate Accounts Statement.

The instructions for completion of the IMR for the Separate Accounts Statement are incorporated in the instructions for completion of the IMR of the General Account Statement. Refer to those instructions for guidance.

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ASSET VALUATION RESERVE

Asset Valuation Reserve (AVR) requirements for investments reported in the Separate Accounts Statement are applied on an account-by account-basis. If an AVR is required for a separate account, all of the investments in that separate account are subject to the requirement. If an AVR is not required for a separate account, none of the investments in that separate account are subject to the requirement (except to the extent that such investments represent the company's capital and surplus interest in those investments).

Whether or not an AVR is required for separate account assets depends primarily on whether the reporting entity or policyholder/contract holder suffers the loss in the event of asset default or market value loss. An important exception to this is when specific state regulation provides an alternative to the AVR.

An AVR is required for separate account investments unless:

1. The asset default or market value risk is essentially borne directly by the policyholders, or

2. The regulatory authority for such separate accounts already explicitly provides for establishment of a reserve for asset default risk where such reserves are essentially equivalent to the AVR.

For example, assets supporting traditional variable annuities and variable life insurance do not require an AVR because the policyholders/contract holders bear the risk of change in the value of assets. However, an AVR is required for that portion representing the company's equity interest in the investments of such a separate account (seed money interest, for example). Assets supporting typical modified guaranteed contracts or market value adjusted contracts do require an AVR because the company is responsible for credit related asset loss. Another category of contracts requiring an AVR is contracts with book value guarantees similar to contracts generally found in the general account.

An example of the exception referred to in (2) above are contracts with market value separate accounts funding guaranteed benefits where state regulation provides alternatives to the AVR.

The following criteria are presented to assist in determining when an AVR or an IMR are required for investments in the Separate Accounts Statement:

Assets	Liabilities	Does Co. Suffer Asset Loss?	If Yes, Any Other Provision?	AVR*	IMR	Example Product
Market	Market	No	--	No	No	Variable Annuity
Market	Market**	Yes	No	Yes	No	Modified Gtd. Annuity
Market	Market	Yes	Yes	No***	No	MV S/A funding Gtd. Benefits
Book	Book	No	--	No	No	--
Book	Book	Yes	No	Yes	Yes	GIC in S/A
Book	Book	Yes	Yes	No***	Yes	--

* However, an AVR is required for that portion representing the company's equity interest in the investments of such a separate account.

** But not less than adjusted cash surrender value.

*** You must establish an AVR reserve unless there is a statutory requirement for the equivalent of an AVR reserve for such products.

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If an AVR is required for investments in the Separate Accounts Statement, it is combined with the General Account AVR and accounted for in the General Account Statement. Worksheets supporting the separate accounts portion of the reserve are included in the Separate Accounts Statement.

When the AVR Default Component covers assets valued at market, use one of the following two methods (applied consistently by separate account) to determine when a gain or loss (net of capital gains tax) is credited or charged to the AVR:

1. A gain or (loss) is recorded as for the general account rules, i.e., upon sale of an asset which has changed more than one designation category or upon asset default. Once an asset is in default, all subsequent market value changes are reflected in the AVR, or

2. A similar procedure to Method 1 above is followed but, additionally, a gain or (loss) is recorded whenever an asset held changes by more than one designation category. As there might be more than one such event for a particular asset, e.g., a two designation downgrade followed by subsequent sale of the asset, the amount charged the AVR is net of any prior amounts charged for that asset.

When an AVR is required for the company's equity or capital and surplus interest in the investments of a particular separate account that does not otherwise require an AVR, the AVR requirement is based on the company's equity interest as of the statement date, expressed as a percent of total assets of the particular separate account. Once the equity interest percentage has been determined, it is applied to the realized and unrealized capital gains and losses and the investments of that particular separate account to determine the amounts to be included in the separate accounts data used for development of the current AVR. If the company's equity interest in all such separate accounts is less than 1/10th of 1% of the company's total admitted assets, the equity interest in the investments of such separate accounts is exempt from AVR requirements.

The instructions for completion of the AVR for the Separate Accounts Statement are incorporated in the instructions for completion of the AVR of the General Account Statement. Refer to those instructions for guidance.

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SCHEDULE DA –VERIFICATION BETWEEN YEARS
SHORT-TERM INVESTMENTS

Report the aggregate amounts required by type of short-term invested asset. The categories of assets to be reported are: bonds, mortgage loans, other short-term invested assets, and investments in parent, subsidiaries and affiliates. A grand total of all activity is also required.

Line 1 – Book/Adjusted Carrying Value, December 31 of Prior Year

Report the market value per Page 2, Line 7, Column 1 of the prior year's Separate Accounts Statement.

Line 2 – Cost of Short-Term Investments Acquired

Report the aggregate cost of short-term investments acquired during the year. A reporting entity may summarize all "overnight" transactions and report the net amount as an increase in short-term investments on this line; all other transactions shall be recorded gross.

Line 6 – Deduct Consideration Received on Disposal of Short-term Investments

Report the proceeds received on disposal of short-term investments. A reporting entity may summarize all "overnight" transactions and report the net amount as a decrease in short-term investments on this line; all other transactions shall be recorded gross.

Line 12 – Statement Value at End of Current Period,

Enter the amount of Line 10 less Line 11. The amount reported on this line should agree with Page 2, Line 7, Column 1.

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GENERAL INSTRUCTIONS FOR SCHEDULE DB

Each derivative instrument should be reported in Parts A, B or C according to the nature of the instrument, as follows:

Part A: Positions in Options, Caps, Floors, Collars, Swaps and Forwards*

Part B: Positions in Futures Contracts

Part C: Positions in Replicated (Synthetic) Assets

* Forward commitments that are not derivative instruments (for example, the commitment to purchase a GNMA security two months after the commitment date, or a private placement six months after the commitment date) should not be on Schedule DB (see General account instructions).

** Forward commitments that are not derivative instruments (for example, the commitment to purchase a GNMA security two months after the commitment date, or a private placement six months after the commitment date) should not be on Schedule DB (see General account instructions).

Part D should be used to report the counterparty exposure, (i.e., the exposure to credit risk on derivative instruments) to each counterparty (or guarantor as appropriate).

If the reporting entity engages in derivative instruments, the following adjustments should be made to the Separate Accounts Statement:

Include, if a debit balance, the statement values individually for Parts A and B in the Separate Accounts Statement as follows:

Page 2, Line 8 – Derivatives

Include, if a credit balance, the statement values individually for Parts A and B in the Separate Accounts Statement as follows:

Page 3, Line 12 – Derivatives

See the general account instructions for complete information on completing Schedule DB.

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APPENDIX

INSTRUCTIONS FOR USE OF BARCODES

It is the responsibility of the company to prepare and utilize barcodes correctly.

The upper right-hand corner of the jurat page, and other pages and forms as identified on the Document Identifier Codes listing, will be the location of a 17-digit barcode symbol. The barcode standard to be utilized is the 3 of 9 (or 39) methodology. The barcode should be printed using at least a 24-point font. In addition to the barcode symbols, the name of the reporting entity, the year, and the document code should be printed on the barcode label. When the barcode is printed as part of the page rather than an affixed label, the reporting entity's name need not be printed above the barcode.

The barcode consists of the entity identifier (5 digits), the year (YYYY-4 digits), the document identifier (3 digits), the state code (2 digits), if state specific page, the data indicator (1 digit) and a filing type identifier (1 digit).

This 17th digit should utilize the following codes:

0 to represent the annual filings

1 to represent the March quarterly filing

2 to represent the June quarterly filing

3 to represent the September quarterly filing

4 to represent the Health Maintenance Organization's fourth quarter filing

5 to represent amended annual filings

6 to represent amended March quarterly filing

7 to represent amended June quarterly filing

8 to represent amended September quarterly filing

For filings of a reporting entity, the entity identifier is the NAIC company code number.

The year is represented as the last four digits of the filing year. For the 2018 annual statement due March 1, 2019, the year would be 2018.

The document identifier represents what page, schedule, exhibit, etc., is being filed. The respective identifiers for those documents requiring a barcode are included on the document identifier listing.

The state code represents if the document identifier can be filed for each individual state (e.g., the state business pages). The two-digit code would be the same as used on Schedule T. If it is not a state-specific form, the state code is 00. The state code Other is 58, and the code for Grand Total is 59. If the reporting entity has nothing to report on any state-specific supplemental schedule or exhibit, the barcode included in the Supplemental Exhibits and Schedules Interrogatories should contain a state code of 59.

The data indicator represents if the document contains data. For filings containing data place a one (1) in this field. If the document is a NONE, place a zero (0) in this field.

The filing type identifier is used to indicate the filing of NAIC filing components or state mandated (state specific) filing requirements other than those required by the NAIC. For NAIC filing requirements, the type code is 0. For state filing requirements, the type code is 1.

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If forms which are required to have a separate barcode as identified on the Document Identifier Codes listing are bound in the statement, these forms MUST have the barcode affixed to them. If a reporting entity submits with the March 1 filing a page requiring a barcode and that page has not been completed due to a later filing date, the barcode should not be affixed for the March filing. If the filing includes a page listing none schedules (and the state in which you are filing permits such a filing) and any of these schedules fall within that listing that requires a barcode, the barcode must be placed to the right of the name of the page, exhibit or schedule. On those forms which are completed on a by-state basis and are marked none because the company does not write that type of business or that particular state page is none, place the appropriate identifier with the data indicator of zero (0). State pages which have values reported must use the appropriate state barcode identifier from Schedule T. If any state requires the filing of a none "by-state basis" page, the name of the appropriate state must still be printed on the hard copy after "For the State of _______."

A listing of the Document Identifier Codes can be found at *www.naic.org/cmte_e_app_blanks.htm*.

The reporting entity is required to affix the appropriate barcode next to the respective Supplemental Interrogatory using the document identifier code provided. Note that it is only Supplemental Interrogatories to which the reporting entity has responded "NO" that it does not have to file a particular exhibit or form, and for which the physical page or form is marked none that the appropriate barcode be affixed. For supplements that are state specific, the only instance a barcode should be affixed is when that type of business is not written at all in any state.

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COUNTRY OF DOMICILE

APPENDIX OF ABBREVIATIONS

This is a comprehensive list of ISO Alpha 3 country abbreviations: Please note the following exception. Use NAT for Native American Tribes.

AFG – Afghanistan
ALA – Aland Islands
ALB – Albania
DZA – Algeria
ASM – American Samoa
AND – Andorra
AGO – Angola
AIA – Anguilla
ATA – Antarctica
ATG – Antigua and Barbuda
ARG – Argentina
ARM – Armenia
ABW – Aruba
AUS – Australia
AUT – Austria
AZE – Azerbaijan
BHS – Bahamas
BHR – Bahrain
BGD – Bangladesh
BRB – Barbados
BLR – Belarus
BEL – Belgium
BLZ – Belize
BEN – Benin
BMU – Bermuda
BTN – Bhutan
BOL – Bolivia
BES Bonaire, Sint Eustatius and Saba
BIH – Bosnia and Herzegovina
BWA – Botswana
BVT – Bouvet Island
BRA – Brazil
VGB – British Virgin Islands
IOT – British Indian Ocean Territory
BRN – Brunei Darussalam
BGR – Bulgaria
BFA – Burkina Faso
BDI – Burundi
KHM – Cambodia
CMR – Cameroon
CAN – Canada
CPV – Cape Verde
CYM – Cayman Islands
CAF – Central African Republic
TCD – Chad
CHL – Chile
CHN – China
CUW Curaçao
CXR – Christmas Island
CCK – Cocos (Keeling) Islands
COL – Colombia
COM – Comoros
COG – Congo (Brazzaville)
COD – Congo, Democratic Republic of the
COK – Cook Islands
CRI – Costa Rica
CIV – Côte d'Ivoire
HRV – Croatia
CUB – Cuba
CYP – Cyprus
CZE – Czech Republic
DNK – Denmark
DJI – Djibouti
DMA – Dominica
DOM – Dominican Republic
ECU – Ecuador
EGY – Egypt
SLV – El Salvador
GNQ – Equatorial Guinea
ERI – Eritrea
EST – Estonia
ETH – Ethiopia
FLK – Falkland Islands (Malvinas)
FRO – Faroe Islands
FJI – Fiji
FIN – Finland
FRA – France
GUF – French Guiana
PYF – French Polynesia
ATF – French Southern Territories
GAB – Gabon
GMB – Gambia
GEO – Georgia
DEU – Germany
GHA – Ghana
GIB – Gibraltar
GRC – Greece
GRL – Greenland
GRD – Grenada
GLP – Guadeloupe
GUM – Guam
GTM – Guatemala
GGY – Guernsey
GIN – Guinea
GNB – Guinea-Bissau
GUY – Guyana
HTI – Haiti
HMD – Heard Island and McDonald Islands
VAT – Holy See (Vatican City State)
HKG – Hong Kong, Special Administrative Region of China
HND – Honduras

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HUN	–	Hungary
ISL	–	Iceland
IND	–	India
IDN	–	Indonesia
IRN	–	Iran, Islamic Republic of
IRQ	–	Iraq
IRL	–	Ireland
IMN	–	Isle of Man
ISR	–	Israel
ITA	–	Italy
JAM	–	Jamaica
JPN	–	Japan
JEY	–	Jersey
JOR	–	Jordan
KAZ	–	Kazakhstan
KEN	–	Kenya
KIR	–	Kiribati
PRK	–	Korea, Democratic People's Republic of
KOR	–	Korea, Republic of
KWT	–	Kuwait
KGZ	–	Kyrgyzstan
LAO	–	Lao PDR
LVA	–	Latvia
LBN	–	Lebanon
LSO	–	Lesotho
LBR	–	Liberia
LBY	–	Libyan Arab Jamahiriya
LIE	–	Liechtenstein
LTU	–	Lithuania
LUX	–	Luxembourg
MAC	–	Macao, Special Administrative Region of China
MKD	–	Macedonia, Republic of
MDG	–	Madagascar
MWI	–	Malawi
MYS	–	Malaysia
MDV	–	Maldives
MLI	–	Mali
MLT	–	Malta
MHL	–	Marshall Islands
MTQ	–	Martinique
MRT	–	Mauritania
MUS	–	Mauritius
MYT	–	Mayotte
MEX	–	Mexico
FSM	–	Micronesia, Federated States of
MDA	–	Moldova
MCO	–	Monaco
MNG	–	Mongolia
MNE	–	Montenegro
MSR	–	Montserrat
MAR	–	Morocco
MOZ	–	Mozambique
MMR	–	Myanmar
NAM	–	Namibia
NRU	–	Nauru
NPL	–	Nepal
NLD	–	Netherlands

NCL	–	New Caledonia
NZL	–	New Zealand
NIC	–	Nicaragua
NER	–	Niger
NGA	–	Nigeria
NIU	–	Niue
NFK	–	Norfolk Island
MNP	–	Northern Mariana Islands
NOR	–	Norway
OMN	–	Oman
PAK	–	Pakistan
PLW	–	Palau
PSE	–	Palestinian Territory, Occupied
PAN	–	Panama
PNG	–	Papua New Guinea
PRY	–	Paraguay
PER	–	Peru
PHL	–	Philippines
PCN	–	Pitcairn
POL	–	Poland
PRT	–	Portugal
PRI	–	Puerto Rico
QAT	–	Qatar
REU	–	Réunion
ROU	–	Romania
RUS	–	Russian Federation
RWA	–	Rwanda
BLM	–	Saint-Barthélemy
SHN	–	Saint Helena
KNA	–	Saint Kitts and Nevis
LCA	–	Saint Lucia
MAF	–	Saint-Martin (French part)
SPM	–	Saint Pierre and Miquelon
VCT	–	Saint Vincent and Grenadines
WSM	–	Samoa
SMR	–	San Marino
STP	–	Sao Tome and Principe
SAU	–	Saudi Arabia
SEN	–	Senegal
SRB	–	Serbia
SYC	–	Seychelles
SLE	–	Sierra Leone
SGP	–	Singapore
SVK	–	Slovakia
SVN	–	Slovenia
SLB	–	Solomon Islands
SOM	–	Somalia
ZAF	–	South Africa
SGS	–	South Georgia and the South Sandwich Islands
SSD		South Sudan
ESP	–	Spain
LKA	–	Sri Lanka
SDN	–	Sudan
SUR	–	Suriname *
SJM	–	Svalbard and Jan Mayen Islands
SWZ	–	Swaziland
SWE	–	Sweden
CHE	–	Switzerland

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SYR – Syrian Arab Republic
TWN – Taiwan, Republic of China
TJK – Tajikistan
TZA – Tanzania *, United Republic of
THA – Thailand
TLS – Timor-Leste
TGO – Togo
TKL – Tokelau
TON – Tonga
TTO – Trinidad and Tobago
TUN – Tunisia
TUR – Turkey
TKM – Turkmenistan
TCA – Turks and Caicos Islands
TUV – Tuvalu
UGA – Uganda
UKR – Ukraine
ARE – United Arab Emirates
GBR – United Kingdom
USA – United States of America
UMI – United States Minor Outlying Islands
URY – Uruguay
UZB – Uzbekistan
VUT – Vanuatu
VEN – Venezuela (Bolivarian Republic of)
VNM – Viet Nam
VIR – Virgin Islands, U.S.
WLF – Wallis and Futuna Islands
ESH – Western Sahara
YEM – Yemen
ZMB – Zambia
ZWE – Zimbabwe

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