**** Columns 8 through 11 will be electronic only. ****

Column 8 – Fair Value Hierarchy Level and Method Used to Obtain Fair Value Code

Whenever possible, fair value should represent the price at which the security could be sold, based on market information. Fair value should only be determined analytically when the market-based value cannot be obtained.

The following is a listing of valid fair value level indicators to show the fair value hierarchy level.

"1" for Level 1

"2" for Level 2

"3" for Level 3

The following is a listing of the valid method indicators to show the method used by the reporting entity to determine the Rate Used to Obtain Fair Value.

"a" for securities where the rate is determined by a pricing service.

"b" for securities where the rate is determined by a stock exchange.

"c" for securities where the rate is determined by a broker or custodian. The reporting entity should obtain and maintain the pricing policy for any broker or custodian used as a pricing source. In addition, the broker must either be approved by the reporting entity as a counterparty for buying and selling securities or be an underwriter of the security being valued.

"d" for securities where the rate is determined by the reporting entity. The reporting entity is required to maintain a record of the pricing methodology used.

"e" for securities where the rate is determined by the unit price published in the NAIC *Valuation of Securities*.

Enter a combination of hierarchy level and method indicator. The fair value hierarchy level indicator would be listed first and the method used to determine fair value indicator would be listed next. For example, use "1b" to report Level 1 for the fair value hierarchy level and stock exchange for the method used to determine fair value.

The guidance in *SAP No. 100R—Fair Value* allows the use of net asset value per share (NAV) instead of fair value for certain investments. If NAV is used instead of fair value leave blank.

Column 9 – Source Used to Obtain Fair Value

For Method Code "a," identify the specific pricing service used.

For Method Code "b," identify the specific stock exchange used.

The listing of most **stock exchange codes can be found in the Investment Schedules General Instructions or the following Web address**:

www.fixprotocol.org/specifications/exchanges.shtml

For Method Code "c," identify the specific broker or custodian used.

For Method Code "d," leave blank.

For Method Code "e," leave blank.

If net asset value (NAV) is used instead of fair value, the reporting entity should use "NAV" to indicate net asset value used instead of fair value.

Column 10 – Legal Entity Identifier (LEI)

Provide the 20-character Legal Entity Identifier (LEI) for any mortgagor, issuer or counterparty as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.

Column 11 – ISIN Identification

The International Securities Identification Numbering (ISIN) system is an international standard set up by the International Organization for Standardization (ISO). It is used for numbering specific securities, such as stocks, bonds, options and futures. ISIN numbers are administered by a National Numbering Agency (NNA) in each of their respective countries, and they work just like serial numbers for those securities. Record the ISIN number only if no valid CUSIP, CINS or PPN exists to report in Column 1.

The ISIN reported for this column should be same for the security as reported in other schedules for the lines shown below:

Lines 0199999 through 7099999 ..... Schedule D, Part 1, Column 1
Lines 7199999 through 7399999 ..... Schedule D, Part 2, Section 1, Column 1
Lines 7499999 through 7799999 ..... Schedule D, Part 2, Section 2, Column 1

The ISIN number should be zero-filled for the following lines:

Real Estate (Schedule A) 8699999
Mortgage Loans on Real Estate (Schedule B) 8799999
Other Invested Assets (Schedule BA) 8899999
Short-Term Invested Assets (Schedule DA, Part 1) 8999999
Cash (Schedule E, Part 1) 9099999
Cash Equivalents (Schedule E, Part 2) 9199999
Other Assets 9299999

General Interrogatories:

1. The total activity for the year represents the net increase (decrease) from the prior year-end to the current year-end.

2. The average balance for the year is the average daily balance.

   Average daily balance: Total of daily balances divided by the number of days. Always calculate based on a 365/366 day year. If data is missing for a given date (e.g., weekend, holiday), count the previous day's value multiple times. The actual day count for the year (365/366) would serve as the denominator in the average calculation.

SCHEDULE E – PART 1 – CASH

This schedule shows all banks, trust companies, savings and loan and building and loan associations in which the company maintained deposits at any time during the year and the balances, if any (according to Reporting Entity's record), on December 31 of the current year. Certificates of deposit in banks or other similar financial institutions with maturity dates of one year or less from the acquisition date and other instruments defined as cash in accordance with *SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments* should be reported in this schedule. All Cash Equivalents should be reported in Schedule E, Part 2. Long-term certificates of deposit are to be reported in Schedule D.

In each case where the depository is not incorporated and subject to government supervision, the word "PRIVATE" in capitals and in parentheses — (PRIVATE) — should be inserted to the left of the name of the depository.

Report separately all deposits in excess of $250,000 or less than ($250,000). Deposits not exceeding $250,000 or not less than ($250,000) in federally insured depositories may be combined. Deposits in foreign bank accounts may be combined to the extent that the amount on deposit does not exceed the lesser of $250,000 or the amount of the foreign guarantee. The amount combined should be reported opposite the caption, "Deposits in (insert number) depositories that do not exceed the allowable limit." However, any reporting entity that does not maintain total deposits in any one depository of more than $250,000 is required to list its primary depository; and all entities must list all depositories where the total deposits or overdrafts (as represented by the absolute value) exceed 5% of the total cash as reported on Page 2 of the annual statement.

For Certificate of Deposit Account Registry Service (CDARs) or other similar services that have a maturity of one year or less, each individual banking institution providing a certificate of deposit should be reviewed separately to determine if the balance maintained by the reporting entity at that banking institution meets the criteria set forth above (i.e., does not exceed $250,000 or is not less than ($250,000) in federally insured depositories) for combining with other depository balances. If not, it should be listed individually on the schedule.

Cash in Reporting Entity's Office should be reported in this schedule.

The total of all Cash on Deposit at December 31 plus Cash in Reporting Entity's office (Total Cash, on a gross basis), less any applicable nonadmitted amounts (e.g., nonadmitted cash resulting from state-imposed limitations), should equal the parenthetical amount reported as cash on the Assets Page.

If the reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

Group or Category	Line Number
Deposits in (insert number) depositories that do not exceed allowable limits in any one depository – Open Depositories	0199998
Totals – Open Depositories	0199999
Deposits in (insert number) depositories that do not exceed allowable limits in any one depository – Suspended Depositories	0299998
Totals – Suspended Depositories	0299999
Total Cash on Deposit	0399999
Cash in Company's Office	0499999
Total Cash	0599999

Column 1 – Depository

Give full name and location. Indicate whether the depository is a parent, subsidiary, or affiliate. Give maturity date in the case of certificates of deposit or time deposits.

Column 2 – Code

Enter "^" in this column for all assets that are bifurcated between the insulated separate account filing and the non-insulated separate account filing.

If cash is not under the exclusive control of the company as shown in the General Interrogatories, it is to be identified by placing one of the **symbols identified in the Investment Schedules General Instructions** in this column.

Separate Account Filing Only:

If the asset is a bifurcated asset between the insulated separate account filing and the non-insulated separate account filing, the "^" should appear first, immediately followed by the appropriate code (**identified in the Investment Schedules General Instructions**).

Column 3 – Rate of Interest

Show the rate as stated on the face of the note. Where the original stated rate has been renegotiated show the latest modified rate. All information reported in this field must be a numeric value.

Column 4 – Amount of Interest Received During Year

Include: Investment income directly related to the securities reported in this schedule.

Column 7 – * Column

Place an "*" in this column when the reporting entity is taking credit for the estimated amount recoverable in a suspended deposit.

**** Column 8 will be electronic only. ****

Column 8 – Legal Entity Identifier (LEI)

Provide the 20-character Legal Entity Identifier (LEI) for any depository as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.

SCHEDULE E – PART 2 – CASH EQUIVALENTS

List all investments owned whose maturities (or repurchase dates under repurchase agreement) at the time of acquisition were three months or less, and defined as cash equivalents in accordance with *SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments*. Include Money Market Mutual Funds.

Refer to *SSAP No. 23—Foreign Currency Transactions and Translations* for accounting guidance related to foreign currency transactions and translations.

Short Sales:

> Selling a security short is an action by a reporting entity that results with the reporting entity recognizing proceeds from the sale and an obligation to deliver the sold security. For statutory accounting purposes, obligations to deliver securities resulting from short sales shall be reported as contra-asset (negative assets) in the investment schedule, with an investment code in the code column detailing the item as a short sale. The obligation (negative asset) shall be initially reflected at fair value, with changes in fair value recognized as unrealized gains and losses. These unrealized gains and losses shall be realized upon settlement of the short sale obligation. Interest on short sale positions shall be accrued periodically and reported as interest expense.

If a reporting entity has any detail lines reported for any of the following required categories or subcategories, it shall report the subtotal amounts of the corresponding category or subcategory with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number.

NOTE: See the Investment Schedules General Instructions for the following:

- **Category definitions for bonds.**
- **Code column list of codes and definitions for securities not under the exclusive control of the reporting entity.**

Category	Line Number
Bonds:	
U.S. Governments	
Issuer Obligations	0199999
Residential Mortgage-Backed Securities	0299999
Commercial Mortgage-Backed Securities	0399999
Other Loan-Backed and Structured Securities	0499999
Subtotals – U.S. Governments	0599999
All Other Governments	
Issuer Obligations	0699999
Residential Mortgage-Backed Securities	0799999
Commercial Mortgage-Backed Securities	0899999
Other Loan-Backed and Structured Securities	0999999
Subtotals – All Other Governments	1099999
U.S. States, Territories and Possessions (Direct and Guaranteed)	
Issuer Obligations	1199999
Residential Mortgage-Backed Securities	1299999
Commercial Mortgage-Backed Securities	1399999
Other Loan-Backed and Structured Securities	1499999
Subtotals – States, Territories and Possessions (Direct and Guaranteed)	1799999

U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)

Issuer Obligations 1899999
Residential Mortgage-Backed Securities 1999999
Commercial Mortgage-Backed Securities 2099999
Other Loan-Backed and Structured Securities 2199999
Subtotals – Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) 2499999

U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions

Issuer Obligations 2599999
Residential Mortgage-Backed Securities 2699999
Commercial Mortgage-Backed Securities 2799999
Other Loan-Backed and Structured Securities 2899999
Subtotals – Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions 3199999

Industrial and Miscellaneous (Unaffiliated)

Issuer Obligations 3299999
Residential Mortgage-Backed Securities 3399999
Commercial Mortgage-Backed Securities 3499999
Other Loan-Backed and Structured Securities 3599999
Subtotals – Industrial and Miscellaneous (Unaffiliated) 3899999

Hybrid Securities

Issuer Obligations 4299999
Residential Mortgage-Backed Securities 4399999
Commercial-Backed Securities 4499999
Other Loan-Backed and Structured Securities 4599999
Subtotals – Hybrid Securities 4899999

Parent, Subsidiaries and Affiliates Bonds

Issuer Obligations 4999999
Residential Mortgage-Backed Securities 5099999
Commercial Mortgage-Backed Securities 5199999
Other Loan-Backed and Structured Securities 5299999
Subtotals – Parent, Subsidiaries and Affiliates Bonds 5599999

SVO Identified Funds

Exchange Traded Funds – as Identified by the SVO 5899999
Bond Mutual Funds – as Identified by the SVO 5999999
Subtotals – SVO Identified Funds 6099999

Bank Loans

Bank Loans – Issued 6399999
Bank Loans – Acquired 6499999
Subtotals – Bank Loans 6599999

Total Bonds

Subtotals – Issuer Obligations 7799999
Subtotals – Residential Mortgage-Backed Securities 7899999
Subtotals – Commercial Mortgage-Backed Securities 7999999
Subtotals – Other Loan-Backed and Structured Securities 8099999
Subtotals – SVO Identified Funds 8199999
Subtotals – Bank Loans 8299999
Subtotals – Bonds 8399999

Sweep Accounts 8499999

Exempt Money Market Mutual Funds – as Identified by SVO 8599999

All Other Money Market Mutual Funds 8699999

Other Cash Equivalents 8799999

Total Cash Equivalents 8899999

A money market fund shall be reported in this schedule as an Exempt Money Market Mutual Fund if each money market fund is identified by the SVO as meeting the required conditions found in Part Six, Section 2(b)(i) of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*. All money market mutual funds that are not identified by the SVO on the U.S. Direct Obligations/Full Faith and Credit Exempt List shall be reported in this schedule as an "all other money market mutual fund."

Column 1 – CUSIP Identification

All CUSIP numbers entered in this column must conform to those published in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*, Part Six, Sections 2(f) and (g).

CUSIP identification is **required and valid only** for Exempt Money Market Mutual Funds – as Identified by SVO (Line 8599999) and All Other Money Market Mutual Funds (Line 8699999).

Column 2 – Description

Give a complete and accurate description.

Column 3 – Code

Enter "^" in this column for all assets that are bifurcated between the insulated separate account filing and the non-insulated separate account filing.

If a cash equivalent is not under the exclusive control of the company as shown in the General Interrogatories, it is to be identified by placing one of the **codes identified in the Investment Schedules General Instructions** in this column.

Separate Account Filing Only:

If the asset is a bifurcated asset between the insulated separate account filing and the non-insulated separate account filing, the "^" should appear first, immediately followed by the appropriate code (**identified in the Investment Schedules General Instructions**).

Column 4 – Date Acquired

For public placements use trade date, not settlement date. For private placements, use funding date. Each issue of bonds or stocks acquired at public offerings on more than one date may be totaled on one line and the date of last acquisition inserted.

Column 5 – Rate of Interest

Show rate of interest as stated on the face of the issue. Cash equivalent bonds with various issues of the same issuer use the last rate of interest. All information reported in this field must be a numeric value.

Column 6 – Maturity Date

Reporting entities may total on one line purchases of various issues of the same issuer of cash equivalent investments and insert the date of last maturity.

Column 9 – Amount Received During Year

Include: Investment income directly related to the securities reported in this schedule.

Accrual of discount and amortization of premium, where applicable.

Report amounts net of foreign withholding tax.

** **Column 10 will be electronic only.** **

Column 10 – Legal Entity Identifier (LEI)

Provide the 20-character Legal Entity Identifier (LEI) for any issuer as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.

SCHEDULE E – PART 3 – SPECIAL DEPOSITS

The amounts reported in this schedule also are included in the various asset schedules of the company.

Exclude from this schedule all deposits or operating accounts in financial institutions that the company uses in the normal course of its business.

Column 1 – Type of Deposit

Include in this column, one of the following indicators:

B – Bond
S – Stocks
M – Mortgages
C – Certificates of Deposit
R – Real Estate
ST – Cash/Short-Term Investments
O – Other (Use this symbol when multiple types of assets are on deposit within a particular jurisdiction.)

Column 2 – Purpose of Deposit

The following are examples of suggested entries for stating the purpose of the deposit:

Bail Bonds
Workers' Compensation
Property & Casualty
Fidelity & Surety
HMO
Life Insurance
Collateral for _____
Pledged for _____
Escrow for _____
Reinsurance with _____

If needed, you may enter multiple purposes in Column 2, if the totals in Columns 3 through 6 include multiple deposits.

Columns 3 and 4 – Deposits for the Benefit of All Policyholders

Report only the statutory deposit held for the benefit of all policyholders. **DO NOT INCLUDE** deposits held for a special purpose. Reporting entities must report these special purpose deposits in Columns 5 and 6.

Columns 5 and 6 – All Other Special Deposits

Report any deposits not included in Column 3 and 4 which are held for any special or statutory purpose.

Include: Deposits held for a special purpose.

Deposits to secure reinsurance obligations.

Deposits to satisfy a particular claim or litigation (list separately).

Exclude: Deposits held for the benefit of all policyholders (reported in Columns 3 and 4).

Deposits or operating accounts in financial institutions that the company uses in the normal course of its business.

Columns 3 and 5 – Book/Adjusted Carrying Value

Enter the balance sheet value of each deposit.

Columns 4 and 6 – Fair Value

Enter the fair value of each special deposit.

Details of Write-ins Aggregated at Line 58 – Aggregate Alien and Other

List separately each deposit to secure reinsurance obligations and reflect these amounts in the appropriate parts of the reinsurance schedules.

List separately each deposit to satisfy a particular claim or litigation.

SUPPLEMENTAL COMPENSATION EXHIBIT

Each reporting entity shall file with its state of domicile and any state that requests it in writing a Supplemental Compensation Exhibit for such directors, officers, and employees and in such manner as provided below.

The Exhibit shall be filed as a supplement to each reporting entity's annual statement to the domiciliary Department on or before March 1. The purpose of the Exhibit is to provide information to the regulator concerning payments to senior management and directors that could negatively impact a reporting entity's financial condition.

Insurers that are part of a group of insurers or other holding company system may file amounts paid to officers and employees of more than one insurer in the group or system either on a total gross basis or by allocation to each insurer.

Compensation shall consist of any and all remuneration paid to or on behalf of an officer, employee, or director covered by this requirement, including, but not limited to, wages, salaries, bonuses, commissions, stock grants, gains from the exercise of stock options, and any other emolument.

Supplemental Compensation Exhibit

- A table disclosing the total of all compensation paid to the named officers on behalf provided.
- The table shall cover a three-year period, although companies may phase in the required disclosures over the first three years of reporting.
- For awards of stock, the dollar amount reported shall be based upon the aggregate grant date value of awards computed in accordance with *SSAP No. 104R—Share-Based Payments*.
- Provide a narrative description of any material factors necessary to gain an understanding of the information disclosed in the tables in Part 4.

Part 2

Officer and Employee Compensation

Reporting entities shall disclose the compensation of:

1. All individuals serving as the principal executive officer ("PEO") or acting in a similar capacity during the last completed fiscal year, regardless of compensation level;
2. All individuals serving as the principal financial officer ("PFO") or acting in a similar capacity during the last completed fiscal year, regardless of compensation level;
3. The reporting entity's three most highly compensated executive officers, other than the PEO and PFO, who were serving as executive officers at the end of the last completed fiscal year; and
4. The next five most highly compensated employees whose individual total compensation exceeds $100,000.

The determination as to which executive officers are most highly compensated shall be made by reference to total compensation for the last completed fiscal year provided; however, no disclosure need be provided for any executive officer, other than the PEO and PFO, whose total compensation, as so reduced, does not exceed $100,000.

If the PEO or PFO served in that capacity during any part of a fiscal year with respect to which information is required, information should be provided as to all of his or her compensation for the full fiscal year. If a named executive officer (other than the PEO or PFO) served as an executive officer of the reporting entity (whether or not in the same position) during any part of the fiscal year with respect to which information is required, information shall be provided as to all compensation of that individual for the full fiscal year.

Definitions. For purposes of this disclosure:

1. The term "**stock**" means instruments such as common stock, restricted stock, restricted stock units, phantom stock, phantom stock units, common stock equivalent units or any similar instruments that do not have option-like features, and the term option means instruments such as stock options, stock appreciation rights and similar instruments with option-like features. The term stock appreciation rights (SARs) refers to SARs payable in cash or stock, including SARs payable in cash or stock at the election of the registrant or a named executive officer. The term "**equity**" is used to refer generally to stock and/or options.
2. The terms "**date of grant**" or "**grant date**" refer to the grant date determined for financial statement reporting purposes pursuant to *SSAP No. 104R—Share-Based Payments*.

Column 3 – Salary

The dollar value of the base salary (cash and non-cash) paid to the named officer or employee during the fiscal year covered.

Column 4 – Bonus

The dollar value of any bonus (cash and non-cash) paid to the named officer or employee during the fiscal year covered.

Column 5 – Stock Awards

For awards of stock, the aggregate grant date value computed in accordance with *SSAP No. 104R—Share-Based Payments*.

Column 6 – Option Awards

For awards of options, with or without tandem SARs (including awards that subsequently have been transferred), the aggregate grant date value computed in accordance with *SSAP No. 104R—Share-Based Payments*.

Column 7 – Sign-on Payments

All compensation received as a result of the acceptance of an employment offer.

Column 8 – Severance Payments

Any termination, including without limitation through retirement, resignation, severance or constructive termination (including a change in responsibilities) of such executive officer's employment with the reporting entity's and its subsidiaries

Column 9 – All Other Compensation

All other compensation for the covered fiscal year that the reporting entity could not properly report in any other column. Each compensation item that is not properly reportable in other columns, regardless of the amount of the compensation item, must be included.

Such compensation must include, but is not limited to:

- Perquisites and other personal benefits, or property, unless the aggregate amount of such compensation is less than $10,000;
- All "gross-ups" or other amounts reimbursed during the fiscal year for the payment of taxes;
- Reporting entity contributions or other allocations to vested and unvested defined contribution plans;
- A change in control of the reporting entity;
- The dollar value of any insurance premiums paid by, or on behalf of, the reporting entity during the covered fiscal year with respect to life insurance for the benefit of a named officer or employee; and
- The dollar value of any dividends or other earnings paid on stock or option awards, when those amounts were not factored into the grant date fair value required to be reported for the stock or option award.

Part 3

Director Compensation

Reporting entities shall also disclose all compensation paid to or on behalf of all directors, other than full-time officers and employees of the reporting entity whose total compensation included service as a director and is disclosed under Part 2. Amounts disclosed must include all compensation paid for services on board and committees, as well as any other compensation for any other activity or service such as consulting agreements.

Part 4

Provide a narrative description of any material factors necessary to gain an understanding of the information disclosed in the Part 2 and Part 3 tables.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

This set of Supplemental Interrogatories is to assist regulators in identifying and analyzing the risks inherent in the entity's investment portfolio. The Supplemental Investment Risks Interrogatories apply only to general account assets. These lines were determined based upon the investment categories contained in the NAIC Statutory Statement and considered as invested assets. The reported amounts are to be consistent with net admitted amounts reported by the entity in the statement and supporting schedules, not on a consolidated basis. Compute the percentage calculations by dividing the reported amount by the total admitted assets reported in Line 1 of the Interrogatories unless otherwise indicated. It is recommended that the first step in responding to this set of Interrogatories is for the person preparing this document to read through the Interrogatories to gain an understanding of the reporting requirements.

All reporting entities must answer Interrogatories 1 through 4, 11 through 16, 18, 19 and, if applicable, 20 through 23. Answer each Interrogatory 5 through 10 only if the reporting entity's aggregate holdings in foreign investments as addressed in Interrogatory 4 equals or exceeds 2.5% of the reporting entity's total admitted assets. Answer Interrogatory 17 only if the reporting entity's aggregate holdings in mortgage loans as addressed in Interrogatory 16 equals or exceeds 2.5% of the reporting entity's total admitted assets. For Life and Fraternal blanks, responses are to exclude Separate Accounts. For the Property/Casualty blank, responses are to exclude Protected Cell Accounts.

If listing a Supranational, put Supranational and the union or member on the line (Example: Supranational – World Trade Organization).

The following definitions apply to interrogatories 4 through 10, unless otherwise defined by state statute.

Foreign investment: An investment in a foreign jurisdiction, or an investment in a person, real estate or asset domiciled in a foreign jurisdiction. An investment shall not be deemed to be foreign if the issuing person, qualified primary credit source or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction, unless:

(a) The issuing person is a shell business entity; and

(b) The investment is not assumed, accepted, guaranteed or insured or otherwise backed by a domestic jurisdiction or a person, that is not a shell business entity, domiciled in a domestic jurisdiction.

Domestic jurisdiction: The United States, Canada, any state, any province of Canada or any political subdivision of any of the foregoing.

Foreign jurisdiction: A jurisdiction other than a domestic jurisdiction.

Shell business entity: A business entity having no economic substance, except as a vehicle for owning interests in assets issued, owned or previously owned by a person domiciled in a foreign jurisdiction.

Qualified guarantor: A guarantor against which a reporting entity has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

Qualified primary credit source: The credit source to which a reporting entity looks for payment as to an investment and against which a reporting entity has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

Supranational: Entities with more than one sovereign government as a member

Line 1 – Report the reporting entity's total admitted assets as reported on Page 2 of the annual statement.

Report the total net admitted assets for the current year, Page 2, Assets, Column 3, excluding Separate Account, Protected Cell or Segregated Account business.

Line 2 – Report the single 10 largest exposures to a single issuer/borrower/investment.

Determine the ten largest exposures by first, aggregating investments from all investment categories (except the excluded categories) by issuer. The first six digits of the CUSIP number can be used as a starting point; however, please note that the same issuer may have more than one unique series of the first six digits of the CUSIP. For example, the reporting entity owns bonds issued by the XYZ Company of $500,000 and common stock of the XYZ Company of $600,000. In addition the reporting entity has a mortgage loan to the XYZ Company of $300,000. The total exposure to Issuer XYZ Company is $1.4 million ($500,000+$600,000+$300,000).

Excluding: U.S. government securities (Part Six, Section 2(a)), U.S. government agency securities (Part Six, Section 2(e)), those U.S. government money market funds (Part Six, Section 2(f)) listed in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* as exempt; property occupied by the company; and policy loans. Also exclude asset types that are investment companies (mutual funds) and common trust funds that are diversified within the meaning of the Investment Company Act of 1940 [Section 5(b)(1)].

In Column 2, list the categories of securities that are included in the total for each issuer (e.g., bonds, mortgage loans, etc.)

Line 3 – Report by NAIC designation, the amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks.

Report the total amount for each subcategory. The amounts reported in the bond subcategories should be consistent with the amounts reported in Schedule D, Part 1A, Section 1, Column 7, Lines 11.1 – 11.6. Schedule D, Part 1A, Section 1 is reported gross and will not tie to this line if any amounts are reported and not admitted for bonds and preferred stocks on the asset page.

Line 4 – Report the amounts and percentages of the reporting entity's total admitted assets held in foreign investments (regardless of whether there is any foreign currency exposure) and unhedged foreign currency exposure.

Line 4.02 – Report the aggregate amount of foreign investments as determined by the rules or statutes of the state of domicile (regardless of whether there is any foreign currency exposure).

Line 4.03 – Report the portion of the aggregate amount of foreign investments that supports insurance liabilities denominated in that same foreign currency.

The amount reported in 4.03 should be included in all answers to Lines 5 through 10.

Line 4.04 – Report the amount of the insurance liabilities associated with the investments reported in 4.03 and that are denominated in the same currency.

Lines 5-10 should be answered only if the reporting entity's aggregate foreign investments exceed 2.5% of total admitted assets (response to 4.01 is no). The NAIC designations for Lines 5, 6, 8 and 9 relate to country ratings, not investment ratings. If the country does not have a rating, include the investment in the NAIC-3 or below category.

Line 5 – Report the aggregate foreign investment exposure (regardless of currency exposure) categorized by the country's NAIC sovereign designation. Aggregate foreign investments first by foreign jurisdiction and then by NAIC sovereign designation.

The sovereign ratings and designation equivalents are available on the NAIC Web site.

Line 6 – Within each of the following three categories of NAIC country sovereign designations, which are available on the NAIC Web site (1, 2, and 3 or below), identify the two countries in which the company has its largest aggregate foreign investment exposures (regardless of currency exposure), and report the dollar value and percentage of company investments issued within each of those countries.

Line 8 – Report the aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation. Aggregate unhedged foreign currency exposures first by foreign jurisdiction and then by NAIC sovereign designation.

The sovereign ratings and designation equivalents are available on the NAIC Web site.

Line 9 – Within each of the following three categories of NAIC country sovereign designations, which are available on the NAIC Web site (1, 2, and 3 or below), identify the two countries in which the company has its largest aggregate unhedged foreign currency exposures, and report the dollar value and percentage of company investments issued within each of those countries.

Line 10 – Report the 10 largest non-sovereign (i.e., non-governmental) exposures to a foreign issuer/borrower/ investment.

Determine the ten largest foreign exposures by first aggregating investments from all foreign investment categories by issuer. See example in Line 2. If the investment does not have an NAIC designation, indicate the investment category, i.e., mortgage loan, in the NAIC Designation Column after first indicating any available NAIC designations for that issuer/borrower.

Line 11 – Report the amounts and percentages of the reporting entity's total admitted assets held in Canadian investments, including Canadian-currency denominated investments, Canadian insurance liabilities ("Canadian Investments") and unhedged Canadian currency exposure.

Line 11.03 – Report the aggregate amount of Canadian investments that support insurance liabilities denominated in Canadian currency.

The amount listed in Line 11.03 should be included in all answers to Line 11.

Line 11.04 – Report the aggregate amount of the insurance liabilities associated with the investments reported in Line 11.03.

Line 11.05 – Unhedged Canadian Currency Exposure

If the reporting entity's aggregate Canadian investments exceed 2.5% of total admitted assets, answer this question.

Line 12 – Report the aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions (defined as investments having restrictions that prevent investment from being sold within 90 days).

Line 12.02 – The aggregate amount reported in this line is limited to investments with contractual restrictions. It does not include, for instance, investments that have procedural requirements to be met prior to sale or internal company restrictions.

Line 13.02 through 13.11 – Report the amounts and percentages of admitted assets held in the ten largest equity interests (including investments in the shares of mutual funds, preferred stocks, publicly traded equity securities, and other equity securities (including Schedule BA equity interests), and excluding money market and bond mutual funds listed in Part Six, Sections 2(f) and (g) of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* as exempt or NAIC 1).

Determine the ten largest equity interests by first aggregating investments included in this line by issuer. For example, the reporting entity owns preferred stock of the XYZ Company of $600,000 and common stock of the XYZ Company of $300,000. The total is $900,000 ($600,000+$300,000). The reporting entity also owns bonds issued by the XYZ Company of $500,000 that are excluded from this calculation because bonds are debt instruments. Other equity securities include partnerships and Limited Liability Companies (LLC) and any other investments reported in Schedule BA classified as equity.

Line 14 – Report the amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities (included in other equity securities) and excluding securities eligible for sale under Securities Exchange Commission (SEC) Rule 144a or SEC Rule 144 without volume restrictions.

Line 14.02 – The amount reported in this line is a subset of the Line 14 amount that excludes any public securities, any affiliated equity interests and any securities that can be sold under SEC Rule 144 or under Rule 144a without any volume restrictions.

Line 15 – Report the amounts and percentages of the reporting entity's total admitted assets held in general partnership interests (included in other equity securities).

Line 15.02 – Report the aggregate amount of all general partnership interests reported in Schedule BA. The amount excludes limited partnership interests or limited LLC investments.

Lines 15.03 through 15.05 – Report the details of the three largest general partnership interests if the aggregate amount reported in Interrogatory 15.01 exceeds 2.5% of admitted assets.

Line 16 – With respect to mortgage loans reported in Schedule B, report the amounts and percentages of the reporting entity's total admitted assets.

Line 16.02 through 16.11 – The aggregate mortgage interest represents the combined value of all mortgages secured by the same property or group of properties.

Report the details of the ten largest mortgage interests if the aggregate amount exceeds 2.5% of admitted assets.

The amounts reported in 16.11, 16.14 and 16.16 should be consistent with the corresponding subtotals reported in Column 8 of Schedule B, Part 1.

Line 17 – Report the aggregate mortgage loans having the indicated loan-to-value ratios as determined from the most current appraisal as of the annual statement date.

Line 17.01 through 17.05 – For each mortgage loan, determine its loan-to-value ratio and assign it to one of the five loan-to-value categories, separated into residential, commercial or agricultural. Aggregate the amounts for each category and calculate the percent of admitted assets.

Line 18.02 through 18.06 – Report the amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in one parcel or group of contiguous parcels of real estate reported in Schedule A, excluding property occupied by the company, if the aggregate amount reported in Interrogatory 18.01 exceeds 2.5% of admitted assets.

Line 19 – Report the amounts and percentages of potential exposure (defined as the amount determined in accordance with the *Annual Statement Instructions*) for mezzanine real estate loans.

Line 19.01 – If the response is yes, the reporting entity need not complete the remainder of Interrogatory 19.

Line 20 – Report the amounts and percentages of the reporting entity's total admitted assets subject to securities lending agreements, repurchase agreements, reverse repurchase agreements, dollar repurchase agreements and dollar reverse repurchase agreements.

Line 20.01 through 20.05 – Report the aggregate amount for each category at year-end and at the end of each quarter. Calculate the percentage of admitted assets at year-end.

Line 21 – Report the amounts and percentages for warrants not attached to other financial instruments, options, caps and floors.

Line 21.01 through 21.03 – Report the aggregate amount for each category and calculate the percentage of admitted assets. The amounts should also agree with amounts reported in Schedule DB.

Line 22 – Report the amounts and percentages of potential exposure (defined as the amount determined in accordance with the *Annual Statement Instructions*) for collars, swaps and forwards.

Line 22.01 through 22.04 – Report the aggregate amount for each category at year-end and at the end of each quarter. Calculate the percentage of admitted assets at year-end. The amounts should also agree with amounts reported in Schedule DB.

Line 23 – Report the amounts and percentages of potential exposure (defined as the amount determined in accordance with the *Annual Statement Instructions*) for futures contracts.

Line 23.01 through 23.04 – Report the aggregate amount for each category at year-end and at the end of each quarter. Calculate the percentage of admitted assets at year-end. The amounts should also agree with amounts reported in Schedule DB.

ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT

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

1. The name of the company 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, traveler 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.

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.

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).

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 only, ambulatory, 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.

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 Written During the Year

Underwriting and Investment Exhibit, Part 1, Line 9, Column 1.

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

1. Unearned Premium Reserve

Underwriting and Investment Exhibit Part 2D, Line 1, Column 1.

2. Reserves for Rate Credits or Experience Rating Refunds

Underwriting and Investment Exhibit Part 2D, Line 4, 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

Underwriting and Investment Exhibit, Part 2, Line 12.1, Column 1 minus Column 10.

NOTE: This excludes payments for any administrative costs.

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

Underwriting and Investment Exhibit, Part 2D, Line 2, Column 1. Current year minus prior year.

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

Underwriting and Investment Exhibit, Part 2D, Line 3, Column 1. Current year minus prior year.

C. Less the Change in the Premium Deficiency Reserve

Footnote (a) Underwriting and Investment Exhibit Part 2D. 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.

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

Medicare Supplement is defined as those forms which are qualified as Medicare Supplement under the Federal Certification Requirements or the NAIC Medicare Supplement Insurance Minimum Standards Model Act and Regulation, or that are filed under other state programs to satisfy separate form filing requirements for Medicare Supplement forms.

This exhibit should be completed on a direct basis and should include all Medicare Supplement insurance acquired through assumption of a block of business. In the event that a policyholder of the company relocates to another state, experience under that policy is to continue to be reported in the state in which the policy was originally issued. The nationwide aggregate earned premium on all Medicare supplement policies should be disclosed in the annual statement General Interrogatory related to Medicare Supplement insurance.

This exhibit is to be completed on a state basis.

In the event that a refiling of any state page is warranted, the amended page should be filed with the NAIC and with the state.

1. Experience on policies issued more than three years prior to the reporting year should be shown separately as indicated on the form. For example, for the reporting year ended December 31, 2018 (filed on March 1, 2019), experience on policies issued in 2015 and prior should be shown separately from that of policies issued in 2016 and later. For group insurance, the year of issue should be based on when the certificate was issued, if available. Otherwise, use the master policy year of issue.

2. Allocation of reserves on a state-by-state basis should rely on sound actuarial principles and be consistent as to methodology from year to year.

3. Include membership or policy fees, if any, with premiums earned.

4. Include mass marketed group insurance subject to individual loss ratio standards with individual.

5. Subtract dividends from premiums earned.

6. Do not adjust incurred claims nor premiums earned for changes in policy (additional) reserves.

DEFINITIONS

Column 1 – Compliance with OBRA

Respond with "YES", "NO" or "NA", to indicate compliance with OBRA requirements.

Column 3 – Standardized Medicare Supplement Benefit Plan

Means the standard plans A-N as required by Section 9E of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act. This includes all plans identified as A-N issued prior to a state's revisions to its regulatory program and identified as a standard plan at the time of issue. Policies issued prior to the effective date of this state's revisions to its Medicare supplement regulatory program pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990, and no longer offered in a state, should be designated with "P." Policies not meeting either of these definitions should be designated with "O." This includes policies issued in MN, MA, and WI (states that qualified for and received a waiver under federal law from the A-N requirements). A policy issued in these three states that did not require changes, as the result of modifications to the state regulatory program should be reported as "O." All policies identified as "O" must be explained in Medicare Supplement General Interrogatory 4. Theoretically, a policy should never be identified as "O" except in those states receiving a waiver from the A-N requirements.

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.

SCHEDULE SIS

STOCKHOLDER INFORMATION SUPPLEMENT

The Stockholder Information Supplement shall be completed by all stock companies incorporated in the U.S.A. that have 100 or more stockholders. Such supplement shall be filed with the insurance commissioner of the company's domiciliary state as a part of its annual statement. The information required to be contained in this supplement is to be furnished to the best of the knowledge of the company. Where appropriate, the company should obtain the required information, in writing, from its directors or officers and from any person known to the company to be the beneficial owner of more than 10% of any class of its equity securities.

The term "officer" means a president, vice-president, treasurer, actuary, secretary, controller and any other person who performs for the company functions corresponding to those performed by the foregoing officers.

INFORMATION REGARDING MANAGEMENT AND DIRECTORS

1. This information applies to any person who was a director or officer of the company at any time during the year. However, information need not be given for any portion of the year during which such person was not a director or officer of the company.

2. Include under "Other Employee Benefits" information for such items as pensions plans, deferred compensation plans, thrift plans, profit-sharing plans, etc., or other contracts, authorizations or arrangements, whether or not set forth in any formal document. Briefly describe such "plans" and the basis upon which directors or officers participate therein, if not previously described in a prior "Stockholder Information Supplement" indicating date thereof. Company cost of benefits accrued or set aside need not be stated with respect to payments computed on an actuarial basis under any plan that provides for fixed benefits on retirement at a specified age or after a specified number of years of service.

3. Information need not be included as to payments made for or benefits received from, group life or accident insurance, group hospitalization or similar group payments or benefits.

4. If it is impractical to state the amount of the estimated annual benefits proposed to be made upon retirement, the aggregate amount set aside or accrued to date in respect of such payment should be stated, together with an explanation of the basis for future payments.

5. Attach separate sheets if necessary to fully answer questions.

STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES

Column 1 – Name and Title

Indicate relationship of the person to the company, for example: "director," "director and vice-president," "beneficial owner of more than 10% of the company's common stock," etc.

Column 2 – Title of Security

The statement of the title of a security should be such as to clearly identify the security, even though there may be only one class, for example: "common stock," "4% convertible preferred stock," etc.

Column 3 – Nature of Ownership

Under the "Nature of Ownership", state whether ownership of securities is "direct" or "indirect." If the ownership is indirect (i.e., through a partnership, corporation, trust or other entity), indicate in a footnote or other appropriate manner the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and from those owned through a different type of indirect ownership.

Column 4 – Number of Shares Owned at the End of Prior Year and
Column 8 – Number of Shares Owned at the End of Current Year

In the case of securities owned indirectly, the entire amount of securities owned by the partnership, corporation, trust or other entity shall be stated. There may also be indicated in a footnote or other appropriate manner the extent of the security holder's interest in such partnership, corporation, trust or other entity.

If a transaction in securities of the company was with the company or one of its subsidiaries, so state. If it involved the purchase of securities through the exercise of options, so state. If any other purchase or sale was effected otherwise than in the open market, that fact shall be indicated. If the transaction was not a purchase or sale, indicate its character, for example, gift, stock dividend, etc., as the case may be.

Any additional information or explanation deemed relevant by the company should be included as a footnote or in other appropriate manner.

Column 9 – Percentage of Voting Stock Directly and Indirectly Owned or Controlled at the End of the Current Year

Report the percentage of voting stock directly and indirectly owned or controlled at the end of the current year by each director, officer and/or any other entity/person who directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10% of more of the voting interests of the entity. See *SSAP No. 25—Affiliates and Other Related Parties* for the definition of control.

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).

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.

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.

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).

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 five years, 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 that information was previously reported 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 years 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.

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.

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.

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 premium 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
${}_t\text{Paid Claims}_{iy}$ = Paid claims during claim duration t from claims incurred in year iy, t = 0, 1, 2, 3, . . . T
${}_T\text{Case Reserve}_{iy}$ = Case reserve at end of report year from claims incurred in iy

Incurred claims for incurred year iy :

For T=0

$${}_0\text{Paid Claims}_{iy} \times v^{½} + {}_0\text{Case Reserve}_{iy} \times v^{½} + {}_0\text{IBNR}_{iy} \times v^{½}.$$

For T>0

$${}_0\text{Paid Claims}_{iy} \times v^{½} + {}_1\text{Paid Claims}_{iy} \times v^{1} + {}_2\text{Paid Claims}_{iy} \times v^{2} + \ldots + {}_T\text{Paid Claims}_{iy} \times v^{T} + {}_T\text{Case Reserve}_{iy} \times v^{T+½} + ({}_T\text{IBNR}_{iy} \times v^{T+½})$$

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 costs 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 shall 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.

[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 changes 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.

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

${}_tIC_n$ = 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.

$_tCLiab^E_n$ – The claim liability of all business of CYI n in calendar duration t for the reporting year. $_tCLiab^E$ 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

$_tLR_n$ = The incurred claims loss ratio in calendar duration t for all business of CYI n.

$_tLR_n$ = $_tIC^E_n / {}_tEP_n$

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 all 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

$_tP_n$ The annual valuation net premium for all business of CYI n in calendar duration t.

$_tP_n$ = $_tEP_n$ 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.

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

$_tIF_n$ = 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

$$_tV^E_n = [(_{t-1}V^E_n) + {}_tP_t] \times (1+ i_n) - {}_tIC^E_n \times (1+ i_n)^{1/2}$$

Where:

$_tV^E_n$ = 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.

$_tP_t$ = 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.

$_tIC^E_n$ = 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 Reserve

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

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.

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

$${}_{iy}\text{Paid Claims}_{iy} \times v^{½} + {}_{iy}\text{Case Reserve}_{iy} \times v^{½} + {}_{iy}\text{IBNR}_{iy} \times v^{½} + \text{Transferred Reserve}_{iy} \times v^{½}$$

For T>0

$${}_{iy}\text{Paid Claims}_{iy} \times v^{½} + {}_{iy+1}\text{Paid Claims}_{iy} \times v^{1} + {}_{iy+2}\text{Paid Claims}_{iy} \times v^{1½} + \ldots + {}_{iy+T}\text{Paid Claims}_{iy} \times v^{T}$$
$$+ {}_{iy+T}\text{Case Reserve}_{iy} \times v^{T+½} + ({}_{iy+T}\text{IBNR}_{iy} \times v^{T+½}) + \text{Transferred Reserve}_{iy} \times v^{T+½}$$

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.

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.

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).

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.

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.

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).

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.

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 5.1 (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.

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.

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

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; state, 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 relieving 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 offset 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.

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 1, 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 amounts 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).

Include: 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.

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 – Deductibles, 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.

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 the 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.

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

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

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.

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.)

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 5, 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.

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 2.5 of Part 2:

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

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 2.5 (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.

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.

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 services 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.

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).

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.

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 Reduce 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.

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 reducing 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.

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.

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.

- 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 in 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, medical 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.

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 4 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 agent/office 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 3 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 1% 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.

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.

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.

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

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

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)

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.

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

LIFE, HEALTH AND ANNUITY GUARANTY ASSOCIATION MODEL ACT ASSESSMENT BASE RECONCILIATION EXHIBIT

The exhibit for any state, District of Columbia and Puerto Rico in which the company is licensed should be submitted to that jurisdiction. In addition, an exhibit should be prepared for any state, District of Columbia and Puerto Rico in which the company received any direct premiums or deposits. DO NOT SUBMIT exhibits for American Samoa, Guam, U.S. Virgin Islands, Canada, Northern Mariana Islands and other alien jurisdictions. A copy of each jurisdiction and a grand total page for the exhibits that are submitted should be sent to the state of domicile and the NAIC Support and Services Office.

Only companies that are members of the life, health and annuity guaranty associations should complete this exhibit. If a company is unsure if it is a member of a life, health and annuity guaranty association, it should contact the state life, health and annuity guaranty associations in its state of domicile or state(s) where it is licensed to write life, health and annuity business.

For the purpose of these instructions, references to Schedule T apply to the Life and Health blank and references to the Exhibit of Premiums and Losses apply to the Property blank.

The columnar headings correspond to the annual statement, Schedule T (Life or Health blank) or Exhibit of Premiums and Losses (Property blank) as follows:

Health Blank Schedule T Column Reference	Col. 6 Life & Annuity Premiums & Other Considerations (In part)	Col. 6 Life & Annuity Premiums & Other Considerations (In part)	Col. 2-5 Accident and Health Insurance Premiums	Col. 9 Deposit-type Contract Funds	Col. 6 Life & Annuity Premiums & Other Considerations (In part)
Base Exhibit	Col. 1 Life Insurance Premiums	Col. 2 Annuity Considerations	Col. 3 A & H Premiums	Col. 4 Deposit-Type Contract Funds	Col. 4 Other Considerations
Life Blank Schedule T Column Reference	Col. 2 Life Contracts – Life Insurance Premiums	Col. 3 Life Contracts – Annuity Considerations	Col. 4 Accident and Health Insurance Premiums	Col. 7 Deposit-Type Contract Funds	Col. 5 Other Considerations
Base Exhibit	Col. 1 Life Insurance Premiums	Col. 2 Annuity Considerations	Col. 3 A & H Premiums	Col. 4 Deposit-Type Contract Funds	Col. 4 Other Considerations
Property Blank Exhibit of Premiums and Losses (Statutory Page 14) Column and Lines Reference			Col. 1 Direct Premiums Written Lines 13-15.8 (Various Accident and Health Insurance Premiums)		
Base Exhibit	Col. 1 Life Insurance Premiums	Col. 2 Annuity Considerations	Col. 3 A & H Premiums	Col. 4 Deposit-Type Contract Funds	Col. 4 Other Considerations

In the event that this detailed information is not available in the reporting entity's accounting records, recognized allocation to estimation processes may be utilized if consistently applied.

Adjustments to the exhibit may be required by states that have not adopted the *Life and Health Insurance Guaranty Association Model Act* (#520).

PURPOSE OF THE LIFE, HEALTH AND ANNUITY GUARANTY ASSOCIATION MODEL ACT ASSESSMENT BASE RECONCILIATION EXHIBIT

It is desirable to display on one page the various types of annuity considerations, deposit-type contract funds and other considerations received directly by the reporting entity, separated by state, as is currently reported in the applicable Schedule T or Exhibit of Premiums and Losses. However, it is not possible to use such data for state guaranty association assessments without further modification. This is because of: (a) the limits placed on certain considerations for assessment purposes; (b) the variations by states in designation of "funds" for assessments; and (c) other factors that are interpreted differently by the individual states.

As a result, the NAIC has developed a specific exhibit, the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit ("Base Reconciliation Exhibit) which uses the state figures in Schedule T or Exhibit of Premiums and Losses as the starting point for development of the guaranty association assessment base (as defined in the NAIC *Life and Health Insurance Guaranty Association Model Act* (#520)). States should not use Schedule T or Exhibit of Premiums and Losses as the basis for guaranty association assessments, but instead use the Base Reconciliation Exhibit as the starting point.

Introduction

These instructions are intended to assist companies in completing the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (Base Reconciliation Exhibit) and Adjustments to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (Adjustments Exhibit).

The Base Reconciliation Exhibit starts with premiums, deposit-type contract funds and other considerations as reported in the applicable Schedule T or Exhibit of Premiums and Losses and then makes necessary adjustments (both positive and negative) to establish the premium assessment base as defined by the current Model #520. The Base Reconciliation Exhibit must be completed for each state (as well as the District of Columbia and Puerto Rico) in which the company is licensed or does business.

Should you have questions about how to fill out the Base Reconciliation Exhibit, and the answers are not provided in the instructions below, you may wish to consult the Model #520, particular State Guaranty Acts, the *Annual Statement Instructions* manual, your company attorney, particular State Insurance Departments or particular State Guaranty Association Administrators.

The Base Reconciliation Exhibit has four columns: Column 1 is for all individual and group life insurance premiums; Column 2 is for all individual and group allocated annuity amounts (whether called premiums, deposit-type contract funds or other considerations); Column 3 is for all individual and group accident and health premiums; and Column 4 is for all unallocated annuity amounts (whether called premiums, deposit-type contract funds or other considerations).

Base Reconciliation Exhibit

Premiums, Considerations and Deposits from Schedule T or the Exhibit of Premiums and Losses

Line 1 – **These amounts must exactly match the amounts reported by your company on Schedule T or the Exhibit of Premiums and Losses for all lines of business.**

Modifications to Premiums, Considerations and Deposits

Lines 2 through 10 are required to adjust amounts reported on your company's Annual Statement Schedule T to its Assessable Premium Base and are critical in transforming premium data prepared for Annual Statement purposes into data suitable for Guaranty Association purposes.

Line 2 – Enter any life, annuity or health premiums, deposit-type contract funds and other considerations received by your company that were not reported on Schedule T or the Exhibit of Premiums and Losses and, therefore, not included in Line 1 above. The total of Line 2 should equal Line 2.1 + Line 2.2. Such amounts should be reported in the appropriate column based on whether such amounts relate to life insurance, annuity, accident and health, or annuity and deposit-type business. Include all amounts received for insurance contracts. Guaranteed investment contract receipts, universal life insurance deposits and any other amounts received by the company for covered contracts that were not reported on the company's Schedule T or the Exhibit of Premiums and Losses (sometimes referred to as FASB 97 deposit reporting) must be reported on Line 2. Annuity amounts entered on Lines 1 and 2 must include, but are not limited to, amounts received for immediate or deferred annuity contracts, structured settlement agreements, lottery contracts, group annuity contracts, guaranteed interest or investment contracts, deposit administration contracts and allocated or unallocated funding obligations. In addition, allocate by state and include on Line 2 amounts reported on the applicable Schedule T as Company Contributions for Employee Benefit Plans (Line 60 (Health blank) or 90 (Life blank) of Schedule T), Dividends Applied to Purchase Paid-up Additions and Annuities, Dividends Applied to Shorten Endowment or Premium-Paying Period, Premium or Annuity Considerations Waived Under Disability or Other Contract Provisions and Aggregate Other Amounts Not Allocable by State.

Line 2.1 – Enter fees and charges for investment management, administration and contract guarantees from the Separate Account associated with variable contracts reduced by any contractholder dividends representing a return of such fees and charges. Specifically, in the case of variable annuity products, those portions of fees and charges paid to the general account with respect to living and death benefit guarantees, M&E charges and annual contract charges. In the case of variable life products with guaranteed death benefits, the portion of fees/charges paid to the general account would include the cost of insurance in addition to M&E charges and annual contract charges. Because the fees and charges are reportable by state, a reporting entity may use either a seriatim, i.e., specific contract identification by state, or an allocation method. An appropriate allocation method would be to calculate a ratio of fee income to total variable premium for the product line and multiply the ratio by the state specific variable premium.

Line 2.2 – Enter any other life, annuity or health premiums, deposit-type contract funds and other considerations received by your company that were not reported on Schedule T or the Exhibit of Premiums and Losses.

Lines 3.1 – 3.99 –

The primary purpose of Lines 3.1 to 3.99 is to add back amounts that, as a result of statutory accounting practices, were deducted from the amounts reported on Line 1 or 2. For the most part, these deductions represent current year benefit payouts, transfers, surrenders or withdrawals.

Enter any amounts deducted prior to determining amounts included in Lines 1 and 2. Companies reporting net amounts on Lines 1 and 2 must complete Lines 3.1 through 3.99 in order to provide gross premiums and deposits. Amounts reported on these lines should include transfers to separate accounts, GIC rollovers to other companies, surrenders, excess interest, and any other amounts deducted from or not included in the company's gross premium figures. Amounts that were reported as "Deposit-Type Contract Funds and Other Considerations" (Column 4) in the year of receipt and transferred in the current year to "Annuity Considerations" (Column 2), as individuals are "annuitized" are to be included on Line 3.3 of Column 4 if these amounts were deducted from the amounts reported on Lines 1 or 2.

As an example, most pension plan unallocated annuities provide for the purchase of an annuity payout benefit ("annuitization") for an individual. In the year of the receipt of the consideration for the unallocated annuity, that consideration, subject to limitations, is to be included in the total assessment base reported in Line 11, Column 4. In the year of annuitization, the amounts transferred to fund the annuity payout benefits are to be included in the total assessment base reported in Line 11, Column 2. There should be no corresponding reduction to the total assessment base reported in Line 11, Column 4 for the amount transferred to fund the annuitization to the extent that such amounts would not have been included in an assessment base. When an annuity payout benefit is, pursuant to that contract, purchased for an individual from monies previously deposited with the Company, it is assumed that there is no new contract rather, it is an internal rollover of funds, i.e., no new funds have been received by the Company.

In order to correctly report amounts subject to assessment in Columns 2 and 4, companies should maintain transaction level detail for each deposit type contract. On a cumulative basis, the assessable premium can never be less than $0 on any given contract. For example, the following will illustrate the correct reporting of deposit type contracts that partially or fully annuitize in a model act state (i.e., assessable premium up to $5 million per unallocated annuity contract). The amount reported on Line 7.4 is a balancing amount such that the assessable premium for any unallocated contract never exceeds $5 million nor is less than $0 over the life of the contract. The same approach applies to any state that covers unallocated annuities, irrespective of the limits. In this example, there is a $50 million unallocated contract in Year 1 and the company reports $5 million in Column 4. If the contract is completely annuitized in year 2, the company must report $50 million in Column 2 as allocated premium and $5 million on Line 3.3 (as an add-back) in the unallocated premium column. The Company should report a deduction of $5 million on Line 7.4 in Column 4 in the second year, since it has reported the full $5 million received in Column 2 by the end of the second year. On a cumulative basis, $0 is reported in Column 4. The Company has not subjected to assessment more premium than it has received.

(Millions of Dollars)

Example Contract		YEAR 1				YEAR 2	
		Col. 2	Col. 4			Col. 2	Col. 4
Deposit	50	X	X		0	X	X
Annuitize	0	X	X		50	X	X
Amt. Rep. Lines 1 & 2	X	0	50		X	50	-50
Amt. Rep. Line 3.3	X	X	0		X	0	-50
Amt. Rep. Line 5	X	0	50		X	50	0
Amt. Rep. Line 7.4	X	X	45		X	0	5
Amt. Rep. Line 11	X	0	5		X	50	-5
Cumulative All Years Line 11	X	0	5		X	0	0

Four additional examples will further illustrate the correct reporting of deposit type contracts that partially or fully annuitize in a model act state. In these examples, it can be seen that at any point in time, the Company has never included more in the assessable premium base (Columns 2 and 4 combined) than what was received by the Company over that period of time. Also, the Company never included more than $5 million of assessable premium in Column 4 at any point in time.

(Millions of Dollars)

Contract #1		Yr 1			Yr 2			Yr 3			Yr 4			Yr 5			Cum	
		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4
Deposit	5	X	X	5	X	X	5	X	X	5	X	X	5	X	X	25	X	X
Annuitize	1	X	X	3	X	X	2	X	X	1	X	X	8	X	X	15	X	X
Amt. Rep. Lines 1 & 2	X	1	4	X	3	5	X	2	3	X	1	4	X	8	-3	X	15	10
Amt. Rep. Line 3.3	X	X	1	X	X	3	X	X	2	X	X	1	X	X	8	X	X	15
Amt. Rep. Line 5	X	1	4	X	3	5	X	2	5	X	1	5	X	8	5	X	15	25
Amt. Rep. Line 7.4	X	X	1	X	X	4	X	X	5	X	X	5	X	X	5	X	X	20
Amt. Rep. Line 11	X	1	4	X	3	1	X	2	0	X	1	0	X	8	0	X	15	5
Cumulative All Years Line 11	X	1	4	X	4	5	X	6	5	X	7	5	X	15	5	X	X	X

For Contract #1, the Company received $25 million of deposits and included $20 million in the assessable premium base ($15 million as annuity considerations and $5 million as deposit funds) over the five-year period.

(Millions of Dollars)

Contract #2		Yr 1			Yr 2			Yr 3			Yr 4			Yr 5			Cum	
		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4
Deposit	10	X	X	10	X	X	5	X	X	5	X	X	5	X	X	35	X	X
Annuitize	1	X	X	3	X	X	2	X	X	1	X	X	28	X	X	35	X	X
Amt. Rep. Lines 1 & 2	X	1	9	X	3	7	X	2	3	X	1	4	X	28	-23	X	35	0
Amt. Rep. Line 3.3	X	X	1	X	X	3	X	X	2	X	X	1	X	X	28	X	X	35
Amt. Rep. Line 5	X	1	10	X	3	10	X	2	5	X	1	5	X	28	[illegible]	X	35	35
Amt. Rep. Line 7.4	X	X	5	X	X	10	X	X	5	X	X	5	X	X	10	X	X	35
Amt. Rep. Line 11	X	1	5	X	3	0	X	2	0	X	1	0	X	28	-5	X	35	0
Cumulative All Years Line 11	X	1	5	X	4	5	X	6	5	X	7	5	X	35	0	X	X	X

For Contract #2, the Company received $35 million of deposits and included $35 million in the assessable premium base ($35 million as annuity considerations and $0 as deposit funds) over the five-year period.

(Millions of Dollars)

Contract #3		Yr 1			Yr 2			Yr 3			Yr 4			Yr 5			Cum	
		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4
Deposit	10	X	X	10	X	X	0	X	X	0	X	X	0	X	X	20	X	X
Annuitize	1	X	X	3	X	X	2	X	X	1	X	X	8	X	X	15	X	X
Amt. Rep. Lines 1 & 2	X	1	9	X	3	7	X	2	-2	X	1	-1	X	8	-8	X	15	5
Amt. Rep. Line 3.3	X	0	1	X	X	3	X	X	2	X	X	1	X	X	8	X	X	15
Amt. Rep. Line 5	X	1	10	X	3	10	X	2	0	X	1	0	X	8	0	X	15	20
Amt. Rep. Line 7.4	X	0	5	X	X	10	X	X	0	X	X	0	X	X	0	X	X	15
Amt. Rep. Line 11	X	1	5	X	3	0	X	2	0	X	1	0	X	8	0	X	15	5
Cumulative All Years Line 11	X	1	5	X	4	5	X	6	5	X	7	5	X	15	5	X	X	X

For Contract #3, the Company received $20 million of deposits and included $20 million in the assessable premium base ($15 million as annuity considerations and $5 million as deposit funds) over the five-year period.

(Millions of Dollars)

Contract #4		Yr 1			Yr 2			Yr 3			Yr 4			Yr 5			Cum	
		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4
Deposit	5	X	X	5	X	X	5	X	X	5	X	X	5	X	X	25	X	X
Annuitize	1	X	X	6	X	X	0	X	X	0	X	X	8	X	X	15	X	X
Amt. Rep. Lines 1 & 2	X	1	4	X	6	-1	X	0	5	X	0	5	X	8	-3	X	15	10
Amt. Rep. Line 3.3	X	X	1	X	X	6	X	X	0	X	X	0	X	X	8	X	X	15
Amt. Rep. Line 5	X	1	5	X	6	5	X	0	5	X	0	5	X	8	-3	X	15	25
Amt. Rep. Line 7.4	X	X	1	X	X	6	X	X	3	X	X	5	X	X	5	X	X	20
Amt. Rep. Line 11	X	1	4	X	6	-1	X	0	2	X	0	0	X	8	0	X	15	5
Cumulative All Years Line 11	X	1	4	X	7	3	X	7	5	X	7	5	X	15	5	X	X	X

For Contract #4, the Company received $25 million of deposits and included $20 million in the assessable premium base ($15 million as annuity considerations and $5 million as deposit funds) over the five-year period. Contract #4 is different from Contract #1 in that after Year 2, only $3 million has been included in Column 4 since $7 million of the $10 million of deposits received has annuitized. For Year 3, $2 million is included in Column 4, bringing the cumulative total to $5 million, since a total of $15 million has been received, but only $7 million has annuitized.

You must provide a clear explanation of any amounts listed on Lines 3.501, 3.502, 3.503, etc. Line 3.99 (Total) should represent the difference between gross and net premiums for each column.

Line 4.1 – Transfer amounts received to fund annuity contracts qualified under Internal Revenue Code Section 403(b) (sometimes referred to as tax-sheltered annuities) from the Annuity Considerations column (Column 2) to the Deposit-Type Contract Funds and Other Considerations column (Column 4). This transfer line should be completed by companies that report 403(b) annuity amounts in the Life Contracts – Annuity Considerations column 3 (Life blank) or Life & Annuity Premiums & Other Considerations Columns in part (Health blank) of Schedule T. All 403(b) amounts in that column should be transferred to Column 4 of the Base Reconciliation Exhibit, whether the 403(b) contract was issued to a governmental or non-governmental policyholder. The amount entered as a negative in the Annuity Considerations column must exactly match the amount entered as a positive in the Deposit-Type Contract Funds and Other Considerations column.

NOTE: In 1995, the NAIC adopted changes to Section 6.A(1)(b) and 6.A(1)(c) of the Model #520 which effectively reclassified contracts issued under a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code from the unallocated annuity to the allocated annuity account (Non-governmental 401 and 403(b) contracts funded by an unallocated annuity contract remain in the unallocated annuity account.) Although now inconsistent with the adopted change, Base Exhibit, Line 4.1 must continue to be completed in accordance with the instructions in the preceding paragraph since no state has yet adopted this change. Changes to future annual statement instructions, forms or formula charts will be considered at such future date if and when adopted by individual state(s).

Line 4.2 – Transfer any allocated annuity amounts included in the Deposit-Type Contract Funds and Other Considerations column (Column 4) to the Annuity Considerations column (Column 2), except for amounts received to fund annuity contracts qualified under Internal Revenue Code Section 403(b) contracts. This includes all allocated annuity contracts, regardless of whether the annuity is in deferred or payout status, whether the annuity is group or individual, and whether the annuity is qualified or non-qualified for tax purposes.

According to Model #520, an "unallocated annuity contract means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by a reporting entity under such contract or certificate." An annuity is considered allocated unless it is unallocated. Examples of unallocated annuity contracts might be guaranteed investment contracts, deposit administration contracts, and unallocated funding agreements where no contract or agreement issued by the reporting entity, nor any certificate issued by the reporting entity thereunder, guarantees individual benefits to specifically identified individuals.

Group annuities may be allocated or unallocated. (The term "unallocated" is not synonymous with the term "group".) A group contract or certificate that guarantees annuity benefits to an individual (this is not the guarantee typically found in a guaranteed investment contract or deposit administration contract which allows the pension trustee or administrator to purchase an annuity for a plan participant at a guaranteed purchase rate) should be considered allocated. In addition to contracts under which periodic payments are being made to individuals, group annuity contracts should be considered allocated if the reporting entity is obligated under the contract upon the request of an individual (or his or her beneficiary) to make either partial or full cash withdrawal payments, which may be subject to plan or statutory restrictions, to the individual (or his or her beneficiary).

The reporting entity will be considered to be obligated upon the request of an individual to make either partial or full cash withdrawal payments if withdrawals or death benefit payments are made from that participant's account maintained (by the reporting entity or its designee) under the terms of the group annuity contract and regardless of whether such requests are submitted to the reporting entity directly by the individual (or his or her beneficiary) or indirectly through the plan trustee, administrator, sponsor or contract holder at the direction of the individual. As discussed in Line 4.1, the NAIC adopted a change to Model #520 that reclassifies governmental retirement plans established under Section 401, 403(b) and 457 of the Internal Revenue Code to the allocated annuity account. However, until adopted by a state legislature, 403(b) annuities should remain in the Deposit-Type Contract Funds and Other Considerations column (Column 4) to be consistent with existing statutes that require that these contracts be included with unallocated annuities for assessment purposes where applicable. Note that the amount entered as a negative in the Deposit-Type Contract Funds and Other Considerations column must exactly match the amount entered as a positive in the Annuity Considerations column.

Line 4.3 – Transfer any finalized matured annuity amounts included in the Annuity Considerations column (Column 2) to the Deposit-Type Contract Funds and Other Considerations column (Column 4). The amount entered as a negative in the Annuity Considerations column must exactly match the amount entered as a positive in the Deposit-Type Contract Funds and Other Considerations column.

Development of Amounts Included in Lines 1 Through 5 That Should Be Deducted in Determining the Base

Lines 6 through 9.99 are deductions from assessable premium based on the *Life and Health Insurance Guaranty Association Model Act* (#520) provisions. Companies must be careful not to deduct the same premium or deposits on more than one line. For example, amounts deducted on Line 6.1 as non-guaranteed separate account deposits should not be deducted a second time on Line 7.3 if those separate account deposits represent unallocated annuity deposits for a pension plan contract in excess of $5 million. Companies may only deduct amounts on Lines 6 through 9.99 (except for amounts on Line 8) to the extent those amounts have been included on Lines 1 through 5 of the Base Reconciliation Exhibit.

Lines 6.01 – 6.99 – Enter amounts received for any portion of a policy or contract not guaranteed by the reporting entity or under which the investment risk is borne entirely by the policy or contract holder. These amounts are those specified at the time of deposit as intended for deposit in separate accounts. Amounts entered on these lines are typically non-guaranteed separate account premiums. DO NOT INCLUDE on these lines amounts transferred to any guaranteed separate accounts. Two types of annuity contracts that should NOT be reported on Line 6 are: (i) modified guaranteed annuities, market-adjusted annuities, or other contracts where the amounts payable on at least one future date do not (or may not) depend solely on the investment performance of assets in the separate accounts, and (ii) guaranteed investment contracts issued to fund pension plans even if there are not mortality guarantees or only incidental mortality guarantees. Such contracts are not properly includable on Line 6 since the reporting entity retains an investment risk.

Amounts entered on Line 6 should correspond to amounts reported on the Annual Statement of Separate Accounts to the extent amounts are included in Lines 1 through 5 of the Base Reconciliation Exhibit. Specify deductions and indicate where such amounts were reported in the Annual Statement. Lines 6.1 – 6.99 should not include transfers to a separate account except to the extent such transfers represent current year premiums included on Lines 1 through 5 of the Base Reconciliation Exhibit. Companies must specifically identify deductions on Lines 6.01 through 6.99 and indicate where such amounts are reported in the Annual Statement (blue book) and where they are reported on Lines 1 through 5 of the Base Reconciliation Exhibit.

Lines 7.1 – 7.4 – Enter unallocated amounts that meet the descriptions provided on Lines 7.1, 7.2 and 7.3.

Line 7.1 – Allows a deduction for any unallocated annuity contract that is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery. An example of an appropriate Line 7.1 deduction would be amounts received to fund a municipal guaranteed investment contract.

Line 7.2 – Allows a deduction for any unallocated annuity contract issued to an employee benefit plan protected under the Federal Pension Benefit Guaranty Corporation (PBGC). Employee benefit plans protected by the PBGC are defined benefit plans only and do not include defined contribution plans.

Line 7.3 – Allows a deduction for unallocated annuity premiums in excess of $5 million for unallocated government lotteries and for any unallocated employee, union or association of natural persons benefit plans that is not: (a) governmental retirement plan established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code or (b) protected under the Federal Pension Benefit Guaranty Corporation. Line 7.3 should only include those amounts in excess of $5 million. For example, for a $15 million guaranteed investment contract issued to an employee benefit plan, the company should report $10 million (i.e., amounts in excess of $5 million) on Line 7.3. Do not include on Lines 7.1, 7.2 or 7.3 amounts that have been reported as transfers or deductions on any other lines (e.g., Lines 4.2, 6, 7.1, 7.2 or 7.3).

Line 8 – Enter dividends and experience rating credits, but only if such amounts were not guaranteed in advance. Examples of items that might be reported on Line 8 include: (i) non-guaranteed amounts that constitute a return of premiums collected in the current year and paid out of divisible surplus; and (ii) non-guaranteed experience rating credits that were not already deducted in determining Lines 1 and 2. Excess interest should not be deducted as dividends.

Lines 9.01 – 9.99 – Enter any other deductible amounts with a clear explanation of the nature of such deduction on Lines 9.01, 9.02, 9.03, etc. An example of an appropriate deduction is the premiums received for the Federal Employee Health Benefits Plan contracts in the Accident and Health column (Column 3). Deductions are not permitted for premiums received for the Federal Employee Group Life Insurance. Line 9 should not be used as a substitute for deductions that are to be reported on any of the above lines. Deductions are not permitted in the first three columns for amounts received in excess of coverage limits specified in the Guaranty Laws (i.e., a reporting entity cannot deduct amounts received or contract values in excess of $100,000 related to allocated annuity contracts).

Model Act Base

Line 11 – Line 11 equals Line 5 minus Line 10.

ADJUSTMENTS TO THE LIFE, HEALTH AND ANNUITY GUARANTY ASSOCIATION MODEL ACT ASSESSMENT BASE RECONCILIATION EXHIBIT

To be filed on or before April 1.

Introduction

The purpose of the Adjustments to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (Adjustments Exhibit) is to collect premium information needed by State Guaranty Associations to make assessments. The Adjustments Exhibit must be prepared with the same care and accuracy that would be used in preparing the Annual Statement, since the information is being provided to the Guaranty Fund Associations.

These instructions are intended to assist companies in completing the Adjustments Exhibit. **COMPANIES MUST READ THESE INSTRUCTIONS CAREFULLY AND REFER TO THE RELEVANT GUARANTY ASSOCIATION ACTS, WHERE APPROPRIATE.**

Only companies that are members of the life, health and annuity guaranty associations should complete this exhibit. If a company is unsure if it is a member of a life, health and annuity guaranty association, it should contact the state life, health and annuity guaranty associations in its state of domicile or state(s) where it is licensed to write life, health and annuity business.

The Adjustments Exhibit has four columns: Column 1 is for all individual and group life insurance premiums; Column 2 is for all individual and group allocated annuity amounts (whether called premiums, deposits, or considerations); Column 3 is for all individual and group accident and health premiums; and Column 4 is for all unallocated annuity amounts (whether called premiums, deposits or considerations). However, the Adjustments Exhibit requires annuity information only for states that have not adopted the most recent *Life and Health Insurance Guaranty Association Model Act* (#520). Companies are required to complete each line of the Adjustments Exhibit for all states, District of Columbia and Puerto Rico in which they were licensed or had business during the reporting year, except for those states that use the Base Reconciliation Exhibit for their respective assessment premium base (these states may be identified by referring to the respective assessment premium base formulas). DO NOT SUBMIT the Adjustments Exhibit for American Samoa, Guam, U.S. Virgin Islands, Canada, Northern Mariana Islands and other alien jurisdictions. If your company writes only life and/or accident and health insurance, there is no need to submit the Adjustments Exhibit (you may enter any miscellaneous adjustment your company may have to life and accident and health business on Line 9 of the Base Exhibit pursuant to the applicable instructions.)

Should you have questions about how to fill out the Adjustments Exhibit, and the answers are not provided in the instructions below, you may wish to consult the Model #520, particular State Guaranty Acts, the *Annual Statement Instructions*, your company attorney, particular State Insurance Departments, or particular State Guaranty Association Administrators.

Adjustments to the Base Reconciliation Exhibit

All Lines (except Lines 5.3, 6.4 and 9) of Column 4 (Unallocated Annuity Considerations and Other Unallocated Fund Deposits) and Line 2 of Column 2 (Allocated Annuity and Other Allocated Fund Deposits) must be completed for all states in which your company is licensed or did business during the survey year, except for those states that use the Base Reconciliation Exhibit for their respective assessment premium base. (These states may be identified by referring to the respective assessment premium base formulas.) DO NOT SUBMIT the Adjustments Exhibit for American Samoa, U.S. Virgin Islands, Canada, Northern Mariana Islands and other alien jurisdictions.

Deductions related to unallocated annuity contracts MUST be detailed on Lines 3 through 9, where appropriate. Deductions on Line 10 related to amounts received on unallocated annuity contracts WILL NOT be allowed.

Line 1 – Model Act Base

The amount from Line 11 of the Base Reconciliation Exhibit should be transferred to Line 1 of the Adjustments Exhibit.

Line 2 – All 403(b) annuities are included in Column 4 (Unallocated Annuity and Other Unallocated Fund Deposits) on the Base Reconciliation Exhibit and must be transferred to Column 2 (Allocated Annuity and Other Allocated Fund Deposits) for certain states that have not adopted the most recent Model #520 in its entirety. The amount to be transferred from Column 4 to Column 2 represents the amount of 403(b) annuity premiums included in Line 1 of the Adjustments Exhibit, regardless of whether it was originally reported in Column 2 or Column 4 of the Base Reconciliation Exhibit. Those companies that originally reported 403(b) premiums in Column 4 of the Base Reconciliation Exhibit must transfer such amounts to Column 2 even though no original transfer was required on Line 4.1 of the Base Reconciliation Exhibit.

Lines 3.1 and 3.2 – Companies that have unallocated funding obligations that are not issued to or in connection with a specific employee, union or association of natural persons benefit plan or government lottery (Line 7.1 of the Base Reconciliation Exhibit) must report such amounts on Lines 3.1 and 3.2. Line 3.2 should include any amounts reported on Line 3.1.

Lines 4.1, 4.2 4.3 and 4.5 – Companies that have unallocated funding obligations issued to fund government lotteries or employee, union or association of natural persons benefit plans that are NOT: (a) governmental retirement plans established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code, or (b) protected by the Federal Pension Benefit Guaranty Corporation must report such amounts on Lines 4.1, 4.2 and 4.3. Line 4.4 equals the sum of Lines 4.1, 4.2 and 4.3. Lines 4.1, 4.2 and 4.3 are mutually exclusive. Line 4.5 needs to be completed for Minnesota business only.

Lines 5.1, 5.2 5.3 and 5.4 – Companies that have unallocated funding obligations issued to fund governmental retirement plans established under Sections 401 and 457 of the U.S. Internal Revenue Code must report such amounts on Lines 5.1, 5.2 and 5.3. Line 5.2 should include the amounts reported on Line 5.1. Line 5.3 needs to be completed for New Jersey business only. Line 5.4 needs to be completed for Minnesota business only.

Lines 6.1, 6.2 6.4 and 6.5 – Companies that have unallocated funding obligations issued to fund governmental retirement plans established under Section 403(b) of the U.S. Internal Revenue Code must report such amounts on Lines 6.1 and 6.2. Line 6.3 equals the sum of Lines 6.1 and 6.2. Lines 6.1 and 6.2 are mutually exclusive. Line 6.4 needs to be completed for New Jersey business only. Line 6.5 needs to be completed for Minnesota business only.

Lines 7.1, 7.2 and 7.3 – Companies that have unallocated annuity contracts issued to an employee benefit plan protected by the Federal Pension Benefit Guaranty Corporation (Line 7.2 of the Base Reconciliation Exhibit) must report such amounts on Lines 7.1 and 7.2. Line 7.2 should include the amounts reported on Line 7.1. Line 7.3 needs to be completed for New Jersey business only.

Line 8 – Companies that have unallocated funding obligations issued to fund government lotteries must report such amounts up to $5 million per contract holder. This line should be completed for New Jersey business only.

Line 9 – Companies that have unallocated funding obligations that fund employee or association of natural persons benefit plans in New Jersey in excess of $2 million need to report receipts up to $5 million per contract. This line should be completed for New Jersey business only.

Line 10 – Aggregate Write-ins for Other Deductions

Enter the total of the write-ins listed in schedule "Details of Write-ins Aggregated at Line 10 for Other Deductions."

Line 11 – Represents the preliminary assessment base calculation for those states that have not adopted the most recent Model #520.

Details of Write-ins Aggregated at Line 10 for Other Deductions

The company must provide a clear explanation of the amounts included on Line 10. Amounts deducted on any other lines on the Base Reconciliation Exhibit or Adjustments Exhibit should not be reported here, since to do so would amount to a duplicate deduction. Line 10 should not be used as a substitute for deductions that are to be reported on any of the above lines. In addition, deductions are not permitted in the first three columns for amounts received in excess of coverage limitations specified in the Guaranty Laws (e.g., a reporting entity cannot deduct amounts received or contract values in excess of $100,000 related to allocated annuity contracts).

NOTE: Cross check for Adjustments Exhibit Lines 3.2, 4.3 and 7.2 Column 4

The aggregate amounts on Adjustments Exhibit Lines 3.2, 4.3 and 7.2 should equal the aggregate of the amounts on Base Exhibit Lines 7.1, 7.2 and 7.3 less the amount reported on Base Exhibit Line 3.3.

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LIFE SUPPLEMENT
TO THE HEALTH ANNUAL STATEMENT

NOTE: Only companies licensed as Life, Accident & Health insurers should complete the schedules included in the Life Supplement to the Health Annual Statement.

EXHIBIT 5 – AGGREGATE RESERVES FOR LIFE CONTRACTS

To be filed on or before March 1.

Refer to *SSAP No. 50—Classifications of Insurance or Managed Care Contracts* for life, accident and health and deposit-type contract definitions and *SSAP No. 51R—Life Contracts*. Reserves should be computed on a "gross" basis, i.e., direct and reinsurance assumed combined. Then, deductions for reinsurance ceded should be computed, using the same assumptions for mortality and interest and using the same valuation method, but reflecting the actual mode of reinsurance. If the assuming reinsurer uses different valuation assumptions or method (e.g., reinsurer uses net level, but ceding entity uses CRVM), then deductions for reinsurance ceded by the ceding reporting entity will not necessarily equal reserves established by the assuming reporting entity. No deductions should be taken for reserves ceded under a modified coinsurance arrangement.

If necessary, companies may add lines to report each reserve basis used.

Column 1 — Valuation Standard

State table of mortality, disability, etc. rate of interest; distinguish between: (1) net level premium, and (2) preliminary term, modified preliminary term, and select and ultimate standards. Identify reserve basis applicable to new business by inserting "N.B." on respective lines. Valuation assumptions for mortality, morbidity and other contingencies, interest and the valuation method should be indicated by years of issue. For annuities, indicate whether immediate, deferred, or both.

In describing the valuation assumptions and valuation methods, abbreviate as follows:

Mortality and Morbidity

AE ..... American Experience Table.
AM (5) ..... American Men (Ultimate) Table.
41 CSO ..... Commissioners 1941 Standard Ordinary Table.
41 STD IND ..... 1941 Standard Industrial Table.
41 STD INT ..... 1941 Standard Intermediate Table.
58 CSO ..... Commissioners 1958 Standard Ordinary Table.
58 CET ..... Commissioners 1958 Extended Term Table.
60 CSG ..... Commissioners 1960 Standard Group Table.
61 CSI ..... Commissioners 1961 Standard Industrial Table.
80 CSO ..... Commissioners 1980 Standard Ordinary Table or any modification of such table adopted by the NAIC.
80 CET ..... Commissioners 1980 Extended Term Table or any modification of such table adopted by the NAIC.
37 SA ..... 1937 Standard Annuity Table.
[illegible] ..... Combined Annuity Table.
a-1949 ..... Annuity Table for 1949.
71 IAM ..... 1971 Individual Annuity Mortality Table.
51 GAM ..... Group Annuity Mortality Table for 1951.
51 GAM PROJ ..... Group Annuity Mortality Table for 1951 with Projection.
71 GAM ..... 1971 Group Annuity Mortality Table.
83a ..... 1983 Table a.
83 GAM ..... 1983 Group Annuity Mortality Table.
1994 GAR ..... 1994 Group Annuity Mortality Table.
a-2000 ..... Annuity 2000 Mortality Table.
INTERCO DI ..... Inter-Company Double Indemnity Table.
IND DI ..... Industrial Double Indemnity.

59 ADB ..... 1959 Accidental Death Benefits Table.
52 INTERCO DISA ..... 1952 Inter-Company Disability Table.
70 INTERCO DISA ..... 1970 Inter-Company Group Life Disability Table.
64 CDT ..... 1964 Commissioners Disability Table.
26 Class (3) ..... Class (3) Disability Table (1926).
56 TASK FORCE IV ..... 1956 Task Force IV Morbidity Table.
85 CIDA ..... 1985 Commissioners Individual Disability Tables A.
85 CIDB ..... 1985 Commissioners Individual Disability Tables B.

Interest

4 1/2% ..... Interest at 4 1/2% for all durations.
5%/10/2% ..... Interest at 5% for the first 10 years after issue; 2% thereafter.

Valuation Method

NLP ..... Net Level Premium Reserve Method.
CRVM ..... Commissioners Reserve Valuations Method.
NJ ..... NJ Modified Reserve Method.
ILL ..... Illinois Modified Reserve Method.
CARVM ..... Commissioners Annuity Reserve Valuation Method.
MOD ..... Other Modified Reserve Method (e.g., CRVM graded into Net Level).

Age Basis

ANB ..... Age Nearest Birthday.
ALB ..... Age Last Birthday.
(-1) ..... With Ages Reduced One Year.

Other

CRF ..... Curtate Functions.
CNF ..... Continuous Functions.
CP ..... Continuous Premiums (but curtate death benefit).
IDB ..... Immediate Death Benefit (but non-continuous premiums).
55-79 ..... Issue years 1955 to 1979 inclusive.

For example, typical entries for two life insurance reserve bases in Exhibit 5 might be:

LIFE INSURANCE NLP ANB CRF unless otherwise indicated

1. 41 CSO 2 1/2% 47-65

2. 58 CSO 4%/10/2% CRVM ALB CNF ..... 78-80 NB

If additional space is needed to adequately describe the basis of valuation, use Note 21 of the Notes to Financial Statements to write in this information.

Column 5 – Credit (Group and Individual)

Include: Business not exceeding 120 months.

Refer to *SSAP No. 59—Credit Life and Accident and Health Insurance Contracts* for accounting guidance.

Life Insurance

Include the reserve for future transfers of un-accrued tabular net premiums to the end of the current contract year for variable life insurance contracts.

Accidental Death Benefits

If reserve for accidental death benefits under group life contracts is carried in Life Insurance, write "Included Above" in Column 6.

Disability – Active Lives

If reserve for disability under group life contracts is carried in Life Insurance, write "Included Above" in Column 6.

Disability – Disabled Lives

Include "un-accrued" portion of liability for incurred claims (whether reported or unreported).

Miscellaneous Reserves

Classification by mortality and interest standards not required.

If the company has no liability in respect to one of these items, write "None" in the total Column. If the liability in respect to one of these items is carried under Life Insurance to Disability, write "Included on preceding page" in the total Column.

The words "return of premiums" in Line 2 of this section do not refer to benefits under so-called return premium contracts, but to the return of some part of the premium paid for the period current at the time of death. Compute reserve on basis of level premiums, not successive one-year term premiums.

Include the reserve for variable life insurance minimum death benefit guarantees in this section.

EXHIBIT 5 – INTERROGATORIES

To be filed on or before March 1.

Interrogatories 1 and 2

If the response to Interrogatories 1 and 2 indicate that the reporting entity issues or has issued participating insurance, the reporting entity shall supply the response to these interrogatories and the actuarial opinion shall be supplied as an attachment to the annual statement.

The following interrogatories deal with dividends or refunds:

i. Apportioned for payment during (year following year of statement); and

ii. In effect as of January 1, (year following year of statement) that are illustrated for payment on new or existing business in (second year following year of statement) and later that are authorized for illustration by the reporting entity.

INSTRUCTIONS FOR ACTUARIAL OPINION

Process of Dividend or Refund Determination

Describe the general methods and procedures used to determine dividends or refunds. The term "refunds" is limited to amounts declared by Fraternal organizations, paid or payable, to its members. Experience rating refunds are excluded.

Description of Experience Factors

Describe the basis used in making any distinction in experience factors that underlie the determination of dividends or refunds. The description should specifically include the basis for the following:

a. Investment income factors
b. Claims factors
c. Expense factors
d. Termination factors
e. Any other factors that may have a material effect on the dividends or refunds of any group of contracts.

Also, describe in a qualitative way any material changes made in the bases used to determine those factors.

Actuarial Interrogatories

I. Has the contribution principle been followed in determining dividends or refunds? If not, describe.

II. Has any material change occurred with respect to the determination of contract factors? If yes, describe.

III. Have there been any changes in the scales of dividends or refunds on new or existing business authorized for illustration by the reporting entity? If yes, describe in general the changes that were made,

IV. Have there been any changes in the scales of dividends or refunds apportioned for payment? If yes, describe in general the changes that were made.

V. For each major block of business, indicate when the dividend or refund scale was last changed (including changes described in IV, above), and indicate the extent of such change in terms of the percentage by which dividends or refunds payable under the new scale exceeded or were less than those that would have been paid in the year of change had the scale not been changed.

VI. Does the dividend or refund scale incorporate the use of projections or forecasts of experience factors for any period in excess of two years beyond the effective date of the scale? If yes, describe.

VII. In the basis of determining investment income experience factors, state whether the reporting entity uses (a) a portfolio average approach, (b) an investment generation approach, or (c) a combination of the two approaches. If (b) or (c), describe the general basis used, including the issue year groupings.

VIII. With respect to contract loan provisions:

Describe how differences in such provisions affect dividends or refunds.

Does the dividend or refund scale contain any provision for varying the amount of dividend or refund in accordance with the extent to which an individual contract's loan provision is utilized? If yes, indicate the blocks of business where this treatment pertains, and describe the basis of variation used.

IX. Does the reporting entity pay termination dividends or refunds on its contracts? If yes:

a. Are they payable on death, surrender, and maturity?

b. Are they payable or credited either upon the commencement of nonforfeiture insurance or upon termination thereof by death, surrender, or maturity?

c. Do they reflect the incidence, size, and growth of amounts that may be attributed to the contracts in question?

If the answer to a., b., or c. is no, describe the basis used.

X. Does the reporting entity maintain separate participating and non-participating accounts? If yes, describe the basis.

XI. Are any transfers made from a participating account to another participating, non-participating, or shareholders' account? If yes, describe the basis for the transfers.

XII. Does the undersigned believe there is a substantial probability that, because of expected deterioration of experience or for any other reason, the dividends or refunds illustrated on new or existing business cannot be supported for at least two years? If yes, explain why.

XIII. Describe any aspects of the determination of the dividend or refund scale not covered above that involve material departures from the Actuarial Standards of Practice issued by the Actuarial Standards Board applicable to the determination of dividends or refunds.

XIV. Describe any material changes in the basis of determination of the dividend or refund scale that are not covered above.

The actuarial opinion should include a paragraph such as the following regarding dividends and refunds:

ACTUARIAL OPINION

"I, (name, title), am (relationship to Reporting Entity) and a Member of the American Academy of Actuaries. I have examined the actuarial assumptions and methods used in determining dividends or refunds under the dividend or refund scale for the individual participating life insurance contracts of the reporting entity issued for delivery in the United States. The dividends or refunds encompassed by this scale include:

i. Apportioned for payment during (year following year of statement); and
ii. In effect as of January 1, (year following year of statement) that are illustrated for payment on new or existing business in (second year following year of statement) and later that are authorized for illustration by the reporting entity.

My examination included such review of the actuarial assumptions and methods of the underlying basic records and such tests of the actuarial calculations, as I consider necessary. In my opinion, these dividends or refunds have been determined in accordance with Actuarial Standards of Practice issued by the Actuarial Standards Board applicable to the determination of dividends or refunds except as described above.

_____
Signature of Actuary

_____
Date

Interrogatory 3

This interrogatory relates to the determination of nonguaranteed elements in individual life insurance and annuity contracts that provide for the adjustment of benefits, premiums or charges from time to time. For purposes of this question, the term "determination" shall mean both determination at issue and subsequent redetermination.

For the purpose of this interrogatory, "Individual Contracts" includes contracts issued under the "group" umbrella of any trust that does not have the discretion to select the reporting entity(ies) on behalf of all the individual reporting entities.

The specific types of business encompassed by this question include, but are not limited to, the following types of contracts if they contain nonguaranteed elements:

1. Single and periodic premium deferred annuities.

2. Universal Life contracts providing for fixed and/or flexible premiums.

3. Adjustable periodic premium life contracts, also known as indeterminate premium life contracts.

4. Single and periodic premium life contracts.

5. Renewable and convertible term insurance contracts which do not guarantee the premiums payable upon renewal, or which provide for renewal on the then current premium basis.

The term "nonguaranteed" does not apply to charges or benefits that contractually follow a separate account result or a defined index.

INSTRUCTIONS FOR ACTUARIAL OPINION

Determination Procedures

For all contracts subject to this interrogatory which were first introduced during the current year and for any other such contracts not previously reported, define the reporting entity's contract to be used in the process of determining nonguaranteed elements, with particular reference to the degree of discretion reserved for the reporting entity, together with the general methods and procedures which are expected to be used.

Actuarial Interrogatories

I. Since this statement was last filed, have there been any changes in the values of nonguaranteed elements on new or existing business authorized for illustration by the reporting entity? If yes, describe the changes that were made.

II. Since this statement was last filed, have there been any changes in the values of nonguaranteed elements actually charged or credited? If yes, describe the changes that were made.

III. Indicate to what extent any change described in 1 or 2 varies from the contract and/or general methods and procedures last reported for the affected contracts.

IV. Are the anticipated experience factors underlying any nonguaranteed elements different from current experience? If yes, describe in general terms the ways in which future experience is anticipated to differ from current experience and the nonguaranteed element factors that are affected by such anticipation.

V. State whether anticipated investment income experience factors are based on: (a) a portfolio average approach, (b) an investment generation approach, or (c) other. If (b) or (c), describe the general basis used, including the investment generation groupings.

VI. Describe how the reporting entity allocates anticipated experience among its various classes of business.

VII. Does the undersigned believe there is a substantial probability that illustrations authorized by the reporting entity to be presented on new and existing business cannot be supported by currently anticipated experience? If yes, indicate which classes and explain.

VIII. Describe any aspects of the determination of nonguaranteed elements not covered above that involve material departures from the Actuarial Standards of Practice issued by the Actuarial Standards Board, applicable to the determination of nonguaranteed elements.

The actuarial opinion should include a paragraph such as the following regarding nonguaranteed elements:

ACTUARIAL OPINION

"I, (name, title), am (relationship to Company) and a Member of the American Academy of Actuaries. I have examined the actuarial assumptions and methods used in determining nonguaranteed elements for the individual life insurance and annuity contracts of the reporting entity used for delivery in the United States. The nonguaranteed elements included are those:

i. Paid, credited, charged or determined in (year of statement); and

ii. Authorized by the Reporting Entity to be illustrated on new and existing business during (year of statement).

My examination included such review of the actuarial assumptions and methods of the underlying basic records and such tests of the actuarial calculations, as I considered necessary. In my opinion, the nonguaranteed elements described above have been determined in accordance with Actuarial Standards of Practice issued by the Actuarial Standards Board applicable to the determination of nonguaranteed elements, except as described above.

_____

Signature of Actuary

_____

Date

Interrogatory 7

For purposes of this footnote disclosure, a synthetic GIC is defined as a contract or agreement in which the insurance entity guarantees specified payouts under the terms of an employee benefit plan from assets not owned by the insurance entity.

Interrogatory 8

For purposes of this footnote disclosure, a Contingent Deferred Annuity is defined as an annuity contract that establishes a life insurer's obligation to make periodic payments for the annuitant's lifetime at the time designated investments, which are not owned or held by the insurer, are depleted to a contractually defined amount due to contractually permitted withdrawals, market performance, fees and/or other charges.

Interrogatory 9

For purposes of this footnote disclosure, a Guaranteed Lifetime Income Benefit is defined as a fixed deferred annuity contract, agreement or rider in which the insurance entity guarantees specified payouts during the lifetime of the insured(s) regardless of the performance of a contractual account value that is used to determine cash surrender values and traditional withdrawal benefits.

EXHIBIT 7 – DEPOSIT-TYPE CONTRACTS

To be filed on or before March 1.

This exhibit is intended to capture information about the activity, before and after any reinsurance, 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.

Column 4 – Supplemental Contracts (Without Life Contingencies)

Include: Amounts resulting from proceeds settled under a settlement option provision of a life or annuity contract without any mortality or morbidity risk.

Column 5 – Dividend Accumulations, or Refunds

Include: Amounts held on account related to contracts without 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 contract holders that increased the fund balance.

The amounts reported should be consistent with those reported on the Cash Flow page.

Line 3 – Investment Earnings Credited to the Account

Include: Amounts earned and/or credited to the account.

Line 4 – Other Net Changes 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.

Exclude: Interest earned and/or credited to the account reported in Line 3.

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 company.

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.

The amounts reported should be consistent with those reported on the Cash Flow page.

Line 14 – Net Balance at the End of the Current Year After Reinsurance

The amounts reported should be consistent with those reported on the Liability page.

SCHEDULE S – REINSURANCE

These parts (except Part 1 that shows reinsurance assumed) provide an analysis by reinsurance carrier of reinsurance ceded data shown in total in various parts of the statement. Information is included on all reinsurance ceded to other entities authorized as well as unauthorized or certified in the state of domicile of the reporting entity. Additional data for unauthorized companies is displayed in Part 4; additional data for certified reinsurers is displayed in Part 5.

NOTE: Certified reinsurer status applies on a prospective basis, and is determined by the state of domicile of the ceding insurer. As such, it is possible that a ceding insurer will report reinsurance balances applicable to a single assuming insurer under multiple classifications within Schedule S. For example, with respect to a certified reinsurer that was considered unauthorized prior to certification, balances attributable to contracts entered into prior to the assuming insurer's certification would be reported in the unauthorized classification, while balances attributable to contracts entered into or renewed on or after the assuming insurer's certification would be reported in the certified classification. Proper classification of such balances is essential to ensure accurate reporting of collateral requirements applicable to specific balances and the corresponding calculation of the liability for unauthorized and/or certified reinsurance.

Effective date as used in this schedule is the date the contract originally went into effect.

Where name of company is specified, show the full corporate name of the company to which reinsurance is ceded.

The reinsurance type should be entered in all capital letters, and all reinsurance types must be followed by /G (for Group) or /I (for Individual).

Illustration for reporting MODCO activity

From time to time, an entity that assumes the risk on a block of business may cede that same block to another entity. This type of transaction is often called a "retrocession." The following example illustrates the reporting. Entity A enters into a modified coinsurance arrangement with Entity B for new individual life insurance policies. At year-end the "modco" reserves held by Entity A totaled $1,000. Concurrent with the agreement, Entity B enters into a similar arrangement with Entity C covering the same block of business. Entity A would list Entity B on Schedule S, Part 3 Section 1 with a type code of MCO/I and report $1,000 in Column 14 along with the other relevant information. Entity B would list Entity A in Schedule S, Part 1 Section 1, with a type code of MCO/I and report $1,000 in Column 8 and 11 along with the other relevant information. Entity B would also list Entity C in Schedule S, Part 3 Section 1, reporting $1,000 in Column 14 along with the other relevant information. Entity C would list Entity B in Schedule S, Part 1, Section 1, reporting $1,000 in Column 8 and 11 along with the other relevant information.

Index to Schedule S

* These parts of Schedule S are included as part of the Health Annual Statement

** These parts of Schedule S are included as part of the Life Supplement to the Health Annual Statement

Due Date

To be filed on or before March 1.

ID Number

Most parts of Schedule S require that the "ID Number" be reported for assuming or ceding entities.

Reinsurance intermediaries should not to be listed, because Schedule S is intended to identify only risk-bearing entities.

Use of Federal Emplover Identification Number

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the "ID Number" for other alien insurers, even if the federal government has issued such a number.

Alien Insurer Identification Number (AIIN)

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule S instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at *FDRCCREQ@NAIC.ORG* for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Pool and Association Numbers

In order to report transactions involving non-risk bearing pools or associations consisting of nonaffiliated companies correctly, the company must include on Schedule S the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC *Listing of Companies*. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at *FDRCCREQ@NAIC.ORG* for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Certified Reinsurer Identification Number (CRIN)

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule S instead of the FEIN or Alien Insurer Identification Number (AIIN). The CRIN is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at *FDRCCREQ@NAIC.ORG* for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

NAIC Company Code

Company codes are assigned by the NAIC and are listed in the NAIC *Listing of Companies*. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The "NAIC Company Code" field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the "Pool and Association Numbers" section above for details on assignment of Pool/Association Identification Numbers. Risk-bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk-bearing entity (e.g., risk-bearing pools or associations) does not appear in the NAIC *Listing of Companies*, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at *FDRCCREQ@NAIC.ORG* for numbers assigned since the last publication or for information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

Domiciliary Jurisdiction

In those parts of Schedule S requiring disclosure of the "Domiciliary Jurisdiction," for each domestic reinsurer or U.S. branch listed, the column should be completed with the state where the reinsurer maintains its statutory home office. For pools and associations, enter the state where the administrative office of such pool or association is located. For alien reinsurers, this column should be completed with the country where the alien is domiciled. Enter the two-character U.S. postal code abbreviation for the domiciliary jurisdiction for U.S. states, territories and possessions. A comprehensive listing of three-character (ISO Alpha-3) abbreviations for foreign countries is available in the appendix of these instructions.

Lloyd's of London

The following procedure will apply as respects annual statement filings for 1995 and subsequent years:

Cessions to Lloyd's under reinsurance agreements having an inception date on or before July 31, 1995, and which are not amended or renewed thereafter should continue to be reported using the collective Lloyd's number, AA-1122000, on an aggregate basis, under "Authorized – Other Non-U.S. Insurers." As respects continuous reinsurance agreements, the anniversary date shall be deemed to be the renewal date of the agreement. Any revision of terms and conditions shall be deemed to be an amendment of the reinsurance agreement.

Cessions to Lloyd's under reinsurance agreements having an inception, amendment or renewal date on or after August 1, 1995, must be reported using the specific number of each subscribing syndicate, as listed in the alien section of the NAIC *Listing of Companies*. Such syndicates should be listed individually, under "Authorized – Other Non-U.S. Insurers."

Syndicates for which an identification number does not appear in the NAIC *Listing of Companies* must be treated as unauthorized as respects cessions under reinsurance agreements having an inception, amendment or renewal date on or after August 1, 1995, and should be reported, on an aggregated basis, under "Unauthorized – Other Non-U.S. Insurers," using a new collective number, AA-1123000.

Reinsurance assumed from syndicates at Lloyd's should continue to be reported on Schedule S, Part 1 using the original collective Lloyd's number, AA-1122000.

Dates

All dates reported in Schedule S must be in the format MM/DD/YYYY. For example, the date December 13, 2011 should be reported as 12/13/2011.

Determination of Authorized Status

The determination of the authorized, unauthorized or certified status of an insurer or reinsurer listed in any part of Schedule S shall be based on the status of that insurer or reinsurer in the reporting entity's state of domicile.

Captive Affiliate Line Category

For the purpose of reporting a reinsurer as captive affiliate on Schedule S, the captive affiliate line categories shall include affiliated non-traditional insurers/reinsurers.

Definition of Affiliated Non-Traditional Insurer/Reinsurer

This disclosure is intended to capture cessions to affiliated insurance/reinsurance entities that are subject to a financial solvency regulatory system separate from that generally applicable to traditional insurers and/or reinsurers in the ceding entity's domestic jurisdiction. The definition of "Affiliate" is established in the NAIC Model Holding Company Act. An affiliated non-traditional insurer/reinsurer is an insurance or reinsurance company that reinsures risks only from its parent or affiliates, and is subject to a financial solvency regulatory system separate from that generally applicable to traditional insurers and/or reinsurers in the ceding entity's domestic jurisdiction. For the purpose of annual statement reporting, this definition shall be presumed to include the following, subject to the cedant's rebuttal to its domicile:

1. An affiliated insurance or reinsurance company licensed, authorized or otherwise granted the authority to operate in a single United States jurisdiction under any captive insurer law, special purpose insurer law, or other similar law separate from those applicable to traditional insurers and/or reinsurers.

2. An affiliated insurance or reinsurance company licensed, authorized or otherwise granted the authority to operate in any jurisdiction outside the United States under any captive insurer law, special purpose insurer law, or other similar law separate from those applicable to traditional insurers and/or reinsurers in that non-United States jurisdiction.

3. Any other affiliated insurance or reinsurance company that by law, regulation, or order, or contract is authorized to insure or reinsure only risks from its parent or affiliate.

SCHEDULE S – PART 1 – SECTION 1

REINSURANCE ASSUMED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS LISTED BY REINSURED COMPANY AS OF DECEMBER 31, CURRENT YEAR

To be filed on or before March 1.

This section should include data on all reinsurance assumed for life insurance, annuities, deposit fund and other liabilities without life or disability contingencies, and related benefits by reinsured company as of December 31, current year.

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number:

Group or Category	Line Number
General Account	
Affiliates	
U.S.	
Captive	0199999
Other	0299999
Total	0399999
Non-U.S.	
Captive	0499999
Other	0599999
Total	0699999
Total Affiliates	0799999
Non-Affiliates	
U.S. Non-Affiliates	0899999
Non-U.S. Non-Affiliates	0999999
Total Non-Affiliates	1099999
Total General Account	1199999
Separate Accounts	
Affiliates	
U.S.	
Captive	1299999
Other	1399999
Total	1499999
Non-U.S.	
Captive	1599999
Other	1699999
Total	1799999
Total Affiliates	1899999
Non-Affiliates	
U.S. Non-Affiliates	1999999
Non-U.S. Non-Affiliates	2099999
Total Non-Affiliates	2199999
Total Separate Accounts	2299999
Total U.S. (Sum of 0399999, 0899999, 1499999 and 1999999)	2399999
Total Non-U.S. (Sum of 0699999, 0999999, 1799999 and 2099999)	2499999
Total (Sum of 1199999 and 2299999)	9999999

Column 2 – ID Number

Enter one of the following as appropriate for the entity 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)
Pool/Association Identification Number	

Column 5 – Domiciliary Jurisdiction

Report the two-character U.S. postal code abbreviation for the domiciliary jurisdiction for U.S. states, territories and possessions. A comprehensive listing of three-character (ISO Alpha 3) abbreviations for foreign countries is available in the appendix of these instructions.

If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.

Column 6 – Type of Reinsurance Assumed

Use the following abbreviations to identify the plan and type of reinsurance. For example, group coinsurance with funds withheld should be identified as COFW/G. (If there is more than one type of reinsurance in the same reinsurance company, show each type on a separate line.)

Abbreviations:

I	Individual
G	Group

All Reinsurance Types should be followed by /I or /G.

REINSURANCE TYPES

CO	Coinsurance	YRT	Yearly renewable term
COFW	Coinsurance with funds withheld	YRTFW	Yearly renewable term with funds withheld
MCO	Modified coinsurance	COMB	Combination coinsurance/modified coinsurance
MCOFW	Modified coinsurance with funds withheld	COMBW	Combination coinsurance/modified coinsurance with funds withheld
CAT	Catastrophe	OTH	Other reinsurance

NOTE: The insurance type should be entered in all capital letters.

Column 7 – Type of Business Assumed

Use only one of the following codes per line to identify the type of business assumed. If there is more than one type of business assumed from the same reinsurance company, show each type on a separate line.

Abbreviations:

IL	Industrial Life	FA	Fixed Annuities
XXXL	XXX Life	IA	Indexed Annuities
XXXLO	XXX Life Other	VA	Variable Annuities
AXXX	AXXX Life	OA	Other Annuities
CL	Credit Life	ADB	Accidental Death Benefits
SC	Supplementary Contracts	DIS	Disability Benefits
OL	Other Life		

NOTE: The Type of Business Assumed code should be entered in all capital letters.

All types of business shown above are as reported in the Analysis of Operations by Lines of Business and the Analysis of Annuity Operations by Lines of Business except as noted below:

XXX Life: Used to describe the actuarial reserves required to be held under Section 6 of the NAIC *Valuation of Life Insurance Policies Model Regulation* (#830) (other than risk assumed from a ceding insurer for policies eligible for exemption under Section 6F, Section 6G, Section 6H or to the portion of the reserve pursuant to YRT Reinsurance under Section 6E), which is commonly referred to as Regulation XXX (or, more simply, XXX).

XXX Life Other: Used to describe the actuarial reserves required to be held under Section 6 of the Model #830 for risk assumed from a ceding insurer for policies described under Section 6F, Section 6G, Section 6H or to the portion of the reserve pursuant to YRT Reinsurance under Section 6E, which is commonly referred to as Regulation XXX (or, more simply, XXX).

AXXX Life: Used to describe the actuarial reserves required to be held under Section 7 of Regulation XXX as further clarified by the NAIC *Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation* (AG 38), which is commonly referred to as AXXX.

OL Other Life: Used for assumed life business not appropriately included in one of the other life categories in the table above.

Column 8 – Amount of In Force at End of Year

For catastrophe-reinsurance (CAT), disability benefits (DIS), accidental death benefit benefits (ADB) and annuity benefits, leave this Column blank.

Column 10 – Premiums

To agree with Underwriting and Investment Exhibit, Part 1, Line 10, Column 2.

For deposit funds and other liabilities without life or disability contingencies, leave this Column blank.

Column 11 – Reinsurance Payable on Paid and Unpaid Losses

For deposit funds and other liabilities without life or disability contingencies, leave this Column blank.

Column 12 – Modified Coinsurance Reserve

Report the amount of reserves held by the ceding company under modified coinsurance contracts. Include separate accounts modified coinsurance reserves. See examples for MODCO transactions contained in the general instructions for Schedule S.

Column 13 – Funds Withheld Under Coinsurance

Report the amount of funds withheld by the ceding company on coinsurance contracts.

SCHEDULE S – PART 3 – SECTION 1

REINSURANCE CEDED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS LISTED BY REINSURING COMPANY AS OF DECEMBER 31, CURRENT YEAR

To be filed on or before March 1.

NOTE: This schedule is to include Exhibit 7 (life supplement) cessions. Include actual reinsurance ceded on group cases but exclude jointly underwritten group contracts.

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number:

Group or Category	Line Number
General Account	
Authorized	
Affiliates	
U.S.	
Captive	0199999
Other	0299999
Total	0399999
Non-U.S.	
Captive	0499999
Other	0599999
Total	0699999
Total Authorized Affiliates	0799999
Non-Affiliates	
U.S. Non-Affiliates	0899999
Non-U.S. Non-Affiliates	0999999
Total Authorized Non-Affiliates	1099999
Total General Account Authorized	1199999
Unauthorized	
Affiliates	
U.S.	
Captive	1299999
Other	1399999
Total	1499999
Non-U.S.	
Captive	1599999
Other	1699999
Total	1799999
Total Unauthorized Affiliates	1899999
Non-Affiliates	
U.S. Non-Affiliates	1999999
Non-U.S. Non-Affiliates	2099999
Total Unauthorized Non-Affiliates	2199999
Total General Account Unauthorized	2299999

Certified
Affiliates
U.S.
Captive 2399999
Other 2499999
Total 2599999
Non-U.S.
Captive 2699999
Other 2799999
Total 2899999
Total Certified Affiliates 2999999
Non-Affiliates
U.S. Non-Affiliates 3099999
Non-U.S. Non-Affiliates 3199999
Total Certified Non-Affiliates 3299999
Total General Account Certified 3399999
Total General Account Authorized, Unauthorized and Certified 3499999
Separate Accounts
Authorized
Affiliates
U.S.
Captive 3599999
Other 3699999
Total 3799999
Non-U.S.
Captive 3899999
Other 3999999
Total 4099999
Total Authorized Affiliates 4199999
Non-Affiliates
U.S. Non-Affiliates 4299999
Non-U.S. Non-Affiliates 4399999
Total Authorized Non-Affiliates 4499999
Total Separate Accounts Authorized 4599999
Unauthorized
Affiliates
U.S.
Captive 4699999
Other 4799999
Total 4899999
Non-U.S.
Captive 4999999
Other 5099999
Total 5199999
Total Unauthorized Affiliates 5299999
Non-Affiliates
U.S. Non-Affiliates 5399999
Non-U.S. Non-Affiliates 5499999
Total Unauthorized Non-Affiliates 5599999
Total Separate Accounts Unauthorized 5699999

Certified

Affiliates

U.S.

Captive 5799999
Other 5899999
Total 5999999

Non-U.S.

Captive 6099999
Other 6199999
Total 6299999

Total Certified Affiliates 6399999

Non-Affiliates

U.S. Non-Affiliates 6499999
Non-U.S. Non-Affiliates 6599999
Total Certified Non-Affiliates 6699999

Total Separate Accounts Certified 6799999

Total Separate Accounts Authorized, Unauthorized and Certified 6899999

Total U.S. (Sum of 0399999, 0899999, 1499999, 1999999, 2599999, 3099999, 3799999, 4299999, 4899999 5399999, 5999999 and 6499999) 6999999

Total Non-U.S. (Sum of 0699999, 0999999, 1799999, 2099999, 2899999, 3199999, 4099999, 4399999, 5199999, 5499999, 6299999 and 6599999) 7099999

Total (Sum of 3499999 and 6899999) 9999999

Column 2 – ID Number

Enter one of the following as appropriate for the entity 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)
Pool/Association Identification Number	

Column 5 – Domiciliary Jurisdiction

Report the two character U.S. postal code abbreviation for the domiciliary jurisdiction for U.S. states, territories and possessions. A comprehensive listing of three-character (ISO Alpha 3) abbreviations for foreign countries is available in the appendix of these instructions.

If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.

Column 6 – Type of Reinsurance Ceded

Use the following abbreviations to identify the plan and type of reinsurance. For example, group coinsurance with funds withheld should be identified as COFW/G. (If there is more than one type of reinsurance in the same reinsurance company, show each type on a separate line.)

Abbreviations:

I	Individual
G	Group

{ All Reinsurance Types should be followed by /I or /G.

REINSURANCE TYPES

CO	Coinsurance	YRT	Yearly renewable term
COFW	Coinsurance with funds withheld	YRTFW	Yearly renewable term with funds withheld
MCO	Modified coinsurance	COMB	Combination coinsurance/modified coinsurance
MCOFW	Modified coinsurance with funds withheld	COMBW	Combination coinsurance/modified coinsurance with funds withheld
CAT	Catastrophe	OTH	Other reinsurance

NOTE: The insurance type should be entered in all capital letters.

Column 7 – Type of Business Ceded

Use only one of the following codes per line to identify the type of business ceded. If there is more than one type of business ceded to the same reinsurance company, show each type on a separate line.

Abbreviations:

IL	Individual Life	FA	Fixed Annuities
XXXL	XXX Life	IA	Indexed Annuities
XXXLO	XXX Life Other	VA	Variable Annuities
AXXX	AXXX Life	ADB	Accidental Death Benefits
SC	Supplementary Contracts	DIS	Disability Benefits
OL	Other Life		

NOTE: The Type of Business Ceded code should be entered in all capital letters.

The types of business shown above are as reported in the Analysis of Operations by Lines of Business and the Analysis of Annuity Operations by Lines of Business except as noted below:

XXX Life: Used to describe the actuarial reserves required to be held under Section 6 of the NAIC *Valuation of Life Insurance Policies Model Regulation* (#830) (other than risk ceded to an assuming insurer for policies eligible for exemption under Section 6F, Section 6G, Section 6H or to the portion of the reserve pursuant to YRT Reinsurance under Section 6E), which is commonly referred to as Regulation XXX (or, more simply, XXX).

XXX Life Other: Used to describe the actuarial reserves required to be held under Section 6 of the NAIC *Valuation of Life Insurance Policies Model Regulation* (#830) for risk ceded to an assuming insurer for policies described under Section 6F, Section 6G, Section 6H or to the portion of the reserve pursuant to YRT Reinsurance under Section 6E, which is commonly referred to as Regulation XXX (or, more simply, XXX).

AXXX Life: Used to describe the actuarial reserves required to be held under Section 7 of Regulation XXX as further clarified by the NAIC *Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation* (AG 38), which is commonly referred to as AXXX.

OL Other Life Used for ceded life business not appropriately included in one of the other life categories in the table above.

Column 8 – Amount in Force at End of Year

Report the ceded amount of the basic life insurance policy only.

For catastrophe-reinsurance (CAT), disability reinsurance (DIS), accidental death benefit reinsurance (ADB) and annuity reinsurance (ACO and AMCO), leave this Column blank.

Column 9 – Reserve Credit Taken Current Year

To agree with appropriate lines in Exhibit 5 (life supplement) and Exhibit 7 (life supplement). See examples for modco transactions contained in the general instructions for Schedule S.

Column 11 – Premiums

Amounts included in this Column should represent reinsurance ceded premiums on an incurred basis, to agree with Line 10 of Underwriting and Investment Exhibit, Part 1, Column 3.

For deposit funds and other liabilities without life or disability contingencies, leave this Column blank.

Columns 12 – Outstanding Surplus Relief – Current Year and
Columns 13 – Outstanding Surplus Relief – Prior Year

Outstanding surplus relief means the amount of surplus not yet reported as income in Commissions and Expense Allowance on Reinsurance Ceded, attributable to reinsurance agreements described in *SSAP No. 61—Life, Deposit-Type and Accident and Health Reinsurance*.

Report the amount of initial commissions and expense allowance not yet recovered by the reinsurer for the following types of treaties (individual or group): CO, ACO, MCO, AMCO, COFW, ACOFW, MCOFW, AMCOFW, COMB or ACOMB. This Column does not apply to CAT, DIS, ADB, YRT or other non-proportional reinsurance treaties.

Include the outstanding surplus resulting from reinsurance of separate accounts business.

Column 14 – Modified Coinsurance Reserve

Report the amount of reserves held under modified coinsurance contracts. Include separate accounts modified coinsurance reserves.

Column 15 – Funds Withheld Under Coinsurance

Report the amount of funds withheld on coinsurance contracts.

STATE PAGE

To be filed on or before March 1. Only companies licensed as Life, Accident & Health insurers should complete this schedule.

A schedule should be prepared and submitted to the state of domicile for each jurisdiction in which the company has written direct business, has direct losses paid or direct losses incurred. To other states in which the company is licensed it should submit only a schedule for that state.

Direct premiums by state may be estimated by formula on the basis of countrywide ratios for the respective lines of business except where adjustments are required to recognize special situations.

Company's participation in the FEGLI and SGLI policies is shown in this exhibit as direct business.

This exhibit should be shown excluding reinsurance assumed. Reinsurance ceded should not be deducted.

Column 2 – Credit Life (Group and Individual)

Include: Business not exceeding 120 months duration.

Column 5 – Total

Line 1 – Direct Premiums for Life Contracts Excluding Reinsurance Assumed and Without Deduction of Reinsurance Ceded

and

Line 2 – Direct Annuity Considerations for Life Contracts Excluding Reinsurance Assumed and Without Deduction of Reinsurance Ceded

The amounts reported should be consistent with those reported on Schedule T, Column 6.

Line 3 – Deposit-type Contracts Fund

Report all deposits and other amounts received for contracts without any mortality and morbidity risk and not reported on Line 1, Line 2 or Line 4. The amounts reported should be consistent with amounts reported on Schedule T, Column 9.

Line 4 – Other Considerations

Include: Unallocated annuity considerations and other unallocated deposits which incorporate any mortality or morbidity risk and are not reported on Line 1, Line 2 or Line 3. See the instructions to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit and Adjustments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit for allocated and unallocated annuities. Report allocated annuities in Line 2.

Line 6 – Life Insurance Direct Dividends to Policyholders Excluding Reinsurance Assumed and Without Deduction of Reinsurance Ceded

and

Line 7 – Annuity Direct Dividends to Policyholders Excluding Reinsurance Assumed and Without Deduction of Reinsurance Ceded

Report dividends paid or left on deposit, dividends applied to pay premiums or considerations, or applied to provide paid-up additions or annuities. Also report dividends used to shorten the endowment or premium paying period.

Line 13 – Aggregate Write-ins for Miscellaneous Direct Claims and Benefits Paid

Enter the total of the write-ins listed in schedule Detail of Write-ins Aggregated at Line 13 for Miscellaneous Direct Claims and Benefits Paid.

Lines 24
to 26 – Accident and Health Insurance

Report health premiums collected during the year, excluding reinsurance accepted and without deduction of reinsurance ceded.

Report on Line 24.1 those premiums, dividends and losses allocable to the Federal Employees Health Benefits Plan premiums that are exempted from state taxes or other fees by Section 8909(f)(1) of Title 5 of the United States Code.

For Line 24.2, include business not exceeding 120 months' duration.

For Line 25, the development of data into various health policy categories should be done by inventory of the policy records.

Details of Write-ins Aggregated on Line 13 for Miscellaneous Direct Claims and Benefits Paid

List separately each category of direct claims and benefits paid for which there is no pre-printed line on the state page.

For Health Business: – Complete the information below the Accident and Health block regarding number of persons covered under PPO managed care products and number of persons covered under indemnity only products. Include in PPO business health insurance products that provide access to higher level of benefits whenever participating provider networks are used.

ANALYSIS OF ANNUITY OPERATIONS BY LINES OF BUSINESS

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

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 2 – Individual Fixed Annuities and
Column 7 – Group Fixed Annuities

Include: Market Value Adjusted Annuities

Column 6 – Individual Other Annuities and
Column 11 – Group Other Annuities

Exclude: Market Value Adjusted Annuities

Line 34 – Policies/certificates in force end of year

In force for Individual (Columns 2 through 6) refers to number of policies
In force for Group (Columns 7 through 11) refers to number of certificates

ANALYSIS OF INCREASE IN ANNUITY RESERVES DURING THE YEAR

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

This exhibit analyzes the development of life policy 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 2 – Individual Fixed Annuities and
Column 7 – Group Fixed Annuities

Include: Market Value Adjusted Annuities

Column 6 – Individual Other Annuities and
Column 11 – Group Other Annuities

Exclude: Market Value Adjusted Annuities

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.

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.

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	COM	–	Comoros
ALA	–	Aland Islands	COG	–	Congo (Brazzaville)
ALB	–	Albania	COD	–	Congo, Democratic Republic of the
DZA	–	Algeria	COK	–	Cook Islands
ASM	–	American Samoa	CRI	–	Costa Rica
AND	–	Andorra	CIV	–	Côte d'Ivoire
AGO	–	Angola	HRV	–	Croatia
AIA	–	Anguilla	CUB	–	Cuba
ATA	–	Antarctica	CYP	–	Cyprus
ATG	–	Antigua and Barbuda	CZE	–	Czech Republic
ARG	–	Argentina	DNK	–	Denmark
ARM	–	Armenia	DJI	–	Djibouti
ABW	–	Aruba	DMA	–	Dominica
AUS	–	Australia	DOM	–	Dominican Republic
AUT	–	Austria	ECU	–	Ecuador
AZE	–	Azerbaijan	EGY	–	Egypt
BHS	–	Bahamas	SLV	–	El Salvador
BHR	–	Bahrain	GNQ	–	Equatorial Guinea
BGD	–	Bangladesh	ERI	–	Eritrea
BRB	–	Barbados	EST	–	Estonia
BLR	–	Belarus	ETH	–	Ethiopia
BEL	–	Belgium	FLK	–	Falkland Islands (Malvinas)
BLZ	–	Belize	FRO	–	Faroe Islands
BEN	–	Benin	FJI	–	Fiji
BMU	–	Bermuda	FIN	–	Finland
BTN	–	Bhutan	FRA	–	France
BOL	–	Bolivia	GUF	–	French Guiana
BES		Bonaire, Sint Eustatius and Saba	PYF	–	French Polynesia
BIH	–	Bosnia and Herzegovina	ATF	–	French Southern Territories
BWA	–	Botswana	GAB	–	Gabon
BVT	–	Bouvet Island	GMB	–	Gambia
BRA	–	Brazil	GEO	–	Georgia
VGB	–	British Virgin Islands	DEU	–	Germany
IOT	–	British Indian Ocean Territory	GHA	–	Ghana
BRN	–	Brunei Darussalam	GIB	–	Gibraltar
BGR	–	Bulgaria	GRC	–	Greece
BFA	–	Burkina Faso	GRL	–	Greenland
BDI	–	Burundi	GRD	–	Grenada
KHM	–	Cambodia	GLP	–	Guadeloupe
CMR	–	Cameroon	GUM	–	Guam
CAN	–	Canada	GTM	–	Guatemala
CPV	–	Cape Verde	GGY	–	Guernsey
CYM	–	Cayman Islands	GIN	–	Guinea
CAF	–	Central African Republic	GNB	–	Guinea-Bissau
TCD	–	Chad	GUY	–	Guyana
CHL	–	Chile	HTI	–	Haiti
CHN	–	China	HMD	–	Heard Island and McDonald Islands
CUW		Curaçao	VAT	–	Holy See (Vatican City State)
CXR	–	Christmas Island	HKG	–	Hong Kong, Special Administrative Region of China
CCK	–	Cocos (Keeling) Islands			
COL	–	Colombia	HND	–	Honduras

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

SYR	–	Syrian Arab Republic	UKR	–	Ukraine
TWN	–	Taiwan, Republic of China	ARE	–	United Arab Emirates
TJK	–	Tajikistan	GBR	–	United Kingdom
TZA	–	Tanzania *, United Republic of	USA	–	United States of America
THA	–	Thailand	UMI	–	United States Minor Outlying Islands
TLS	–	Timor-Leste	URY	–	Uruguay
TGO	–	Togo	UZB	–	Uzbekistan
TKL	–	Tokelau	VUT	–	Vanuatu
TON	–	Tonga	VEN	–	Venezuela (Bolivarian Republic of)
TTO	–	Trinidad and Tobago	VNM	–	Viet Nam
TUN	–	Tunisia	VIR	–	Virgin Islands, U
TUR	–	Turkey	WLF	–	Wallis and Futu Islands
TKM	–	Turkmenistan	ESH	–	Western Saha
TCA	–	Turks and Caicos Islands	YEM	–	Yemen
TUV	–	Tuvalu	ZMB	–	Zambia
UGA	–	Uganda	ZWE	–	Zimbabwe

DEFINITIONS OF LINES OF BUSINESS

Riders/Endorsements/Floaters:

If a rider, endorsement or floater acts like a separate policy with separate premium, deductible and limit, then it is to be recorded on the same line of business as if it were a stand-alone policy regardless of whether it is referred to as a rider, endorsement or floater. If there is no additional premium, separate deductible or limit, the rider, endorsement or floater should be reported on the same line of business as the base policy.

Comprehensive (Hospital & Medical):

Business that provides for medical coverage including hospital, surgical, & major medical. Includes State Children's Health Insurance Program (SCHIP) Medicaid Program (Title XXI) risk contracts. Also includes medical only programs that provide medical only benefits without hospital coverage. Does not include self-insured business as well as federal employees health benefit programs (FEHBP), Medicare & Medicaid programs, and dental only business.

Medicare Supplement:

Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statements. Does not include Medicare (Title XVIII) or Medicaid (Title XIX) risk contracts.

Dental-Only:

Policies providing for dental only coverage issued as stand-alone dental or as a rider to a medical policy that is not related to the medical policy through, premiums, deductibles or out-of-pocket limits. Does not include self-insured business, as well as federal employees health benefits plans (FEHBP), or Medicare and Medicaid programs.

Vision-Only:

Policies providing for vision only coverage issued as stand-alone vision or as a rider to a medical policy that is not related to the medical policy through, premiums, deductibles or out-of-pocket limits. Does not include self-insured business, federal employees health benefits plans (FEHBP), or Medicare and Medicaid programs.

Federal Employees Health Plans (FEHBP):

Business allocable to the Federal Employees Health Benefit Plan premium that are exempted from state taxes or other fees by Section 8909(f)(1) of Title 5 of the United States Code. Does not include Medicare & Medicaid programs.

Medicare Cost:

Contracts with the Centers for Medicare & Medicaid Services (CMS) to provide services that are paid a pre-determined monthly amount per member based on a total estimated budget. The beneficiary can use providers outside the provider network. Does not include policies providing stand alone Medicare Part D Prescription Drug Coverage which are reported within the Other Health line of business.

Medicare [illegible]:

Contracts with the Centers for Medicare & Medicaid Services (CMS) whereby managed care is paid a per capita premium per member. Assume full financial risk for all care provided to Medicare Risk members. With the exception of emergency and out-of area urgent care, members must receive all of their care through the managed care plan; however, an out-of network option can be provided. Does not include policies providing stand alone Medicare Part D Prescription Drug Coverage which are reported within the Other Health line of business.

Medicare Other:

Health Care Prepayment Plans (HCPP) – similar to Medicare Cost. Contracts with the Centers for Medicare & Medicaid Services (CMS) but only covers part of the Medicare Benefit package. HCCP's do not cover Medicare Part A services (inpatient hospital care, skilled nursing, hospice and some home health care).

Medicare +Choice –Contracts with the Centers for Medicare & Medicaid Services (CMS) and a variety of different managed care and fee-for-service entities (i.e., HMO, PPO, PSO) with benefits to members similar to Medicare Risk as defined under the Balanced Budget Act of 1997.

Does not include policies providing stand alone Medicare Part D Prescription Drug Coverage which are reported within the Other Health line of business.

Medicaid Cost:

Those members enrolled under a prepaid contract between the reporting entity and the appropriate state agency administering medical assistance under a state plan approved under Title XIX of the Social Security Act where that agency agrees to pay part or all of the member's financial obligation to the reporting entity. The beneficiary can use providers outside the provider network.

Medicaid Risk:

A prepaid contract between a managed care entity and the appropriate state agency administering medical assistance under a state plan approved under Title XIX of the Social Security Act where that agency agrees to pay part or all of the member's financial obligation to the Health Organization.

Self-Funded:

Business where the health-care organization agrees to provide services to a third party self-insured group. Includes Administrative Services Contracts where the organization advances its own funds in payment of claims and issues its own membership card and use of their provider network to the members of the groups and Administrative Services Only Contracts where the organization utilizes the group's funds in payment of claims.

PRODUCT LINES:

HMO (Health Maintenance Organization):

An entity that provides, arranges or offers coverage of designated health services needed by plan members for a fixed prepaid premium.

There are four basic HMO models:

a. Group Model

b. Individual Practice Association

c. Network Model

d. Staff Model

An entity must have three characteristics to be an HMO:

1. An organized system for providing health care or otherwise assuring health care delivery in a geographic area.

2. An agreed upon set of basic and supplemental health maintenance and treatment services.

3. A voluntary enrolled group of people.

PPO (Preferred Provider Organization):

A program in which contracts are established with providers of medical care, referred to as preferred providers. Usually the benefit contract offers better benefits (fewer copayments) for services received from a preferred provider, thus encouraging members to use these providers. Members are allowed benefits for non-participating provider services on an indemnity basis with significant copayments. Providers may be paid on a discounted fee-for service basis. A PPO arrangement can be insured or uninsured

POS (Point of Service):

A type of health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers.

There are several ways POS can be provided:

a. An HMO may allow members to obtain limited services from non-participating providers.

b. An HMO may provide non-participating benefits through a supplemental major medical policy.

c. A PPO may be used to provide both participating and non-participating levels of coverage and access.

Hospital/Surgical:

An entity that provides coverage for inpatient care and surgical procedures associated with this inpatient care.

Dental (Only):

Entity providing Dental coverage in addition to health care coverage. Can also be a rider offered by the insuring company but covered by the dental insurer.

Vision (Only):

Entity providing Vision coverage in addition to health coverage provided by health care company.

Other (Specify):

Coverage provided by entities that do not fall within any of the other categories, including stop loss, disability and long-term care. Indemnity plans where the insured person is reimbursed for covered expenses would fall within this area.

Miscellaneous Definitions:

Encounter:

A contact between a member and a provider of health care services who exercise independent judgment in the area and provision of health services to the member. A claim would be one encounter.

Hospital Encounter:

An encounter administered in a hospital environment. Includes emergency room services.

Non-hospital Encounter:

An encounter administered outside a hospital environment, such as in the health care provider office.

Physician:

A licensed doctor of medicine or osteopathy licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

Non-physician:

Anyone other than a physician who is licensed, where required, to render covered services. Non-physician providers can include:

a. Chiropractor

b. Clinical Psychologist

c. Dentist

d. Optometrist

e. Physical Therapist

f. Physician Assistant

g. Nurse Practitioner

h. Social Worker

Inpatient:

A member who is treated as a registered bed patient in a hospital and for whom a room and board charge is made.

Outpatient:

A member not officially admitted as an inpatient, but who receives hospital care without occupying a hospital bed or receiving a room and board charge.

Admission:

Hospital inpatient care for any medical condition.

Hospital Day:

A day for which contractual coverage is provided to a member while receiving inpatient care. A stay up to and including midnight of the date of admission shall be considered one day, and an additional day will be counted at each midnight census after the first day that the member is still a patient.

Individual:

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

Group:

The health organization contracts with an entity to provide health care services to a group of subscribers.

Member:

A person who has enrolled as a subscriber or an eligible dependent of a subscriber and for whom the health organization has accepted the responsibility for the provision of health services as may be contracted for.

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