STATE OF INDIANA

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To: Legislative Council
CC: House Insurance Committee, Senate Insurance and Financial Institutions Committee
From: Indiana Department of Insurance
Date: October 31st, 2019

In accordance with the reporting requirements established under IC 27-1-1.5-1(d), the Indiana Department of Insurance (IDOI) submits a list of the following amendments that were made to materials currently incorporated by reference in the Indiana Code under Title 27.

The materials incorporated by reference include manuals and handbooks published by the National Association of Insurance Commissioners (NAIC) that are used in the regulation of insurance by the IDOI.

Below is a link to the webpage hosted by the IDOI which provides the most up to date version of each of the referenced manuals and handbooks:

https://www.in.gov/idoi/3076.htm

The following list of amendments were implemented after the publication date of the manuals and handbooks incorporated by reference in the Indiana Code under Title 27 and published after October 31st, 2018.

The following technical changes were made to materials that are currently incorporated by reference in the Indiana Code under Title 27:

E Committee Memos
Accounting Practices & Procedures Manual

Financial Condition Examiner's Handbook

Financial Analysis Handbook

Annual Statements & Related Material

Purposes &Procedures Manual

Risk Based Capital Instructions

Own Risk Solvency Assessment Manual

Uniform Product Coding Matrix

A Committee Changes
Valuation Manual

D Committee Changes
Market Regulation Handbook

F Committee Changes
Accreditation Manual

Action Taken During 2018 Spring National Meeting

Date Released to Executive (EX) Committee and Plenary Members: April 10, 2018
Objections Due from Executive (EX) Committee and Plenary Members: April 20, 2018

The following technical items were adopted by the Financial Condition (E) Committee at the 2018 Spring National Meeting:

1. *Accounting Practices and Procedures Manual* (AP&P Manual) Changes and Related Items

- Adopted the following nonsubstantive revisions to statutory accounting guidance:

  - *SSAP No. 41R—Surplus Notes* and *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities*: Revisions clarify the existing concept restricting the double-counting of surplus notes. (Ref #2017-21)

  - *SSAP No. 47—Uninsured Plans*: Revisions reject U.S. generally accepted accounting principles (GAAP) related to revenue recognition: *Accounting Standards Update (ASU) 2014-09, Revenue from Contracts with Customers; ASU 2015-14, Revenue from Contracts with Customers, Deferral of the Effective Date; ASU 2016-08, Revenue from Contracts with Customers, Principal versus Agent Considerations; ASU 2016-10, Revenue from Contracts with Customers, Identifying Performance Obligations and Licensing;* and *ASU 2016-12, Revenue from Contracts with Customers, Narrow-Scope Improvements and Practical Expedients.* (Ref #2017-37 and #2016-19)

  - *SSAP No. 68—Business Combinations and Goodwill*: Revisions require additional disclosures on goodwill. A blanks proposal will request the disclosure for year-end 2018 reporting. (Ref #2017-18)

  - *SSAP No. 86—Derivatives*: Revisions add individual contract disclosures for derivative contracts with financing premiums. A blanks proposal will consider Schedule DB changes for year-end 2018 reporting. (Ref #2016-48)

  - *SSAP No. 92—Postretirement Benefits Other Than Pensions* and *SSAP No. 102—Pensions:* Revisions remove the level 3 fair value reconciliation disclosure for pension and other post-retirement plan assets. (Ref #2017-30)

  - *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*: Revisions exclude cash equivalents, derivatives and short-term investments with credit assessments equivalent to an NAIC 1 or NAIC 2 designation from the wash sale disclosure and clarify that the wash sale disclosure should be in the financial statements for the period in which the security is sold. (Ref #2017-31)

  - *Appendix D—Nonapplicable GAAP Pronouncements:* Revisions reject *ASU 2017-06: Defined Benefit Pension Plans, Defined Contribution Pension Plans and Health and Welfare Benefit Plans – Master Trust Reporting* as not applicable to statutory accounting. (Ref #2017-03)

  - *Interpretation (INT) 18-01: Updated Tax Estimates Under the Tax Cuts and Jobs Act*: Adopted INT 18-01 to provide a limited-time, limited-scope exception to *SSAP No. 9—Subsequent Events* to not require recognition of changes in reasonable estimates as Type I subsequent events after the issuance of statutory financial statements. INT also provided instruction for reporting changes in deferred taxes.

  - *INT 02-22: Accounting for U.S. Terrorism Risk Insurance Program* and *INT 09-08: Accounting for Loans Received Under the Federal TALF Program* Revisions update the effective dates in the interpretations, with INT 09-08 also nullified as the Federal Reserve's Term Asset Loan Facility (TALF) program has ended. (Ref #2017-36)

2. *Financial Condition Examiners Handbook* Changes, Other Examination Tools and Related Items

- None

3. *Financial Analysis Handbook* Changes and Related Items

- None

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4. *Implementation Guide for the Annual Financial Reporting Model Regulation* (#205) Changes and Related Items

- None.

5. *Annual Statement Instructions* Changes and Related Items

- Adopted the following changes to the financial annual statement blanks and/or instructions:

  - 2017-21BWG – Add language to General Interrogatory merger questions (5.1 annual and 4.1 quarterly) to require the filing of merger history with the NAIC, if the questions are answered "YES."

  - 2017-22BWG – Add a question to the Supplemental Exhibits and Schedules Interrogatories regarding the filing of the Statement of Exemption in the second quarter.

  - 2017-23BWG – Modify the *Annual Statement Instructions* to reflect the requirement of filing the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit and the Adjustments to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit by companies that are members of the life, health and annuity guaranty associations and write the respective lines of business.

  - 2017-24BWG – Add new category lines for bank loans to Schedule D, Part 1, Part 3, Part 4 and Part 5; Schedule D; Schedule DL, Part 1 and Part 2; and Schedule E, Part 2. Adjust the category line number reference in the "Default Component – Basic Contribution, Reserve Objective and Maximum Reserve Calculations" section of the *Annual Statement Instructions*. Add a new section to Schedule D, Part 1A for bank loans, and add references to bank loans to the Summary by Country. Update reference to annual Schedule D, Part 1A, Section 1 in quarterly Schedule D, Part 1B.

  - 2017-25BWG – Add language to the cash flow statement instructions regarding the inclusion of restricted cash or restricted cash equivalents in the beginning and ending balance.

  - 2017-26BWG – Modify the category line descriptions for property/casualty (P/C) Schedule F, Part 3, and add crosschecks for line 1499999, line 2899999, line 4299999, line 4399999, line 4499999 and line 9999999 to clarify the subtotal calculations for protected cells and authorization categories. Replace old references to "Part 5" with updated "Part 3" references throughout. Revise the calculation references in the headings for Column 60, Column 66 and Column 74. Revise the calculation references for Column 72 and Column 73 to clarify certain calculations related to amounts in dispute.

  - Editorial changes/nonsubstantive corrections to delete the reference to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) from the column 8 blank heading of Schedule D, Part 6, Section 1.

6. *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) and Related Items

- Adopted an amendment to the P&P Manual to modernize and align instructions for subsidiary, controlled and affiliated (SCA) investments with statutory accounting guidance.

- Adopted amendments to the P&P Manual to include filing instructions, documentation requirements and analytical methodology in one place for Power Generation, Working Capital Finance Investments, Credit Tenant Loans, Structured Transactions, the Procedures for Defaulted Securities, Certified Capital Company (CAPCO) Securities and Lottery Securities. The amendments are part of an ongoing project to simplify the P&P Manual.

- Adopted an amendment to the P&P Manual to revise the description of the nationally recognized statistical rating organization (NRSRO) status of HR Ratings de Mexico, S.A. to reflect it has NRSRO status in two additional categories of securities.

7. NAIC Risk-Based Capital (RBC) Formula Changes and Related Items

- Adopted the Removal of Unaffiliated Common stock for Money Market Mutual Fund proposal. The revisions avoid double-counting now that money market mutual funds (MMMFs) are reported as cash equivalents.

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- Adopted the Medicaid Pass-Through Payments proposal. The revisions allow Medicaid pass-through payments to be excluded from receiving a full underwriting charge. Instead, these programs will be treated like uninsured business and receive a 2% charge.

- Adopted the Risk Adjustment and Risk Corridor Sensitivity Test proposal. The revisions remove guidance for the temporary program that ended in 2016.

- Adopted the ACA Reinsurance proposal. The revisions remove reporting lines for the temporary federal Affordable Care Act (ACA) reinsurance program.

- Adopted the Removal of XR012A, LR020A, PR020A and FR020A, which were informational-only pages for analysis of the ACA impact in RBC.

- Adopted the Affiliated Bonds proposal. The revisions will provide consistent treatment for affiliated investments in all three RBC formulas.

- Adopted the Operational Risk proposal. The revisions incorporate 2018 structural changes and factor for basic operational risk add-on.

- Adopted the Federal Home Loan Bank proposal. The revisions reduce the charge for collateral held for Federal Home Loan Bank (FHLB) advances when that liability is part of C-3 modeling and a factor based on the risk of the FHLB for any collateral in excess.

8. *Uniform Certificate of Authority Application* (UCAA) and *Company Licensing Best Practices Handbook* and Related Items

- Adopted revisions to the biographical affidavit requirements. With the revisions, the biographical affidavit will be accepted up to six months after the signature date.

9. *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual) and Related Items

- None

10. *Receivers Handbook for Insurance Company Insolvencies* and Related Items

- Adopted revisions to Chapter 5 of the *Receivers Handbook for Insurance Company Insolvencies* for additional guidance related to communication and coordination with reinsurers.

11. Process for Developing and Maintaining the *NAIC List of Qualified Jurisdictions* and Related Items

- None.

12. Process for Developing and Maintaining the *NAIC List of Certified Reinsurers* and Related Items

- None.

13. NAIC Enterprise Risk Report (Form F) Implementation Guide and Related Items

- The NAIC Enterprise Risk Report (Form F) Implementation Guide was adopted to assist insurers and state insurance regulators in maximizing the usefulness of the Form F by proposing best practices for consideration in preparing and reviewing Form F filings.
- A companion document, the Form F/ORSA Comparison Chart, was also adopted and posted to the NAIC website.

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Action Taken During 2018 Spring National Meeting

Date Released to Executive (EX) Committee and Plenary Members: Aug. 20, 2018
Objections Due from Executive (EX) Committee and Plenary Members: Aug. 30, 2018

The following technical items were adopted by the Financial Condition (E) Committee at the 2018 Spring National Meeting:

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1. *Accounting Practices and Procedures Manual* (AP&P Manual) Changes and Related Items

- Adopted the following nonsubstantive revisions to statutory accounting guidance:

  - *Statement of Statutory Accounting Principle (SSAP) No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures* and *Appendix A-001—Investments of Reporting Entities:* Revisions align the reporting schedule lines to the investment schedules, allowing for cross-checks and less manual allocations to develop with a Jan. 1, 2019 effective date. (Ref #2018-16)

  - SSAP No. 1 and *SSAP No. 32—Preferred Stock:* Revisions reflect the removal of the preferred stock administrative symbol from the NAIC designation and removal of duplicative language. (Ref #2018-05)

  - *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, SSAP No. 41R—Surplus Notes, SSAP No. 52—Deposit-Type Contracts,* and *SSAP No. 62R—Property and Casualty Reinsurance*: Revisions reflect editorial changes. (Ref #2018-13EP)

  - *SSAP No. 21—Other Admitted Assets:* Revisions restrict the guidance when a reporting entity is the owner and beneficiary of a life insurance contract to require that the life insurance policy be in compliance with Internal Revenue Code (IRC) §7702 and to require disclosures of the underlying investment vehicles. The Statutory Accounting Principles (E) Working Group agreed not to incorporate language to address products that are not compliant with IRC §7702 (including variable annuities), noting that under *SSAP No. 4—Assets and Nonadmitted Assets*, these items would be nonadmitted. (Ref #2018-08)

  - *SSAP No. 26R—Bonds, SSAP No. 30—Unaffiliated Common Stock,* SSAP No. 32*, SSAP No. 43R—Loan-backed and Structured Securities, SSAP No. 86—Derivatives,* and *SSAP No. 100R—Fair Value:* Revisions reject *Accounting Standards Update (ASU) 2018-03, Recognition and Measurement of Financial Assets and Financial Liabilities*. (Ref #2018-12)

  - *SSAP No. 49—Policy Loans* and *SSAP No. 56—Separate Accounts:* Revisions clarify the reporting of policy loans and specify that policy loans that originate from separate account (SA) policies must be "funded" to the general account (GA) in order for the policy loan to be admitted. (Ref #2017-35)

  - SSAP No. 56*:* Revisions incorporate SA disclosure of non-U.S. Securities and Exchange Commission (SEC) registered products issued by insurers initially in the year-end 2018 financial statements. (Ref #2018-08)

  - *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities:* Revisions incorporate disclosures when a reporting entity's share of losses in a subsidiary, controlled or affiliated (SCA) entity exceed its investment in the SCA. (Ref #2018-09)

  - *SSAP No. 101—Income Taxes:* Revisions reflect changes in response to the federal Tax Cuts and Jobs Act (TCJA) including the addition of footnotes and explicit reporting guidance. (Ref #2018-01)

  - *Interpretation (INT) 05-05—Accounting for Revenues Under Medicare Part D Coverage:* Revisions provide guidance that the Coverage Gap Discount Program payments are reported as uninsured plans. (Ref #2018-14)

  - *INT 18-02—ACA Section 9010 Assessment Moratoriums* and *INT 16-01—ACA Section 9010 Assessment:* Adopted INT 18-02 to provide guidance for the 2019 moratorium and future moratoriums for the federal Affordable Care Act (ACA) Section 9010 fee and updated INT 16-01 to remove reference to fee accruals payable in 2019 with nullification of INT 16-01 at year-end 2018. (Ref #2018-10)

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- *INT 18-03—Additional Elements Under the Federal Tax Cuts and Jobs Act:* Adopted INT 18-03 to address the Repatriation Transition Tax (RTT), the Alternative Minimum Tax (AMT) Credit, and the Global Intangible Low-Taxed Income (GILTI) Tax from the TCJA. (Ref #2018-15)

- *Appendix D—Nonapplicable GAAP Pronouncements:* Revisions reject *ASU 2017-15, Codification Improvements to Topic 995, U.S. Steamship Entities: Elimination of Topic 995*. (Ref #2018-11)

2. *Financial Condition Examiners Handbook* Changes, Other Examination Tools and Related Items

- None

3. *Financial Analysis Handbook* Changes and Related Items

- None

4. Implementation Guide for the *Annual Financial Reporting Model Regulation* (#205) Changes and Related Items

- None.

5. *Annual Statement Instructions* Changes and Related Items

- Adopted the following changes to the financial annual statement blanks and/or instructions:

  - 2018-01BWG—Update the language for the different lines on the Schedule DB, Part D, and Section 1 regarding exchange traded funds and centrally cleared derivatives.

  - 2018-03BWG—Add the definition of “supranational” to the Supplemental Investment Risks Interrogatories section of the Annual Statement Instructions.

  - 2018-04BWG Modified—Adjust coding to better identify the Type of Reinsurance Assumed and Type of Reinsurance Ceded for Schedule S. Add a Type of Business Assumed column to Schedule S, Part 1, Sections 1 and 2. Add code to Schedule S, Part 1, Section 1 and Schedule S, Part 3, Section 1 to identify GA versus SA.

  - 2018-05BWG—Change the instructions for the Property/Casualty (P/C) Statement of Actuarial Opinion to incorporate the *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) requirements and to increase disclosures for accident and health (A&H) reported on a P/C blank.

  - 2018-06BWG—Add “999” to the end of all line numbers for Schedule DBs. This will increase the number of lines available from 9,996 to 9,999,996, eliminating the need to accumulate data within certain categories.

  - 2018-07BWG Modified—Add new “PL” and “PLGI” symbols to the instructions to identify private letter rated securities. Add a “YE” and “IF” symbol as indication of a new “carry-over” administrative procedure of the NAIC Securities Valuation Office (SVO). Modify definitions of the symbol “Z” to indicate a security is in transition from one reporting status to another. Add a general interrogatory for PL securities issued prior to Jan. 1, 2018. Effective date of annual 2018. Remove designation matrices from the instructions and replace them with a list of administrative symbols valid for use on Schedule BA and Schedule D. Eliminate the use of “P” and “RP” with the designation and add specific line categories for perpetual preferred and redeemable preferred stock. Remove the “Market Indicator” column from Schedule D, Part 2, Section 2 for common stocks. Effective for the year-end 2019 statutory financial statements.

  - 2018-08BWG Modified—Modify the instructions and illustration for Note 3A to reflect disclosure changes adopted by the Statutory Accounting Principles (E) Working Group.

  - 2018-09BWG—Modify the instructions for Note 20A, Note 20C and Note 20D to reflect changes to SSAP No. 100R. Add a new disclosure Note 20E. Modify the illustrations for Note 20A and Note 20C to move the “NAV” column and data-capture it.

  - 2018-10BWG—Modify the instructions for Line 2 of the interest maintenance reserve (IMR) and Line 2 of the asset valuation reserve (AVR) regarding bifurcation of other-than-temporary impairment (OTTI) investments subject to SSAP No. 26R.

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- 2018-11BWG—Add additional instruction to the “Fixed or Variable Interest Rate Investments that Have the Underlying Characteristics of a Bond, Mortgage Loan or Other Fixed Income Instrument” and “Joint Ventures or Partnership Interests for Which the Primary Underlying Investments are Considered to Be Fixed Income Instruments” categories to clarify not reporting investments in those categories when there is a specific category for the investment.

- 2018-12BWG Modified—Add illustration for Note 8H to be data-captured. Add electronic-only columns related to derivatives with financing premiums and additional instructions to the description column related to derivatives with financing premiums to Schedule DB, Part A and Part B for both Section 1 and Section 2. Add a new code to the “Code” column instructions for Schedule DB, Part A. Add a definition of “finance premiums” to the Schedule DB General Instructions. Add additional instructions to Schedule DB, Part A for Column 11 and Column 12 of Section 1 and Column 13 of Section 2.

- 2018-13BWG—Modify the VM-20, Reserves Supplement, Part 3 and Exhibit 5—Aggregate Reserves for Life Contracts blanks and instructions to be consistent with the changes made to the *Valuation Manual*. Add a new Part 4 for the reporting of “Other Exclusions from Life PBR.”

- 2018-14BWG Modified—Split the Column 2 for Question 1.01 in the Separate Accounts General Interrogatories into two new columns (“Registered with the SEC” and “Not Registered with the SEC”) and renumber the remaining columns. Add a new Question 101A for private placement variable annuities and private placement life insurance.

- 2018-15BWG Modified—Add a new disclosure to Note 10 to reflect changes to SSAP No. 97 adopted by the Statutory Accounting Principles (E) Working Group. New instructions and illustration will be added as Note 10O. The illustration will be data-captured.

- 2018-16BWG—Delete the instruction and illustration for Note 12C(2) and renumber Note 12C(3) to Note 12C(2).

- 2018-17BWG—Modify the instruction for Note 17C—Wash Sales.

- 2018-18BWG Modified—Combine the annual and quarterly reporting for life and fraternal companies onto one blank. This combined blank will be based on changes to the existing life blank. Life blank pages that are not being modified but have additional lines or columns not present on the fraternal blank are provided in the proposal as a reference for fraternal companies.

- 2018-19BWG—Add an Annual Statement Line (ASL) 29 for “International” to the Exhibit of Premiums and Losses (state page) and provide instruction that data should only be provided for the “Other Alien” page and the “Grand Total” page. Change to the general instructions to allow for the reporting at a six point font for the P/C state page.

- 2018-20BWG—Split the column for ASL for the illustration of Note 31A(1), High Deductibles, into two columns with one to capture ASL number and the other to capture the ASL description.

- 2018-21BWG—Add new line to Note 32, Analysis of Annuity Actuarial Reserves and Deposit Type Contracts by Withdrawal Characteristics, that identifies surrender charges over 5% in the current year that will be less than 5% in the subsequent year. Add new Note 33, Analysis of Life Actuarial Reserves and Deposit Type Liabilities by Withdrawal Characteristics.

- 2018-22BWG—Partial adoption to add columns to Life and Fraternal Analysis of Operations and Analysis of Reserves for types of life insurance; separate into individual life, group life, individual annuities and group annuities. Delete Interest Sensitive Supplement and Annuities Supplements. Add new appendix for Definitions of Lines of Business and move expense allocation instructions from Analysis of Operations to appendices. Renumber all subsequent pages. Delete current Analysis of Operations and Analysis of Reserves in Separate Accounts and replace with proposed revisions.

- Editorial/nonsubstantive listing with a friendly amendment to delete the net asset value (NAV) instruction references from Schedule A, Part 1; Schedule DB, Part A, Section 1; and Schedule DB, Part B, Section 1.

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6. *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) and Related Items

- Adopted an amendment to the P&P Manual to add Swiss generally accepted accounting principles (GAAP) as a National Financial Presentation Standard in the NAIC definition of Audited Financial Statement.

- Adopted an amendment to delete the List of Broker-Dealers Eligible to Act as Custodian for Insurance Company Assets from the P&P Manual.

- Adopted an amendment to the P&P Manual to delete the Administrative Symbols "RP" and "P" for Preferred Stock and Related Text effective Dec. 31, 2019.

7. NAIC Risk-Based Capital (RBC) Formula Changes and Related Items

- Adopted the Broker Receivables Factors.

- Adopted additional language to the health RBC instructions to exclude beneficiary premium and incurred claims from the stand-alone Medicare Part D Coverage and incurred claims reported on XR014, Line 22.1.

- Adopted clarifying language to include Administrative Service Contract (ASC) and Administrative Services Only (ASO) Broker commissions in line 8 an d9 on XR021.

- Adopted a correction to the factor for all other low income housing tax credits on XR007, line 31.

- Adopted a modification to the ACA sensitivity test exemption for property and casualty RBC.

- Adopted an annual factor update for the property and casualty underwriting factors for premiums and reserves.

- Adopted factor updates for life RBC due to the tax reform.

- Adopted clarifying label for Asset Risk in all RBC formulas to "Subsidiary Insurance Companies and Misc. Off-Balance Sheet".

- Adopted updates to Appendix 2—Terms for Medicare Part D to remove duplicate definitions and reference the definitions located in the Annual Statement Instructions.

- Adopted clarifying language to the catastrophe risk interrogatory instructions for exemptions.

- Adopted Using Models Other Than the Five Approved Commercially Available Model Losses to include internal models outside of the acceptable commercially available models.

8. *Uniform Certificate of Authority Application* (UCAA), *Company Licensing Best Practices Handbook* and Related Items

- Adopted revisions to the corporate amendment instructions to include the importance of viewing the states' seasoning requirements prior to submitting a corporate amendment application.

- Adopted the Speed to Market process regarding expansion application for Applicant Companies requesting licensure into multiple states to be monitored by the National Treatment and Coordination (E) Working Group.

9. *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual) and Related Items

- None

10. *Receivers Handbook for Insurance Company Insolvencies* and Related Items

- None

11. Process for Developing and Maintaining the *NAIC List of Qualified Jurisdictions* and Related Items

- None.

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12. Process for Developing and Maintaining the *NAIC List of Certified Reinsurers* and Related Items

- None.

13. NAIC Enterprise Risk Report (Form F) Implementation Guide and Related Items

- None

Action Taken During 2018 Fall National Meeting

Date Released to Executive (EX) Committee and Plenary Members: Dec. 3, 2018
Objections Due from Executive (EX) Committee and Plenary Members: Dec. 13, 2018

The following technical items were adopted by the Financial Condition (E) Committee at the 2018 Fall National Meeting:

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1. *Accounting Practices and Procedures Manual* (AP&P Manual) Changes and Related Items

- Adopted the following substantive revisions to statutory accounting guidance:

  - *Statement of Statutory Accounting Principles (SSAP) No. 21—Other Admitted Assets*: Revisions, effective Dec. 31, detail that periodic-certain structured settlements acquired in accordance with state and federal laws are admitted assets. Life-contingent structured settlements and periodic-certain structured settlements not acquired pursuant to state and federal laws are nonadmitted assets. (Ref #2018-17)

  - *SSAP No. 30R—Unaffiliated Common Stock* and *Issue Paper No. 158—Unaffiliated Common Stock*: Revisions, effective Jan. 1, 2019, update the common stock definition to include U.S. Securities and Exchange Commission (SEC) registered closed-end funds and unit-investment trusts within scope. (Ref #2017-32)

  - *SSAP No. 62R—Property and Casualty Reinsurance*: Revisions, effective Jan. 1, 2019, clarify the determination of reinsurance credit and incorporate language from *EITF 93-6, Accounting for Multiple-Year Retrospectively Rated Contracts by Ceding and Assuming Enterprises* and *EITF D-035, FASB Staff Views on Issue No. 93-6*. (Ref #2017-28)

  - *SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees* and *Issue Paper 159—Special Accounting for Limited Derivatives*: Effective, Jan 1, 2020, with early adoption permitted Jan. 1, 2019, new SSAP prescribes guidance for derivatives that hedge interest rate risk of variable annuity guarantees. (Ref #2016-03)

- Adopted the following nonsubstantive revisions to statutory accounting guidance:

  - *SSAP No. 15—Debt and Holding Company Obligations* and *SSAP No. 25—Affiliates and Other Related Parties*: Revisions reference existing guidance in *SSAP No. 72—Surplus and Quasi-Reorganizations* for when there has been forgiveness of a debt owed. (Ref #2018-20)

  - *SSAP No. 22—Leases*: Revisions reject *ASU 2018-01, Leases – Land Easement Practical Expedient for Transition to Topic 842*. Reference of this rejection will also be captured in the proposed substantively revised *SSAP No. 22R—Leases* from the review of *ASU 2016-02, Leases*. (Ref #2018-25)

  - *SSAP No. 43R—Loan-Backed and Structured Securities*: Revisions, effective March 31, 2019, with early adoption permitted Dec. 31, 2018, remove the modified filing exempt (MFE) process for determining NAIC designations. (Ref #2018-19)

  - *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies*: Revisions, effective Dec. 31, require the *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities* loss-tracking disclosure when a reporting entity's share of losses exceeds its investment. (Ref #2018-27)

  - *SSAP No. 51—Life Contracts, SSAP No. 52—Deposit-Type Contracts* and *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance*: Revisions, effective Dec. 31, 2019, add life liquidity disclosures and expand variable annuity liquidity disclosures. (Ref #2018-28)

  - *SSAP No. 68—Business Combinations and Goodwill*: Revisions clarify that statutory mergers include scenarios in which the stock of an owned entity is cancelled, with the parent entity reporting the assumed assets and liabilities. These scenarios are subject to the statutory accounting restatement guidance. (Ref #2018-23)

  - SSAP No. 72: Revisions clarify that when a reporting entity provides a distribution that is a return of capital, it shall be reported with a charge to gross paid in and contributed surplus. (Ref #2018-21)

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- *SSAP No. 86—Derivatives*: Revisions, effective Jan. 1, 2019, with early adoption permitted, adopt limited provisions from *ASU 2017-12, Derivatives and Hedging – Targeted Improvements to Accounting for Hedging Activities* pertaining to hedge effectiveness documentation requirements. Reporting entities that are also U.S. generally accepted accounting principles (GAAP) filers may only early adopt if they have early adopted ASU 2017-12. (Ref #2018-30)

- *Appendix A—Excerpts of NAIC Model Laws*: Revisions remove the phrase "good and sufficient" from *Appendix A-820—Minimum Life and Annuity Reserve Standards*. (Ref #2018-29)

- *Appendix B—Interpretations of Statutory Accounting Principles*: Revisions adopt *INT 18-04—Extension of Ninety-Day Rule for the Impact of Hurricane Florence and Hurricane Michael* to provide a temporary extension to the 90-day rule under *SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers*. (Ref #2018-31)

- Editorial Revisions detailed in Ref #2018-24EP.

2. *Financial Condition Examiners Handbook* Changes, Other Examination Tools and Related Items

- Adopted the following revisions to the Financial Examiners Handbook (Handbook):

  - 2019 examiners' suggested salary expressed as a daily rate.

  - Investments and Underwriting examination repositories.

  - Efficiency revisions intended to align the examination and analysis functions, when appropriate.

  - Exhibit K (key activity matrix) to remove the rows for Overall Risk Statement (row 1b) and Analytical Assessment (row 1c) as these rows add little value to the information provided in the matrix.

  - Considerations when examining troubled insurance companies.

  - Considerations when using Jumpstart reports (regulator only reports).

  - Removal of references to the Analyst Team System (ATS), as the program was eliminated in 2017.

  - Addition of reference to the updated guidance for Service Organization Control (SOC) reports and add reference to the newly created SOC for Cybersecurity reports.

  - Addition of reference to the *Insurance Data Security Model Law* (#668) and create a new tool that maps Handbook guidance to Model #668.

  - Addition of reference to the General Data Protection Regulation within the list of topics an information technology (IT) examiner may discuss as part of the interview and discussion process within the exam.

  - Addition of discussion to Cyber Risk Analytics as a potential report type that regulators can use during the IT review.

3. *Financial Analysis Handbook* Changes and Related Items

- Adopted the 2018 Annual/2019 Quarterly revisions to the Financial Analysis Handbook, which includes: 1) clarifying risk-focused analysis guidance for use of the risk repositories; 2) documentation expectations; 3) risk assessment definition considerations; 4) Form D reviews; 5) examiner/analyst planning; and 6) cybersecurity procedures and guidance.

- Adopted a change to the 2018 Annual benchmarks for property & casualty (P&C) Insurance Regulatory Information System (IRIS) Investment Yield Ratio.

- Adopted regulator only guidance.

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4. Implementation Guide for the *Annual Financial Reporting Model Regulation* (#205) Changes and Related Items

- None.

5. *Annual Statement Instructions* Changes and Related Items

- Adopted the following changes to the financial annual statement blanks and/or instructions:

  - 2018-02BWG—Update the rows in the investment categories column on the Summary Investment Schedule to tie into the different investment schedules. Add column 2 heading reference. Add new publicly traded and other categories for industrial and miscellaneous and parents, subsidiaries and affiliates for common stock so that publicly traded and non-publicly traded common stock can be identified. Remove aggregate categories for mortgage loans available for use by property, health and title companies.

  - 2018-22BWG—Final modifications to proposal to add columns to Life and Fraternal Analysis of Operations and Analysis of Reserves for types of life insurance; separate into individual life, group life, individual annuities and group annuities. Delete Interest Sensitive Supplement and Annuities Supplements. Add new appendix for Definitions of Lines of Business and move expense allocation instructions from Analysis of Operations to appendices. Renumber all subsequent pages. Delete current Analysis of Operations and Analysis of Reserves in Separate Accounts and replace with proposed revisions.

  - 2018-26BWG—Add Analysis of Operations by Lines of Business – Summary blank page and instructions for the general and separate accounts. Modify crosschecks in the Summary of Operations and Analysis of Operations by Lines of Business pages for life (individual and group), annuities (individual and group), and health to have a direct tie between the Summary of Operations and the Analysis of Operations by Lines of Business – Summary.

  - Editorial/nonsubstantive listing.

6. *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) and Related Items

- Adopted the following amendments to the P&P Manual:

  - Moved the description of financial modeling to the Structured Securities Group's (SSG) website.

  - Added administration of filing exemption (FE) to on-going Securities Valuation Office (SVO) operations.

  - Modified the Administrative Symbol from "NR" (not rated) to "ND".

  - Deleted an outdated clause from numerous asset specific instructions.

  - Aligned notching guidance with the NAIC Designation Category framework.

  - Editorial revisions to bring the P&P Manual into compliance with NAIC Standard Procedures for Amending Manuals/Handbooks.

  - Added text to the compilation instructions to further explain the relationship of NAIC reinsurance standards to the SVO List of Investment Securities.

  - Revisions to modernize credit substitution methodology used when the NAIC Designation is based on an enforceable third-party promise to pay the insurer obligations of a lower or unrated obligor.

7. NAIC Risk-Based Capital (RBC) Formula Changes and Related Items

- Adopted the 2018 Catastrophe Event List.

8. *Uniform Certificate of Authority Application* (UCAA), *Company Licensing Best Practices Handbook* and Related Items

- Adopted revisions to the proforma excel templates for all lines of business.

9. *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual) and Related Items

- None

10. *Receivers Handbook for Insurance Company Insolvencies* and Related Items

- None

11. Process for Developing and Maintaining the *NAIC List of Qualified Jurisdictions* and Related Items

- None.

12. Process for Developing and Maintaining the *NAIC List of Certified Reinsurers* and Related Items

- None.

13. NAIC Enterprise Risk Report (Form F) Implementation Guide and Related Items

- None

Action Taken During 2019 Spring National Meeting

Date Released to Executive (EX) Committee and Plenary Members: April 24, 2019
Objections Due from Executive (EX) Committee and Plenary Members: May 3, 2019

The following technical items were adopted by the Financial Condition (E) Committee at the 2019 Spring National Meeting:

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1. *Accounting Practices and Procedures Manual* (AP&P Manual) Changes and Related Items

- Adopted the following substantive revisions to statutory accounting guidance:

  - *Issue Paper No. 160—Structured Settlements Acquired as Investments*: Adopted the issue paper, which documents the substantive revisions adopted to *Statement of Statutory Accounting Principles (SSAP) No. 21R—Other Admitted Assets* for structured settlements. (Ref #2018-17)

- Adopted the following nonsubstantive revisions to statutory accounting guidance:

  - *SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments, SSAP No. 26R—Bonds, SSAP No. 43R—Loan-Backed and Structured Securities* and *SSAP No. 86—Derivatives*: Revisions, effective Dec. 31, 2019, clarify the accounting and reporting for structured notes (Ref #2018-18). A structured note is defined as an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due. Structured notes reflect derivative instruments (e.g., put options or forward contracts) that are wrapped by a debt structure. The adopted revisions include the following:
    1. SSAP No. 2R: Derivative instruments shall not be reported as cash equivalents or short-term instruments regardless of their maturity date.
    2. SSAP No. 26R: Structured notes are explicitly excluded from the scope of SSAP No. 26R.
    3. SSAP No. 43R: Structured notes that are mortgage-referenced securities are in scope of SSAP No. 43R.
    4. SSAP No. 86: Structured notes, excluding those in scope of SSAP No. 43R, are considered derivative instruments and shall be captured in scope of SSAP No. 86.

  - *SSAP No. 16R—Electronic Data Processing Equipment and Software:* Revisions adopt with modification *Accounting Standards Update (ASU) 2018-15, Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That is a Service Contract*, allowing the capitalization of implementation costs from a cloud hosting service contract as nonoperating system software with amortization not to exceed five years. Adopted revisions also clarify the accounting for cloud hosting arrangements that are not service contracts. (Ref #2018-40)

  - *SSAP No. 30R—Unaffiliated Common Stock:* Revisions clarify that assets pledged to a Federal Home Loan Bank (FHLB) on behalf of an affiliate shall be nonadmitted pursuant to *SSAP No. 4—Assets and Nonadmitted Assets,* and clarify that transactions entered into on behalf of an affiliate, but that are structured to exclude the affiliate, shall be considered a related party transaction under *SSAP No. 25—Affiliates and Other Related Parties.* (Ref #2018-33)

  - SSAP No. 30R: Revisions explicitly capture foreign open-end fund investments in scope with a Jan. 1, 2019 effective date. The Statutory Accounting Principles (E) Working Group directed a blanks proposal to identify foreign open-end funds on the investment reporting schedule, to incorporate revisions to the Supplemental Investment Reporting Interrogatory (SIRI) to clarify what should be captured in line 2 (top 10 issuers) and to add a new disclosure for investments with fund managers. (Ref #2018-34)

  - *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses:* Revisions clarify the reporting of interest on accident and health claims, with a Jan. 1, 2020, effective date, with early adoption permitted. (Ref #2018-39)

  - SSAP No. 86: Revisions add the Securities Industry and Financial Markets Association (SIFMA) Municipal Swap Rate and the Secured Overnight Financing Rate (SOFR) Overnight Index Swap (OIS) Rate as U.S. benchmark rates for hedge accounting. (Ref #2018-46)

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- *SSAP No. 92—Postretirement Benefits Other Than Pensions* and *SSAP No. 102—Pensions:* Revisions adopt with modification the disclosure amendments in *ASU 2018-14, Changes to the Disclosure Requirements for Defined Benefit Plans.* (Ref #2018-37)

- *SSAP No. 95—Nonmonetary Transactions* and *SSAP No. 104R—Share-Based Payments:* Revisions adopt with modification *ASU 2018-07, Improvements to Nonemployee Share-Based Payment Accounting*, eliminating the section for nonemployee awards and including guidance for nonemployees with the guidance for employees. (Ref #2018-35)

- *SSAP No. 100R—Fair Value:* Revisions adopt with modification the disclosure amendments in *ASU 2018-13, Changes to the Disclosure Requirements for Fair Value Measurement* and clarify prior actions on U.S. generally accepted accounting principles (GAAP). (Ref #2018-36)

- *Appendix B—Interpretations of Statutory Accounting Principles:*

  1. Adopted *Interpretation* (*INT) 19-01—Extension of Ninety-Day Rule for the Impact of California Camp Fire, Hill Fire and Woolsey Fire*, to provide a temporary extension to the 90-day rule under *SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers*. INT 19-01 will be automatically nullified April 24, 2019. (Ref #2019-01)

  2. Adopted *INT 19-02—Single Security Initiative*, to incorporate a limited-scope exception to SSAP No. 26R and prescribe guidance for SSAP No. 43R securities exchanged under the Freddie Mac Single Security Initiative. (Ref #2019-02)

- *Appendix D—Nonapplicable GAAP Pronouncements*: Revisions reject the following ASUs as not applicable:

  1. *ASU 2017-13, Amendments to SEC Paragraphs* (Ref #2018-41)
  2. *ASU 2018-02, Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income* (Ref #2018-42)
  3. *ASU 2018-04, Debt Securities and Regulated Operations* (Ref #2018-43)
  4. *ASU 2018-05, Amendments Pursuant to SEC Staff Accounting Bulletin No. 118* (Ref #2018-44)
  5. *ASU 2018-06, Financial Services – Depository and Lending* (Ref #2018-45)

- Editorial revisions detailed in Ref #2018-47EP: These revisions clarify that investments in scope of *SSAP No.48—Joint Ventures, Partnerships and Limited Liability Companies* are not required to complete SSAP No. 97 disclosures unless directed under SSAP No. 48.

2. *Financial Condition Examiners Handbook* Changes, Other Examination Tools and Related Items

- None

3. *Financial Analysis Handbook* Changes and Related Items

- None

4. Implementation Guide for the *Annual Financial Reporting Model Regulation* (#205) Changes and Related Items

- None

5. *Annual Statement Instructions* Changes and Related Items

- Adopted the following changes to the annual financial statement blanks and/or instructions:

  - 2018-23BWG—Add question 34.1 and question 34.2 to the General Interrogatories, Part 2 for fraternal benefit societies only, along with instructions regarding question 34.2.

  - 2018-24BWG—Adjust asset valuation reserve (AVR) factors in the life, accident & health/fraternal blank for those where the related risk-based capital (RBC) factors have changed due to the federal Tax Cuts and Jobs Act of 2017 (TCJA).

- 2018-25BWG—Modify the reinsurance ceded code list in the health and life, accident & health/fraternal quarterly Schedule S to match the list used for annual financial statement reporting. Add an additional column and associated instructions for type of business ceded.
- 2018-27BWG – Add reference to reporting separate account or protected cell to the instructions for Note 5L(4). Modify the illustrations to include additional lines for separate accounts or protected cells in addition to the general account, with a notation indicating which lines apply to the general account and which lines apply to separate accounts or protected cells.
- 2018-28BWG—Add instructions to Note 9 – Income Taxes for new disclosures, Note 9H – Repatriation Transition Tax (RTT) and Note 9I – Alternative Minimum Tax (AMT) Credit. An illustration will be added for Note 9I and will be data-captured.
- 2018-29BWG—In the separate accounts blank, remove line 5, Contract Loans, from the separate accounts asset page and renumber the remaining lines.
- 2018-30BWG—Modify the instructions and illustration Note 10O – Subsidiary, Controlled or Affiliated (SCA) Loss Tracking to include references to SSAP No. 48 and SSAP No. 48 entities.
- 2018-31BWG—Add two new categories (unit investment trusts and closed-end funds) to the common stock categories on Schedule D. Add the new categories to the Summary Investment Schedule. Add definition of "unit investment trusts" and "closed-end funds" to the Investment Schedules General Instructions and modify the definition of "mutual fund." Add categories for "unit investment trusts" and "closed-end funds" to Schedule DL, Part 1 and Part 2.
- Editorial/nonsubstantive listing

6. *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) and Related Items

- Adopted the following amendments to the P&P Manual:
  - Revisions clarify the "stand-alone" status of the investment security component of a regulatory transaction. The amendment clarifies that a stand-alone investment security is not excluded from being designated because it has been included as a component of a regulatory transaction.
  - Revisions better identify investment securities and transactions that are not eligible for filing exemption. The guidance was moved to the beginning of the filing exempt (FE) instructions, where it would provide the best disclosure.
  - Revisions incorporate a comprehensive and uniform approach to the risk assessment of shares of funds that holds a portfolio of bonds. The amendment expands the existing framework to funds issued by U.S. Securities and Exchange Commission (SEC)-regulated investment companies organized as closed-end management companies and unit investments trusts. Also, with the revisions, private funds would still be reported as joint ventures under SSAP No. 48 and captured on Schedule BA, but would no longer be permitted the assignment of an NAIC designation through the FE process.
  - Revisions reformat the 2019 P&P Manual for year-end 2019 for improved readability.

7. NAIC Risk-Based Capital (RBC) Formula Changes and Related Items

- Adopted the final 2018 U.S. and non-U.S. catastrophe event lists.
- Adopted the updated RBC Procedures to include procedure for referrals.
- Adopted the stop loss proposal to separate the stop loss interrogatories table into two separate tables.
- Adopted the asset concentration proposal to correct the bond and preferred stock descriptions.
- Adopted the underwriting risk factors for property/casualty RBC formula.
- Adopted the asset concentration proposal to edit the line descriptions.
- Adopted the RBC average growth calculation to address inconsistencies in the computation of selected average growth rate.

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8. *Uniform Certificate of Authority Application* (UCAA), *Company Licensing Best Practices Handbook* and Related Items

- Adopted revisions to the Biographical Affidavit to capture subsidiary information if the affiant was employed at a holding company level.
- Adopted changes to the corporate amendment instructions to align the instructions for all corporate amendment change types.
- Referred amended Accreditation Part D standards to the Financial Regulation Standards and Accreditation (E) Committee.

9. *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual) and Related Items

- None.

10. *Receivers Handbook for Insurance Company Insolvencies* and Related Items

- None.

11. Process for Developing and Maintaining the *NAIC List of Qualified Jurisdictions* and Related Items

- None.

12. Process for Developing and Maintaining the *NAIC List of Certified Reinsurers* and Related Items

- None.

13. NAIC Enterprise Risk Report (Form F) Implementation Guide and Related Items

- None.

14. *Troubled Insurance Company Handbook* Changes and Related Items

- Adopted regulator-only guidance.

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Action Taken During 2019 Summer National Meeting

Date Released to Executive (EX) Committee and Plenary Members: Aug. 19, 2019
Objections Due from Executive (EX) Committee and Plenary Members: Aug. 29, 2019

The following technical items were adopted by the Financial Condition (E) Committee at the 2019 Summer National Meeting:

1. *Accounting Practices and Procedures Manual* (AP&P Manual) Changes and Related Items

- Adopted the following substantive revisions to statutory accounting guidance:

  - *Statement of Statutory Accounting Principles (SSAP) No. 22—Leases*: Substantive revisions, resulting in *SSAP No. 22R—Leases* and corresponding *Issue Paper No. 161—Leases*, incorporate guidance from *Accounting Standard Update (ASU) 2016-02, Leases* modified to maintain the operating lease concept, with an effective date of Jan. 1, 2020. (Ref #2016-02)

  - *Issue Paper No. 162—Property and Casualty Reinsurance Credit*: Adopted Issue Paper No. 162 to document for historical purposes the revisions related to *SSAP No. 62R—Property and Casualty Reinsurance* adopted at the 2018 Fall National Meeting. (Ref #2017-28)

- Adopted the following nonsubstantive revisions to statutory accounting guidance:

  - *Preamble, SSAP No. 50—Classifications of Insurance or Managed Care Contracts, SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts, SSAP No. 54R—Individual and Group Accident and Health Contracts, SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses, SSAP No. 56—Separate Accounts, SSAP No. 71—Policy Acquisition Costs and Commissions*, and *SSAP No. 86—Derivatives*: Revisions modify the Preamble to update applicable U.S. generally accepted accounting principles (GAAP) guidance and reject *ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts* for statutory accounting. (Ref #2019-06)

  - *SSAP No. 21R—Other Admitted Assets*: Revisions clarify that an investment captured in scope of another SSAP does not automatically become a collateral loan because it is also secured with collateral. (Ref #2018-04)

  - *SSAP No. 25—Affiliates and Other Related Parties, SSAP No. 26R—Bonds, SSAP No. 32—Preferred Stock, SSAP No. 43R—Loan-Backed and Structured Securities,* and *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies*: Revisions clarify the application of SSAP No. 25, as well as a related party classification (and appropriate designation as an affiliate), when a transaction is in substance a related party (affiliate) transaction. (Ref #2019-03)

  - SSAP No. 26R: Revisions provide guidance when bonds are called for less than par. (Ref #2018-32)

  - SSAP No. 26R and *SSAP No. 72—Surplus and Quasi-Reorganizations*: Revisions direct the initial reported value for a bond received as a property dividend or as a capital contribution. (Ref #2019-07)

  - *SSAP No. 37—Mortgage Loans*: Revisions exclude "bundled" mortgage loans from the scope of the statement and clarify requirements for participation agreements. (Ref #2018-22)

  - SSAP No. 43R: Revisions require securities with differing NAIC designations by lot to be reported in aggregate at the worst NAIC designation or separately by lot. (Ref #2018-03)

  - SSAP No. 62R: Revisions clarify the effective date of reinsurance credit guidance adopted in agenda item 2017-28, noting application to contracts in effect as of Jan. 1, 2019. (Ref #2019-11)

  - *SSAP No. 101—Income Taxes*: Revisions to the Implementation Q&A effective for financial reporting years ending Dec. 31, 2019:

    1. Updated examples and guidance in response to the federal Tax Cuts and Jobs Act (TCJA). (Ref #2019-09)

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2. Clarified the admittance of deferred tax assets that can be offset by deferred tax liabilities noting that scheduling is only required to the extent that it was necessary to use the reversal patterns of deferred tax items in determining the valuation allowance. (Ref #2019-10)

- *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*: Revisions reduce the disclosure requirements for repurchase and reverse repurchase transactions. (Ref #2019-05)

- *Appendix D—Nonapplicable GAAP Pronouncements:* Revisions reject the following ASUs as not applicable to statutory accounting:

  1. *ASU 2015-08, Pushdown Accounting, Amendments to SEC Paragraphs Pursuant to Staff Accounting Bulletin No. 115.* (Ref #2019-16)

  2. *ASU 2019-02, Entertainment, Improvements to Accounting for Costs of Films and License Agreements for Program Materials a consensus of the FASB Emerging Issues Task Force.* (Ref #2019-17)

- Adopted the following editorial revisions to statutory accounting (Ref #2019-15EP):

  1. SSAP No. 62R: Updated Exhibit D – Illustration of Asbestos and Pollution Counterparty Reporting Exception to match the current format of Property and Casualty Annual Statement Schedule F.

  2. *SSAP No. 63—Underwriting Pools*: Updated paragraph references to Schedule F, Part 8 to reference the current section of Property and Casualty Annual Statement Schedule F, Part 3.

  3. *SSAP No. 84—Health Care and Government Insured Plan Receivables*: Deleted the paragraph duplicating *SSAP No. 4—Assets and Nonadmitted Assets.*

  4. SSAP No. 86: Updated language in weather derivative exhibit to eliminate "proposed" wording.

  5. SSAP No. 103R: Updated the footnote regarding investments that are excluded from the wash sale disclosure.

2. *Financial Condition Examiners Handbook* Changes, Other Examination Tools and Related Items

- None

3. *Financial Analysis Handbook* Changes and Related Items

- None

4. Implementation Guide for the *Annual Financial Reporting Model Regulation* (#205) Changes and Related Items

- None

5. *Annual Statement Instructions* Changes and Related Items

- Adopted the following changes to the annual financial statement blanks and/or instructions:

  - 2019-02BWG – For the VM-20 Reserves Supplement, Part 1, match the title under Part 1 to the title used in the blank. Add instructions to clarify the line reporting. Add clarifying column instructions to indicate that the due and deferred premium asset should be reported in accordance with VM-20.

  - 2019-03BWG – Add NAIC Designation column for use with mutual funds to the annual Schedule D, Part 2, Section 2 and modify the instructions to reflect the addition. Modify the instructions for the NAIC Designation and Administrative Symbol column for the quarterly Schedule D, Part 3 and Part 4 to reflect capturing designations for mutual funds.

  - 2019-04BWG – Remove the reference to "life and fraternal only" for Schedule BA General Instructions regarding investments that have the underlying characteristics of bonds or fixed instruments. Also remove the instructions reference for Schedule BA regarding the CUSIP Identification column and the NAIC Designation column. Add

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additional lines to the "Fixed or Variable Interest Rate Investments that Have the Underlying Characteristics of a Bond, Mortgage Loan or Other Fixed Income Instrument" and "Joint Ventures or Partnership Interests for Which the Primary Underlying Investments are Considered to Be Fixed Income Instruments" categories to distinguish between those reviewed and approved by the Securities Valuation Office (SVO) and those that have not.

- 2019-05BWG – Add new instructions and illustration (to be data-captured) to Note 21, Other Items for life policies where the reporting entity is owner and beneficiary or has otherwise obtained rights to control the policy. The new disclosure will be Note 21I for life/fraternal and health and Note 21H for property and title.

- 2019-06BWG – Add a reference for structured settlements acquired by a reporting entity as an investment (where the company has acquired the legal right to receive payments) to the Schedule BA General Instructions in the "any other class of assets" definition.

- 2019-07BWG – Modify the instructions for Note 20, Fair Value to reflect changes adopted for *SSAP No. 100R—Fair Value*. These changes reflect disclosure modifications adopted from U.S. GAAP (*ASU 2018-13, Changes to the Disclosure Requirements for Fair Value Measurement*). The revisions do not change any of the disclosure templates.

- 2019-08BWG – Modify the instructions for Note 12, Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans to reflect changes adopted for *SSAP No. 92—Postretirement Benefits Other Than Pensions* and *SSAP No. 102— Pensions*.

- 2019-09BWG – Add a reference to include mortgage-referenced securities in the "U.S. Special Revenue and Special Assessment Obligations and All Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions" category in the Investment Schedules General Instructions. Also delete Note 5O, Structured Notes and modify the bond characteristics definition for Schedule D, Part 1.

- 2019-10BWG – Add instructions for determining the gain (loss) reported in column 18 and the prepayment penalty and/or acceleration fee amount in column 20 on Schedule D, Parts 4 and 5 for called bonds where consideration received is less than par.

- 2019-11BWG – Modify the instructions and table illustrations for Note 5F, Note 5G, Note 5H and Note 5I to reflect changes to SSAP No. 103R. In addition, the formatting of some tables in the illustrations were changed to fit on the page.

- 2019-12BWG – Add a code for foreign mutual funds to Schedule D, Part 2, Section 2, Column 3. Add instruction for foreign open-end investment funds to be included as mutual funds in the Investment Schedules General Instructions.

- 2019-13BWG – Modify the instructions for question 2 of the Supplemental Investment Risks Interrogatories to exclude diversified foreign mutual funds. Add disclosure of top 10 fund managers.

- 2019-14BWG – Modify the instructions and illustration for Note 8, Derivatives for disclosures adopted by *SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees*. Add categories for variable annuity (VA) guarantees to the instructions for Schedule DB, Part A and Part B. Add instruction and blank page for Schedule DB, Part E. Modify the instructions for the details of write-in for Line 25 of the asset page, as well as Line 25 and Line 34 of the life/fraternal liability page.

- 2019-15BWG – Modify the instructions for the Actual Cost column for Schedule D (Part 1, Part 3, Part 4 and Part 5) and Schedule DA to provide guidance for bonds that are received as a property dividend or capital contribution.

- 2019-16BWG – Add new column "YRT Mortality Risk Only" to the Analysis of Operations by Lines of Business (Summary, Individual Life and Group Life) and Analysis of Increase in Reserves During Year (Individual Life and Group Life) blank pages and instructions for yearly-renewable-term (YRT) reinsurance business where the only risk included is mortality.

- 2019-17BWG – Add two new lines for affiliated bank loans to the parent, subsidiaries and affiliates category and modify the existing lines for bank loans to reference unaffiliated for Schedule D, Part 1; Schedule DA; Schedule

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DL, Parts 1 and 2; and Schedule E, Part 2. The subtotal line for bank loans under the total bond category will be the sum of the affiliated and unaffiliated lines.

- Editorial/nonsubstantive listing.

6. *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) and Related Items

- Adopted the following amendments to the P&P Manual:

  - Revisions update the definition and instructions for structured notes with new guidance now referring to the definition of structured notes in SSAP No. 26R. The definition removed these instruments from being in scope of SSAP No. 26R and, with the exception of mortgage-referenced securities, SSAP No. 43R. The P&P Manual amendment also makes them ineligible for filing exemption (FE).

  - Revisions delete a stray reference to modified filing exempt (MFE), which was previously deleted in Part 6.

7. NAIC Risk-Based Capital (RBC) Formula Changes and Related Items

- Adopted the electronic capitation tables proposal.

- Adopted the underwriting risk line 1 factors.

- Adopted the affiliated investment instructions.

- Adopted the life and fraternal combination blanks proposal.

- Adopted the interest rate risk and market risk proposal.

8. *Uniform Certificate of Authority Application* (UCAA), *Company Licensing Best Practices Handbook* and Related Items

- None.

9. *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual) and Related Items

- None.

10. *Receivers Handbook for Insurance Company Insolvencies* and Related Items

- None.

11. Process for Developing and Maintaining the *NAIC List of Qualified Jurisdictions* and Related Items

- None.

12. Process for Developing and Maintaining the *NAIC List of Certified Reinsurers* and Related Items

- None.

13. NAIC Enterprise Risk Report (Form F) Implementation Guide and Related Items

- None.

14. *Troubled Insurance Company Handbook* Changes and Related Items

- None.

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Action Taken During Aug. 29, 2019, Conference Call

Date Released to Executive (EX) Committee and Plenary Members: Sept. 9, 2019
Objections Due from Executive (EX) Committee and Plenary Members: Sept. 19, 2019

The following technical items were adopted by the Financial Condition (E) Committee during an Aug. 29, 2019, conference call:

1. ***Accounting Practices and Procedures Manual* (AP&P Manual) Changes and Related Items**

   - None.

2. ***Financial Condition Examiners Handbook* Changes, Other Examination Tools and Related Items**

   - None.

3. ***Financial Analysis Handbook* Changes and Related Items**

   - None.

4. **Implementation Guide for the *Annual Financial Reporting Model Regulation* (#205) Changes and Related Items**

   - None.

5. ***Annual Statement Instructions* Changes and Related Items**

   - Adopted the following changes to the annual financial statement blanks and/or instructions:

     - 2019-18BWG – Add an NAIC Designation Modifier to the "NAIC Designation" column for Schedule D, Schedule DL and Schedule BA to accommodate the NAIC Designation Category granularity framework adopted by the Valuation of Securities (E) Task Force with an annual 2020 effective date.

     - 2019-20BWG – Add "Qualification Documentation" to the Property and Casualty Actuarial Opinion instructions, as requested by the Casualty Actuarial and Statistical (C) Task Force, requiring the Appointed Actuary to maintain workpapers explaining how the actuary meets the definition of "Qualified Actuary." These proposed changes were adopted by the Task Force on June 11. The Executive (EX) Committee proposes the remainder of the changes, including a new objective definition of "Qualified Actuary" and the results of an assessment of actuarial educational syllabi in an "NAIC-Accepted Actuarial Designation" section. These proposed changes were adopted by the Committee on June 25.

   - Editorial/nonsubstantive listing.

6. ***Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) and Related Items**

   - None.

7. **NAIC Risk-Based Capital (RBC) Formula Changes and Related Items**

   - None.

8. ***Uniform Certificate of Authority Application* (UCAA), *Company Licensing Best Practices Handbook* and Related Items**

   - None.

9. ***NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual) and Related Items**

   - None.

10. *Receivers Handbook for Insurance Company Insolvencies* and Related Items

- None.

11. Process for Developing and Maintaining the *NAIC List of Qualified Jurisdictions* and Related Items

- None.

12. Process for Developing and Maintaining the *NAIC List of Certified Reinsurers* and Related Items

- None.

13. NAIC Enterprise Risk Report (Form F) Implementation Guide and Related Items

- None.

14. *Troubled Insurance Company Handbook* Changes and Related Items

- None.

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VM Maintenance Agenda #	Valuation Manual Reference	**Adopted June 15, 2017 By the Health Insurance and Managed Care (B) Committee**	HATF Adoption Date
	VM-25	With impending changes to the calculation of the single premium immediate annuities valuation interest rate, this proposed change is to allow for the calculation of the calendar year maximum valuation interest rate for certain claim reserves to remain unchanged. The proposed wording provides for the direct calculation (derived from Appendix A-802) but the formula has been revised to replace W with the single value of .8 and to reduce the formula value of .03 by one hundred basis points.	6/2/17
VM Maintenance Agenda #	Valuation Manual Reference	**Adoption on August 6, 2017 By the Life Insurance and Annuities (A) Committee**	LATF Adoption Date
2017-6	VM Section II	Revise Valuation Manual Section II 2. Annuity Products to reflect that the minimum requirements for fixed annuity contract valuation interest rates are defined in VM-22.	8/4/17
VM Maintenance Agenda #	Valuation Manual Reference	**Adopted July 17, 2017 By the Life Insurance and Annuities (A) Committee**	LATF Adoption Date
2017-28	VM-31	Revising sections of VM-31 for consistency with VM-20, other sections of VM-31. Removing redundant information.	7/13/17
2017-34	VM-20 Section 3.B.5.d.ii.	VM-20 Section 3.B.5.d.ii clarification of function limits.	7/13/17
2017-35	VM-20 Section 9.C.6.b.	Clarifying language for the SDP in Section 9.C.6.b.	7/13/17
2017-39	VM-20 Section 3.C	Clarify in VM-20 Section 3.C that the shock lapse for the term NPR is to be applied prior to the collection of the first premium following the level period.	7/13/17

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VM Maintenance Agenda #	Valuation Manual Reference	**Adopted July 17, 2017 By the Life Insurance and Annuities (A) Committee**	LATF Adoption Date
2017-41	VM-20 Section 4, Section 5 and Section 7	Clarification of the existing VM-20 wording regarding the modeling of policy loans and separate account assets, and the list of assets in starting assets.	7/13/17
2017-43	VM-20 Appendix 2	Changes the calculation of spreads from quarterly to monthly and provides other changes for clarification.	7/13/17
2017-52	VM-30	Limits the amount of minimum aggregate reserve required to the amounts required in states in which this company is licensed.	7/13/17
2017-53	VM-20	To clarify that the 2017 CSO is to be used for all years of issue when applying the Actuarial Method as required by Section 6 of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).	7/13/17
2017-32	VM-20 Sections 9.C.6.a and 9.C.6.b.i	Add references for clarity in VM-20 Sections 9.C.6.a and 9.C.6.b.i	6/22/2017
2016-2	VM-22	Revises requirements for the maximum valuation interest rate for SPIAs and similar contracts issued after 12/31/17 to be more responsive to the economic environment.	Editorial change 6/15/17 Adopted 4/6/2017
2017-7	Section II	Revises and consolidates APF 2017-1 and APF 2017-3. Also excludes from the premium amounts counting toward the threshold, premium for preneed life contracts and premiums representing transfer of reserves from reinsurance assumed transactions.	6/15/2017
2017-22	Section I	Modify the process for updating the Spread and Default costs table in order to expedite their approval.	6/1/2017
2017-19	VM-01	This will clarify an inconsistent reference in the footnote to definition 64 about that, in the definition of non-material secondary guarantee, the unloaded CSO is to be used, not the Valuation Basic Table.	5/18/2017

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VM Maintenance Agenda #	Valuation Manual Reference	**Adopted by Life Insurance and Annuities (A) Committee May 19, 2017**	LATF Adoption Date
2017-9	VM-20 Sections 2.A. and 2.B.	The proposal posits that the term "product minimum NPR" is not proper when referring to a subset of policies within that product. Offers recommendations to provide appropriate wording	5/11/17
2017-8	VM-20 Section 3C	A liability exists for recognition of immediate payment of claims but the curtate net premium reserve formula in VM-20 does not recognize one and no reference in VM-20 is made to Actuarial Guideline XXXII.	5/11/17
2017-16	VM-51 Appendices 4 and 6	Propose revisions make VM 51 Appendix 4 and 6 consistent with the NYDFS and KID 2017 Data Call	5/11/17
2017-20	VM-30	Requires the documentation of assumptions to include those related to mortality improvement or deterioration.	5/11/17
2017-10	VM-20 Section 9.D.1.a, 9.D.5	Use consistent reference to "cash surrender value". And, in 9.D.5., clarify that the second sentence is a continuation of the logic from the first sentence and applies to the same policies as the first sentence.	4/6/17
2017-11	VM-20 Section 1.C.8 and 2.G.	Refines the definition of the term "modeled reserve" to capture the necessary references in Section 2	4/6/17
2017-15	VM-20 Section 3.A.1	Proposes clarification of seriatim calculation of NPR and reference to Section II.	4/6/17
2017-21	VM-20 Appendix 2	Remove the tables from VM-20 Appendix 2 and place them on the Related Documents tab of the LATF page to avoid publishing a new VM whenever the tables are updated	4/6/17
2017-5	VM-20	Update the link in VM-20 Section 9C3g to the mortality improvement factors on the SOA website.	3/2/17

HATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions Adopted by Health Insurance and Managed Care (B) Committee June 28, 2018	HATF Adoption Date
2018	VM-30 Section 1A3	AG 51 references the commissioner authority in VM-30 and is in effect beginning year-end 2017. This edit further documents use of this authority by specifically referencing AG 51 in VM-30.	4/30/2018
2019	VM-25, Section A	Specifies the appropriate mortality reserving tables to be used in the calculation of contract reserves for policies other than long-term care individual policies and group certificates.	4/30/2018
LATF VM Amendment	**Valuation Manual Reference**	**Valuation Manual Amendment Proposal Descriptions Adopted by Life Insurance and Annuities (A) Committee July 19, 2018**	**LATF Adoption Date**
2017-66	VM-26	Credit Insurance Reserve Standards	6/21/2018
2017-81	VM-50	Revise Experience Reporting Requirements	6/7/2018
2017-85	VM-20 Section 9.B.1	Add Guidance Note on Recognition of Explicit Margin	6/28/2018
2017-86	VM-01	Guidance Note on Relevant Experience	4/12/2018
2017-87	VM-20 Sec. 5A, Sec. 6A2a, Appendix 1	Correct references to Appendix 1 in VM-20	4/12/2018
2017-88	VM-20 Sec. 3b, Sec. 7B	Clarify handling of secondary guarantees	5/24/2018
2017-89	VM-20 Sec. 3B4c	Specify that the gross premium includes the policy fee	3/22/2018
2017-94	VM-31 Phase 3	Phase 3 of the revisions to VM-31	4/26/2018
2018-01	Sec. II, VM-01, VM-02, VM-20, VM-M	Guaranteed issue mortality tables	6/21/2018
2018-07	VM-20, Section 4C	Clarity of VM-20 Section 4.C language	6/28/2018

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2018-09	VM-20 Section 9.D.5	Proposal to update VM-20 Section 9.D.5 with newer data	6/14/2018
2018-12	Section II (footnote 1)	Reconcile definitions of "Industrial"	6/14/2018
2018-13	VM-20 Section 7.K	Revise Guidance Note on Hedging Strategies	6/14/2018
2018-14	VM-01	Revise the Definition of Claim Reserve	6/21/2018
2018-16	VM-01 Sect 5A	Rewording VM-01 terms to avoid confusion	6/28/2018
2018-19	VM-51	Experience Reporting Statistical Plans	6/7/2018
2018-20	VM-22	Revisions to VM-22	6/28/2018
2018-25	VM-21	Correct Typo	6/14/2018
2018-29	VM-20	Clarify Deterministic Exclusion Test	6/14/2018
2018-30	VM-20 Sect 3	Clarify ULSG Lapse Rates	6/28/2018
2018-31	VM-20 7.D.7	Clarify PIMR Language	6/21/2018
2018-36	VM-01, VM-30	Clarify definition of Actuarial Opinion	6/21/2018
2018-38	VM-20 7.G, VM-21 6.D and 7.H	Consistency of references for equities	6/28/2018
2018-40	VM-31 Section 3.C.5	Add information about inflation assumption to VM-31	6/28/2018

Page Number	LATF VM Amendment	Valuation Manual Reference	Adopted by Life Insurance and Annuities (A) Committee 3/25/18 Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date
3	2017-14	VM-20 Section 2.G	Proposes clarification about simplifications and approximations and adds a Guidance Note.	10/19/17
6	2017-42	VM-20 Section 9.C	Provide clarifying Guidance Note for what is intended by “expected claims” in VM-20 Section 9.C.2.d, (Formerly Appendix A of APF 2017-27)	8/4/2017
7	2017-45	VM-20 Section 7.G.2.c.i	Although the language in VM-20 already says that the subset must be “generated using the prescribed scenario generator” there are some who have interpreted that to mean it is sufficient for the scenarios chosen to come from the prescribed scenario generator, as opposed to the methodology of choosing to come from the prescribed scenario generator, so it seems prudent to provide extra clarity in this passage.	9/14/2017
9	2017-47	Sections 1.C.3 and 1.C.22, VM-01	Some definitions need to be clarified.	2/15/2018
11	2017-55	VM-50	Proposes changes to VM-51 Section 2B2a, Appendix 2, Appendix 4.	9/14/2017
20	2017-57	VM-20 Section 7D	Clarify Collar Language	11/30/17
23	2017-60	VM-01	Move common definitions from various VM sections to VM-01	11/2/2017
43	2017-61	VM-01, VM-26	Revise certain definitions in the VM	9/28/2017
55	2017-65	VM-20 Sec 9C	Changes the references to UCS to refer to the Relative Risk Tool	10/5/2017
58	2017-67	VM-M	VM-02 section 5 (nonforfeiture) mentions Appendix M and VM-M. These edits make mention of nonforfeiture in the VM-M title	9/28/2017
60	2017-68	VM-20 Section 9F2c	Clarifies the definition of WAL / changes Swap Spread Table heading	10/5/2017
63	2017-69	TOC, Sec I, Sec II, VM-01, Vm-20, VM-26, VM-G	Removes VM-05 from the Valuation Manual, and deletes or replaces the references to VM-05 as needed.	11/2/2017

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Page Number	LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date
67	2017-73	VM -20 Section 7.F.1.a	VM-20 Section 7.F.1.a, as currently worded, somewhat confusingly seems to suggest that a seriatim approach will understate reserves.	2/15/2018
69	2017-74	VM-20 Section 5.A.	Clarify what type of shift is meant in VM-20 Section 5.A.	11/9/2017
72	2017-76	VM-51	Proposes revisions to VM-51 to correct minor oversights	2/15/2018
76	2017-77	VM-20 Section 9.C.6.b.iii	Propose revisions to the mortality grading methodology to remove significant discontinuities.	2/15/2018

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Attachment Number	Page Number	LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date
1	3	2017-70	VM Section II	Revisions to the reserve methodology for valuing term riders	8/3/2018
2	7	2018-03	VM-20 Section 7.D.1, 7.D.3, and 7.D.7	Clarifying Starting Asset Language	8/3/2018
3	16	2018-06	VM-02, VM-20	Definition of Ordinary Life	11/13/2018
4	18	2018-08	Introduction, Part II, Section D	Life PBR Exemption Revision	9/27/2018
5	20	2018-11	VM-20 Sect. 6.A.2, 6.A.3 VM-31 Sect 3.C.10	Clarify details of Stochastic Exclusion Tests and results	12/13/2018
6	23	2018-15	VM-01, VM20 Section 5.A	Add Definitions to VM-01	2/21/2019
7	25	2018-17	VM-20 Sect 9.C., VM-31 Sect 3.C.3	Aggregation of Mortality Segments - Credibility	11/13/2018
8	28	2018-41	VM-02 Sect 3 and 5, VM-20 Sect 3.C.1.a.	Move VM-02 Definitions to VM-01.	1/31/2019
9	32	2018-42	VM-20 Sections 9.C.2 and 9.C.4	Clarify when capping of face amounts is appropriate	4/25/2019
10	35	2018-43	VM-01	Provide a definition for Insurance Department	4/4/2019
11	36	2018-44	VM-20 Sect 7.F.6	IUL Deterministic Reserve	3/14/2019
12	41	2018-45	VM-20 Sect 9C	Adjustments to company experience mortality rates	5/30/2019
13	48	2018-48	VM-20 Sections 3.B.4.a, 3.C.3.b.	Clarify handling of YRT reinsurance assumed, term riders and paid-up term	2/21/2019
14	52	2018-49	VM-20 Section 3.B.6.d.iii	Update to reflect adoption of APF 2017-88	11/13/2018

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Attachment Number	Page Number	LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date
15	54	2018-50	VM-31 Section 3.C.2.a	Require modeling system version number	11/13/2018
16	56	2018-51	VM-31 Section 2	Revision of VM-31 reporting requirements	11/13/2018
17	58	2018-52	VM-20 Section 3.C.1	Revise NPR calculation to address substandard mortality	11/13/2018
18	60	2018-53	VM-20 Section 7.E.1.g, VM-31 Sections 3.C.6, 3.C.13, VM-G 3.A.6.d.ii	Clarify Alternative Investment Strategy parameters	5/14/2019
19	64	2018-54	VM-31 Section 11.j	Additional instructions for ULSG reserve reporting	11/13/2018
20	66	2018-55	VM-01, VM-20 Sect. 2, 4, 5 VM-31 Sect. 11	Replace references to Product Group	5/9/2019
21	71	2018-56	VM-20 Section 8.D.1	Determination of a Pre-Reinsurance-Ceded Minimum Reserve	5/14/2019
22	73	2018-57	VM-20 Section 3.C.1, VM-31 Section 3.C.3	Adjustments to the NPR Mortality	6/20/2019
23	75	2018-61	VM-31 Section 3.C.3.h	Clarify the VM-31 definition of credibility	1/31/2019
24	77	2018-62	VM-31 Section 3.C.2.e	Revise VM-31 Actuarial Report Requirements to properly reflect the degree of model validation	3/7/2019
25	79	2018-63	VM-20 Section 3.C.3.c.ii	Clarify the appropriate annual lapse rate	3/14/2019
26	81	2018-64	VM-A/VM-C	Clarify that the requirements of VM-A and VM-C are not limited to reserves	4/4/2019
27	83	2018-66	VM-20 Section 2.D	Delete VM-20 Section 2.D	4/4/2019
28	87	2019-01	VM-20 Section 6.B. and VM-31 Section 3.C.10	Modify DET for conservatively reserved policies	6/20/2019

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Attachment Number	Page Number	LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date
29	92	2019-04	VM-20 Section 3.B.5 and 3.B.6	Clarifying the ULSG expense allowance formulas.	4/4/2019
30	96	2019-05	VM-31 Section 3.C.11	Clarify VM-31 reporting requirement mandated in previously adopted APF 2018-54	2/21/2019
31	98	2019-06	VM-20 Section 9.E.1, VM-31 Section 3.C.5	Recommendations 20 and 21 from VAWG's memo regarding PBR Recommendations and Referrals to LATF.	5/21/2019
32	101	2019-07	VM-31 Section 3.C.3.j	Recommendation #11 from VAWG's memo regarding PBR Recommendations and Referrals to LATF. The new post-level term language relates to VAWG recommendation #17.	5/9/2019
33	103	2019-08	VM-31 Section 3.C.3.i.	Recommendation #14 from VAWG's memo regarding the PBR Recommendations and Referrals to LATF.	4/4/2019
34	105	2019-09	VM-31 Section 3.C.6.i	Recommendation #22 from VAWG's 10/24/18 memo regarding PBR Recommendations and Referrals to LATF.	4/4/2019
35	107	2019-10	VM-20 Section 8.D.2 and VM-31 Section 3.C.10.c	Recommendation #28 from VAWG's 10/24/2018 memo regarding PBR Recommendations and Referrals to LATF. It also provides clarity in VM-20 Section 8.D.2.	4/4/2019
36	109	2019-11	VM-20 Sec 9.D.3.e, 9.D.6 and VM-31 Sec 3.C.4	Clarify requirements for documentation of A/E ratios and testing sufficiency of lapse margins	5/9/2019
37	114	2019-12	VM-01 and VM-20 Section 7.D.7	Revise PIMR language	4/4/2019
38	116	2019-13	Guidance Note following VM-20 Section 6.A.2.a	Guidance Note to Clarify SERT Numerator	4/4/2019
39	119	2019-14	VM-31 Section 3.B.3 and VM-G Section 1.E	Additional governance documentation	5/21/2019
40	121	2019-15	VM-31 Section 3.C.11	Recommendations #18, #29, #30 and third consideration in recommendation #5 from VAWG memo	4/4/2019
41	125	2019-16	VM-20 Sec. 9.C.3.c.ii, 9.C.4.b.ii, 9.C.6 and VM-31 Sec. 3.C.3.k, 3.C.3.c.ii	Recommendations #35 and #36 from VAWG memo	5/2/2019
42	134	2019-18	VM-20 Section 9.G.8.b	Make VM-20 consistent with VM-21 as to revenue-sharing rules.	5/2/2019

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Attachment Number	Page Number	LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date
43	136	2019-19	VM-20 Section 9.E.1.b	Clarify Guidance Note about expense spreading.	5/9/2019
44	138	2019-21	VM-20 Section 9.C.3.g	Specify date associated with 2008 VBT Table	5/9/2019
45	140	2019-22	VM-20 Section 9.D	Need for limiting modeling of option elections to those that could contain an element of anti-selection.	5/9/2019
46	142	2019-23	VM-31 Sec. 3.C.1, 3.C.3, VM-20 9.B.1/9.C.2.e	Recommendation #6, #7 and part of #4 of VAWG memo	5/21/2019
47	147	2019-25	VM-31 Sec. 3.C.3.h	Recommendation #12 and part of #34 of VAWG memo	5/2/2019
48	149	2019-26	VM-01	Revisions to VM-01	6/20/2019
49	160	2019-27	VM-21	Revisions to VM-21	6/20/2019
50	291	2019-28	VM-31	Revisions to VM-31	6/20/2019
51	332	2019-29	VM-20 Sec. 6.A.1.b	CDHS and Stochastic Exclusion	6/4/2019
52	334	2019-31	Section 2.D	Revision to the Life PBR Exemption	6/25/2019
53	336	2019-32	VM-20 Section 2.C	Allocation of the DR/SR Excess as Appropriate	5/9/2019
54	337	2019-35	VM-31 Section 3.C.8.a	Clarification of whether a reinsurance agreement involves a captive	5/9/2019
55	339	2019-36	Section II	Clarify Section II Reserve Requirements for Deposit Type Contracts	6/20/2019
56	341	2019-37	VM-G	VM-G requirements when exclusion tests are passed	5/14/2019

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Adopted by Life Insurance and Annuities (A) Committee - July 10, 2019

Attachment Number	Page Number	LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date
57	347	2019-38	VM-02 Sec 5E	Revert to 2001 CSO for GI business	5/30/2019
58	349	2019-39	VM-20 Sec 8.C	Interim solution of YRT Reinsurance Treatment	6/20/2019
59	353	2019-43	VM-20 Section 2.A and 3.D	Addresses VAWG Recommendation #32	5/21/2019
60	356	2019-44	VM-31 Section 3.B	Addresses VAWG Recommendation #3 and #4	5/21/2019
61	360	2019-46	VM-50 Sec 3.B.6 VM51 Sec 2.D	Experience reporting Agent Trigger	6/20/2019
62	365	2019-52	Intro, VM-01, VM-20, VM-31	Addresses VAWG Recommendation #5	5/30/2019
63	371	2019-53	VM-20 Sec 9.C.2.g & 9.C.6.c	Clarify the language related to smoothing	6/4/2019
64	374	2019-54	VM-31 Section 3.C.12	Addresses VAWG Recommendation #2	6/4/2019
65	376	2019-55	VM-20 Sec 7.L	Delete a CHDS criterion that was moved to VM-01	6/20/2019

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2019 RELEASE OF THE *MARKET REGULATION HANDBOOK*

The following items represent all revisions adopted by the NAIC in 2018, which are incorporated into the 2019 release of the NAIC *Market Regulation Handbook.*

- Regulator guidance relating to the following was incorporated into the online reference documents of the *Market Regulation Handbook*:
    - Six new stand alone annuity-related standardized data requests, addressing:
        - Claims;
        - In force contracts;
        - New business declinations;
        - Payment, withdrawal and surrender;
        - Plan codes; and
        - Replaced annuity contracts.

    Four new stand alone life insurance-related standardized data requests were adopted by the NAIC in 2017, therefore, the combined NAIC Life and Annuity Standardized Data Request, Revised 2006 is replaced by the above-referenced new annuity-related standardized data requests along with the stand alone life insurance-related standardized data requests adopted in 2017.

- Updated guidance setting forth the formal procedures for amending the *Market Regulation Handbook.* The procedures are posted on the Working Group web page on the Related Documents tab at: https://www.naic.org/cmte_d_market_conduct_exam_standards.htm.

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2018 RELEASE OF THE *MARKET REGULATION HANDBOOK*

The following items represent all revisions adopted by the NAIC in 2017, which are incorporated into the 2018 release of the NAIC *Market Regulation Handbook.*

Chapter 2—Continuum of Market Actions (Previously known as Chapter 2-Continuum of Regulatory Responses)
- Revised guidance re: continuum of market actions

Chapter 7—Putting it All Together: Market Analysis (Previously known as Chapter 4)
- Updated language relating to relating to regulator tools and systems in Section A. Framework for Market Analysis and Section B. Developing a Market Analysis Program

Chapter 10—Market Analysis Level 1 Questions (Previously known as Appendix B)
- Updated language relating to regulator tools and systems in Question 7

Chapter 15—Standardized Data Requests (Previously known as Chapter 13)
- Revised guidance regarding regulator use of standardized data requests

Chapter 16—Scheduling, Coordinating and Communicating (Previously known as Chapter 12)
- Updated language relating to regulator tools and systems in Section R. Market Conduct Uniform Examination Outline

Chapter 18—Automated Examinations Tools and Techniques (Previously known as Chapter 11)
- Updated language relating to regulator tools and systems in Section B. Automation Tools, Section C. Reference Tools, Training and Assistance, Section D. Data Requests and Access, Section F. Sampling and Section I. Marketing and Sales

Chapter 22—Conducting the Title Insurance Company and Title Insurance Agent Examination (Previously known as Chapter 18)
- Revised language relating to title insurance company and title insurance agent oversight

Chapter 23—Conducting the Life and Annuity Examination (Previously known as Chapter 19)
- Revised guidance re: NAIC *Actuarial Guideline 49 – The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49)

Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination (Previously known as Chapter 20A)
- New examination standards regarding network adequacy

Chapter 25—Conducting the Medicare Supplement Examination (Previously known as Chapter 21)
- Revised Operations/Management Examination Standard #2 with regard to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

Chapter 29—Conducting the Advisory Organization Examination (Previously known as Chapter 25)
- Revised language relating to advisory organization examination oversight

Reference Documents (Standardized Data Requests):
- The below standardized data requests replace the NAIC Producer, Commission and Complaint Standardized Data Request, Revised 2006
  - Producer Standardized Data Request
  - Commission Standardized Data Request
  - Marketing and Sales Standardized Data Request
  - Complaint Standardized Data Request
- The below standardized data requests replace the Life portion of the NAIC Life and Annuity Standardized Data Request, Revised 2006
  - Life Claims Standardized Data Request
  - Life Declinations Standardized Data Request
  - Life In Force Standardized Data Request
  - Life Replacement Standardized Data Request

Reference Documents (other than Standardized Data Requests)
- New regulatory guidance for closing continuum actions
- Revised Comprehensive Annual Analysis (CAA) Form (used in the oversight of advisory organization examinations)

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Market Regulation Handbook Chapter/Section Cross-Reference Table

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Volume I-Overview of Market Regulation Oversight (Pages 1-88)

Chapter/Section Title	Location in Handbooks Published 2006-2017	Location in 2018 Handbook and Subsequent Years' Handbooks
Introduction	Chapter 1	Chapter 1
Continuum of Market Actions	Chapter 2	Chapter 2
Market Regulation Investigation Guidelines	Chapter 7	Chapter 3
Collaborative Actions	Chapter 6	Chapter 4
Core Competencies	Appendix D	Chapter 5

Volume II-What is Market Analysis (Pages 89-174)

Chapter/Section Title	Location in Handbooks Published 2006-2017	Location in 2018 Handbook and Subsequent Years' Handbooks
Basic Analytical Tools	Chapter 3	Chapter 6
Putting it all Together: Market Analysis	Chapter 4	Chapter 7
Enhancing State Market Analysis	Chapter 5	Chapter 8
iSite+ Reports	Appendix A	Chapter 9
Market Analysis Level 1 Questions	Appendix B	Chapter 10
Level 2 Analysis Guide	Appendix C	Chapter 11

Volume III-How to Conduct Market Conduct Examinations (Pages 175-276)

Chapter/Section Title	Location in Handbooks Published 2006-2017	Location in 2018 Handbook and Subsequent Years' Handbooks
Examination Introduction	Chapter 8	Chapter 12
Types of Examinations	Chapter 10	Chapter 13
Examiner Classifications, Qualifications and Compensation (was previously titled Examiner Qualifications and Compensation)	Chapter 9	Chapter 14
Standardized Data Requests	Chapter 13	Chapter 15
Scheduling, Coordinating and Communicating	Chapter 12	Chapter 16
Sampling	Chapter 14	Chapter 17
Automated Examinations Tools and Techniques	Chapter 11	Chapter 18
Writing the Examination Report	Chapter 15	Chapter 19

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Market Regulation Handbook Chapter/Section Cross-Reference Table, cont'd

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Volume IV-Review/Examination Criteria for Specific Types of Insurance and Regulated Entities (Pages 277-1117)

Chapter/Section Title	Location in Handbooks Published 2006-2017	Location in 2018 Handbook and Subsequent Years' Handbooks
General Examination Standards	Chapter 16	Chapter 20
Conducting the Property and Casualty Examination	Chapter 17	Chapter 21
Conducting the Title Insurance Company and Title Insurance Agent Examination	Chapter 18	Chapter 22
Conducting the Life and Annuity Examination	Chapter 19	Chapter 23
Conducting the Health Examination	Chapter 20	Chapter 24
Conducting the Affordable Care Act (ACA) Related Examination	Chapter 20A	Chapter 24A
Conducting the Medicare Supplement Examination	Chapter 21	Chapter 25
Conducting the Long-Term Care Examination	Chapter 22	Chapter 26
Conducting the Consumer Credit Examination	Chapter 23	Chapter 27
Conducting the Surplus Lines Broker Examination	Chapter 24	Chapter 28
Conducting the Advisory Organization Examination	Chapter 25	Chapter 29
Conducting the Third-Party Administrator Examination	Chapter 26	Chapter 30
Conducting the Examination of a Viatical Settlement Provider	Chapter 27	Chapter 31
Conducting the Premium Finance Company Examination	Chapter 28	Chapter 32

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Uniform Life, Accident & Health, Annuity and Credit Product Coding Matrix

FOR USE WITH THE UNIFORM LIFE, ACCIDENT & HEALTH, ANNUITY CREDIT TRANSMITTAL DOCUMENT: Item 8, Type of Insurance, on the Uniform Life, Accident & Health, Annuity, Credit Transmittal Document is completed by listing all appropriate Filing Codes from this matrix. Please read the descriptions carefully as the policy reviewers will be looking at these filing codes when deciding what review standards/checklists are appropriate for this filing.

TOI	Sub-TOI	Description
Annuities		An arrangement whereby an annuitant is guaranteed to receive a series of payments commencing either immediately or at some future date.
A01 Annuities – Assumption Agreement	A01.000 Annuities – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
A02G Group Annuities – Deferred Non-variable		An annuity contract that provides an accumulation based on funds that accumulate based on a guaranteed crediting interest rate or additional interest rate. This annuity contract provides for the initiation of payments at some designated future date.
	A02G.001 Fixed Premium	An annuity where premium payments are fixed.
	A02G.002 Flexible Premium	The premium payments are flexible.
	A02G.003 Single Premium	Purchase by the payment of one lump sum.
	A02G.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A02G.005 Limited Flexible Premium	The premium payments are specified for a designated time frame, i.e. 5 years.
A02I Individual Annuities- Deferred Non-Variable		An annuity contract that provides an accumulation based on funds that accumulate based on a guaranteed crediting interest rate or additional interest rate. This annuity contract provides for the initiation of payments at some designated future date.
	A02I.001 Fixed Premium	An annuity where premium payments are fixed.
	A02I.002 Flexible Premium	The premium payments are flexible.
	A02I.003 Single Premium	Purchase by the payment of one lump sum.

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	A02I.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A021.005 Limited Flexible Premium	The premium payment are specified for a designated time frame, i.e. 5 years.
A02.1G Group Annuities – Deferred Non-Variable and Variable		An annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some designated future date.
	A02.1G.001 Fixed Premium	An annuity where premium payments are fixed.
	A02.1G.002 Flexible Premium	The premium payments are flexible.
	A02.1G.003 Single Premium	Purchase by the payment of one lump sum.
	A02.1G.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A02.1G.005 Limited Flexible Premium	The premium payments are specified for a designated time frame, i.e. 5 years.
A02.1I Individual Annuities- Deferred Non-Variable and Variable		An annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some designated future date.
	A02.1I.001 Fixed Premium	An annuity where premium payments are fixed.
	A02.1I.002 Flexible Premium	The premium payments are flexible.
	A02.1I.003 Single Premium	Purchase by the payment of one lump sum.
	A02.1I.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A02.1I.005 Limited Flexible Premium	The premium payments are specified for a designated time frame, i.e. 5 years.

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A03G Group Annuities – Deferred Variable		An annuity contract that provides an accumulation based fund where the accumulation varies in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. Must include at least one option to have the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder and may include at least one option to have the series of payments vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. This annuity contract provides for the initiation of payments at some designated future date.
	A03G.001 Fixed Premium	An annuity where premium payments are fixed.
	A03G.002 Flexible Premium	Premium payments are flexible.
	A03G.003 Single Premium	Purchase by the payment of one lump sum.
	A03G.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A03G.005 Limited Flexible Premium	The premium payment are specified for a designated time frame, i.e. 5 years.
A03I Individual Annuities – Deferred Variable		An annuity contract that provides an accumulation based fund where the accumulation varies in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. Must include at least one option to have the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder and may include at least one option to have the series of payments vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. This annuity contract provides for the initiation of payments at some designated future date.
	A03I.001 Fixed Premium	An annuity where premium payments are fixed.
	A03I.002 Flexible Premium	Premium payments are flexible.
	A03I.003 Single Premium	Purchase by the payment of one lump sum.
	A03I.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A03I.005 Limited Flexible Premium	The premium payment are specified for a designated time frame, i.e. 5 years.

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A05G Group Annuities – Immediate Non-variable	A05G.000 Annuities – Immediate Non-variable	An annuity contract that provides for the fixed payment of the annuity at the end of the first interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months.
A05I Individual Annuities- Immediate Non-Variable	A05I.000 Annuities – Immediate Non-variable	An annuity contract that provides for the fixed payment of the annuity at the end of the first interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months.
A06G Group Annuities – Immediate Variable	A06G.000 Annuities – Immediate Variable	An annuity contract that provides for the first payment of the annuity at the end of the fixed interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months. The amount varies with the value of equities (separate account) purchased as investments by the insurance companies.
A06I Individual Annuities – Immediate Variable	A06I.000 Annuities – Immediate Variable	An annuity contract that provides for the first payment of the annuity at the end of the fixed interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months. The amount varies with the value of equities (separate account) purchased as investments by the insurance companies.
A06.1G Group Annuities – Immediate Non-Variable and Variable	A06.1G.000 Annuities – Immediate Non-Variable and Variable	An annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some interval that may vary, however the annuity payouts must begin within 13 months
A06.1I Individual Annuities- Immediate Non Variable and Variable	A06.1I.000 Annuities – Immediate Variable and Non-Variable	An annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some interval that may vary, however the annuity payouts must begin within 13 months.
A07G Group Annuities – Special		Contracts with certain noteworthy attributes.

	A07G.001 Equity Indexed	A fixed annuity that earns interest or provides benefits that are linked to an external reference or equity index, subject to a minimum guarantee.
	A07G.002 Modified Guaranteed	An annuity that contains a provision that adjusts the value of withdrawn funds based on a formula in the contract. The formula reflects market value adjustments.
	A07G.003 Contingent Deferred	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.
A07I Individual Annuities – Special		Contracts with certain noteworthy attributes.
	A07I.001 Equity Indexed	A fixed annuity that earns interest or provides benefits that are linked to an external reference or equity index, subject to a minimum guarantee.
	A07I.002 Modified Guaranteed	An annuity that contains a provision that adjusts the value of withdrawn funds based on a formula in the contract. The formula reflects market value adjustments.
	A07I.003 Contingent Deferred	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.
A08G Group Annuities – Unallocated		Annuity contracts or portions thereof where the Insurer purchases an annuity for the retirees.
	A08G.001 Funding Agreement	Contracts that guarantee principal and interest for a specified period of time and do not include the option to purchase immediate annuities that depend on the survival of the annuitant.
	A08G.002 GIC	Contracts that guarantee principal and interest for a specified period of time and include the option to purchase immediate annuities that depend on the survival of the annuitant.

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	A08G.003 Deposit Administration	Annuity contracts that typically provide for an unallocated fund accumulation for active lives out of which immediate annuities are purchased for individuals at retirement and deferred annuities are purchased for terminated employees with vested benefits.
A10 Annuities – Other	A10.000 Annuities – Other	Not specifically described above.
Continuing Care Retirement Communities		
CC01G Group Continuing Care Retirement Communities		Continuing Care Retirement Communities are senior housing arrangements that in addition to housing include some provision for skilled nursing care.
	CC01G.000 CCRC – Type A	Type A communities are also referred to as Life Care Communities. There is no increase in the required monthly fee when the resident enters the skilled nursing facility.
	CC02G.000 CCRC – Type B	Type B communities are those that don't meet the definition of Type A or Type C. They may involve some combination of full skilled nursing home benefits, but only for a limited period of time and/or an increase in the monthly fee when the resident enters the skilled nursing facility but not up to full market rates.
	CC03G.000 CCRC – Type C	Type C communities guarantee access to a skilled nursing home bed but the residents pays the full market rate.
	CC04G.000 CCRC – Other	Not specifically described above.
CC01I Individual Continuing Care Retirement Communities	CC01I.000 CCRC – Type A	Type A communities are also referred to as Life Care Communities. There is no increase in the required monthly fee when the resident enters the skilled nursing facility.
	CC02I.000 CCRC – Type B	Type B communities are those that don't meet the definition of Type A or Type C. They may involve some combination of full skilled nursing home benefits, but only for a limited period of time and/or an increase in the monthly fee when the resident enters the skilled nursing facility but not up to full market rates.
	CC03I.000 CCRC – Type C	Type C communities guarantee access to a skilled nursing home bed but the residents pays the full market rate.
	CC04I.000 CCRC – Other	Not specifically described above.
Credit		Coverage on a debtor in favor of a creditor to pay off or reduce the balance due on a loan/credit transaction in the event of a covered loss.

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CR01 Credit – Assumption Agreement	CR01.000 Credit – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
CR02G Group Credit – Credit Disability		Makes monthly loan/credit transaction payments to the creditor upon the disablement of an insured debtor.
	CR02G.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR02G.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR02G.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
	CR02G.004 Full Term	Coverage for the entire term of the loan/credit transaction.
	CR02G.005 Critical Period	Disability benefits are limited to a specific number of months or for the remaining term of the loan/credit transaction, if less.
	CR02G.006 Truncated	Coverage for a term less than the term of the loan/credit transaction.
	CR02G.007 Other	Not specifically described above.
CR02I Individual Credit – Credit Disability		Makes monthly loan/credit transaction payments to the creditor upon the disablement of an insured debtor.

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	CR02I.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR02I.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR02I.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
	CR02I.004 Full Term	Coverage for the entire term of the loan/credit transaction.
	CR02I.005 Critical Period	Disability benefits are limited to a specific number of months or for the remaining term of the loan/credit transaction, if less.
	CR02I.006 Truncated	Coverage for a term less than the term of the loan/credit transaction.
	CR02I.007 Other	Not specifically described above.
CR03G Group Credit – FMLA		Makes loan/credit transaction payments to the creditor when the debtor is on unpaid leave from his/her job under the Family and Medical Leave Act (FMLA)

	CR03G.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR03G.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR03G.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
CR03I Individual Credit -FMLA		Makes loan/credit transaction payments to the creditor when the debtor is on unpaid leave from his/her job under the Family and Medical Leave Act (FMLA)
	CR03I.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.

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	CR03I.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR03I.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
CR04G Group Credit – Life		Contracts sold in connection with loan/credit transactions or other credit transactions, which do not exceed a stated duration and/or amount and provide insurance protection against death.
	CR04G.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR04G.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR04G.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
	CR04G.004 Gross	Coverage for the total amount payable on the loan/credit transaction (the net indebtedness plus the scheduled interest charges).

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	CR04G.005 Net	Coverage for the scheduled or actual unpaid principal amount of the loan/credit transaction.
	CR04G.006 Truncated	Coverage for a term less than the term of the loan/credit transaction.
CR04I Individual Credit – Life		Contracts sold in connection with loan/credit transactions or other credit transactions, which do not exceed a stated duration and/or amount and provide insurance protection against death.
	CR04I.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR04I.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR04I.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
	CR04I.004 Gross	Coverage for the total amount payable on the loan/credit transaction (the net indebtedness plus the scheduled interest charges).
	CR04I.005 Net	Coverage for the scheduled or actual unpaid principal amount of the loan/credit transaction.
	CR04I.006 Truncated	Coverage for a term less than the term of the loan/credit transaction.

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CR05 Credit – Property		This section is for use where credit personal property is handled by the life and/or health section of the state insurance department. Under CR05.002 through CR05.004 credit insurance may be either "single interest" or "dual interest". Single interest means insurance that protects only the creditor's interest in the collateral securing a debtor's credit transaction. Dual interest (also commonly referred to as "limited dual interest") means insurance that protects the creditor's and the debtor's interest in the collateral securing the debtor's credit transaction.
	CR05.002 Creditor-Placed Home	Single interest or dual interest credit insurance purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss to property that would either impair a creditor's interest or adversely affect the value of collateral on homes, mobile homes, and other real estate.
	CR05.003 Creditor-Placed Auto	Single interest or dual interest credit insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss to property that would either impair a creditor's interest or adversely affect the value of collateral on automobiles, boats, or other vehicles.
	CR05.004 Personal Property	Single interest or dual interest credit insurance (where collateral is not a motor vehicle, mobile home, or real estate) that covers perils to goods purchased or used as collateral and that concerns a creditor's interest in the purchased goods or pledged collateral either in whole or in part; or covers perils to goods purchased in connection with an open-end credit transaction.
	CR05.005 Credit Family Leave	Credit insurance that provides a monthly or lump sum benefit during an unpaid leave of absence from employment resulting from specified causes, such as illness of a close relative, adoption or birth of a child.
	CR05.006 Personal Gap Insurance	Credit insurance that insures the excess of the outstanding indebtedness over the primary property insurance benefits in the event of a total loss to a collateral asset.
	CR05.007 Other	Not specifically described above.

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CR06 Credit – Involuntary Unemployment		This section is for use where credit unemployment is handled by the life and/or health section of the state insurance department. This coverage makes loan/credit transaction payments to the creditor when the debtor becomes involuntarily unemployed.
	CR06.001 Monthly Premium – Open-End	“Open-end credit” means credit extended by a creditor by an agreement that is a line of credit loan/credit transaction, a revolving charge plan, or any other open-end self-replenishing credit arrangement between the creditor and a customer that may be drawn upon from time to time by the customer without renegotiating the lending agreement. The customer may repay the full outstanding balance at any time, or a specified minimum portion of the indebtedness.
	CR06.002 Monthly Premium – Closed-End	"Closed-end credit" means a credit agreement on which payments are due in equal monthly installments for a fixed term.
	CR06.003 Single Premium	“Single premium” means the purchase of insurance by the payment of one lump sum on the date coverage begins.
CR07 Credit – Other	CR07.000 Credit – Other	Not specifically described above.
Health		Accident & health contracts provide benefits for losses resulting from accident, sickness or medical condition.
H01 Health – Assumption Agreement	H01.000 Health – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
H02G Group Health – Accident Only	H02G.000 Health – Accident Only	An insurance contract that provides 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 accident.
H02I Individual Health – Accident Only	H02I.000 Health – Accident Only	An insurance contract that provides 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 accident.
H03G Group Health – Accidental Death & Dismemberment	H03G.000 Health – Accidental Death & Dismemberment	An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.
H03I Individual Health – Accidental Death & Dismemberment	H03I.000 Health – Accidental Death & Dismemberment	An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

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H04 Health – Blanket Accident/Sickness	H04.000 Health – Blanket Accident/Sickness	A health insurance contract that covers all of a class of persons not individually identified in the contract.
	H04.001 Student	A health insurance contract that covers a class of students not individually identified in the contract. If student health insurance is contemplated under the ACA use the TOI of H22 Student Health Insurance.
	H04.002 Health - Blanket Sickness Only	A health insurance contact that covers sickness only of a class of persons not individually identified in the contract.
	H04.003 Health - Blanket Accident Only	A health insurance contract that covers accident only of a class of persons not individually identified in the contract.
H05 Health – Champus/Tricare Supplement	H05.000 Health – Champus/Tricare Supplement	Civilian Health and Medical Program of the Uniformed Services (Champus). A private health plan that provides beneficiaries eligible for Champus with supplemental health care coverage.
H06 Health – Conversion	H06.000 Health – Conversion	Guarantees an insured whose coverage is ending for specified reasons a right to purchase a policy without presenting evidence of insurability.
H07G Group Health – Specified Disease – Limited Benefit		Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum.
	H07G.001 Critical Illness	Benefits can be paid as expense incurred, per diem, or as a principle sum.
	H07G.002 Dread Disease	Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid on as expense incurred, per diem, or a principle sum.
	H07G.002A Dread Disease – Cancer Only	Provides benefits for losses resulting from cancer and its associated diagnosis and treatments. Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum.
	H07G.003 HIV Indemnity	Provides benefits for losses resulting from occupational exposure and infection of the Human Immunodeficiency Virus. Benefits often include some form of occupational income replacement. Benefits can be paid as expense incurred, per diem, or a principle sum.
H07I Individual Health – Specified Disease – Limited Benefit		Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum.

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	H07I.001 Critical Illness	Benefits can be paid as expense incurred, per diem, or as a principle sum.
	H07I.002 Dread Disease	Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid on as expense incurred, per diem, or a principle sum.
	H07I.002A Dread Disease – Cancer Only	Provides benefits for losses resulting from cancer and its associated diagnosis and treatments. Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum.
	H07I.003 HIV Indemnity	Provides benefits for losses resulting from occupational exposure and infection of the Human Immunodeficiency Virus. Benefits often include some form of occupational income replacement. Benefits can be paid as expense incurred, per diem, or a principle sum.
H08G Group Health – Intensive Care – Limited Benefit	H08G.000 Health – Intensive Care – Limited Benefit	Provides a daily benefit for confinement in a qualified intensive care unit of a certified hospital. Benefits are specific to services delivered by the staff of a hospital intensive care unit. Benefits not to exceed a stated dollar amount per day.
H08I Individual Health – Intensive Care – Limited Benefit	H08I.000 Health – Intensive Care – Limited Benefit	Provides a daily benefit for confinement in a qualified intensive care unit of a certified hospital. Benefits are specific to services delivered by the staff of a hospital intensive care unit. Benefits not to exceed a stated dollar amount per day.
H09G Group Health – Organ & Tissue Transplant – Limited Benefit	H09G.000 Health – Organ & Tissue Transplant – Limited Benefit	Provides benefits for services incurred as a result of human and/or non-human organ transplant. Benefits are specific to the delivery of care associated with the covered organ or tissue transplant. Benefits not to exceed a stated dollar amount per day.
H09I Individual Health – Organ & Tissue Transplant – Limited Benefit	H09I.000 Health – Organ & Tissue Transplant – Limited Benefit	Provides benefits for services incurred as a result of human and/or non-human organ transplant. Benefits are specific to the delivery of care associated with the covered organ or tissue transplant. Benefits not to exceed a stated dollar amount per day.
H10G Group Health – Dental	H10G.000 Health – Dental	Insurance that provides benefits for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.

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	H10G.001 Health - Pediatric Dental	Pediatric dental as contemplated under the ACA.
H10I Individual Health – Dental	H10I.000 Health – Dental	Insurance that provides benefits for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.
	H10I.001 Health - Pediatric Dental	Pediatric dental as contemplated under the ACA.
H11G Group Health – Disability Income		A policy designed to compensate insured individuals for a portion of the income they lose because of a disabling injury or illness.
	H11G.001 Business Overhead Expense	A policy designed to compensate insured individuals by paying a benefit to replace income/revenue lost because of a disabling injury or sickness where the lost income/revenue paid business overhead expenses.
	H11G.002 Short Term	Disability income insurance that provides a benefit for a short disability. Group short-term disability usually specifies a maximum benefit period of less than one year.
	H11G.003 Long-Term	The group disability maximum benefit period commonly extends to retirement or age 70.Group long-term disability usually specifies a maximum benefit period of at least one year.
	H11G.004 Other	Not specifically described above.
	H11G.005 Combined Short Term and Long-Term	Disability income insurance that provides a benefit for both short term and long term disability.
H11I Individual Health – Disability Income		A policy designed to compensate insured individuals for a portion of the income they lose because of a disabling injury or illness.
	H11I.001 Business Overhead Expense —Unrelated to marketing with employer or association groups	A policy designed to compensate insured individuals by paying a benefit to replace income/revenue lost because of a disabling injury or illness where the lost income/revenue paid business overhead expenses.
	H11I.002 Short Term—Unrelated to marketing with employer or association groups	Disability income insurance that provides a benefit for a short disability. Individual short-term disability insurance features a maximum benefit period of from six months to 5 years.
	H11I.003 Long-Term—Unrelated to marketing with employer or association groups	In individual long term disability income insurance, the maximum benefit period is always greater than 5 years, commonly extending to age 65 or for the insured’s lifetime.
	H11I.004 Other	Not specifically described in other H11I categories.

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	H11I.005 Business Overhead Expense —Related to marketing with employer or association groups	A policy designed to compensate insured individuals by paying a benefit to replace income/revenue lost because of a disabling injury or illness where the lost income/revenue paid business overhead expenses. The coverage is issued based upon some type of employer or association involvement.
	H11I.006 Short Term—Related to marketing with employer or association groups	Disability income insurance that provides a benefit for a short disability. Individual short-term disability insurance features a maximum benefit period of from six months to 5 years. The coverage is issued based upon some type of employer or association involvement.
	H11I.007 Long-Term—Related to marketing with employer or association groups	In individual long term disability income insurance, the maximum benefit period is always greater than 5 years, commonly extending to age 65 or for the insured's lifetime. The coverage is issued based upon some type of employer or association involvement.
	H11I.008 Combined Short Term and Long-Term—Unrelated to marketing with employer or association groups	Individual disability income insurance that provides for a maximum benefit period as short as six months up to the insured's lifetime, depending on the option chosen by the insured, but all maximum benefit periods are offered through the same policy.
	H11I.009 Combined Short Term and Long-Term—Related to marketing with employer or association groups	Individual disability income insurance that provides for a maximum benefit period as short as six months up to the insured's lifetime, depending on the option chosen by the insured, but all maximum benefit periods are offered through the same policy. The coverage is issued based upon some type of employer or association involvement.
H12 Health – Excess/Stop Loss		This type of insurance may be extended to either a health plan or a self-insured employer plan. Its purpose is to insure against the risk that any one claim will exceed a specific dollar amount or that an entire plan's losses will exceed a specific amount.
	H12.001 Accident & Sickness	Accident is a form of insurance against loss from an unforeseen mishap that results in bodily injury to the insured. Sickness refers to those insurance contracts that guard against losses associated with the illness and disease of the insured.

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	H12.002 Managed Care	A system of health care delivery where the primary goal is to deliver value by giving people access to high quality, cost-effective health care through monitoring and recommending utilization of services, and overseeing costs of services.
	H12.003 Provider	Any individual or group of individuals that provides a health care services. A provider may be, but is not limited to, a physician, hospital, group medical practice, nurse, nursing home or a pharmacy.
	H12.004 Self-Funded Health Plan	An insurance contract that covers an employer's exposure to losses incurred under a self-funded health plan.
H13G Group Health – Short Term Care		Coverage that provides medical and other services to insured's who need constant care in their own home or in a nursing facility for periods of less than one year.
	H13G.001 Home Health Care	Coverage that provides medical and non--medical services provided to ill, disabled or infirm persons in their residences.
	H13G.002 Nursing Home	Coverage provided in a facility setting for health related services for the purpose of supporting frail, impaired elderly or other disabled adults who require continued care and attention.
	H13G.003 Adult Day Care	Coverage provided for individuals of social and health related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who benefit from care in a group setting outside the home.
H13I Individual Health – Short Term Care		Coverage that provides medical and other services to insured's who need constant care in their own home or in a nursing facility for periods of less than one year.
	H13I.001 Home Health Care	Coverage that provides medical and non--medical services provided to ill, disabled or infirm persons in their residences.
	H13I.002 Nursing Home	Coverage provided in a facility setting for health related services for the purpose of supporting frail, impaired elderly or other disabled adults who require continued care and attention.

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	H13I.003 Adult Day Care	Coverage provided for individuals of social and health related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who benefit from care in a group setting outside the home.
H14G Group Health – Hospital Indemnity	H14G.000 Health – Hospital Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred for each day the covered person is confined to the hospital as a result of injury, sickness, and/or medical condition. If other than hospital indemnity, use the TOI of H23G Group Indemnity Other than Hospital.
H14I Individual Health – Hospital Indemnity	H14I.000 Health – Hospital Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred for each day the covered person is confined to the hospital as a result of injury, sickness, and/or medical condition. If other than hospital indemnity, use the TOI of H23I Individual Indemnity Other than Hospital.
H15G Group Health – Hospital/Surgical/Medical Expense		An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition.
	H15G.001 Any Size Group	A hospital/surgical/medical expense contract that may be issued to any size group.
	H15G.002 Large Group Only	A hospital/surgical/medical expense contract that may be issued only to “large groups” as that term is defined in the state in which the contract will be delivered.
	H15G.003 Small Group Only	A hospital/surgical/medical expense contract that may be issued only to “small groups” as that term is defined in the state in which the contract will be delivered.
H15I Individual Health – Hospital/Surgical/Medical Expense	H15I.001 Health – Hospital/Surgical/Medical Expense	An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition.
H16G Group Health – Major Medical		A hospital/surgical/medical expense contract that provides comprehensive benefits as defined in the state in which the contract will be delivered.
	H16G.001A Any Size Group – PPO	A major medical contract that may be issued to any size group. A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.

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	H16G.001B Any Size Group – POS	A major medical contract that may be issued to any size group. A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	H16G.001C Any Size Group – Other	A major medical contract that may be issued to any size group. Not specifically described above.
	H16G.002A Large Group Only – PPO	A major medical contract that may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	H16G.002B Large Group Only – POS	A major medical contract that may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	H16G.002C Large Group Only – Other	A major medical contract that may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. Not specifically described above.
	H16G.003A Small Group Only – PPO	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	H16G.003B Small Group Only – PPO Basic	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A basic plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	H16G.003C Small Group Only – PPO Standard	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A standard plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.

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	H16G.003D Small Group Only – POS	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A combination of traditional indemnity heath insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	H16G.003E Small Group Only – POS Basic	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. One of the benefit plans that must be offered in most states in the small group market. The specifications vary from state to state but the basic plan generally has lower benefits than the other state mandated plan: the standard benefit plan.
	H16G.003F Small Group Only – POS Standard	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. One of the benefit plans that must be offered in most states in the small group market. The specifications vary from state to state but the standard plan generally has higher benefits than the other state mandated plan: the basic benefit plan.
	H16G.003G Small Group Only – Other	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. Not specifically described above.
	H16G.004 Short Term	A major medical policy or plan designed to provide coverage during a "gap" in coverage. Short term policies generally have pre-existing condition exclusions and are not renewable.
H16I Individual Health – Major Medical		A major medical contract that may be issued only to "individuals" as that term is defined in the state in which the contract will be delivered.
	H16I.005A Individual – Preferred Provider (PPO)	A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	H16I.005B Individual – Point-of-Service (POS)	A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	H16I.005C Individual – Other	Not specifically described above.
	H16I.004 Short Term	A major medical policy or plan designed to provide coverage during a "gap" in coverage. Short term policies generally have pre-existing condition exclusions and are not renewable.

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H17G Group Health – Prescription Drug	H17G.000 Health – Prescription Drug	Prescription drug plan that covers the cost of drugs (except those dispensed in a hospital or in an extended care facility) that are required by either state or federal law to be dispensed by prescription. Drugs for which prescriptions are not required by law may be covered.
H17I Individual Health – Prescription Drug	H17I.000 Health – Prescription Drug	Prescription drug plan that covers the cost of drugs (except those dispensed in a hospital or in an extended care facility) that are required by either state or federal law to be dispensed by prescription. Drugs for which prescriptions are not required by law may be covered.
H18G Group Health – Sickness	H18G.000 Health – Sickness	Limited benefit expense policies. Provides benefits for sickness only. Benefits not to exceed a stated dollar amount per day.
H18I Individual Health – Sickness	H18I.000 Health – Sickness	Limited benefit expense policies. Provides benefits for sickness only. Benefits not to exceed a stated dollar amount per day.
H19G Group Health – Travel	H19G.000 Health – Travel	Limited benefit expense policies. Provides benefits for loss incurred while traveling generally outside a 100-mile radius of the US borders. *May extend to domestic as well as foreign travel. May provide both sickness and injury benefits. May include loss of baggage benefits. May include air transportation services for emergencies. Benefits not to exceed a stated dollar amount per day, per month or trip duration. (*Subject to applicable state limitations.)
H19I Individual Health – Travel	H19I.000 Health – Travel	Limited benefit expense policies. Provides benefits for loss incurred while traveling generally outside a 100-mile radius of the US borders. *May extend to domestic as well as foreign travel. May provide both sickness and injury benefits. May include loss of baggage benefits. May include air transportation services for emergencies. Benefits not to exceed a stated dollar amount per day, per month or trip duration. (*Subject to applicable state limitations.)
H20G Group Health – Vision	H20G.000 Health – Vision	Limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.

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H20I Individual Health – Vision	H20I.000 Health – Vision	Limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.
H21 Health – Other	H21.000 Health – Other	Not specifically described above.
H22 Student Health Insurance	H22.000 Student Health Insurance	A health insurance contract that covers a class of students as contemplated under ACA.
H23G Group Health - Indemnity Other than Hospital		An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition. If hospital indemnity, use the TOI of H14G Group Health – Hospital Indemnity.
	H23G.000Accident Only Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of an accident only.
	H23G.001 Sickness Only Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of sickness only.
	H23G.002 Accident/Sickness Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of an accident or sickness only.
	H23G.003 Other Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition, not specifically described above.
H23I Individual Health - Indemnity Other than Hospital		An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition. If hospital indemnity, use the TOI of H14I Individual Health – Hospital Indemnity.
	H23I.000Accident Only Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of an accident only.
	H23I.001 Sickness Only Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of sickness only.
	H23I.002 Accident/Sickness Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of an accident or sickness only.

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	H23I.003 Other Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition, not specifically described above.
H24G Group Health – Limited Wraparound Coverage		Coverage designed/intended to comply with federal regulations defining excepted limited wraparound coverage such as 45 CFR 146.145, or as permitted by the state.
	H24G.001 Any Size Group	Coverage designed/intended to comply with federal regulations defining excepted limited wraparound coverage such as 45 CFR 146.145, or as permitted by the state that may be issued to any size group.
	H24G.002 Large Group Only	Coverage designed/intended to comply with federal regulations defining excepted limited wraparound coverage such as 45 CFR 146.145, or as permitted by the state that may be issued to “large groups” as that term is defined in the state in which the contract will be delivered.
	H24G.003 Small Group Only	Coverage designed/intended to comply with federal regulations defining excepted limited wraparound coverage such as 45 CFR 146.145, or as permitted by the state that may be issued to “small groups” as that term is defined in the state in which the contract will be delivered.
H24I Individual Health - Limited Wraparound Coverage	H24I.000 Individual Health - Limited Wraparound Coverage	Coverage designed/intended to comply with federal regulations defining excepted limited wraparound coverage such as 45 CFR 146.145, or as permitted by the state.
H25G Group Health – Similar Supplemental Coverage		Coverage as designed/intended to comply with federal regulations of similar supplemental coverage such as 45 CFR 146.145 (b)(5)(i)(C), or as permitted by the state
	H25G.001 Any Size Group	Coverage as designed/intended to comply with federal regulations of similar supplemental coverage such as 45 CFR 146.145 (b)(5)(i)(C), or as permitted by the state that may be issued to any size group.
	H25G.002 Large Group Only	Coverage as designed/intended to comply with federal regulations of similar supplemental coverage such as 45 CFR 146.145 (b)(5)(i)(C), or as permitted by the state that may be issued to “large groups” as that term is defined in the state in which the contract will be delivered.
	H25G.003 Small Group Only	Coverage as designed/intended to comply with federal regulations of similar supplemental coverage such as 45 CFR 146.145 (b)(5)(i)(C), or as permitted by the state that may be issued to “small groups” as that term is defined in the state in which the contract will be delivered.

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Health Maintenance (HMO)		A form of health insurance combining a range of coverages in a group basis. These coverages are offered on a prepaid basis to plan members. Members generally must use contracted medical service providers.
HOrg01 Health Organizations – Assumption Agreement	HOrg01.000 Health Organizations – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
HOrg02G Group Health Organizations – Health Maintenance (HMO)		A plan under which an enrollee pays a membership fixed fee in advance in return for a wide range of comprehensive health care services with the HMO's approved providers in a designated service area.
	HOrg02G.001 Conversion	Guarantees an insured whose coverage is ending for specified reasons a right to purchase a policy without presenting evidence of insurability.
	HOrg02G.002A Any Size Group – PPO	Coverage may be issued to any size group. A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.002B Any Size Group – POS	Coverage may be issued to any size group. A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	HOrg02G.002C Any Size Group - HMO [Drafters note -Restricted Network Only -No out of network benefit, OR In Network Only]	Coverage may be issued to "any size" group as that term is defined in the state in which the contract will be delivered. A HMO plan that requires enrollees to use plan providers. Coverage for non-plan provider is only paid in emergency situations.
	HOrg02G.002D Any Size Group - Other	Coverage may be issued only to "any size groups" as that term is defined in the state in which the contract will be delivered. Not specifically described above.
	HOrg02G.003A Large Group Only – PPO	Coverage may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.003B Large Group Only – POS	Coverage may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.

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	HOrg02G.003C Large Group Only - HMO [Drafters note - Restricted Network Only -No out of network benefit, OR In Network Only]	Coverage may be issued to "large groups" as that term is defined in the state in which the contract will be delivered. A HMO plan that requires enrollees to use plan providers. Coverage for non-plan provider is only paid in emergency situations.
	HOrg02G.003D Large Group Only - Other	Coverage may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. Not specifically described above.
	HOrg02G.004A Small Group Only – PPO Basic	Coverage may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A PPO basic plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.004B Small Group Only – PPO Standard	Coverage may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A PPO standard plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.004C Small Group Only – POS Basic	Coverage may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A POS basic plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.004D Small Group Only – POS Standard	Coverage may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A POS standard plan which would provide incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.004F Small Group Only - HMO [Drafters note - Restricted Network Only -No out of network benefit, OR In Network Only]	Coverage may be issued to "small groups" as that term is defined in the state in which the contract will be delivered. A HMO plan that requires enrollees to use plan providers. Coverage for non-plan provider is only paid in emergency situations.
	HOrg02G.004E Small Group Only – Other	Coverage may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. Not specifically described above.
HOrg02I Individual Health Organizations – Health Maintenance (HMO)		Coverage may be issued only to "individuals" as that term is defined in the state in which the contract will be delivered.

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	HOrg02I.005A Individual – Preferred Provider (PPO)	A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02I.005B Individual – Point-of-Service (POS)	A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	Horg02I.005D Individual - HMO [Drafters note -Restricted Network Only -No out of network benefit, OR In Network Only]	A HMO plan that requires enrollees to use plan providers. Coverage for non-plan provider is only paid in emergency situations.
	HOrg02I.005C Individual – Other	Not specifically described above.
HOrg03 Health – Other	HOrg03.000 Health – Other	Not specifically described above.
HOrg04G Group Health - Single Service Dental	HOrg04G.000 Group Health - Single Service Dental	Coverage for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.
	HOrg04G.001 Health – Pediatric Dental	Pediatric dental as contemplated under the ACA.
HOrg04I Individual Health - Single Service Dental	HOrg04I.000 Health – Single Service Dental	Coverage for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.
HOrg05G Group Health - Single Service Vision	HOrg05G.000 Health – Single Service Vision	Limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.
HOrg05I Individual Health - Single Service Vision	HOrg05I.000 Health – Single Service Vision	Limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.
Life		An insurance contract that provides a specified benefit amount to a named beneficiary upon the death of the insured.
L01 Life – Assumption Agreement	L01.000 Life – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
L02G Group Life – Endowment	L02G.000 Life – Endowment	Insurance that pays the same benefit amount should the insured die during the term of the contract, or if the insured survives to the end of the specified coverage term or age regardless of whether the group policyholder, the insured, or both pay the premium.
	L02G.001 Single Life – Fixed/Indeterminate Premium	Endowment on a single insured that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer but not to go beyond a guaranteed maximum for the certificate to remain in force.

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	L02G.002 Single Life – Single Premium	Endowment on a single insured where the insured pays only one specified premium amount at the time the certificate is issued.
	L02G.101 Joint (First to Die) – Fixed/Indeterminate Premium	Endowment on more than one insured where the benefit is payable on first death that requires a premium to be paid by a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L02G.102 Joint (First to Die) – Single Premium	Endowment on more than one insured where the benefit is payable on the first death and the insured pays only one specified premium amount at the time the certificate is issued.
	L02G.201 Joint (Last Survivor) – Fixed/Indeterminate Premium	Endowment on more than one insured where the benefit is payable on the last death that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L02G.202 Joint (Last Survivor) – Single Premium	Endowment on more than one insured where the benefit is payable on the last death and the insured pays only one specified premium amount at the time the certificate is issued.
L02I Individual Life – Endowment	L02I.000 Life – Endowment	An insurance contract that pays the same benefit amount should the insured die during the term of the contract or if the insured survives to the end of the specified policy term or age.
	L02I.001 Single Life – Fixed/Indeterminate Premium	Endowment on a single insured that requires payment of a specified modal of premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L02I.002 Single Life – Single Premium	Endowment on a single insured where the insured pays only one specified premium amount at the time the policy is issued.

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	L02I.101 Joint (First to Die) – Fixed/Indeterminate Premium	Endowment on more than one insured where the benefit is payable on the first death that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L02I.102 Joint (First to Die) – Single Premium	Endowment on a single insured where the insured pays only one specified premium amount at the time the policy is issued.
	L02I.201 Joint (Last Survivor) – Fixed/Indeterminate Premium	Endowment on more than one insured where the benefit is payable on the last death that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L02I.202 Joint (Last Survivor) – Single Premium	Endowment on more than one insured where benefit is payable on last death where the insured pays only one specified premium amount at the time the policy is issued.
L03G Group Life – Special	L03G.000 Group Life – Special	Contracts with certain noteworthy attributes (not otherwise covered).
L03I Individual Life – Special	L03I.000 Individual Life – Special	Contracts with certain noteworthy attributes (not otherwise covered).
L04G Group Life – Term		Life insurance where the policy provides protection only for a specified period of time regardless of whether the group policyholder, the insured, or both pay the premium.
	L04G.003 Single Life – Single Premium	Term on a single insured where the insured pays only one specified premium amount at the time the coverage is issued.
	L04G.004 Joint (First to Die) – Single Premium	Term on more than one insured where the benefit is payable on the first death and there is only one specified premium amount paid at the time the coverage is issued.
	L04G.005 Joint (Last Survivor) – Single Premium	Term on more than one insured where the benefit is payable on last death and the insured pays only one specified premium amount at the time the coverage is issued.
	L04G.103 Renewable – Single Life – Fixed/Indeterminate Premium	Term on a single insured that requires the insured to pay a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force.

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	L04G.104 Renewable – Joint (First to Die) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on first death and the insured pays a specified modal premium that is a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force.
	L04G.105 Renewable – Joint (Last Survivor) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on last death and the insured pays a specified modal premium that is a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force.
	L04G.203 Specified Age or Duration – Single Premium – Single Life	Term on a single insured that requires the payment of a specified single premium where the coverage remains in force to a specified age or for a specified duration.
	L04G.204 Specified Age or Duration – Single Premium – Joint (First to Die)	Term on more than one life that requires the payment of a specified single premium where the death benefit is paid on the first death and the coverage remains in force to a specified age or for a specified duration.
	L04G.205 Specified Age or Duration – Single Premium – Joint (Last Survivor)	Term on more than one life that requires the payment of a specified single premium where the death benefit is paid on the last death and the coverage remains in force to a specified age or for a specified duration.
	L04G.213 Specified Age or Duration – Fixed/Indeterminate Premium – Single Life	Term on a single insured that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The coverage remains in force to a specified age or for a specified duration.
	L04G.214 Specified Age or Duration – Fixed/Indeterminate Premium – Joint (First to Die)	Term on more than one life that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit is paid on the first death and the coverage remains in force to a specified age or for a specified duration.

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	L04G.215 Specified Age or Duration – Fixed/Indeterminate Premium – Joint (Last Survivor)	Term on more than one life that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit is paid on the last death and the coverage remains in force to a specified age or for a specified duration.
	L04G.303 Decreasing – Single Life – Single Premium	Term on a single insured in which the death benefit reduces monthly or annually similar to a mortgage schedule, and only one specified premium amount is paid at the time the coverage is issued.
	L04G.304 Decreasing – Joint (First to Die) – Single Premium	Term on more than one insured where the benefit is payable on first death and the death benefit reduces monthly or annually similar to a mortgage schedule and only one specified premium amount is paid at the time the coverage is issued.
	L04G.305 Decreasing – Joint (Last Survivor) – Single Premium	Term on more than one insured where the benefit is payable on last death and the death benefit reduces monthly or annually similar to a mortgage schedule and only one specified premium amount is paid at the time the coverage is issued.
	L04G.313 Decreasing – Single Life – Fixed/Indeterminate Premium	Term on a single insured that requires the insured to pay a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force. The death benefit reduces monthly or annually similar to a mortgage schedule
	L04G.314 Decreasing – Joint (First to Die) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on the first death and the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force. The death benefit reduces monthly or annually similar to a mortgage schedule.

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	L04G.315 Decreasing – Joint (Last Survivor) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on last death and the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force. The death benefit reduces monthly or annually similar to a mortgage schedule.
	L04G.403 Deposit Term – Single Life	Term on a single insured where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04G.404 Deposit Term – Joint (First to Die)	Term on more than one insured where the death benefit is payable on the first death, and where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04G.405 Deposit Term – Joint (Last to Die)	Term on more than one insured where the death benefit is payable on the last death, and where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04G.500 Other	This sub-TOI should only be used if the product is not identified under any other sub-TOI listed in H04G Group Life - Term.
L04I Individual Life – Term		Life insurance where the policy provides protection only for a specified period of time.
	L04I.003 Single Life – Single Premium	Term on a single insured in which the insured pays only one specified premium amount at the time the policy is issued.
	L04I.004 Joint (First to Die) – Single Premium	Term on more than one insured where the benefit is payable on first death where only one specified premium amount is paid at the time the policy is issued.
	L04I.005 Joint (Last Survivor) – Single Premium	Term on more than one insured where the benefit is payable on the last death and the insured pays only one specified premium amount at the time the policy is issued.
	L04I.103 Renewable – Single Life – Fixed/Indeterminate Premium	Term on a single insured that requires the insured to pay a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.

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	L04I.104 Renewable – Joint (First to Die) – Fixed Premium/Indeterminate Premium	Term on more than one insured where the benefit is payable on first death and the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L04I.105 Renewable – Joint (Last Survivor) – Fixed Premium/Indeterminate Premium	Term on more than one insured where the benefit is payable on the last death and the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L04I.203 Specified Age or Duration – Single Premium – Single Life	Term on a single insured that requires the payment of a specified single premium where the policy remains in force to a specified age or for a specified duration.
	L04I.204 Specified Age or Duration – Single Premium – Joint (First to Die)	Term on more than one life that requires the payment of a specified single premium where the death benefit is paid on the first death and the policy remains in force to a specified age or for a specified duration.
	L04I.205 Specified Age or Duration – Single Premium – Joint (Last Survivor)	Term on more than one life that requires the payment of a specified single premium where the death benefit is paid on the last death and the policy remains in force to a specified age or for a specified duration.
	L04I.213 Specified Age or Duration – Fixed/Indeterminate Premium – Single Life	Term on a single insured that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The policy remains in force to a specified age or for a specified duration.
	L04I.214 Specified Age or Duration – Fixed/Indeterminate Premium – Joint (First to Die)	Term on more than one life that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit is paid on the first death and the policy remains in force to a specified age or for a specified duration.

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	L04I.215 Specified Age or Duration – Fixed/Indeterminate Premium – Joint (Last Survivor)	Term on more than one life that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit is paid on the last death and the policy remains in force to a specified age or for a specified duration.
	L04I.303 Decreasing -Single Life – Single Premium	Term on a single insured where the death benefit reduces monthly or annually similar to a mortgage schedule and only one specified premium amount is paid at the time the policy is issued.
	L04I.304 Decreasing – Joint (First to Die) – Single Premium	Term on more than one insured where the benefit is payable on the first death and the death benefit reduces monthly or annually similar to a mortgage schedule and only one specified premium amount is paid at the time the policy is issued.
	L04I.305 Decreasing – Joint (Last Survivor) – Single Premium	Term on more than one insured where the benefit is payable on the last death and the death benefit reduces monthly or annually similar to a mortgage schedule and only one specified premium amount is paid at the time the policy is issued.
	L04I.313 Decreasing – Single Life – Fixed/Indeterminate Premium	Term on a single insured that requires the insured to pay a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force. Death benefit reduces monthly or annually similar to a mortgage schedule.
	L04I.314 Decreasing – Joint (First to Die) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on the first death and the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit reduces monthly or annually similar to a mortgage schedule.

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	L04I.315 Decreasing – Joint (Last Survivor) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on the last death where the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit reduces monthly or annually similar to a mortgage schedule.
	L04I.403 Deposit Term – Single Life	Term on a single insured where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04I.404 Deposit Term – Joint (First to Die)	Term on more than one insured where the death benefit is payable on the first death and where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04I.405 Deposit Term - Joint (Last to Die)	Term on more than one insured where the death benefit is payable on the last death and where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04I.500 Other	Not specifically described above.
L06G Group Life – Variable		Life insurance whose face value and/or duration varies depending upon the value of underlying securities regardless of whether the group policyholder, the insured, or both pay the premium.
	L06G.001 Single Life – Fixed Premium	Variable life insurance on a single insured requiring the insured to pay a specified modal premium for the coverage to remain in force.
	L06G.002 Single Life – Flexible Premium	Variable life insurance on a single insured that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the account value is sufficient to keep the coverage in force.
	L06G.003 Single Life – Single Premium	Variable life insurance on a single insured in which the insurer pays only one specified premium amount at the time the coverage is issued.
	L06G.004 Single Life – Modified Single Premium	Variable life insurance on a single insured that allows the insured to pay one specified premium amount at the time the coverage is issued and optional subsequent premiums subject to the federal guideline premium limits.
	L06G.101 Joint (First to Die) – Fixed Premium	Variable life insurance on more than one insured where the benefit is payable on the first death and that requires the insured to pay a specified modal premium for the coverage to remain in force.

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	L06G.102 Joint (First to Die) – Flexible Premium	Variable life insurance on more than one insured where the benefit is payable on the first death that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the account value is sufficient to keep the coverage in force.
	L06G.103 Joint (First to Die) – Single Premium	Variable life insurance on more than one insured where the benefit is payable on the first death and the insured pays only one specified premium amount at the time the coverage is issued.
	L06G.104 Joint (First to Die) – Modified Single Premium	Variable life insurance on more than one insured where the benefit is payable on the first death that allows the insured to pay one specified premium amount at the time the coverage is issued and optional subsequent premiums subject to the federal guideline premium limits.
	L06G.201 Joint (Last Survivor) – Fixed Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that requires the insured to pay a specified modal premium for the coverage to remain in force.
	L06G.202 Joint (Last Survivor) – Flexible Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the account value is sufficient to keep the coverage in force.
	L06G.203 Joint (Last Survivor) – Single Premium	Variable life insurance on more than one insured where the benefit is payable on the last death where the insured pays only one specified premium amount at the time the coverage is issued.
	L06G.204 Joint (Last Survivor) – Modified Single Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that allows the insured to pay one specified premium amount at the time the coverage is issued and optional subsequent premiums subject to the federal guideline premium limits.
L06I Individual Life – Variable		Life insurance whose face value and/or duration varies depending upon the value of underlying securities.
	L06I.001 Single Life – Fixed Premium	Life insurance requiring the insured to pay a specified modal premium for the policy to remain in force.

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	L06I.002 Single Life – Flexible Premium	Life insurance that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the policy value is sufficient to keep the policy in force.
	L06I.003 Single Life – Single Premium	Life insurance in which the insured would pay only one specified premium amount at the time the policy is issued.
	L06I.004 Single Life – Modified Single Premium	Variable life insurance on a single insured that allows the insured to pay one specified premium amount at the time the policy is issued and optional subsequent premiums subject to the federal guideline premium limits.
	L06I.101 Joint (First to Die) – Fixed Premium	Variable life insurance on more than one insured where the benefit is payable on the first death that requires the insured to pay a specified modal premium for the policy to remain in force.
	L06I.102 Joint (First to Die) – Flexible Premium	Variable life insurance on more than one insured where the benefit is payable on the first death that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the policy value is sufficient to keep the policy in force.
	L06I.103 Joint (First to Die) – Single Premium	Variable life insurance on more than one insured where the benefit is payable on the first death where the insured pays only one specified premium amount at the time the policy is issued.
	L06I.104 Joint (First to Die) – Modified Single Premium	Variable life insurance on more than one insured where the benefit is payable on the first death that allows the insured to pay one specified premium amount at the time the policy is issued and optional subsequent premiums subject to the federal guideline premium limits.
	L06I.201 Joint (Last Survivor) – Fixed Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that requires the insured to pay a specified modal premium for the policy to remain in force.
	L06I.202 Joint (Last Survivor) – Flexible Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the policy value is sufficient to keep the policy in force.

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	L06I.203 Joint (Last Survivor) – Single Premium	Variable life insurance on more than one insured where the benefit is payable on the last death where the insured pays only one specified premium amount at the time the policy is issued.
	L06I.204 Joint (Last Survivor) – Modified Single Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that allows the insured to pay one specified premium amount at the time the policy is issued and optional subsequent premiums subject to the federal guideline premium limits.
L07G Group Life – Whole		Life insurance that may be kept in force for a person's entire life and that pays a benefit upon the person's death, whenever that may be regardless of whether the group policyholder, the insured, or both pay the premium.
	L07G.101 Fixed/Indeterminate Premium – Single Life	Whole life on a single insured that requires a premium to be paid by a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07G.102 – Fixed/Indeterminate Premium – Joint (First to Die)	Whole life on more than one insured where the benefit is payable on first death that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07G.103 – Fixed/Indeterminate Premium – Joint (Last Survivor)	Whole life on more than one insured where the benefit is payable on last death that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07G.104 Fixed/Indeterminate Premium – Single Life – Funeral Expense	Whole life on a single insured used to fund funeral expense or preneed funeral coverage that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07G.111 Single Premium – Single Life	Whole life insurance with a guaranteed single premium and benefits on one insured.
	L07G.112 Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with a guaranteed single premium and benefits, with the death benefit payable upon the first death.
	L07G.113 Single Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with a guaranteed single premium and benefits, with the death benefit payable upon the last death.

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	L07G.114 Single Premium – Single Life – Funeral Expense	Whole life insurance on more than one insured with a guaranteed single premium and benefits, used to fund funeral expense or a preneed funeral contract.
	L07G.121 Graded Premium – Single Life	Whole life insurance on more than one insured with a guaranteed graded premium and benefits.
	L07G.122 Graded Premium – Joint (First to Die)	Whole life insurance on more than one insured with a guaranteed graded premium and benefits, with the death benefit payable upon the first death.
	L07G.123 Graded Premium -Joint (Last Survivor)	Whole life insurance on more than one insured with a guaranteed graded premium and benefits, with the death benefit payable upon the last death.
	L07G.201 Early Duration Reduced Benefit – Level Premium – Any Policy Design	Whole life insurance with a guaranteed level premium and benefits reduced during the early durations.
	L07G.202 Early Duration Reduced Benefit – Level Premium – Any Policy Design – Funeral Expense	Whole life insurance with a guaranteed level premium and benefits reduced during the early durations and used to fund funeral expense or preneed funeral contracts.
	L07G.211 Early Duration Reduced Benefit – Single Premium – Any Policy Design	Whole life insurance with a single premium and benefits reduced during the early durations.
	L07G.212 Early Duration Reduced Benefit – Single Premium – Any Policy Design – Funeral Expense	Whole life insurance with a single premium and benefits reduced during the early durations used to fund funeral expense or preneed funeral contracts.
	L07G.301 Current Assumption – Fixed Premium – Single Life	Whole life insurance on a single insured with a fixed premium where the certificate value is not guaranteed due to the company's right to change interest, expense and/or mortality assumptions. The policy or certificate holder may pay additional premiums.
	L07G.302 Current Assumption – Fixed Premium – Joint (First to Die)	Whole life insurance on more than one insured with a fixed premium where the certificate value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy or certificate holder may pay additional premiums.
	L07G.303 Current Assumption – Fixed Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with a fixed premium where the certificate value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy or certificate holder may pay additional premiums.

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	L07G.311 Current Assumption – Single Premium – Single Life	Whole life insurance on a single insured with a single premium where the certificate value is dependent on the company's right to change interest, expense and/or mortality assumptions.
	L07G.312 Current Assumption – Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with a single premium where the certificate value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon first death.
	L07G.313 Current Assumption – Single Premium -Joint (Last Survivor)	Whole life insurance on more than one insured with a single premium where the certificate value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death.
	L07G.321 Current Assumption – Indeterminate Premium – Single Life	Whole life insurance on a single insured where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions. The policy or certificate holder may pay additional premiums.
	L07G.322 Current Assumption – Indeterminate Premium – Joint (First to Die)	Whole life insurance on more than one insured where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy or certificate holder may pay additional premiums.
	L07G.323 Current Assumption – Indeterminate Premium -Joint (Last Survivor)	Whole life insurance on more than one insured where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy or certificate holder may pay additional premiums.
	L07G.401 Adjustable – Current Assumption – Indeterminate Premium – Single Life	Whole life insurance on a single insured where the insured may change the plan of insurance or the death benefit and where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions. The policy or certificate holder may pay additional premiums.

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	L07G.402 Adjustable – Current Assumption – Indeterminate Premium – Joint (First to Die)	Whole life insurance on a single insured where the insured may change the plan of insurance or the death benefit and where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy or certificate holder may pay additional premiums.
	L07G.403 Adjustable – Current Assumption – Indeterminate Premium -Joint (Last Survivor)	Whole life insurance on a single insured where the insured may change the plan of insurance or the death benefit and where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy or certificate holder may pay additional premiums.
	L07G.501 External Index- Level Premium – Single Life	Whole life insurance on a single insured with level premium where certificate values are linked to an external or equity index.
	L07G.502 External Index – Level Premium – Joint (First to Die)	Whole life insurance on more than one insured with level premium where certificate values are linked to an external or equity index, with the death benefit payable upon the first death.
	L07G.503 External Index – Level Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with level premium where certificate values are linked to an external or equity index, with the death benefit payable upon the last death.
	L07G.511 External Index – Single Premium – Single Life	Whole life insurance on one insured with a single premium where certificate values are linked to an external or equity index.
	L07G.512 External Index – Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with level premium and where certificate values are linked to an external or equity index, with the death benefit payable upon the first death.
	L07G.513 External Index – Single Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with level premium and where certificate values are linked to an external or equity index, with the death benefit payable upon the last death.
L07I Individual Life – Whole		Life insurance that may be kept in force for a person's entire life and that pays a benefit upon the person's death, whenever that may be.

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	L07I.101 Fixed/Indeterminate Premium – Single Life	Whole life on a single insured that requires payment of a specified modal premium that is a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L07I.102 Fixed/Indeterminate Premium – Joint (First to Die)	Whole life on more than one insured where the benefit is payable on first death that requires payment of a specified modal premium that is a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07I.103 Fixed/Indeterminate Premium – Joint (Last Survivor)	Whole life on more than one insured where the benefit is payable on last death that requires payment of a specified modal premium that is a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07I.104 Fixed/Indeterminate Premium – Single Life – Funeral Expense	Whole life insurance on one insured with guaranteed level premium and benefits used to fund funeral expense or preneed funeral contract.
	L07I.111 Single Premium – Single Life	Whole life insurance on one insured with guaranteed single premium and benefits.
	L07I.112 Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with guaranteed single premium and benefits, with the death benefit payable upon the first death.
	L07I.113 Single Premium -Joint (Last Survivor)	Whole life insurance on more than one insured with guaranteed single premium and benefits, with the death benefit payable upon the last death.
	L07I.114 Single Premium – Single Life – Funeral Expense	Whole life insurance on one insured with guaranteed single premium and benefits used to fund funeral expense or preneed funeral contract.
	L07I.121 Graded Premium – Single Life	Whole life insurance on one insured with guaranteed graded premium and benefits.
	L07I.122 Graded Premium – Joint (First to Die)	Whole life insurance on more than one insured with guaranteed graded premium and benefits, with the death benefit payable upon the first death.
	L07I.123 Graded Premium -Joint (Last Survivor)	Whole life insurance on more than one insured with guaranteed graded premium and benefits, with the death benefit payable upon the last death.

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	L07I.124 Graded Premium – Jumping Juvenile (Term to Age X, Whole Life Thereafter)	Life insurance that is term to age X and then converts to whole life.
	L07I.201 Early Duration Reduced Benefit – Level Premium – Any Policy Design	Whole life insurance with guaranteed level premium and benefits reduced during the early durations.
	L07I.202 Early Duration Reduced Benefit – Level Premium – Any Policy Design – Funeral Expense	Whole life insurance with guaranteed level premium and benefits reduced during the early durations, used to fund funeral expense or a preneed funeral contract.
	L07I.211 Early Duration Reduced Benefit – Single Premium – Any Policy Design	Whole life insurance with single premium and benefits reduced during the early durations.
	L07I.212 Early Duration Reduced Benefit – Single Premium – Any Policy Design – Funeral Expense	Whole life insurance with single premium and benefits reduced during the early durations used to fund funeral expense or a preneed funeral contract.
	L07I.301 Current Assumption – Fixed Premium – Single Life	Whole life insurance on a single insured with a fixed premium where policy value is not guaranteed due to company’s right to change interest, expense and/or mortality assumptions. The policy owner may pay additional premiums.
	L07I.302 Current Assumption – Fixed Premium – Joint (First to Die)	Whole life insurance on more than one insured with a fixed premium where the policy value is dependent on the company’s right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy owner may pay additional premiums.
	L07I.303 Current Assumption – Fixed Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with a fixed premium where the policy value is dependent on the company’s right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy owner may pay additional premiums.
	L07I.311 Current Assumption – Single Premium – Single Life	Whole life insurance on a single insured with a single premium where the policy value is dependent on the company’s right to change interest, expense and/or mortality assumptions.
	L07I.312 Current Assumption – Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with a single premium where the policy value is dependent on the company’s right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death.

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	L07I.313 Current Assumption – Single Premium -Joint (Last Survivor)	Whole life insurance on more than one insured with a single premium where the policy value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death.
	L07I.321 Current Assumption – Indeterminate Premium – Single Life	Whole life insurance on a single insured where premium and policy value are dependent on the company's right to change interest, expense and/or mortality assumptions. The policy owner may pay additional premiums.
	L07I.322 Current Assumption – Indeterminate Premium – Joint (First to Die)	Whole life insurance on more than one insured where premium and policy value are dependent upon the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy owner may pay additional premiums.
	L07I.323 Current Assumption – Indeterminate Premium -Joint (Last Survivor)	Whole life insurance on more than one insured where premium and policy value are dependent upon the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy owner may pay additional premiums.
	L07I.401 Adjustable – Current Assumption – Indeterminate Premium – Single Life	Whole life insurance on a single insured where the insured may change the plan of insurance or the death benefit and where premium and policy value are dependent on the company's right to change interest, expense and/or mortality assumptions. The policy owner may pay additional premiums.
	L07I.402 Adjustable – Current Assumption – Indeterminate Premium – Joint (First to Die)	Whole life insurance on more than one insured where the insured may change the plan of insurance or the death benefit and where premium and policy value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy owner may pay additional premiums.
	L07I.403 Adjustable – Current Assumption – Indeterminate Premium -Joint (Last Survivor)	Whole life insurance on more than one insured where the insured may change the plan of insurance or the death benefit and where premium and policy value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy owner may pay additional premiums.
	L07I.501 External Index – Level Premium	Whole life insurance with level premium where policy values are linked to an external or equity index.

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	L07I.502 External Index – Level Premium – Joint (First to Die)	Whole life insurance on more than one insured with level premium where policy values are linked to an external or equity index, with the death benefit payable upon the first death.
	L07I.503 External Index – Level Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with level premium where policy values are linked to an external or equity index, with the death benefit payable upon the last death.
	L07I.511 External Index – Single Premium	Whole life insurance with a single premium where policy values are linked to an external or equity index.
	L07I.512 External Index – Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with level premium where policy values are linked to an external or equity index, with the death benefit payable upon the first death.
	L07I.513 External Index – Single Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with level premium where policy values are linked to an external or equity index, with the death benefit payable upon the last death.
L08 Life – Other	L08.000 Life – Other	Not specifically described above.
L09G Group Life – Flexible Premium Adjustable Life		A group life insurance that provides a face amount that is adjustable to the certificate holder and allows the certificate holder to vary the modal premium that is paid or to skip a payment so long as the certificate value is sufficient to keep the certificate in force, and under which separately identified interest credits (other than in connection with dividend accumulation, premium deposit funds or other supplementary accounts) and mortality and expense charges are made to individual certificates while providing minimum guaranteed values regardless of whether the group policyholder, the insured, or both pay the premium. Universal life products should be placed under the best matching sub-TOI.
	L09G.001 Single Life	A flexible premium adjustable life policy where the certificate insures one life.
	L09G.002 Joint (Last to Die)	A flexible premium adjustable life policy where the certificate insures more than one life and will pay the specified death benefit upon the last death.
	L09G.003 Joint (First to Die)	A flexible premium adjustable life policy where the certificate insures more than one life and will pay the specified death benefit upon the first death.
	L09G.101 External Indexed – Single Life	A flexible premium adjustable life policy where the certificate insures one life and earns interest or provides benefits that are linked to an external or equity index.

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	L09G.102 External Indexed – Joint (First to Die)	A flexible premium adjustable life policy where the certificate earns interest or provides benefits that are linked to an external or equity index. The certificate insures more than one life and will pay the specified death benefit upon the first death.
	L09G.103 External Indexed – Joint (Last to Die)	A flexible premium adjustable life policy where the certificate earns interest or provides benefits that are linked to an external or equity index. The certificate insures more than one life and will pay the specified death benefit upon the last death.
L09I Individual Life – Flexible Premium Adjustable Life		Life insurance that provides a face amount that is adjustable to the policyholder and allows the policyholder to vary the modal premium that is paid or to skip a payment so long as the account value is sufficient to keep the coverage in force, and under which separately identified interest credits (other than in connection with dividend accumulation, premium deposit funds or other supplementary accounts) and mortality and expense charges are made to a policy that provides minimum nonforfeiture values. Universal life products should be placed under the best matching sub-TOI.
	L09I.001 Single Life	A flexible premium adjustable life policy where the policy insures one life.
	L09I.002 Joint (Last to Die)	A flexible premium adjustable life policy where the policy insures more than one life and will pay the specified death benefit upon the last death.
	L09I.003 Joint (First to Die)	A flexible premium adjustable life policy where the policy insures more than one life and will pay the specified death benefit upon the first death.
	L09I.101 External Indexed – Single Life	A flexible premium adjustable life policy that insures one life and earns interest or provides benefits that are linked to an external or equity index.
	L09I.102 External Indexed – Joint (First to Die)	A flexible premium adjustable life policy that earns interest or provides benefits that are linked to an external or equity index. The policy insures more than one life and will pay the specified death benefit upon the first death.
	L09I.103 External Indexed – Joint (Last to Die)	A flexible premium adjustable life policy that earns interest or provides benefits that are linked to an external or equity index. The policy insures more than one life and will pay the specified death benefit upon the last death.

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Long-Term Care		Coverage that includes long term care, nursing home, and home care contracts that provide reimbursement for these services.
LTC01 Long-Term Care – Assumption Agreement	LTC01.000 Long-Term Care – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
LTC02G Group Long-Term Care – Home Health Care Only		Coverage that provides coverage for non-institutional care provided in a person's own home or in an adult day care setting.
	LTC02G.001 Qualified	A home health care only policy that meets the federal IRS requirements to qualify for a tax deduction.
	LTC02G.002 Non Qualified	A home health care only policy that does not meet the federal IRS requirements.
	LTC02G.004 Partnership	A home health care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC02G.003 Other	Not specifically described above.
LTC02I Individual Long-Term Care – Home Health Care Only		Coverage that provides coverage for non-institutional care provided in a person's own home or in an adult day care setting.
	LTC02I.001 Qualified	A home health care only policy that meets the federal IRS requirements to qualify for a tax deduction.
	LTC02I.002 Non Qualified	A home health care only policy that does not meet the federal IRS requirements.
	LTC02I.004 Partnership	A home health care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC02I.003 Other	Not specifically described above.
LTC03G Group Long-Term Care		Coverage that provides reimbursement for the following long term care services: nursing home care, assisted living care, home health care and adult day care.
	LTC03G.001 Qualified	A long term care policy that meets the federal IRS requirements to qualify for a tax deduction.

	LTC03G.002 Non Qualified	A long term care policy that does not meet the federal IRS requirements to qualify for a tax deduction.
	LTC03G.004 Partnership	A long term care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC03G.003 Other	Not specifically described above.
LTC03I Individual Long-Term Care		Coverage that provides reimbursement for the following long term care services: nursing home care, assisted living care, home health care and adult day care.
	LTC03I.001 Qualified	A long term care policy that meets the federal IRS requirements to qualify for a tax deduction.
	LTC03I.002 Non Qualified	A long term care policy that does not meet the federal IRS requirements to qualify for a tax deduction.
	LTC03I.004 Partnership	A long term care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC03I.003 Other	Not specifically described above.
LTC04G Group Long-Term Care – Nursing Home		A policy or rider that provides coverage only while a policyholder is confined to a nursing home and meets the policy requirements for coverage.
	LTC04G.001 Qualified	Nursing home policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC04G.002 Non Qualified	Nursing home policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC04G.004 Partnership	A nursing home policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC04G.003 Other	Not specifically described above.
LTC04I Individual Long-Term Care – Nursing Home		A policy or rider that provides coverage only while a policyholder is confined to a nursing home and meets the policy requirements for coverage.
	LTC04I.001 Qualified	Nursing home policies that would meet the federal IRS requirements to qualify for a tax deduction.

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	LTC04I.002 Non Qualified	Nursing home policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC04I.004 Partnership	A nursing home policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC04I.003 Other	Not specifically described above.
LTC05G Group Long-Term Care – Nursing Home & Home Health Care		A policy or rider that would includes coverage for both institutional nursing home and home health care.
	LTC05G.001 Qualified	Nursing home and home health care policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC05G.002 Non Qualified	Nursing home and home health care policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05G.004 Partnership	A nursing home and home health care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC05G.003 Other	Not specifically described above.
LTC05I Individual Long-Term Care – Nursing Home & Home Health Care		A policy or rider that would includes coverage for both institutional nursing home and home health care.
	LTC05I.001 Qualified	Nursing home and home health care policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC05I.002 Non Qualified	Nursing home and home health care policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05I.004 Partnership	A nursing home and home health care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC05I.003 Other	Not specifically described above.
LTC05.1G Group Assisted Living Care		A policy or rider that provides coverage only while a policyholder is confined to an assisted living facility and meets the policy requirements for coverage.
	LTC05.1G.001 Qualified	Assisted living policies that would meet the federal IRS requirements to qualify for a tax deduction.

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	LTC05.1G.002 Non Qualified	Assisted living policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.1G.004 Partnership	An assisted living care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC05.1G.003 Other	Not specifically described above.
LTC05.1I Individual Assisted Living Care		A policy or rider that provides coverage only while a policyholder is confined to an assisted living facility and meets the policy requirements for coverage.
	LTC05.1I.001 Qualified	Assisted living policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.1I.002 Non Qualified	Assisted living policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.1I.004 Partnership	An assisted living care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC05.1I.003 Other	Not specifically described above.
LTC05.2G Group Adult Day Care		A policy or rider that provides coverage only for adult day care for an individual who meets the policy requirements for coverage.
	LTC05.2G.001 Qualified	Adult day care policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.2G.002 Non Qualified	Adult day care policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.2G.004 Partnership	An adult day care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC05.2G.003 Other	Not specifically described above.
LTC05.2I Individual Adult Day Care		A policy or rider that provides coverage only for adult day care for an individual who meets the policy requirements for coverage.
	LTC05.2I.001 Qualified	Adult day care policies that would meet the federal IRS requirements to qualify for a tax deduction.

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	LTC05.2I.002 Non Qualified	Adult day care policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.2I.004 Partnership	An adult day care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
	LTC05.2I.003 Other	Not specifically described above.
LTC06 Long-Term Care – Other	LTC06.000 Long-Term Care – Other	Not specifically described above or a combination of two or more, but less than four products.
Multi-Line		Filings that may be submitted for both life and health insurance in one form such as an application.
ML01 Multi-Line – Assumption Agreement	ML01.000 Multi-Line – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company. For example, companies assuming both life and health lines.
ML02 Multi-Line – Other	ML02.000 Multi-Line – Other	Not specifically described above.
Medicare Supplement		Insurance coverage sold on an individual or group basis to help fill the "gaps" in the protections granted by the federal Medicare program. This is strictly supplemental coverage and cannot duplicate any benefits provided by Medicare. It is structured to pay part or all of Medicare's deductibles and co-payments. It may also cover some services and expenses not covered by Medicare. Also known as "Medigap" insurance.
MS01 Medicare Supplement – Assumption Agreement	MS01.000 Medicare Supplement – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
MS02G Group Medicare Supplement – Pre-Standardized	MS02G.000 Medicare Supplement – Pre-Standardized	A plan issued prior to required federal standardization of Medicare supplement policy forms and rates.
MS02I Individual Medicare Supplement – Pre-Standardized	MS02I.000 Medicare Supplement – Pre-Standardized	A plan issued prior to required federal standardization of Medicare supplement policy forms and rates.
MS03G Group Medicare Supplement – Medicare Advantage	MS03G.000 Medicare Supplement – Medicare Advantage	A contract between a Medicare beneficiary and an insurer that has contracted with the federal government to provide both Medicare and Medigap type services to beneficiaries.

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MS03I Individual Medicare Supplement – Medicare Advantage	MS03I.000 Medicare Supplement – Medicare Advantage	A contract between a Medicare beneficiary and an insurer that has contracted with the federal government to provide both Medicare and Medigap type services to beneficiaries.
MS04G Group Medicare Supplement – Medicare Select		A type of Medigap plan under which a policyholder generally must use specific hospitals and, in some cases, doctors to receive full Medigap benefits. **Effective 6/1/2010 no new policies may be issued. Refer to MS07G Group Medicare Supplement – Medicare Select 2010 to file policies for new plans.**
	MS04G.001 Plan A	Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance.
	MS04G.002 Plan B	Basic benefits plus Part A deductible.
	MS04G.003 Plan C	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, and also Foreign Travel Emergency.
	MS04G.004 Plan D	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also At-home Recovery.
	MS04G.005 Plan E	Basic benefits plus skilled nursing coinsurance, Part A deductible, preventative Care, and also Foreign Travel Emergency. Effective 6/1/2010 plan is eliminated.
	MS04G.006 Plan F (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and also Foreign Travel Emergency.
	MS04G.007 Plan F (High)	High deductible option.
	MS04G.008 Plan G	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾80%, At-home Recovery, Foreign Travel Emergency, and At-home Recovery.
	MS04G.009 Plan H	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS04G.010 Plan I	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾100%, Foreign Travel Emergency, At-home Recovery, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS04G.011 Plan J (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Extended Drugs, Part B Excess¾100%, Foreign Travel Emergency, Preventive Care, and also At-home Recovery. Effective 6/1/2010 plan is eliminated.

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	MS04G.012 Plan J (High)	High deductible option. Effective 6/1/2010 plan is eliminated.
	MS04G.013 Plan K	Basic Benefits plus 50% Skilled Nursing Facility Coinsurance, 50% Part A deductible
	MS04G.014 Plan L	Basic Benefits plus 75% Skilled Nursing Facility Coinsurance, 75% Part A deductible
	MS04G.015 Other	Not specifically described above.
	MS04G.016 Multi-Plan	A package filing containing more than one Select Group Medicare Supplement plan in the filing submission.
MS04I Individual Medicare Supplement – Medicare Select		A type of Medigap plan under which a policyholder generally must use specific hospitals and, in some cases, doctors to receive full Medigap benefits. Effective 6/1/2010 no new policies may be issued. Refer to MS07I Group Medicare Supplement – Medicare Select 2010 to file policies for new plans.
	MS04I.001 Plan A	Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance.
	MS04I.002 Plan B	Basic benefits plus Part A deductible.
	MS04I.003 Plan C	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, and also Foreign Travel Emergency.
	MS04I.004 Plan D	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also At-home Recovery.
	MS04I.005 Plan E	Basic benefits plus skilled nursing coinsurance, Part A deductible, preventative Care, and also Foreign Travel Emergency. Effective 6/1/2010 plan is eliminated.
	MS04I.006 Plan F (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and also Foreign Travel Emergency.
	MS04I.007 Plan F (High)	High deductible option.
	MS04I.008 Plan G	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾80%, At-home Recovery, Foreign Travel Emergency, and At-home Recovery.

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	MS04I.009 Plan H	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS04I.010 Plan I	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾100%, Foreign Travel Emergency, At-home Recovery, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS04I.011 Plan J (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Extended Drugs, Part B Excess¾100%, Foreign Travel Emergency, Preventive Care, and also At-home Recovery. Effective 6/1/2010 plan is eliminated.
	MS04I.012 Plan J (High)	High deductible option. Effective 6/1/2010 plan is eliminated.
	MS04I.013 Plan K	Basic Benefits plus 50% Skilled Nursing Facility Coinsurance, 50% Part A deductible
	MS04I.014 Plan L	Basic Benefits plus 75% Skilled Nursing Facility Coinsurance, 75% Part A deductible
	MS04I.015 Other	Not specifically described above.
	MS04I.016 Multi-Plan	A package filing containing more than one Select Individual Medicare Supplement plan in the filing submission.
MS05G Group Medicare Supplement – Standard Plans		A Medigap policy under which a policyholder may obtain services from any provider of care. Effective 6/1/2010 no new policies may be issued. Refer to MS08G Group Medicare Supplement – Standard Plans – 2010 to file policies for new plans.
	MS05G.001 Plan A	Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance.
	MS05G.002 Plan B	Basic benefits plus Part A deductible.
	MS05G.003 Plan C	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, and also Foreign Travel Emergency.
	MS05G.004 Plan D	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also At-home Recovery.

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	MS05G.005 Plan E	Basic benefits plus skilled nursing coinsurance, Part A deductible, Preventive Care, and also Foreign Travel Emergency. Effective 6/1/2010 plan is eliminated.
	MS05G.006 Plan F (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, & Foreign Travel Emergency.
	MS05G.007 Plan F (High)	High deductible option.
	MS05G.008 Plan G	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾80%; At-home Recovery, and also Foreign Travel Emergency.
	MS05G.009 Plan H	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS05G.010 Plan I	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾100%, Foreign Travel Emergency, At-home Recovery, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS05G.011 Plan J (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, Foreign Travel Emergency, Preventive Care, At-home Recovery, and also Extended Drugs. Effective 6/1/2010 plan is eliminated.
	MS05G.012 Plan J (High)	High deductible option. Effective 6/1/2010 plan is eliminated.
	MS05G.013 Plan K	Basic Benefits plus 50% Skilled Nursing Facility Coinsurance, 50% Part A deductible
	MS05G.014Plan L	Basic Benefits plus 75% Skilled Nursing Facility Coinsurance, 75% Part A deductible
	MS05G.015 Multi-Plan	A package filing containing more than one Standard Group Medicare Supplement plan in the filing submission.
MS05I Individual Medicare Supplement – Standard Plans		A Medigap policy under which a policyholder may obtain services from any provider of care. Effective 6/1/2010 no new policies may be issued. Refer to MS08I Individual Medicare Supplement – Standard Plans 2010 to file policies for new plans.

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	MS05I.001 Plan A	Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance.
	MS05I.002 Plan B	Basic benefits plus Part A deductible.
	MS05I.003 Plan C	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, and also Foreign Travel Emergency.
	MS05I.004 Plan D	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also At-home Recovery.
	MS05I.005 Plan E	Basic benefits plus skilled nursing coinsurance, Part A deductible, Preventive Care, and also Foreign Travel Emergency. Effective 6/1/2010 plan is eliminated.
	MS05I.006 Plan F (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, & Foreign Travel Emergency.
	MS05I.007 Plan F (High)	High deductible option.
	MS05I.008 Plan G	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾80%; At-home Recovery, and also Foreign Travel Emergency.
	MS05I.009 Plan H	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS05I.010 Plan I	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾100%, Foreign Travel Emergency, At-home Recovery, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS05I.011 Plan J (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, Foreign Travel Emergency, Preventive Care, At-home Recovery, and also Extended Drugs. Effective 6/1/2010 plan is eliminated.
	MS05I.012 Plan J (High)	High deductible option. Effective 6/1/2010 plan is eliminated.
	MS05I.013 Plan K	Basic Benefits plus 50% Skilled Nursing Facility Coinsurance, 50% Part A deductible

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	MS05I.014Plan L	Basic Benefits plus 75%, Skilled Nursing Facility Coinsurance 75% Part A deductible
	MS05I.015 Multi-Plan	A package filing containing more than one Standard Individual Medicare Supplement plan in the filing submission.
MS06 Medicare Supplement – Other	MS06.000 Medicare Supplement – Other	Not specifically described above.
MS07G Group Medicare Supplement – Medicare Select 2010		Product filings may be submitted prior to 6/1/2010; however plans are not effective until 6/1/2010. A type of Medigap plan under which a policyholder generally must use specific hospitals and, in some cases, doctors to receive full Medigap benefits.
	MS07G.001 Plan A 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.002 Plan B 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Part A deductible. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.003 Plan C 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.004 Plan D 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS07G.005 Plan F (Basic) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.006 Plan F (High) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. High deductible option. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.007 Plan G 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.008 Plan K 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic Benefits plus 50% Skilled Nursing coinsurance, 50% Part A deductible. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 50%, out of pocket [$4,620]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.009 Plan L 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic Benefits plus 75% Skilled Nursing coinsurance, 75% Part A deductible. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 75%, out of pocket [$2,310]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS07G.010 Plan M 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 50% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.011 Plan N 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 100% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new copay structure. The copay is (a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and (b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.012 Other 2010	Product filings may be submitted prior to 6/1/2010; however filing is not effective until 6/1/2010. Not specifically described above.
	MS07G.013 Multi-Plan 2010	A package filing containing more than one Select Group Medicare Supplement plan in the filing submission.
MS07I Individual Medicare Supplement – Medicare Select 2010		Product filings may be submitted prior to 6/1/2010; however plans are not effective until 6/1/2010. A type of Medigap plan under which a policyholder generally must use specific hospitals and, in some cases, doctors to receive full Medigap benefits.
	MS07I.001 Plan A 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.002 Plan B 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Part A deductible. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS07I.003 Plan C 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.004 Plan D 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.005 Plan F (Basic) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.006 Plan F (High) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. High deductible option. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.007 Plan G 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B Excess ¾ 100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.008 Plan K 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic Benefits plus 50% Skilled Nursing coinsurance, 50% Part A deductible. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 50%, out of pocket [$4,620]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS07I.009 Plan L 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic Benefits plus 75% Skilled Nursing coinsurance, 75% Part A deductible. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 75%, out of pocket [$2,310]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.010 Plan M 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 50% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.011 Plan N 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 100% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new copay structure. The copay is (a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and (b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.012 Other 2010	Product filings may be submitted prior to 6/1/2010; however filing is not effective until 6/1/2010. Not specifically described above.
	MS07I.013 Multi-Plan 2010	A package filing containing more than one Select Individual Medicare Supplement plan in the filing submission.
MS08G Group Medicare Supplement – Standard Plans 2010		Product filings may be submitted prior to 6/1/2010; however plans are not effective until 6/1/2010. A Medigap policy under which a policyholder may obtain services from any provider of care.

	MS08G.001 Plan A 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.002 Plan B 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Part A deductible. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.003 Plan C 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.004 Plan D 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.005 Plan F (Basic) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.006 Plan F (High) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. High deductible option. Includes hospice care cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS08G.007 Plan G 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.008 Plan K 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 50%, 50% Skilled Nursing coinsurance, 50% Part A deductible, subject to out of pocket [$4,620]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.009 Plan L 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 75%, 75% Skilled Nursing coinsurance, 75% Part A deductible, out of pocket [$2,310]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.010 Plan M 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 50% coverage of the Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS08G.011 Plan N 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 100% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new copay structure. The copay is (a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and (b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.012 Multi-Plan 2010	A package filing containing more than one Standard Group Medicare Supplement plan in the filing submission.
MS08I Individual Medicare Supplement – Standard Plans 2010		Product filings may be submitted prior to 6/1/2010; however plans are not effective until 6/1/2010. A Medigap policy under which a policyholder may obtain services from any provider of care.
	MS08I.001 Plan A 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

	MS08I.002 Plan B 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Part A deductible. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.003 Plan C 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.004 Plan D 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.005 Plan F (Basic) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.006 Plan F (High) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. High deductible option. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.007 Plan G 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS08I.008 Plan K 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 50%, 50% Skilled Nursing coinsurance, 50% Part A deductible, out of pocket [$4,620]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.009 Plan L 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 75%, 75% Skilled Nursing coinsurance, 75% Part A deductible, out of pocket [$2,310]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.010 Plan M 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 50% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.011 Plan N 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 100% Part A deductible, Skilled Nursing facility care, and Foreign Travel Emergency. In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new copay structure. The copay is the lesser of (a) twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and (b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.012 Multi-Plan 2010	A package filing containing more than one Standard Individual Medicare Supplement plan in the filing submission.
MS09 Medicare Supplement – Other 2010	MS09.000 Medicare Supplement Other 2010	Not specifically described above.

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Life Settlements		
LS01 Life Settlements	LS01.000 Life Settlements	A contract or agreement in which a policyholder agrees to sell or transfer ownership in all or part of a life insurance policy to a third party for compensation that is less than the expected death benefit of a policy.
Network Access		
NA01 Network Access Provider Contract		An arrangement whereby a carrier and provider guarantee access to the provider to receive covered services at in-network cost share without being balanced billed.
	NA01.000 Network Access Provider Contract	A written contract between a carrier and a provider for any health care service rendered to an enrollee.
	NA01.001 Provider Contract Addendum	A contract form attached to a provider contract that adds, deletes, or changes the terms of the core contract.
	NA01.002 Provider Directory	The master list of participating providers who are contracted with a carrier to deliver services to enrollees.
	NA01.003 Provider Leasing Agreement	A written contract between a carrier and a intermediary that has agreed to provide access to providers under contractual obligation to the intermediary to render covered services to enrollees of the contracting carrier.
	NA01.004 Other	Not specifically described above.
Viatical Settlements		
VS01 Viatical Settlements	VS01.000 Viatical Settlements	Contracts or agreements in which a buyer agrees to purchase all or a part of a life insurance policy.

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Uniform Life, Accident & Health, Annuity and Credit Product Coding Matrix

FOR USE WITH THE UNIFORM LIFE, ACCIDENT & HEALTH, ANNUITY CREDIT TRANSMITTAL DOCUMENT: Item 8, Type of Insurance, on the Uniform Life, Accident & Health, Annuity, Credit Transmittal Document is completed by listing all appropriate Filing Codes from this matrix. Please read the descriptions carefully as the policy reviewers will be looking at these filing codes when deciding what review standards/checklists are appropriate for this filing.

TOI	Sub-TOI	Description
Annuities		An arrangement whereby an annuitant is guaranteed to receive a series of payments commencing either immediately or at some future date.
A01 Annuities – Assumption Agreement	A01.000 Annuities – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
A02G Group Annuities – Deferred Non-variable		An annuity contract that provides an accumulation based on funds that accumulate based on a guaranteed crediting interest rate or additional interest rate. This annuity contract provides for the initiation of payments at some designated future date.
	A02G.001 Fixed Premium	An annuity where premium payments are fixed.
	A02G.002 Flexible Premium	The premium payments are flexible.
	A02G.003 Single Premium	Purchase by the payment of one lump sum.
	A02G.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A02G.005 Limited Flexible Premium	The premium payments are specified for a designated time frame, i.e. 5 years.
A02I Individual Annuities- Deferred Non-Variable		An annuity contract that provides an accumulation based on funds that accumulate based on a guaranteed crediting interest rate or additional interest rate. This annuity contract provides for the initiation of payments at some designated future date.
	A02I.001 Fixed Premium	An annuity where premium payments are fixed.
	A02I.002 Flexible Premium	The premium payments are flexible.
	A02I.003 Single Premium	Purchase by the payment of one lump sum.
	A02I.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A021.005 Limited Flexible Premium	The premium payment are specified for a designated time frame, i.e. 5 years.

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A02.1G Group Annuities – Deferred Non-Variable and Variable		An annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some designated future date.
	A02.1G.001 Fixed Premium	An annuity where premium payments are fixed.
	A02.1G.002 Flexible Premium	The premium payments are flexible.
	A02.1G.003 Single Premium	Purchase by the payment of one lump sum.
	A02.1G.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A02.1G.005 Limited Flexible Premium	The premium payments are specified for a designated time frame, i.e. 5 years.
A02.1I Individual Annuities- Deferred Non-Variable and Variable		An annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some designated future date.
	A02.1I.001 Fixed Premium	An annuity where premium payments are fixed.
	A02.1I.002 Flexible Premium	The premium payments are flexible.
	A02.1I.003 Single Premium	Purchase by the payment of one lump sum.
	A02.1I.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A02.1I.005 Limited Flexible Premium	The premium payments are specified for a designated time frame, i.e. 5 years.
A03G Group Annuities – Deferred Variable		An annuity contract that provides an accumulation based fund where the accumulation varies in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. Must include at least one option to have the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder and may include at least one option to have the series of payments vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. This annuity contract provides for the initiation of payments at some designated future date.
	A03G.001 Fixed Premium	An annuity where premium payments are fixed.

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	A03G.002 Flexible Premium	Premium payments are flexible.
	A03G.003 Single Premium	Purchase by the payment of one lump sum.
	A03G.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A03G.005 Limited Flexible Premium	The premium payment are specified for a designated time frame, i.e. 5 years.
A03I Individual Annuities – Deferred Variable		An annuity contract that provides an accumulation based fund where the accumulation varies in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. Must include at least one option to have the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder and may include at least one option to have the series of payments vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. This annuity contract provides for the initiation of payments at some designated future date.
	A03I.001 Fixed Premium	An annuity where premium payments are fixed.
	A03I.002 Flexible Premium	Premium payments are flexible.
	A03I.003 Single Premium	Purchase by the payment of one lump sum.
	A03I.004 Modified Single Premium	Purchased by payment of a lump sum and additional payments during the first 12 months.
	A03I.005 Limited Flexible Premium	The premium payment are specified for a designated time frame, i.e. 5 years.
A05G Group Annuities – Immediate Non-variable	A05G.000 Annuities – Immediate Non-variable	An annuity contract that provides for the fixed payment of the annuity at the end of the first interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months.
A05I Individual Annuities- Immediate Non-Variable	A05I.000 Annuities – Immediate Non-variable	An annuity contract that provides for the fixed payment of the annuity at the end of the first interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months.
A06G Group Annuities – Immediate Variable	A06G.000 Annuities – Immediate Variable	An annuity contract that provides for the first payment of the annuity at the end of the fixed interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months. The amount varies with the value of equities (separate account) purchased as investments by the insurance companies.

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A06I Individual Annuities – Immediate Variable	A06I.000 Annuities – Immediate Variable	An annuity contract that provides for the first payment of the annuity at the end of the fixed interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months. The amount varies with the value of equities (separate account) purchased as investments by the insurance companies.
A06.1G Group Annuities – Immediate Non-Variable and Variable	A06.1G.000 Annuities – Immediate Non-Variable and Variable	An annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some interval that may vary, however the annuity payouts must begin within 13 months
A06.1I Individual Annuities- Immediate Non Variable and Variable	A06.1I.000 Annuities – Immediate Variable and Non-Variable	An annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some interval that may vary, however the annuity payouts must begin within 13 months.
A07G Group Annuities – Special		Contracts with certain noteworthy attributes.
	A07G.001 Equity Indexed	A fixed annuity that earns interest or provides benefits that are linked to an external reference or equity index, subject to a minimum guarantee.
	A07G.002 Modified Guaranteed	An annuity that contains a provision that adjusts the value of withdrawn funds based on a formula in the contract. The formula reflects market value adjustments.
	A07G.003 Contingent Deferred	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.
A07I Individual Annuities – Special		Contracts with certain noteworthy attributes.
	A07I.001 Equity Indexed	A fixed annuity that earns interest or provides benefits that are linked to an external reference or equity index, subject to a minimum guarantee.

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	A07I.002 Modified Guaranteed	An annuity that contains a provision that adjusts the value of withdrawn funds based on a formula in the contract. The formula reflects market value adjustments.
	A07I.003 Contingent Deferred	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.
A08G Group Annuities – Unallocated		Annuity contracts or portions thereof where the Insurer purchases an annuity for the retirees.
	A08G.001 Funding Agreement	Contracts that guarantee principal and interest for a specified period of time and do not include the option to purchase immediate annuities that depend on the survival of the annuitant.
	A08G.002 GIC	Contracts that guarantee principal and interest for a specified period of time and include the option to purchase immediate annuities that depend on the survival of the annuitant.
	A08G.003 Deposit Administration	Annuity contracts that typically provide for an unallocated fund accumulation for active lives out of which immediate annuities are purchased for individuals at retirement and deferred annuities are purchased for terminated employees with vested benefits.
A10 Annuities – Other	A10.000 Annuities – Other	Not specifically described above.
A11 Reversionary Annuity	A11.000 Reversionary Annuity	A policy that combines an insurance policy with an immediate annuity to provide for a surviving spouse. Upon the insured's death, the beneficiary receives a guaranteed lifetime income instead of a lump sum payment.
Continuing Care Retirement Communities		
CC01G Group Continuing Care Retirement Communities		Continuing Care Retirement Communities are senior housing arrangements that in addition to housing include some provision for skilled nursing care.
	CC01G.000 CCRC – Type A	Type A communities are also referred to as Life Care Communities. There is no increase in the required monthly fee when the resident enters the skilled nursing facility.
	CC02G.000 CCRC – Type B	Type B communities are those that don't meet the definition of Type A or Type C. They may involve some combination of full skilled nursing home benefits, but only for a limited period of time and/or an increase in the monthly fee when the resident enters the skilled nursing facility but not up to full market rates.

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	CC03G.000 CCRC – Type C	Type C communities guarantee access to a skilled nursing home bed but the residents pays the full market rate.
	CC04G.000 CCRC – Other	Not specifically described above.
CC01I Individual Continuing Care Retirement Communities	CC01I.000 CCRC – Type A	Type A communities are also referred to as Life Care Communities. There is no increase in the required monthly fee when the resident enters the skilled nursing facility.
	CC02I.000 CCRC – Type B	Type B communities are those that don't meet the definition of Type A or Type C. They may involve some combination of full skilled nursing home benefits, but only for a limited period of time and/or an increase in the monthly fee when the resident enters the skilled nursing facility but not up to full market rates.
	CC03I.000 CCRC – Type C	Type C communities guarantee access to a skilled nursing home bed but the residents pays the full market rate.
	CC04I.000 CCRC – Other	Not specifically described above.
Credit		Coverage on a debtor in favor of a creditor to pay off or reduce the balance due on a loan/credit transaction in the event of a covered loss.
CR01 Credit – Assumption Agreement	CR01.000 Credit – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
CR02G Group Credit – Credit Disability		Makes monthly loan/credit transaction payments to the creditor upon the disablement of an insured debtor.
	CR02G.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.

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	CR02G.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR02G.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
	CR02G.004 Full Term	Coverage for the entire term of the loan/credit transaction.
	CR02G.005 Critical Period	Disability benefits are limited to a specific number of months or for the remaining term of the loan/credit transaction, if less.
	CR02G.006 Truncated	Coverage for a term less than the term of the loan/credit transaction.
	CR02G.007 Other	Not specifically described above.
CR02I Individual Credit – Credit Disability		Makes monthly loan/credit transaction payments to the creditor upon the disablement of an insured debtor.
	CR02I.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR02I.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR02I.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
	CR02I.004 Full Term	Coverage for the entire term of the loan/credit transaction.
	CR02I.005 Critical Period	Disability benefits are limited to a specific number of months or for the remaining term of the loan/credit transaction, if less.

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	CR02I.006 Truncated	Coverage for a term less than the term of the loan/credit transaction.
	CR02I.007 Other	Not specifically described above.
CR03G Group Credit – FMLA		Makes loan/credit transaction payments to the creditor when the debtor is on unpaid leave from his/her job under the Family and Medical Leave Act (FMLA)
	CR03G.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR03G.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR03G.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
CR03I Individual Credit -FMLA		Makes loan/credit transaction payments to the creditor when the debtor is on unpaid leave from his/her job under the Family and Medical Leave Act (FMLA)
	CR03I.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.

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	CR03I.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR03I.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
CR04G Group Credit – Life		Contracts sold in connection with loan/credit transactions or other credit transactions, which do not exceed a stated duration and/or amount and provide insurance protection against death.
	CR04G.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR04G.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR04G.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
	CR04G.004 Gross	Coverage for the total amount payable on the loan/credit transaction (the net indebtedness plus the scheduled interest charges).
	CR04G.005 Net	Coverage for the scheduled or actual unpaid principal amount of the loan/credit transaction.
	CR04G.006 Truncated	Coverage for a term less than the term of the loan/credit transaction.
CR04I Individual Credit – Life		Contracts sold in connection with loan/credit transactions or other credit transactions, which do not exceed a stated duration and/or amount and provide insurance protection against death.

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	CR04I.001 Monthly Premium – Open-End	A fixed rate is applied each month to the declining outstanding balance owed on an open-end loan/credit transaction or revolving charge account (i. e. the loan/credit transaction does not have a fixed termination date). Actual premium amounts decline along with the declining outstanding balance from month to month. Premium charges track accordingly. The outstanding balance may increase from time to time when an additional advance is taken on a line of credit or additional credit card charges are made by the insured; monthly premium charges will track accordingly. The debtor is charged monthly for coverage on a loan/credit transaction that allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR04I.002 Monthly Premium – Closed-End	A fixed rate is applied each month to the declining outstanding balance owed on a closed-end loan/credit transaction (i.e. the loan/credit transaction has a fixed termination date). Premium amounts are determined based on the declining outstanding balance. Premiums can be charged on a declining monthly basis or level monthly basis. The debtor is charged monthly for coverage on a loan/credit transaction that does not allows for the debtor (subject to credit limits) to increase the indebtedness upon demand.
	CR04I.003 Single Premium	The debtor is charged by a single premium for this insurance protection.
	CR04I.004 Gross	Coverage for the total amount payable on the loan/credit transaction (the net indebtedness plus the scheduled interest charges).
	CR04I.005 Net	Coverage for the scheduled or actual unpaid principal amount of the loan/credit transaction.
	CR04I.006 Truncated	Coverage for a term less than the term of the loan/credit transaction.
CR05 Credit – Property		This section is for use where credit personal property is handled by the life and/or health section of the state insurance department. Under CR05.002 through CR05.004 credit insurance may be either "single interest" or "dual interest". Single interest means insurance that protects only the creditor's interest in the collateral securing a debtor's credit transaction. Dual interest (also commonly referred to as "limited dual interest") means insurance that protects the creditor's and the debtor's interest in the collateral securing the debtor's credit transaction.
	CR05.002 Creditor-Placed Home	Single interest or dual interest credit insurance purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss to property that would either impair a creditor's interest or adversely affect the value of collateral on homes, mobile homes, and other real estate.

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	CR05.003 Creditor-Placed Auto	Single interest or dual interest credit insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss to property that would either impair a creditor's interest or adversely affect the value of collateral on automobiles, boats, or other vehicles.
	CR05.004 Personal Property	Single interest or dual interest credit insurance (where collateral is not a motor vehicle, mobile home, or real estate) that covers perils to goods purchased or used as collateral and that concerns a creditor's interest in the purchased goods or pledged collateral either in whole or in part; or covers perils to goods purchased in connection with an open-end credit transaction.
	CR05.005 Credit Family Leave	Credit insurance that provides a monthly or lump sum benefit during an unpaid leave of absence from employment resulting from specified causes, such as illness of a close relative, adoption or birth of a child.
	CR05.006 Personal Gap Insurance	Credit insurance that insures the excess of the outstanding indebtedness over the primary property insurance benefits in the event of a total loss to a collateral asset.
	CR05.007 Other	Not specifically described above.
CR06 Credit – Involuntary Unemployment		This section is for use where credit unemployment is handled by the life and/or health section of the state insurance department. This coverage makes loan/credit transaction payments to the creditor when the debtor becomes involuntarily unemployed.
	CR06.001 Monthly Premium – Open-End	"Open-end credit" means credit extended by a creditor by an agreement that is a line of credit loan/credit transaction, a revolving charge plan, or any other open-end self-replenishing credit arrangement between the creditor and a customer that may be drawn upon from time to time by the customer without renegotiating the lending agreement. The customer may repay the full outstanding balance at any time, or a specified minimum portion of the indebtedness.
	CR06.002 Monthly Premium – Closed-End	"Closed-end credit" means a credit agreement on which payments are due in equal monthly installments for a fixed term.
	CR06.003 Single Premium	"Single premium" means the purchase of insurance by the payment of one lump sum on the date coverage begins.
CR07 Credit – Other	CR07.000 Credit – Other	Not specifically described above.

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Health		Accident & health contracts provide benefits for losses resulting from accident, sickness or medical condition.
H01 Health – Assumption Agreement	H01.000 Health – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
H02G Group Health – Accident Only	H02G.000 Health – Accident Only	An insurance contract that provides 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 accident.
H02I Individual Health – Accident Only	H02I.000 Health – Accident Only	An insurance contract that provides 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 accident.
H03G Group Health – Accidental Death & Dismemberment	H03G.000 Health – Accidental Death & Dismemberment	An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.
H03I Individual Health – Accidental Death & Dismemberment	H03I.000 Health – Accidental Death & Dismemberment	An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.
H04 Health – Blanket Accident/Sickness	H04.000 Health – Blanket Accident/Sickness	A health insurance contract that covers all of a class of persons not individually identified in the contract.
	H04.001 Student	A health insurance contract that covers a class of students not individually identified in the contract. If student health insurance is contemplated under the ACA use the TOI of H22 Student Health Insurance.
	H04.002 Health - Blanket Sickness Only	A health insurance contact that covers sickness only of a class of persons not individually identified in the contract.
	H04.003 Health - Blanket Accident Only	A health insurance contract that covers accident only of a class of persons not individually identified in the contract.
H05 Health – Champus/Tricare Supplement	H05.000 Health – Champus/Tricare Supplement	Civilian Health and Medical Program of the Uniformed Services (Champus). A private health plan that provides beneficiaries eligible for Champus with supplemental health care coverage.
H06 Health – Conversion	H06.000 Health – Conversion	Guarantees an insured whose coverage is ending for specified reasons a right to purchase a policy without presenting evidence of insurability.
H07G Group Health – Specified Disease – Limited Benefit		Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum.
	H07G.001 Critical Illness	Benefits can be paid as expense incurred, per diem, or as a principle sum.
	H07G.002 Dread Disease	Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid on as expense incurred, per diem, or a principle sum.

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	H07G.002A Dread Disease – Cancer Only	Provides benefits for losses resulting from cancer and its associated diagnosis and treatments. Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum.
	H07G.003 HIV Indemnity	Provides benefits for losses resulting from occupational exposure and infection of the Human Immunodeficiency Virus. Benefits often include some form of occupational income replacement. Benefits can be paid as expense incurred, per diem, or a principle sum.
H07I Individual Health – Specified Disease – Limited Benefit		Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum.
	H07I.001 Critical Illness	Benefits can be paid as expense incurred, per diem, or as a principle sum.
	H07I.002 Dread Disease	Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid on as expense incurred, per diem, or a principle sum.
	H07I.002A Dread Disease – Cancer Only	Provides benefits for losses resulting from cancer and its associated diagnosis and treatments. Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum.
	H07I.003 HIV Indemnity	Provides benefits for losses resulting from occupational exposure and infection of the Human Immunodeficiency Virus. Benefits often include some form of occupational income replacement. Benefits can be paid as expense incurred, per diem, or a principle sum.
H08G Group Health – Intensive Care – Limited Benefit	H08G.000 Health – Intensive Care – Limited Benefit	Provides a daily benefit for confinement in a qualified intensive care unit of a certified hospital. Benefits are specific to services delivered by the staff of a hospital intensive care unit. Benefits not to exceed a stated dollar amount per day.
H08I Individual Health – Intensive Care – Limited Benefit	H08I.000 Health – Intensive Care – Limited Benefit	Provides a daily benefit for confinement in a qualified intensive care unit of a certified hospital. Benefits are specific to services delivered by the staff of a hospital intensive care unit. Benefits not to exceed a stated dollar amount per day.
H09G Group Health – Organ & Tissue Transplant – Limited Benefit	H09G.000 Health – Organ & Tissue Transplant – Limited Benefit	Provides benefits for services incurred as a result of human and/or non-human organ transplant. Benefits are specific to the delivery of care associated with the covered organ or tissue transplant. Benefits not to exceed a stated dollar amount per day.

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H09I Individual Health – Organ & Tissue Transplant – Limited Benefit	H09I.000 Health – Organ & Tissue Transplant – Limited Benefit	Provides benefits for services incurred as a result of human and/or non-human organ transplant. Benefits are specific to the delivery of care associated with the covered organ or tissue transplant. Benefits not to exceed a stated dollar amount per day.
H10G Group Health – Dental	H10G.000 Health – Dental	Insurance that provides benefits for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.
	H10G.001 Health - Pediatric Dental	Pediatric dental as contemplated under the ACA.
H10I Individual Health – Dental	H10I.000 Health – Dental	Insurance that provides benefits for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.
	H10I.001 Health - Pediatric Dental	Pediatric dental as contemplated under the ACA.
H11G Group Health – Disability Income		A policy designed to compensate insured individuals for a portion of the income they lose because of a disabling injury or illness.
	H11G.001 Business Overhead Expense	A policy designed to compensate insured individuals by paying a benefit to replace income/revenue lost because of a disabling injury or sickness where the lost income/revenue paid business overhead expenses.
	H11G.002 Short Term	Disability income insurance that provides a benefit for a short disability. Group short-term disability usually specifies a maximum benefit period of less than one year.
	H11G.003 Long-Term	The group disability maximum benefit period commonly extends to retirement or age 70.Group long-term disability usually specifies a maximum benefit period of at least one year.
	H11G.004 Other	Not specifically described above.
	H11G.005 Combined Short Term and Long-Term	Disability income insurance that provides a benefit for both short term and long term disability.
H11I Individual Health – Disability Income		A policy designed to compensate insured individuals for a portion of the income they lose because of a disabling injury or illness.
	H11I.001 Business Overhead Expense —Unrelated to marketing with employer or association groups	A policy designed to compensate insured individuals by paying a benefit to replace income/revenue lost because of a disabling injury or illness where the lost income/revenue paid business overhead expenses.
	H11I.002 Short Term—Unrelated to marketing with employer or association groups	Disability income insurance that provides a benefit for a short disability. Individual short-term disability insurance features a maximum benefit period of from six months to 5 years.

	H11I.003 Long-Term—Unrelated to marketing with employer or association groups	In individual long term disability income insurance, the maximum benefit period is always greater than 5 years, commonly extending to age 65 or for the insured's lifetime.
	H11I.004 Other	Not specifically described in other H11I categories.
	H11I.005 Business Overhead Expense —Related to marketing with employer or association groups	A policy designed to compensate insured individuals by paying a benefit to replace income/revenue lost because of a disabling injury or illness where the lost income/revenue paid business overhead expenses. The coverage is issued based upon some type of employer or association involvement.
	H11I.006 Short Term—Related to marketing with employer or association groups	Disability income insurance that provides a benefit for a short disability. Individual short-term disability insurance features a maximum benefit period of from six months to 5 years. The coverage is issued based upon some type of employer or association involvement.
	H11I.007 Long-Term—Related to marketing with employer or association groups	In individual long term disability income insurance, the maximum benefit period is always greater than 5 years, commonly extending to age 65 or for the insured's lifetime. The coverage is issued based upon some type of employer or association involvement.
	H11I.008 Combined Short Term and Long-Term—Unrelated to marketing with employer or association groups	Individual disability income insurance that provides for a maximum benefit period as short as six months up to the insured's lifetime, depending on the option chosen by the insured, but all maximum benefit periods are offered through the same policy.
	H11I.009 Combined Short Term and Long-Term—Related to marketing with employer or association groups	Individual disability income insurance that provides for a maximum benefit period as short as six months up to the insured's lifetime, depending on the option chosen by the insured, but all maximum benefit periods are offered through the same policy. The coverage is issued based upon some type of employer or association involvement.
H12 Health – Excess/Stop Loss		This type of insurance may be extended to either a health plan or a self-insured employer plan. Its purpose is to insure against the risk that any one claim will exceed a specific dollar amount or that an entire plan's losses will exceed a specific amount.
	H12.001 Accident & Sickness	Accident is a form of insurance against loss from an unforeseen mishap that results in bodily injury to the insured. Sickness refers to those insurance contracts that guard against losses associated with the illness and disease of the insured.

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	H12.002 Managed Care	A system of health care delivery where the primary goal is to deliver value by giving people access to high quality, cost-effective health care through monitoring and recommending utilization of services, and overseeing costs of services.
	H12.003 Provider	Any individual or group of individuals that provides a health care services. A provider may be, but is not limited to, a physician, hospital, group medical practice, nurse, nursing home or a pharmacy.
	H12.004 Self-Funded Health Plan	An insurance contract that covers an employer's exposure to losses incurred under a self-funded health plan.
H13G Group Health – Short Term Care		Coverage that provides medical and other services to insured's who need constant care in their own home or in a nursing facility for periods of less than one year.
	H13G.001 Home Health Care	Coverage that provides medical and non--medical services provided to ill, disabled or infirm persons in their residences.
	H13G.002 Nursing Home	Coverage provided in a facility setting for health related services for the purpose of supporting frail, impaired elderly or other disabled adults who require continued care and attention.
	H13G.003 Adult Day Care	Coverage provided for individuals of social and health related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who benefit from care in a group setting outside the home.
H13I Individual Health – Short Term Care		Coverage that provides medical and other services to insured's who need constant care in their own home or in a nursing facility for periods of less than one year.
	H13I.001 Home Health Care	Coverage that provides medical and non--medical services provided to ill, disabled or infirm persons in their residences.
	H13I.002 Nursing Home	Coverage provided in a facility setting for health related services for the purpose of supporting frail, impaired elderly or other disabled adults who require continued care and attention.
	H13I.003 Adult Day Care	Coverage provided for individuals of social and health related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who benefit from care in a group setting outside the home.

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H14G Group Health – Hospital Indemnity	H14G.000 Health – Hospital Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred for each day the covered person is confined to the hospital as a result of injury, sickness, and/or medical condition. If other than hospital indemnity, use the TOI of H23G Group Indemnity Other than Hospital.
H14I Individual Health – Hospital Indemnity	H14I.000 Health – Hospital Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred for each day the covered person is confined to the hospital as a result of injury, sickness, and/or medical condition. If other than hospital indemnity, use the TOI of H23I Individual Indemnity Other than Hospital.
H15G Group Health – Hospital/Surgical/Medical Expense		An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition.
	H15G.001 Any Size Group	A hospital/surgical/medical expense contract that may be issued to any size group.
	H15G.002 Large Group Only	A hospital/surgical/medical expense contract that may be issued only to “large groups” as that term is defined in the state in which the contract will be delivered.
	H15G.003 Small Group Only	A hospital/surgical/medical expense contract that may be issued only to “small groups” as that term is defined in the state in which the contract will be delivered.
	H15G.004 Short Term	Short term limited duration medical plans that are not required to comply with all state or federal mandates for health benefits. Prior to January 1, 2019, these plans were reported under H16G.004 Short Term.
H15I Individual Health – Hospital/Surgical/Medical Expense	H15I.001 Health – Hospital/Surgical/Medical Expense	An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition.
	H15I.002 Short Term	Short term limited duration medical plans that are not required to comply with all state or federal mandates for health benefits. Prior to January 1, 2019, these plans were reported under H16I.004 Short Term.
H16G Group Health – Major Medical		A hospital/surgical/medical expense contract that provides comprehensive benefits as defined in the state in which the contract will be delivered.
	H16G.001A Any Size Group – PPO	A major medical contract that may be issued to any size group. A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.

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	H16G.001B Any Size Group – POS	A major medical contract that may be issued to any size group. A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	H16G.001C Any Size Group – Other	A major medical contract that may be issued to any size group. Not specifically described above.
	H16G.001D Any Size Group – EPO	A major medical contract that may be issued to any size group. A plan that requires enrollees to use plan providers.
	H16G.002A Large Group Only – PPO	A major medical contract that may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	H16G.002B Large Group Only – POS	A major medical contract that may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	H16G.002C Large Group Only – Other	A major medical contract that may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. Not specifically described above.
	H16G.002D Large Group Only – EPO	A major medical contract that may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. A plan that requires enrollees to use plan providers.
	H16G.003A Small Group Only – PPO	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	H16G.003B Small Group Only – PPO Basic	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A basic plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.

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	H16G.003C Small Group Only – PPO Standard	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A standard plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	H16G.003D Small Group Only – POS	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A combination of traditional indemnity heath insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	H16G.003E Small Group Only – POS Basic	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. One of the benefit plans that must be offered in most states in the small group market. The specifications vary from state to state but the basic plan generally has lower benefits than the other state mandated plan: the standard benefit plan.
	H16G.003F Small Group Only – POS Standard	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. One of the benefit plans that must be offered in most states in the small group market. The specifications vary from state to state but the standard plan generally has higher benefits than the other state mandated plan: the basic benefit plan.
	H16G.003G Small Group Only – Other	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. Not specifically described above.
	H16G.003H Small Group Only – EPO	A major medical contract that may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A plan that requires enrollees to use plan providers.
	H16G.004 Short Term	A major medical policy or plan designed to provide coverage during a "gap" in coverage. Short term policies generally have pre-existing condition exclusions and are not renewable. Effective January 1, 2019, this product should be filed under H15G.004 Short Term.
H16I Individual Health – Major Medical		A major medical contract that may be issued only to "individuals" as that term is defined in the state in which the contract will be delivered.

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	H16I.004 Short Term	A major medical policy or plan designed to provide coverage during a "gap" in coverage. Short term policies generally have pre-existing condition exclusions and are not renewable. Effective January 1, 2019, this product should be filed under H15I.004 Short Term.
	H16I.005A Individual – Preferred Provider (PPO)	A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	H16I.005B Individual – Point-of-Service (POS)	A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	H16I.005C Individual – Other	Not specifically described above.
	H16I.005D Individual – EPO	A plan that requires enrollees to use plan providers.
H17G Group Health – Prescription Drug	H17G.000 Health – Prescription Drug	Prescription drug plan that covers the cost of drugs (except those dispensed in a hospital or in an extended care facility) that are required by either state or federal law to be dispensed by prescription. Drugs for which prescriptions are not required by law may be covered.
H17I Individual Health – Prescription Drug	H17I.000 Health – Prescription Drug	Prescription drug plan that covers the cost of drugs (except those dispensed in a hospital or in an extended care facility) that are required by either state or federal law to be dispensed by prescription. Drugs for which prescriptions are not required by law may be covered.
H18G Group Health – Sickness	H18G.000 Health – Sickness	Limited benefit expense policies. Provides benefits for sickness only. Benefits not to exceed a stated dollar amount per day.
H18I Individual Health – Sickness	H18I.000 Health – Sickness	Limited benefit expense policies. Provides benefits for sickness only. Benefits not to exceed a stated dollar amount per day.
H19G Group Health – Travel	H19G.000 Health – Travel	Limited benefit expense policies. Provides benefits for loss incurred while traveling generally outside a 100-mile radius of the US borders. *May extend to domestic as well as foreign travel. May provide both sickness and injury benefits. May include loss of baggage benefits. May include air transportation services for emergencies. Benefits not to exceed a stated dollar amount per day, per month or trip duration. (*Subject to applicable state limitations.)
H19I Individual Health – Travel	H19I.000 Health – Travel	Limited benefit expense policies. Provides benefits for loss incurred while traveling generally outside a 100-mile radius of the US borders. *May extend to domestic as well as foreign travel. May provide both sickness and injury benefits. May include loss of baggage benefits. May include air transportation services for emergencies. Benefits not to exceed a stated dollar amount per day, per month or trip duration. (*Subject to applicable state limitations.)

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H20G Group Health – Vision	H20G.000 Health – Vision	Limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.
H20I Individual Health – Vision	H20I.000 Health – Vision	Limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.
H21 Health – Other	H21.000 Health – Other	Not specifically described above.
H22 Student Health Insurance	H22.000 Student Health Insurance	A health insurance contract that covers a class of students as contemplated under ACA.
H23G Group Health - Indemnity Other than Hospital		An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition. If hospital indemnity, use the TOI of H14G Group Health – Hospital Indemnity.
	H23G.000Accident Only Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of an accident only.
	H23G.001 Sickness Only Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of sickness only.
	H23G.002 Accident/Sickness Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of an accident or sickness only.
	H23G.003 Other Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition, not specifically described above.
H23I Individual Health - Indemnity Other than Hospital		An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition. If hospital indemnity, use the TOI of H14I Individual Health – Hospital Indemnity.
	H23I.000Accident Only Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of an accident only.
	H23I.001 Sickness Only Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of sickness only.
	H23I.002 Accident/Sickness Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of an accident or sickness only.

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	H23I.003 Other Indemnity	An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition, not specifically described above.
H24G Group Health – Limited Wraparound Coverage		Coverage designed/intended to comply with federal regulations defining excepted limited wraparound coverage such as 45 CFR 146.145, or as permitted by the state.
	H24G.001 Any Size Group	Coverage designed/intended to comply with federal regulations defining excepted limited wraparound coverage such as 45 CFR 146.145, or as permitted by the state that may be issued to any size group.
	H24G.002 Large Group Only	Coverage designed/intended to comply with federal regulations defining excepted limited wraparound coverage such as 45 CFR 146.145, or as permitted by the state that may be issued to “large groups” as that term is defined in the state in which the contract will be delivered.
	H24G.003 Small Group Only	Coverage designed/intended to comply with federal regulations defining excepted limited wraparound coverage such as 45 CFR 146.145, or as permitted by the state that may be issued to “small groups” as that term is defined in the state in which the contract will be delivered.
H24I Individual Health - Limited Wraparound Coverage	H24I.000 Individual Health - Limited Wraparound Coverage	Coverage designed/intended to comply with federal regulations defining excepted limited wraparound coverage such as 45 CFR 146.145, or as permitted by the state.
H25G Group Health – Similar Supplemental Coverage		Coverage as designed/intended to comply with federal regulations of similar supplemental coverage such as 45 CFR 146.145 (b)(5)(i)(C), or as permitted by the state
	H25G.001 Any Size Group	Coverage as designed/intended to comply with federal regulations of similar supplemental coverage such as 45 CFR 146.145 (b)(5)(i)(C), or as permitted by the state that may be issued to any size group.
	H25G.002 Large Group Only	Coverage as designed/intended to comply with federal regulations of similar supplemental coverage such as 45 CFR 146.145 (b)(5)(i)(C), or as permitted by the state that may be issued to “large groups” as that term is defined in the state in which the contract will be delivered.
	H25G.003 Small Group Only	Coverage as designed/intended to comply with federal regulations of similar supplemental coverage such as 45 CFR 146.145 (b)(5)(i)(C), or as permitted by the state that may be issued to “small groups” as that term is defined in the state in which the contract will be delivered.

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H26G Group Health – Hearing	H26G.000 Group Health - Hearing	Limited benefit expense policy. Provides benefits for hearing and auditory related costs, services and supplies.
H26I Individual Health – Hearing	H26G.000 Individual Health - Hearing	Limited benefit expense policy. Provides benefits for hearing and auditory related costs, services and supplies.
Health Maintenance (HMO)		A form of health insurance combining a range of coverages in a group basis. These coverages are offered on a prepaid basis to plan members. Members generally must use contracted medical service providers.
HOrg01 Health Organizations – Assumption Agreement	HOrg01.000 Health Organizations – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
HOrg02G Group Health Organizations – Health Maintenance (HMO)		A plan under which an enrollee pays a membership fixed fee in advance in return for a wide range of comprehensive health care services with the HMO's approved providers in a designated service area.
	HOrg02G.001 Conversion	Guarantees an insured whose coverage is ending for specified reasons a right to purchase a policy without presenting evidence of insurability.
	HOrg02G.002A Any Size Group – PPO	Coverage may be issued to any size group. A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.002B Any Size Group – POS	Coverage may be issued to any size group. A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	HOrg02G.002C Any Size Group - HMO [Drafters note -Restricted Network Only -No out of network benefit, OR In Network Only]	Coverage may be issued to "any size" group as that term is defined in the state in which the contract will be delivered. A HMO plan that requires enrollees to use plan providers. Coverage for non-plan provider is only paid in emergency situations.
	HOrg02G.002D Any Size Group - Other	Coverage may be issued only to "any size groups" as that term is defined in the state in which the contract will be delivered. Not specifically described above.
	HOrg02G.003A Large Group Only – PPO	Coverage may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.

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	HOrg02G.003B Large Group Only – POS	Coverage may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	HOrg02G.003C Large Group Only - HMO [Drafters note - Restricted Network Only -No out of network benefit, OR In Network Only]	Coverage may be issued to "large groups" as that term is defined in the state in which the contract will be delivered. A HMO plan that requires enrollees to use plan providers. Coverage for non-plan provider is only paid in emergency situations.
	HOrg02G.003D Large Group Only - Other	Coverage may be issued only to "large groups" as that term is defined in the state in which the contract will be delivered. Not specifically described above.
	HOrg02G.004A Small Group Only – PPO Basic	Coverage may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A PPO basic plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.004B Small Group Only – PPO Standard	Coverage may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A PPO standard plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.004C Small Group Only – POS Basic	Coverage may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A POS basic plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.004D Small Group Only – POS Standard	Coverage may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. A POS standard plan which would provide incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02G.004E Small Group Only – Other	Coverage may be issued only to "small groups" as that term is defined in the state in which the contract will be delivered. Not specifically described above.
	HOrg02G.004F Small Group Only - HMO [Drafters note - Restricted Network Only -No out of network benefit, OR In Network Only]	Coverage may be issued to "small groups" as that term is defined in the state in which the contract will be delivered. A HMO plan that requires enrollees to use plan providers. Coverage for non-plan provider is only paid in emergency situations.
HOrg02I Individual Health Organizations – Health Maintenance (HMO)		Coverage may be issued only to "individuals" as that term is defined in the state in which the contract will be delivered.

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	HOrg02I.005A Individual – Preferred Provider (PPO)	A plan that provides incentives to enrollees to use plan providers, but still provides lesser coverage if the enrollee chooses a non-plan provider.
	HOrg02I.005B Individual – Point-of-Service (POS)	A combination of traditional indemnity health insurance and an HMO under which an enrollee is able to select the type of coverage at the time a service is needed.
	HOrg02I.005C Individual – Other	Not specifically described above.
	Horg02I.005D Individual - HMO [Drafters note -Restricted Network Only -No out of network benefit, OR In Network Only]	A HMO plan that requires enrollees to use plan providers. Coverage for non-plan provider is only paid in emergency situations.
HOrg03 Health – Other	HOrg03.000 Health – Other	Not specifically described above.
HOrg04G Group Health - Single Service Dental	HOrg04G.000 Group Health - Single Service Dental	Coverage for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.
	HOrg04G.001 Health – Pediatric Dental	Pediatric dental as contemplated under the ACA.
HOrg04I Individual Health - Single Service Dental	HOrg04I.000 Health – Single Service Dental	Coverage for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.
HOrg05G Group Health - Single Service Vision	HOrg05G.000 Health – Single Service Vision	Provides benefits for eye care and eye care accessories. May include surgical benefits for injury or sickness associated with the eye.
HOrg05I Individual Health - Single Service Vision	HOrg05I.000 Health – Single Service Vision	Provides benefits for eye care and eye care accessories. May include surgical benefits for injury or sickness associated with the eye.
HOrg06G Group Health – Hearing	HOrg06G.000 Group Health - Hearing	Limited benefit expense policy. Provides benefits for hearing and auditory related costs, services and supplies.
HOrg06I Individual Health – Hearing	HOrg06I.000 Individual Health - Hearing	Limited benefit expense policy. Provides benefits for hearing and auditory related costs, services and supplies.
Life		An insurance contract that provides a specified benefit amount to a named beneficiary upon the death of the insured.
L01 Life – Assumption Agreement	L01.000 Life – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
L02G Group Life – Endowment	L02G.000 Life – Endowment	Insurance that pays the same benefit amount should the insured die during the term of the contract, or if the insured survives to the end of the specified coverage term or age regardless of whether the group policyholder, the insured, or both pay the premium.

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	L02G.001 Single Life – Fixed/Indeterminate Premium	Endowment on a single insured that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L02G.002 Single Life – Single Premium	Endowment on a single insured where the insured pays only one specified premium amount at the time the certificate is issued.
	L02G.101 Joint (First to Die) – Fixed/Indeterminate Premium	Endowment on more than one insured where the benefit is payable on first death that requires a premium to be paid by a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L02G.102 Joint (First to Die) – Single Premium	Endowment on more than one insured where the benefit is payable on the first death and the insured pays only one specified premium amount at the time the certificate is issued.
	L02G.201 Joint (Last Survivor) – Fixed/Indeterminate Premium	Endowment on more than one insured where the benefit is payable on the last death that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L02G.202 Joint (Last Survivor) – Single Premium	Endowment on more than one insured where the benefit is payable on the last death and the insured pays only one specified premium amount at the time the certificate is issued.
L02I Individual Life – Endowment	L02I.000 Life – Endowment	An insurance contract that pays the same benefit amount should the insured die during the term of the contract or if the insured survives to the end of the specified policy term or age.
	L02I.001 Single Life – Fixed/Indeterminate Premium	Endowment on a single insured that requires payment of a specified modal of premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L02I.002 Single Life – Single Premium	Endowment on a single insured where the insured pays only one specified premium amount at the time the policy is issued.
	L02I.101 Joint (First to Die) – Fixed/Indeterminate Premium	Endowment on more than one insured where the benefit is payable on the first death that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.

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	L02I.102 Joint (First to Die) – Single Premium	Endowment on a single insured where the insured pays only one specified premium amount at the time the policy is issued.
	L02I.201 Joint (Last Survivor) – Fixed/Indeterminate Premium	Endowment on more than one insured where the benefit is payable on the last death that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L02I.202 Joint (Last Survivor) – Single Premium	Endowment on more than one insured where benefit is payable on last death where the insured pays only one specified premium amount at the time the policy is issued.
L03G Group Life – Special	L03G.000 Group Life – Special	Contracts with certain noteworthy attributes (not otherwise covered).
L03I Individual Life – Special	L03I.000 Individual Life – Special	Contracts with certain noteworthy attributes (not otherwise covered).
L04G Group Life – Term		Life insurance where the policy provides protection only for a specified period of time regardless of whether the group policyholder, the insured, or both pay the premium.
	L04G.003 Single Life – Single Premium	Term on a single insured where the insured pays only one specified premium amount at the time the coverage is issued.
	L04G.004 Joint (First to Die) – Single Premium	Term on more than one insured where the benefit is payable on the first death and there is only one specified premium amount paid at the time the coverage is issued.
	L04G.005 Joint (Last Survivor) – Single Premium	Term on more than one insured where the benefit is payable on last death and the insured pays only one specified premium amount at the time the coverage is issued.
	L04G.103 Renewable – Single Life – Fixed/Indeterminate Premium	Term on a single insured that requires the insured to pay a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force.
	L04G.104 Renewable – Joint (First to Die) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on first death and the insured pays a specified modal premium that is a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force.
	L04G.105 Renewable – Joint (Last Survivor) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on last death and the insured pays a specified modal premium that is a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force.

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	L04G.203 Specified Age or Duration – Single Premium – Single Life	Term on a single insured that requires the payment of a specified single premium where the coverage remains in force to a specified age or for a specified duration.
	L04G.204 Specified Age or Duration – Single Premium – Joint (First to Die)	Term on more than one life that requires the payment of a specified single premium where the death benefit is paid on the first death and the coverage remains in force to a specified age or for a specified duration.
	L04G.205 Specified Age or Duration – Single Premium – Joint (Last Survivor)	Term on more than one life that requires the payment of a specified single premium where the death benefit is paid on the last death and the coverage remains in force to a specified age or for a specified duration.
	L04G.213 Specified Age or Duration – Fixed/Indeterminate Premium – Single Life	Term on a single insured that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The coverage remains in force to a specified age or for a specified duration.
	L04G.214 Specified Age or Duration – Fixed/Indeterminate Premium – Joint (First to Die)	Term on more than one life that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit is paid on the first death and the coverage remains in force to a specified age or for a specified duration.
	L04G.215 Specified Age or Duration – Fixed/Indeterminate Premium – Joint (Last Survivor)	Term on more than one life that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit is paid on the last death and the coverage remains in force to a specified age or for a specified duration.
	L04G.303 Decreasing – Single Life – Single Premium	Term on a single insured in which the death benefit reduces monthly or annually similar to a mortgage schedule, and only one specified premium amount is paid at the time the coverage is issued.
	L04G.304 Decreasing – Joint (First to Die) – Single Premium	Term on more than one insured where the benefit is payable on first death and the death benefit reduces monthly or annually similar to a mortgage schedule and only one specified premium amount is paid at the time the coverage is issued.

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	L04G.305 Decreasing – Joint (Last Survivor) – Single Premium	Term on more than one insured where the benefit is payable on last death and the death benefit reduces monthly or annually similar to a mortgage schedule and only one specified premium amount is paid at the time the coverage is issued.
	L04G.313 Decreasing – Single Life – Fixed/Indeterminate Premium	Term on a single insured that requires the insured to pay a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force. The death benefit reduces monthly or annually similar to a mortgage schedule
	L04G.314 Decreasing – Joint (First to Die) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on the first death and the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force. The death benefit reduces monthly or annually similar to a mortgage schedule.
	L04G.315 Decreasing – Joint (Last Survivor) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on last death and the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the coverage to remain in force. The death benefit reduces monthly or annually similar to a mortgage schedule.
	L04G.403 Deposit Term – Single Life	Term on a single insured where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04G.404 Deposit Term – Joint (First to Die)	Term on more than one insured where the death benefit is payable on the first death, and where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04G.405 Deposit Term – Joint (Last to Die)	Term on more than one insured where the death benefit is payable on the last death, and where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04G.500 Other	This sub-TOI should only be used if the product is not identified under any other sub-TOI listed in H04G Group Life - Term.
L04I Individual Life – Term		Life insurance where the policy provides protection only for a specified period of time.
	L04I.003 Single Life – Single Premium	Term on a single insured in which the insured pays only one specified premium amount at the time the policy is issued.
	L04I.004 Joint (First to Die) – Single Premium	Term on more than one insured where the benefit is payable on first death where only one specified premium amount is paid at the time the policy is issued.

	L04I.005 Joint (Last Survivor) – Single Premium	Term on more than one insured where the benefit is payable on the last death and the insured pays only one specified premium amount at the time the policy is issued.
	L04I.103 Renewable – Single Life – Fixed/Indeterminate Premium	Term on a single insured that requires the insured to pay a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L04I.104 Renewable – Joint (First to Die) – Fixed Premium/Indeterminate Premium	Term on more than one insured where the benefit is payable on first death and the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L04I.105 Renewable – Joint (Last Survivor) – Fixed Premium/Indeterminate Premium	Term on more than one insured where the benefit is payable on the last death and the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.
	L04I.203 Specified Age or Duration – Single Premium – Single Life	Term on a single insured that requires the payment of a specified single premium where the policy remains in force to a specified age or for a specified duration.
	L04I.204 Specified Age or Duration – Single Premium – Joint (First to Die)	Term on more than one life that requires the payment of a specified single premium where the death benefit is paid on the first death and the policy remains in force to a specified age or for a specified duration.
	L04I.205 Specified Age or Duration – Single Premium – Joint (Last Survivor)	Term on more than one life that requires the payment of a specified single premium where the death benefit is paid on the last death and the policy remains in force to a specified age or for a specified duration.
	L04I.213 Specified Age or Duration – Fixed/Indeterminate Premium – Single Life	Term on a single insured that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The policy remains in force to a specified age or for a specified duration.
	L04I.214 Specified Age or Duration – Fixed/Indeterminate Premium – Joint (First to Die)	Term on more than one life that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit is paid on the first death and the policy remains in force to a specified age or for a specified duration.

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	L04I.215 Specified Age or Duration – Fixed/Indeterminate Premium – Joint (Last Survivor)	Term on more than one life that requires the payment of a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the policy owner, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit is paid on the last death and the policy remains in force to a specified age or for a specified duration.
	L04I.303 Decreasing -Single Life – Single Premium	Term on a single insured where the death benefit reduces monthly or annually similar to a mortgage schedule and only one specified premium amount is paid at the time the policy is issued.
	L04I.304 Decreasing – Joint (First to Die) – Single Premium	Term on more than one insured where the benefit is payable on the first death and the death benefit reduces monthly or annually similar to a mortgage schedule and only one specified premium amount is paid at the time the policy is issued.
	L04I.305 Decreasing – Joint (Last Survivor) – Single Premium	Term on more than one insured where the benefit is payable on the last death and the death benefit reduces monthly or annually similar to a mortgage schedule and only one specified premium amount is paid at the time the policy is issued.
	L04I.313 Decreasing – Single Life – Fixed/Indeterminate Premium	Term on a single insured that requires the insured to pay a specified modal premium where the premium is either a fixed amount or dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force. Death benefit reduces monthly or annually similar to a mortgage schedule.
	L04I.314 Decreasing – Joint (First to Die) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on the first death and the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit reduces monthly or annually similar to a mortgage schedule.
	L04I.315 Decreasing – Joint (Last Survivor) – Fixed/Indeterminate Premium	Term on more than one insured where the benefit is payable on the last death where the insured pays a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force. The death benefit reduces monthly or annually similar to a mortgage schedule.
	L04I.403 Deposit Term – Single Life	Term on a single insured where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.

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	L04I.404 Deposit Term – Joint (First to Die)	Term on more than one insured where the death benefit is payable on the first death and where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04I.405 Deposit Term - Joint (Last to Die)	Term on more than one insured where the death benefit is payable on the last death and where there is an additional premium paid at issue that provides an endowment at the end of the initial term period.
	L04I.500 Other	Not specifically described above.
L06G Group Life – Variable		Life insurance whose face value and/or duration varies depending upon the value of underlying securities regardless of whether the group policyholder, the insured, or both pay the premium.
	L06G.001 Single Life – Fixed Premium	Variable life insurance on a single insured requiring the insured to pay a specified modal premium for the coverage to remain in force.
	L06G.002 Single Life – Flexible Premium	Variable life insurance on a single insured that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the account value is sufficient to keep the coverage in force.
	L06G.003 Single Life – Single Premium	Variable life insurance on a single insured in which the insurer pays only one specified premium amount at the time the coverage is issued.
	L06G.004 Single Life – Modified Single Premium	Variable life insurance on a single insured that allows the insured to pay one specified premium amount at the time the coverage is issued and optional subsequent premiums subject to the federal guideline premium limits.
	L06G.101 Joint (First to Die) – Fixed Premium	Variable life insurance on more than one insured where the benefit is payable on the first death and that requires the insured to pay a specified modal premium for the coverage to remain in force.
	L06G.102 Joint (First to Die) – Flexible Premium	Variable life insurance on more than one insured where the benefit is payable on the first death that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the account value is sufficient to keep the coverage in force.
	L06G.103 Joint (First to Die) – Single Premium	Variable life insurance on more than one insured where the benefit is payable on the first death and the insured pays only one specified premium amount at the time the coverage is issued.
	L06G.104 Joint (First to Die) – Modified Single Premium	Variable life insurance on more than one insured where the benefit is payable on the first death that allows the insured to pay one specified premium amount at the time the coverage is issued and optional subsequent premiums subject to the federal guideline premium limits.

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	L06G.201 Joint (Last Survivor) – Fixed Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that requires the insured to pay a specified modal premium for the coverage to remain in force.
	L06G.202 Joint (Last Survivor) – Flexible Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the account value is sufficient to keep the coverage in force.
	L06G.203 Joint (Last Survivor) – Single Premium	Variable life insurance on more than one insured where the benefit is payable on the last death where the insured pays only one specified premium amount at the time the coverage is issued.
	L06G.204 Joint (Last Survivor) – Modified Single Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that allows the insured to pay one specified premium amount at the time the coverage is issued and optional subsequent premiums subject to the federal guideline premium limits.
L06I Individual Life – Variable		Life insurance whose face value and/or duration varies depending upon the value of underlying securities.
	L06I.001 Single Life – Fixed Premium	Life insurance requiring the insured to pay a specified modal premium for the policy to remain in force.
	L06I.002 Single Life – Flexible Premium	Life insurance that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the policy value is sufficient to keep the policy in force.
	L06I.003 Single Life – Single Premium	Life insurance in which the insured would pay only one specified premium amount at the time the policy is issued.
	L06I.004 Single Life – Modified Single Premium	Variable life insurance on a single insured that allows the insured to pay one specified premium amount at the time the policy is issued and optional subsequent premiums subject to the federal guideline premium limits.
	L06I.101 Joint (First to Die) – Fixed Premium	Variable life insurance on more than one insured where the benefit is payable on the first death that requires the insured to pay a specified modal premium for the policy to remain in force.
	L06I.102 Joint (First to Die) – Flexible Premium	Variable life insurance on more than one insured where the benefit is payable on the first death that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the policy value is sufficient to keep the policy in force.
	L06I.103 Joint (First to Die) – Single Premium	Variable life insurance on more than one insured where the benefit is payable on the first death where the insured pays only one specified premium amount at the time the policy is issued.

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	L06I.104 Joint (First to Die) – Modified Single Premium	Variable life insurance on more than one insured where the benefit is payable on the first death that allows the insured to pay one specified premium amount at the time the policy is issued and optional subsequent premiums subject to the federal guideline premium limits.
	L06I.201 Joint (Last Survivor) – Fixed Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that requires the insured to pay a specified modal premium for the policy to remain in force.
	L06I.202 Joint (Last Survivor) – Flexible Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that allows the insured to vary the modal premium that is paid or to skip a payment, so long as the policy value is sufficient to keep the policy in force.
	L06I.203 Joint (Last Survivor) – Single Premium	Variable life insurance on more than one insured where the benefit is payable on the last death where the insured pays only one specified premium amount at the time the policy is issued.
	L06I.204 Joint (Last Survivor) – Modified Single Premium	Variable life insurance on more than one insured where the benefit is payable on the last death that allows the insured to pay one specified premium amount at the time the policy is issued and optional subsequent premiums subject to the federal guideline premium limits.
L07G Group Life – Whole		Life insurance that may be kept in force for a person’s entire life and that pays a benefit upon the person’s death, whenever that may be regardless of whether the group policyholder, the insured, or both pay the premium.
	L07G.101 Fixed/Indeterminate Premium – Single Life	Whole life on a single insured that requires a premium to be paid by a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07G.102 – Fixed/Indeterminate Premium – Joint (First to Die)	Whole life on more than one insured where the benefit is payable on first death that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07G.103 – Fixed/Indeterminate Premium – Joint (Last Survivor)	Whole life on more than one insured where the benefit is payable on last death that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.

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	L07G.104 Fixed/Indeterminate Premium – Single Life – Funeral Expense	Whole life on a single insured used to fund funeral expense or preneed funeral coverage that requires payment of a specified modal premium of a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07G.111 Single Premium – Single Life	Whole life insurance with a guaranteed single premium and benefits on one insured.
	L07G.112 Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with a guaranteed single premium and benefits, with the death benefit payable upon the first death.
	L07G.113 Single Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with a guaranteed single premium and benefits, with the death benefit payable upon the last death.
	L07G.114 Single Premium – Single Life – Funeral Expense	Whole life insurance on more than one insured with a guaranteed single premium and benefits, used to fund funeral expense or a preneed funeral contract.
	L07G.121 Graded Premium – Single Life	Whole life insurance on more than one insured with a guaranteed graded premium and benefits.
	L07G.122 Graded Premium – Joint (First to Die)	Whole life insurance on more than one insured with a guaranteed graded premium and benefits, with the death benefit payable upon the first death.
	L07G.123 Graded Premium -Joint (Last Survivor)	Whole life insurance on more than one insured with a guaranteed graded premium and benefits, with the death benefit payable upon the last death.
	L07G.201 Early Duration Reduced Benefit – Level Premium – Any Policy Design	Whole life insurance with a guaranteed level premium and benefits reduced during the early durations.
	L07G.202 Early Duration Reduced Benefit – Level Premium – Any Policy Design – Funeral Expense	Whole life insurance with a guaranteed level premium and benefits reduced during the early durations and used to fund funeral expense or preneed funeral contracts.
	L07G.211 Early Duration Reduced Benefit – Single Premium – Any Policy Design	Whole life insurance with a single premium and benefits reduced during the early durations.
	L07G.212 Early Duration Reduced Benefit – Single Premium – Any Policy Design – Funeral Expense	Whole life insurance with a single premium and benefits reduced during the early durations used to fund funeral expense or preneed funeral contracts.
	L07G.301 Current Assumption – Fixed Premium – Single Life	Whole life insurance on a single insured with a fixed premium where the certificate value is not guaranteed due to the company's right to change interest, expense and/or mortality assumptions. The policy or certificate holder may pay additional premiums.

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	L07G.302 Current Assumption – Fixed Premium – Joint (First to Die)	Whole life insurance on more than one insured with a fixed premium where the certificate value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy or certificate holder may pay additional premiums.
	L07G.303 Current Assumption – Fixed Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with a fixed premium where the certificate value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy or certificate holder may pay additional premiums.
	L07G.311 Current Assumption – Single Premium – Single Life	Whole life insurance on a single insured with a single premium where the certificate value is dependent on the company's right to change interest, expense and/or mortality assumptions.
	L07G.312 Current Assumption – Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with a single premium where the certificate value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon first death.
	L07G.313 Current Assumption – Single Premium -Joint (Last Survivor)	Whole life insurance on more than one insured with a single premium where the certificate value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death.
	L07G.321 Current Assumption – Indeterminate Premium – Single Life	Whole life insurance on a single insured where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions. The policy or certificate holder may pay additional premiums.
	L07G.322 Current Assumption – Indeterminate Premium – Joint (First to Die)	Whole life insurance on more than one insured where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy or certificate holder may pay additional premiums.
	L07G.323 Current Assumption – Indeterminate Premium -Joint (Last Survivor)	Whole life insurance on more than one insured where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy or certificate holder may pay additional premiums.
	L07G.401 Adjustable – Current Assumption – Indeterminate Premium – Single Life	Whole life insurance on a single insured where the insured may change the plan of insurance or the death benefit and where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions. The policy or certificate holder may pay additional premiums.

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	L07G.402 Adjustable – Current Assumption – Indeterminate Premium – Joint (First to Die)	Whole life insurance on a single insured where the insured may change the plan of insurance or the death benefit and where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy or certificate holder may pay additional premiums.
	L07G.403 Adjustable – Current Assumption – Indeterminate Premium -Joint (Last Survivor)	Whole life insurance on a single insured where the insured may change the plan of insurance or the death benefit and where premium and certificate value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy or certificate holder may pay additional premiums.
	L07G.501 External Index- Level Premium – Single Life	Whole life insurance on a single insured with level premium where certificate values are linked to an external or equity index.
	L07G.502 External Index – Level Premium – Joint (First to Die)	Whole life insurance on more than one insured with level premium where certificate values are linked to an external or equity index, with the death benefit payable upon the first death.
	L07G.503 External Index – Level Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with level premium where certificate values are linked to an external or equity index, with the death benefit payable upon the last death.
	L07G.511 External Index – Single Premium – Single Life	Whole life insurance on one insured with a single premium where certificate values are linked to an external or equity index.
	L07G.512 External Index – Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with level premium and where certificate values are linked to an external or equity index, with the death benefit payable upon the first death.
	L07G.513 External Index – Single Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with level premium and where certificate values are linked to an external or equity index, with the death benefit payable upon the last death.
L07I Individual Life – Whole		Life insurance that may be kept in force for a person's entire life and that pays a benefit upon the person's death, whenever that may be.
	L07I.101 Fixed/Indeterminate Premium – Single Life	Whole life on a single insured that requires payment of a specified modal premium that is a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the policy to remain in force.

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	L07I.102 Fixed/Indeterminate Premium – Joint (First to Die)	Whole life on more than one insured where the benefit is payable on first death that requires payment of a specified modal premium that is a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07I.103 Fixed/Indeterminate Premium – Joint (Last Survivor)	Whole life on more than one insured where the benefit is payable on last death that requires payment of a specified modal premium that is a fixed amount or where the premium is dependent on factors that may be changed by the insurer, but not to go beyond a guaranteed maximum for the certificate to remain in force.
	L07I.104 Fixed/Indeterminate Premium – Single Life – Funeral Expense	Whole life insurance on one insured with guaranteed level premium and benefits used to fund funeral expense or preneed funeral contract.
	L07I.111 Single Premium – Single Life	Whole life insurance on one insured with guaranteed single premium and benefits.
	L07I.112 Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with guaranteed single premium and benefits, with the death benefit payable upon the first death.
	L07I.113 Single Premium -Joint (Last Survivor)	Whole life insurance on more than one insured with guaranteed single premium and benefits, with the death benefit payable upon the last death.
	L07I.114 Single Premium – Single Life – Funeral Expense	Whole life insurance on one insured with guaranteed single premium and benefits used to fund funeral expense or preneed funeral contract.
	L07I.121 Graded Premium – Single Life	Whole life insurance on one insured with guaranteed graded premium and benefits.
	L07I.122 Graded Premium – Joint (First to Die)	Whole life insurance on more than one insured with guaranteed graded premium and benefits, with the death benefit payable upon the first death.
	L07I.123 Graded Premium -Joint (Last Survivor)	Whole life insurance on more than one insured with guaranteed graded premium and benefits, with the death benefit payable upon the last death.
	L07I.124 Graded Premium – Jumping Juvenile (Term to Age X, Whole Life Thereafter)	Life insurance that is term to age X and then converts to whole life.
	L07I.201 Early Duration Reduced Benefit – Level Premium – Any Policy Design	Whole life insurance with guaranteed level premium and benefits reduced during the early durations.
	L07I.202 Early Duration Reduced Benefit – Level Premium – Any Policy Design – Funeral Expense	Whole life insurance with guaranteed level premium and benefits reduced during the early durations, used to fund funeral expense or a preneed funeral contract.
	L07I.211 Early Duration Reduced Benefit – Single Premium – Any Policy Design	Whole life insurance with single premium and benefits reduced during the early durations.

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	L07I.212 Early Duration Reduced Benefit – Single Premium – Any Policy Design – Funeral Expense	Whole life insurance with single premium and benefits reduced during the early durations used to fund funeral expense or a preneed funeral contract.
	L07I.301 Current Assumption – Fixed Premium – Single Life	Whole life insurance on a single insured with a fixed premium where policy value is not guaranteed due to company's right to change interest, expense and/or mortality assumptions. The policy owner may pay additional premiums.
	L07I.302 Current Assumption – Fixed Premium – Joint (First to Die)	Whole life insurance on more than one insured with a fixed premium where the policy value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy owner may pay additional premiums.
	L07I.303 Current Assumption – Fixed Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with a fixed premium where the policy value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy owner may pay additional premiums.
	L07I.311 Current Assumption – Single Premium – Single Life	Whole life insurance on a single insured with a single premium where the policy value is dependent on the company's right to change interest, expense and/or mortality assumptions.
	L07I.312 Current Assumption – Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with a single premium where the policy value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death.
	L07I.313 Current Assumption – Single Premium -Joint (Last Survivor)	Whole life insurance on more than one insured with a single premium where the policy value is dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death.
	L07I.321 Current Assumption – Indeterminate Premium – Single Life	Whole life insurance on a single insured where premium and policy value are dependent on the company's right to change interest, expense and/or mortality assumptions. The policy owner may pay additional premiums.
	L07I.322 Current Assumption – Indeterminate Premium – Joint (First to Die)	Whole life insurance on more than one insured where premium and policy value are dependent upon the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy owner may pay additional premiums.
	L07I.323 Current Assumption – Indeterminate Premium -Joint (Last Survivor)	Whole life insurance on more than one insured where premium and policy value are dependent upon the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy owner may pay additional premiums.

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	L07I.401 Adjustable – Current Assumption – Indeterminate Premium – Single Life	Whole life insurance on a single insured where the insured may change the plan of insurance or the death benefit and where premium and policy value are dependent on the company's right to change interest, expense and/or mortality assumptions. The policy owner may pay additional premiums.
	L07I.402 Adjustable – Current Assumption – Indeterminate Premium – Joint (First to Die)	Whole life insurance on more than one insured where the insured may change the plan of insurance or the death benefit and where premium and policy value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the first death. The policy owner may pay additional premiums.
	L07I.403 Adjustable – Current Assumption – Indeterminate Premium -Joint (Last Survivor)	Whole life insurance on more than one insured where the insured may change the plan of insurance or the death benefit and where premium and policy value are dependent on the company's right to change interest, expense and/or mortality assumptions, with the death benefit payable upon the last death. The policy owner may pay additional premiums.
	L07I.501 External Index – Level Premium	Whole life insurance with level premium where policy values are linked to an external or equity index.
	L07I.502 External Index – Level Premium – Joint (First to Die)	Whole life insurance on more than one insured with level premium where policy values are linked to an external or equity index, with the death benefit payable upon the first death.
	L07I.503 External Index – Level Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with level premium where policy values are linked to an external or equity index, with the death benefit payable upon the last death.
	L07I.511 External Index – Single Premium	Whole life insurance with a single premium where policy values are linked to an external or equity index.
	L07I.512 External Index – Single Premium – Joint (First to Die)	Whole life insurance on more than one insured with level premium where policy values are linked to an external or equity index, with the death benefit payable upon the first death.
	L07I.513 External Index – Single Premium – Joint (Last Survivor)	Whole life insurance on more than one insured with level premium where policy values are linked to an external or equity index, with the death benefit payable upon the last death.
L08 Life – Other	L08.000 Life – Other	Not specifically described above.

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L09G Group Life – Flexible Premium Adjustable Life		A group life insurance that provides a face amount that is adjustable to the certificate holder and allows the certificate holder to vary the modal premium that is paid or to skip a payment so long as the certificate value is sufficient to keep the certificate in force, and under which separately identified interest credits (other than in connection with dividend accumulation, premium deposit funds or other supplementary accounts) and mortality and expense charges are made to individual certificates while providing minimum guaranteed values regardless of whether the group policyholder, the insured, or both pay the premium. Universal life products should be placed under the best matching sub-TOI.
	L09G.001 Single Life	A flexible premium adjustable life policy where the certificate insures one life.
	L09G.002 Joint (Last to Die)	A flexible premium adjustable life policy where the certificate insures more than one life and will pay the specified death benefit upon the last death.
	L09G.003 Joint (First to Die)	A flexible premium adjustable life policy where the certificate insures more than one life and will pay the specified death benefit upon the first death.
	L09G.101 External Indexed – Single Life	A flexible premium adjustable life policy where the certificate insures one life and earns interest or provides benefits that are linked to an external or equity index.
	L09G.102 External Indexed – Joint (First to Die)	A flexible premium adjustable life policy where the certificate earns interest or provides benefits that are linked to an external or equity index. The certificate insures more than one life and will pay the specified death benefit upon the first death.
	L09G.103 External Indexed – Joint (Last to Die)	A flexible premium adjustable life policy where the certificate earns interest or provides benefits that are linked to an external or equity index. The certificate insures more than one life and will pay the specified death benefit upon the last death.
L09I Individual Life – Flexible Premium Adjustable Life		Life insurance that provides a face amount that is adjustable to the policyholder and allows the policyholder to vary the modal premium that is paid or to skip a payment so long as the account value is sufficient to keep the coverage in force, and under which separately identified interest credits (other than in connection with dividend accumulation, premium deposit funds or other supplementary accounts) and mortality and expense charges are made to a policy that provides minimum nonforfeiture values. Universal life products should be placed under the best matching sub-TOI.
	L09I.001 Single Life	A flexible premium adjustable life policy where the policy insures one life.
	L09I.002 Joint (Last to Die)	A flexible premium adjustable life policy where the policy insures more than one life and will pay the specified death benefit upon the last death.

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	L09I.003 Joint (First to Die)	A flexible premium adjustable life policy where the policy insures more than one life and will pay the specified death benefit upon the first death.
	L09I.101 External Indexed – Single Life	A flexible premium adjustable life policy that insures one life and earns interest or provides benefits that are linked to an external or equity index.
	L09I.102 External Indexed – Joint (First to Die)	A flexible premium adjustable life policy that earns interest or provides benefits that are linked to an external or equity index. The policy insures more than one life and will pay the specified death benefit upon the first death.
	L09I.103 External Indexed – Joint (Last to Die)	A flexible premium adjustable life policy that earns interest or provides benefits that are linked to an external or equity index. The policy insures more than one life and will pay the specified death benefit upon the last death.
Life Settlements		
LS01 Life Settlements	LS01.000 Life Settlements	A contract or agreement in which a policyholder agrees to sell or transfer ownership in all or part of a life insurance policy to a third party for compensation that is less than the expected death benefit of a policy.
Long-Term Care		Coverage that includes long term care, nursing home, and home care contracts that provide reimbursement for these services.
LTC01 Long-Term Care – Assumption Agreement	LTC01.000 Long-Term Care – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
LTC02G Group Long-Term Care – Home Health Care Only		Coverage that provides coverage for non-institutional care provided in a person's own home or in an adult day care setting.
	LTC02G.001 Qualified	A home health care only policy that meets the federal IRS requirements to qualify for a tax deduction.
	LTC02G.002 Non Qualified	A home health care only policy that does not meet the federal IRS requirements.
	LTC02G.003 Other	Not specifically described above.
	LTC02G.004 Partnership	A home health care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC02I Individual Long-Term Care – Home Health Care Only		Coverage that provides coverage for non-institutional care provided in a person's own home or in an adult day care setting.
	LTC02I.001 Qualified	A home health care only policy that meets the federal IRS requirements to qualify for a tax deduction.
	LTC02I.002 Non Qualified	A home health care only policy that does not meet the federal IRS requirements.
	LTC02I.003 Other	Not specifically described above.

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	LTC02I.004 Partnership	A home health care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC03G Group Long-Term Care		Coverage that provides reimbursement for the following long term care services: nursing home care, assisted living care, home health care and adult day care.
	LTC03G.001 Qualified	A long term care policy that meets the federal IRS requirements to qualify for a tax deduction.
	LTC03G.002 Non Qualified	A long term care policy that does not meet the federal IRS requirements to qualify for a tax deduction.
	LTC03G.003 Other	Not specifically described above.
	LTC03G.004 Partnership	A long term care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC03I Individual Long-Term Care		Coverage that provides reimbursement for the following long term care services: nursing home care, assisted living care, home health care and adult day care.
	LTC03I.001 Qualified	A long term care policy that meets the federal IRS requirements to qualify for a tax deduction.
	LTC03I.002 Non Qualified	A long term care policy that does not meet the federal IRS requirements to qualify for a tax deduction.
	LTC03I.003 Other	Not specifically described above.
	LTC03I.004 Partnership	A long term care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC04G Group Long-Term Care – Nursing Home		A policy or rider that provides coverage only while a policyholder is confined to a nursing home and meets the policy requirements for coverage.
	LTC04G.001 Qualified	Nursing home policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC04G.002 Non Qualified	Nursing home policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC04G.003 Other	Not specifically described above.
	LTC04G.004 Partnership	A nursing home policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.

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LTC04I Individual Long-Term Care – Nursing Home		A policy or rider that provides coverage only while a policyholder is confined to a nursing home and meets the policy requirements for coverage.
	LTC04I.001 Qualified	Nursing home policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC04I.002 Non Qualified	Nursing home policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC04I.003 Other	Not specifically described above.
	LTC04I.004 Partnership	A nursing home policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC05G Group Long-Term Care – Nursing Home & Home Health Care		A policy or rider that would includes coverage for both institutional nursing home and home health care.
	LTC05G.001 Qualified	Nursing home and home health care policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC05G.002 Non Qualified	Nursing home and home health care policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05G.003 Other	Not specifically described above.
	LTC05G.004 Partnership	A nursing home and home health care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC05I Individual Long-Term Care – Nursing Home & Home Health Care		A policy or rider that would includes coverage for both institutional nursing home and home health care.
	LTC05I.001 Qualified	Nursing home and home health care policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC05I.002 Non Qualified	Nursing home and home health care policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05I.003 Other	Not specifically described above.
	LTC05I.004 Partnership	A nursing home and home health care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC05.1G Group Assisted Living Care		A policy or rider that provides coverage only while a policyholder is confined to an assisted living facility and meets the policy requirements for coverage.
	LTC05.1G.001 Qualified	Assisted living policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.1G.002 Non Qualified	Assisted living policies that do not meet the federal IRS requirements to qualify for a tax deduction.

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	LTC05.1G.003 Other	Not specifically described above.
	LTC05.1G.004 Partnership	An assisted living care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC05.1I Individual Assisted Living Care		A policy or rider that provides coverage only while a policyholder is confined to an assisted living facility and meets the policy requirements for coverage.
	LTC05.1I.001 Qualified	Assisted living policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.1I.002 Non Qualified	Assisted living policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.1I.003 Other	Not specifically described above.
	LTC05.1I.004 Partnership	An assisted living care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC05.2G Group Adult Day Care		A policy or rider that provides coverage only for adult day care for an individual who meets the policy requirements for coverage.
	LTC05.2G.001 Qualified	Adult day care policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.2G.002 Non Qualified	Adult day care policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.2G.003 Other	Not specifically described above.
	LTC05.2G.004 Partnership	An adult day care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC05.2I Individual Adult Day Care		A policy or rider that provides coverage only for adult day care for an individual who meets the policy requirements for coverage.
	LTC05.2I.001 Qualified	Adult day care policies that would meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.2I.002 Non Qualified	Adult day care policies that do not meet the federal IRS requirements to qualify for a tax deduction.
	LTC05.2I.003 Other	Not specifically described above.
	LTC05.2I.004 Partnership	An adult day care policy that complies with federal requirements as a Partnership policy allowing a state to disregard certain resources when determining Medicaid eligibility.
LTC06 Long-Term Care – Other	LTC06.000 Long-Term Care – Other	Not specifically described above or a combination of two or more, but less than four products.

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Multi-Line		Filings that may be submitted for both life and health insurance in one form such as an application.
ML01 Multi-Line – Assumption Agreement	ML01.000 Multi-Line – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company. For example, companies assuming both life and health lines.
ML02 Multi-Line – Other	ML02.000 Multi-Line – Other	Not specifically described above.
Medicare Supplement		Insurance coverage sold on an individual or group basis to help fill the "gaps" in the protections granted by the federal Medicare program. This is strictly supplemental coverage and cannot duplicate any benefits provided by Medicare. It is structured to pay part or all of Medicare's deductibles and co-payments. It may also cover some services and expenses not covered by Medicare. Also known as "Medigap" insurance.
MS01 Medicare Supplement – Assumption Agreement	MS01.000 Medicare Supplement – Assumption Agreement	An insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.
MS02G Group Medicare Supplement – Pre-Standardized	MS02G.000 Medicare Supplement – Pre-Standardized	A plan issued prior to required federal standardization of Medicare supplement policy forms and rates.
MS02I Individual Medicare Supplement – Pre-Standardized	MS02I.000 Medicare Supplement – Pre-Standardized	A plan issued prior to required federal standardization of Medicare supplement policy forms and rates.
MS03G Group Medicare Supplement – Medicare Advantage	MS03G.000 Medicare Supplement – Medicare Advantage	A contract between a Medicare beneficiary and an insurer that has contracted with the federal government to provide both Medicare and Medigap type services to beneficiaries.
MS03I Individual Medicare Supplement – Medicare Advantage	MS03I.000 Medicare Supplement – Medicare Advantage	A contract between a Medicare beneficiary and an insurer that has contracted with the federal government to provide both Medicare and Medigap type services to beneficiaries.
MS04G Group Medicare Supplement – Medicare Select		A type of Medigap plan under which a policyholder generally must use specific hospitals and, in some cases, doctors to receive full Medigap benefits. **Effective 6/1/2010 no new policies may be issued. Refer to MS07G Group Medicare Supplement – Medicare Select 2010 to file policies for new plans.**
	MS04G.001 Plan A	Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance.
	MS04G.002 Plan B	Basic benefits plus Part A deductible.

	MS04G.003 Plan C	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, and also Foreign Travel Emergency. Plan may not be issued to those newly eligible after December 31, 2019.
	MS04G.004 Plan D	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also At-home Recovery.
	MS04G.005 Plan E	Basic benefits plus skilled nursing coinsurance, Part A deductible, preventative Care, and also Foreign Travel Emergency. Effective 6/1/2010 plan is eliminated.
	MS04G.006 Plan F (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and also Foreign Travel Emergency. Plan may not be issued to those newly eligible after December 31, 2019.
	MS04G.007 Plan F (High)	High deductible option. Plan may not be issued to those newly eligible after December 31, 2019.
	MS04G.008 Plan G	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾80%, At-home Recovery, Foreign Travel Emergency, and At-home Recovery.
	MS04G.009 Plan H	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS04G.010 Plan I	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾100%, Foreign Travel Emergency, At-home Recovery, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS04G.011 Plan J (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Extended Drugs, Part B Excess¾100%, Foreign Travel Emergency, Preventive Care, and also At-home Recovery. Effective 6/1/2010 plan is eliminated.
	MS04G.012 Plan J (High)	High deductible option. Effective 6/1/2010 plan is eliminated.
	MS04G.013 Plan K	Basic Benefits plus 50% Skilled Nursing Facility Coinsurance, 50% Part A deductible
	MS04G.014 Plan L	Basic Benefits plus 75% Skilled Nursing Facility Coinsurance, 75% Part A deductible
	MS04G.015 Other	Not specifically described above.

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	MS04G.016 Multi-Plan	A package filing containing more than one Select Group Medicare Supplement plan in the filing submission.
MS04I Individual Medicare Supplement – Medicare Select		A type of Medigap plan under which a policyholder generally must use specific hospitals and, in some cases, doctors to receive full Medigap benefits. Effective 6/1/2010 no new policies may be issued. Refer to MS07I Group Medicare Supplement – Medicare Select 2010 to file policies for new plans.
	MS04I.001 Plan A	Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance.
	MS04I.002 Plan B	Basic benefits plus Part A deductible.
	MS04I.003 Plan C	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, and also Foreign Travel Emergency. Plan may not be issued to those newly eligible after December 31, 2019.
	MS04I.004 Plan D	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also At-home Recovery.
	MS04I.005 Plan E	Basic benefits plus skilled nursing coinsurance, Part A deductible, preventative Care, and also Foreign Travel Emergency. Effective 6/1/2010 plan is eliminated.
	MS04I.006 Plan F (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and also Foreign Travel Emergency. Plan may not be issued to those newly eligible after December 31, 2019.
	MS04I.007 Plan F (High)	High deductible option. Plan may not be issued to those newly eligible after December 31, 2019.
	MS04I.008 Plan G	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾80%, At-home Recovery, Foreign Travel Emergency, and At-home Recovery.
	MS04I.009 Plan H	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS04I.010 Plan I	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾100%, Foreign Travel Emergency, At-home Recovery, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.

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	MS04I.011 Plan J (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Extended Drugs, Part B Excess¾100%, Foreign Travel Emergency, Preventive Care, and also At-home Recovery. Effective 6/1/2010 plan is eliminated.
	MS04I.012 Plan J (High)	High deductible option. Effective 6/1/2010 plan is eliminated.
	MS04I.013 Plan K	Basic Benefits plus 50% Skilled Nursing Facility Coinsurance, 50% Part A deductible
	MS04I.014 Plan L	Basic Benefits plus 75% Skilled Nursing Facility Coinsurance, 75% Part A deductible
	MS04I.015 Other	Not specifically described above.
	MS04I.016 Multi-Plan	A package filing containing more than one Select Individual Medicare Supplement plan in the filing submission.
MS05G Group Medicare Supplement – Standard Plans		A Medigap policy under which a policyholder may obtain services from any provider of care. Effective 6/1/2010 no new policies may be issued. Refer to MS08G Group Medicare Supplement – Standard Plans – 2010 to file policies for new plans.
	MS05G.001 Plan A	Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance.
	MS05G.002 Plan B	Basic benefits plus Part A deductible.
	MS05G.003 Plan C	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, and also Foreign Travel Emergency. Plan may not be issued to those newly eligible after December 31, 2019.
	MS05G.004 Plan D	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also At-home Recovery.
	MS05G.005 Plan E	Basic benefits plus skilled nursing coinsurance, Part A deductible, Preventive Care, and also Foreign Travel Emergency. Effective 6/1/2010 plan is eliminated.
	MS05G.006 Plan F (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, & Foreign Travel Emergency. Plan may not be issued to those newly eligible after December 31, 2019.
	MS05G.007 Plan F (High)	High deductible option. Plan may not be issued to those newly eligible after December 31, 2019.

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	MS05G.008 Plan G	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾80%; At-home Recovery, and also Foreign Travel Emergency.
	MS05G.009 Plan H	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS05G.010 Plan I	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾100%, Foreign Travel Emergency, At-home Recovery, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS05G.011 Plan J (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, Foreign Travel Emergency, Preventive Care, At-home Recovery, and also Extended Drugs. Effective 6/1/2010 plan is eliminated.
	MS05G.012 Plan J (High)	High deductible option. Effective 6/1/2010 plan is eliminated.
	MS05G.013 Plan K	Basic Benefits plus 50% Skilled Nursing Facility Coinsurance, 50% Part A deductible
	MS05G.014Plan L	Basic Benefits plus 75% Skilled Nursing Facility Coinsurance, 75% Part A deductible
	MS05G.015 Multi-Plan	A package filing containing more than one Standard Group Medicare Supplement plan in the filing submission.
MS05I Individual Medicare Supplement – Standard Plans		A Medigap policy under which a policyholder may obtain services from any provider of care. Effective 6/1/2010 no new policies may be issued. Refer to MS08I Individual Medicare Supplement – Standard Plans 2010 to file policies for new plans.
	MS05I.001 Plan A	Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance.
	MS05I.002 Plan B	Basic benefits plus Part A deductible.
	MS05I.003 Plan C	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, and also Foreign Travel Emergency. Plan may not be issued to those newly eligible after December 31, 2019.
	MS05I.004 Plan D	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also At-home Recovery.

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	MS05I.005 Plan E	Basic benefits plus skilled nursing coinsurance, Part A deductible, Preventive Care, and also Foreign Travel Emergency. Effective 6/1/2010 plan is eliminated.
	MS05I.006 Plan F (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, & Foreign Travel Emergency. Plan may not be issued to those newly eligible after December 31, 2019.
	MS05I.007 Plan F (High)	High deductible option. Plan may not be issued to those newly eligible after December 31, 2019.
	MS05I.008 Plan G	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾80%; At-home Recovery, and also Foreign Travel Emergency.
	MS05I.009 Plan H	Basic benefits plus skilled nursing coinsurance, Part A deductible, Foreign Travel Emergency, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS05I.010 Plan I	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B Excess¾100%, Foreign Travel Emergency, At-home Recovery, and also Basic Drugs. Effective 6/1/2010 plan is eliminated.
	MS05I.011 Plan J (Basic)	Basic benefits plus skilled nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, Foreign Travel Emergency, Preventive Care, At-home Recovery, and also Extended Drugs. Effective 6/1/2010 plan is eliminated.
	MS05I.012 Plan J (High)	High deductible option. Effective 6/1/2010 plan is eliminated.
	MS05I.013 Plan K	Basic Benefits plus 50% Skilled Nursing Facility Coinsurance, 50% Part A deductible
	MS05I.014Plan L	Basic Benefits plus 75%, Skilled Nursing Facility Coinsurance 75% Part A deductible
	MS05I.015 Multi-Plan	A package filing containing more than one Standard Individual Medicare Supplement plan in the filing submission.
MS06 Medicare Supplement – Other	MS06.000 Medicare Supplement – Other	Not specifically described above.

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MS07G Group Medicare Supplement – Medicare Select 2010		Product filings may be submitted prior to 6/1/2010; however plans are not effective until 6/1/2010. A type of Medigap plan under which a policyholder generally must use specific hospitals and, in some cases, doctors to receive full Medigap benefits.
	MS07G.001 Plan A 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.002 Plan B 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Part A deductible. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.003 Plan C 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.
	MS07G.004 Plan D 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.005 Plan F (Basic) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.
	MS07G.006 Plan F (High) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. High deductible option. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.

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	MS07G.007 Plan G 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Effective 1/1/19, file under MS07G.014 for the high deductible option.
	MS07G.008 Plan K 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic Benefits plus 50% Skilled Nursing coinsurance, 50% Part A deductible. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 50%, out of pocket [$4,620]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.009 Plan L 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic Benefits plus 75% Skilled Nursing coinsurance, 75% Part A deductible. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 75%, out of pocket [$2,310]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.010 Plan M 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 50% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07G.011 Plan N 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 100% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new copay structure. The copay is (a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and (b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS07G.012 Other 2010	Product filings may be submitted prior to 6/1/2010; however filing is not effective until 6/1/2010. Not specifically described above.
	MS07G.013 Multi-Plan 2010	A package filing containing more than one Select Group Medicare Supplement plan in the filing submission.
	MS07G.014 Plan G (High) 2020	Product filings may be submitted prior to 1/1/2020; however filing is not effective until 1/1/2020. High deductible option. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. File under MS07G.007 for the standard deductible option.
MS07I Individual Medicare Supplement – Medicare Select 2010		Product filings may be submitted prior to 6/1/2010; however plans are not effective until 6/1/2010. A type of Medigap plan under which a policyholder generally must use specific hospitals and, in some cases, doctors to receive full Medigap benefits.
	MS07I.001 Plan A 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.002 Plan B 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Part A deductible. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.003 Plan C 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.
	MS07I.004 Plan D 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS07I.005 Plan F (Basic) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.
	MS07I.006 Plan F (High) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. High deductible option. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.
	MS07I.007 Plan G 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B Excess ¾ 100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Effective 1/1/19, file under MS07I.014 for the high deductible option.
	MS07I.008 Plan K 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic Benefits plus 50% Skilled Nursing coinsurance, 50% Part A deductible. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 50%, out of pocket [$4,620]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.009 Plan L 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic Benefits plus 75% Skilled Nursing coinsurance, 75% Part A deductible. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 75%, out of pocket [$2,310]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.010 Plan M 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 50% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS07I.011 Plan N 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 100% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new copay structure. The copay is (a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and (b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS07I.012 Other 2010	Product filings may be submitted prior to 6/1/2010; however filing is not effective until 6/1/2010. Not specifically described above.
	MS07I.013 Multi-Plan 2010	A package filing containing more than one Select Individual Medicare Supplement plan in the filing submission.
	MS07I.014 Plan G (High) 2020	Product filings may be submitted prior to 1/1/2020; however filing is not effective until 1/1/2020. High deductible option. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. File under MS07I.007 for the standard deductible option.
MS08G Group Medicare Supplement – Standard Plans 2010		Product filings may be submitted prior to 6/1/2010; however plans are not effective until 6/1/2010. A Medigap policy under which a policyholder may obtain services from any provider of care.
	MS08G.001 Plan A 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.002 Plan B 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Part A deductible. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

	MS08G.003 Plan C 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.
	MS08G.004 Plan D 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.005 Plan F (Basic) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.
	MS08G.006 Plan F (High) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. High deductible option. Includes hospice care cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.
	MS08G.007 Plan G 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Effective 1/1/19, file under MS08G.013 for the high deductible option.
	MS08G.008 Plan K 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 50%, 50% Skilled Nursing coinsurance, 50% Part A deductible, subject to out of pocket [$4,620]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS08G.009 Plan L 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 75%, 75% Skilled Nursing coinsurance, 75% Part A deductible, out of pocket [$2,310]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.010 Plan M 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 50% coverage of the Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.011 Plan N 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 100% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new copay structure. The copay is (a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and (b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08G.012 Multi-Plan 2010	A package filing containing more than one Standard Group Medicare Supplement plan in the filing submission.
	MS08G.013 Plan G (High) 2020	Product filings may be submitted prior to 1/1/2020; however filing is not effective until 1/1/2020. High deductible option. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. File under MS08G.007 for the standard deductible option.
MS08I Individual Medicare Supplement – Standard Plans 2010		Product filings may be submitted prior to 6/1/2010; however plans are not effective until 6/1/2010. A Medigap policy under which a policyholder may obtain services from any provider of care.

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	MS08I.001 Plan A 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits: blood after first 3 pints; Part A hospital coinsurance; Part B medical expense coinsurance. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.002 Plan B 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Part A deductible. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.003 Plan C 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.
	MS08I.004 Plan D 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.005 Plan F (Basic) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.
	MS08I.006 Plan F (High) 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. High deductible option. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Plan may not be issued to those newly eligible after December 31, 2019.

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	MS08I.007 Plan G 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Basic benefits plus Skilled Nursing coinsurance, Part A deductible, Part B Excess¾100%, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. Effective 1/1/19, file under MS08I.013 for the high deductible option.
	MS08I.008 Plan K 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 50%, 50% Skilled Nursing coinsurance, 50% Part A deductible, out of pocket [$4,620]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.009 Plan L 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. Hospitalization and Preventive Care paid at 100% - other basic benefits paid at 75%, 75% Skilled Nursing coinsurance, 75% Part A deductible, out of pocket [$2,310]. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.010 Plan M 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 50% Part A deductible, Skilled Nursing coinsurance, and Foreign Travel Emergency. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
	MS08I.011 Plan N 2010	Product filings may be submitted prior to 6/1/2010; however plan is not effective until 6/1/2010. 100% Part A deductible, Skilled Nursing facility care, and Foreign Travel Emergency. In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new copay structure. The copay is the lesser of (a) twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and (b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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	MS08I.012 Multi-Plan 2010	A package filing containing more than one Standard Individual Medicare Supplement plan in the filing submission.
	MS08I.013 Plan G (High) 2020	Product filings may be submitted prior to 1/1/2020; however filing is not effective until 1/1/2020. High deductible option. Includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses. File under MS08I.007 for the standard deductible option.
MS09 Medicare Supplement – Other 2010	MS09.000 Medicare Supplement Other 2010	Not specifically described above.
Network Access		
NA01 Network Access Provider Contract		An arrangement whereby a carrier and provider guarantee access to the provider to receive covered services at in-network cost share without being balanced billed.
	NA01.000 Network Access Provider Contract	A written contract between a carrier and a provider for any health care service rendered to an enrollee.
	NA01.001 Provider Contract Addendum	A contract form attached to a provider contract that adds, deletes, or changes the terms of the core contract.
	NA01.002 Provider Directory	The master list of participating providers who are contracted with a carrier to deliver services to enrollees.
	NA01.003 Provider Leasing Agreement	A written contract between a carrier and a intermediary that has agreed to provide access to providers under contractual obligation to the intermediary to render covered services to enrollees of the contracting carrier.
	NA01.004 Other	Not specifically described above.
Viatical Settlements		
VS01 Viatical Settlements	VS01.000 Viatical Settlements	Contracts or agreements in which a buyer agrees to purchase all or a part of a life insurance policy.

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Financial Regulation Standards and Accreditation Program

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THE NAIC FINANCIAL REGULATION STANDARDS AND ACCREDITATION PROGRAM

(Note: The official standards, policies and procedures of the NAIC Financial Regulation Standards and Accreditation Program are contained in the Proceedings of the NAIC and should be consulted for complete, accurate and up-to-date information on the Program.

This pamphlet contains only general information about the NAIC Financial Regulation Standards and Accreditation Program and is not a comprehensive statement of the official standards, policies and procedures of the Program. Although this pamphlet is periodically updated to reflect changes in the Program, the reader is advised that it may not reflect the current Program requirements.)

Introduction

What is accreditation?

In general, accreditation is the process by which a program has been certified as fulfilling certain standards by a national professional association. In the terms of the insurance industry, accreditation is a certification given to a state insurance department once it has demonstrated it has met and continues to meet an assortment of legal, financial, organizational, and licensing and change of control standards as determined by a committee of its peers.

Why is accreditation necessary?

The concept of accrediting state insurance departments began in the mid-to-late 1980s when several large insurance companies became insolvent. In May 1988, as a response to the insolvencies, a congressional inquiry began looking at the insolvencies. In turn, the NAIC began discussing and shaping the Financial Regulation Standards and Accreditation Program in September 1988.

It was apparent that a system of effective solvency regulation could provide crucial safeguards for America's insurance consumers. Insurance consumers benefit when the insurance industry is strong enough financially to be able to pay and settle claims in a timely manner, to provide diverse and competitively priced products, and to provide meaningful customer service.

An effective system of solvency regulation has certain basic components. It requires that regulators have adequate statutory and administrative authority to regulate an insurer's corporate and financial affairs. It requires that regulators have the necessary resources to carry out that authority. Finally, it requires that insurance departments have in place organizational and personnel practices designed for effective regulation.

After much discussion, the NAIC took a large step toward establishing a sound program that would aide state insurance departments and solvency regulation by adopting the Financial Regulation Standards (Standards) in June 1989. In an effort to provide guidance to the states regarding the baseline Standards and as an incentive to put them in place, the NAIC adopted in June 1990 a formal certification program. Under this plan, each state's insurance department will be reviewed by an independent review team whose job is to assess that department's compliance with the Standards. Departments meeting the Standards will be publicly acknowledged, while departments not in compliance will be given guidance by the NAIC to bring them into compliance.

The Financial Regulation Standards and Accreditation (F) Committee of the NAIC, consisting of regulators from across the country, ultimately decides whether a state meets the requirements set forth in

the Standards. The meetings in which matters of state accreditation are discussed are held in a regulator only session to protect the states, regulators, and in some instances, insurers from disclosure of confidential information.

What is the program's mission statement?

The mission of the NAIC accreditation program is to establish and maintain standards to promote sound insurance company financial solvency regulation. The accreditation program provides a process whereby solvency regulation of multi-state insurance companies can be enhanced and adequately monitored with emphasis on the following:

1. Adequate solvency laws and regulations in each accredited state to protect consumers and guarantee funds.
2. Effective and efficient financial analysis and examination processes in each accredited state.
3. Appropriate organizational and personnel practices in each accredited state.
4. Effective and efficient processes regarding the review of organization, licensing and change of control of domestic insurers in each accredited state.

The accreditation program will accomplish its mission by continually evaluating the adequacy and appropriateness of accreditation standards in accordance with the changing regulatory environment and through continued monitoring of accredited states by conducting the following accreditation reviews:

- Pre-Accreditation Reviews to occur approximately one year prior to a state's full accreditation review. This review will entail a high-level review of the financial analysis and financial examination functions to identify areas of improvement.
- Full Accreditation Review to occur once every five years subject to interim annual reviews. This review will entail a full review of laws and regulations, the financial analysis and financial examinations functions, organizational and personnel practices, and organization, licensing and change of control of domestic insurers to assist in determining a state's compliance with the accreditation standards.
- Interim Annual Reviews to occur annually to maintain accredited status between full accreditation reviews. This review will entail a review of any law and regulation changes, the financial analysis and financial examination functions, and organizational and personnel practices to ensure continued compliance with the accreditation standards and to identify areas of improvement.

What are the benefits of accreditation?

The accreditation program allows for inter-state cooperation and reduces regulatory redundancies. That is, if a company is domiciled in an accredited state, the other states in which that company is licensed and/or writes business may be assured that, because of its accredited status, the domiciliary state insurance department is adequately monitoring the financial solvency of that company. In fact, each accredited state's laws or regulations on financial examinations contain a provision that all licensed companies are to be examined periodically; however, in lieu of performing its own examination, a state may accept the examination report prepared by an insurance department that was accredited at the time of examination. Therefore, the inter-state reliance that the accreditation program produces ultimately saves millions of dollars in duplicative examination costs.

The accreditation program is a key tool in promoting and maintaining state-based regulation of the insurance industry. The creation of the accreditation program was prompted by a congressional report that

highlighted weaknesses in state-based regulation, to which the Program has aided states in correcting these deficiencies. States that maintain their accredited status demonstrate that the current scheme of regulatory monitoring is intact and continues to work effectively.

Who is accredited?

As of January ~~2018~~2019, there are a total of 52 jurisdictions that are accredited. All fifty states, the District of Columbia and Puerto Rico are accredited, which includes—Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

How the Accreditation Program Works

The accreditation program establishes requirements under which a state insurance department may seek accreditation. Additionally, the program establishes guidelines for states already accredited to maintain their accredited status.

Accreditation Review Process

Procedures in Preparation for an Accreditation Review

1. A state requests an accreditation review by contacting the applicable NAIC staff.
2. The NAIC requests that the state submit a self-evaluation guide. This guide provides the state with the detailed requirements of the accreditation standards including laws and regulations that must be adopted, financial analysis and examination procedures that must be in place organizational and personnel practices that must be established, and organization, licensing and change of control of domestic insurers' practices that must be established.
3. The NAIC assembles proposed review teams consisting of qualified candidates that are considered experts in the insurance industry, to participate on a state's accreditation review. These proposed review teams are reviewed and approved by the chief operation officer.
4. The NAIC notifies the chair and vice-chair of the Financial Regulations Standards and Accreditation (F) Committee (the Committee) that the state has requested an accreditation review and provides the chair and vice-chair with the proposed review team, as approved by the chief operation officer.
5. The chair and vice-chair of the Committee approve the review team and the review team leader and appoint at least one NAIC observer. Review teams generally consist of three to eight individuals depending upon the size of the state as noted in the "Workplan for the Full On-Site Accreditation Review," however, the chair of the Committee may determine that a lesser number is sufficient when the size of the state's insurance industry and scope of the department's responsibilities are notable limited. The review team should include at least one disinterested former executive level regulator.
6. The NAIC notifies the state of the selection of the review team. The state is given the opportunity to object to any of the review team members.

7. The NAIC notifies the review team members. The review team members are paid by the NAIC at a set hourly rate for time spent on the accreditation review plus reasonable actual expenses incurred.
8. The NAIC works with the state to schedule the site visit and notifies the review team of the dates. Generally, a site visit requires three to five days depending upon the size of the state.
9. The NAIC sends copies of the state's completed self-evaluation guide with any applicable supporting documentation to the review team.
10. The NAIC notifies the state of the data, documentation, staff interviews, and other needs of the review team for its on-site review.
11. The NAIC Legal Division reviews the Part A responses and other pertinent information received from the state, and to the extent necessary, may analyze the state's laws, to determine whether the state is in compliance with the Part A standards and to confirm whether the citations provided by the state accurately identify the extent to which the state's laws and regulations evidence compliance with the Part A standards. Questions or concerns are forwarded to the NAIC accreditation staff and, if not resolved, are discussed with the state and, in addition, may be brought to the attention of an accreditation review team leader.
12. The report of the NAIC Legal Division on the Part A standards (Part A Report) reports the findings of the NAIC Legal Division and includes the NAIC Legal Division's conclusion on the state's compliance with the Part A: Laws and Regulations Standards. An exceptions portion of the report will highlight concerns, if any are noted during the review, together with recommendations for the state to consider enhancements to its laws and regulations providing for sound insurance regulation. The department is required to provide a formal response to any exceptions noted by the date indicated by NAIC staff. This response will be included in the accreditation report package provided to the Committee for discussion during the national meeting.
13. The Part A Report is made part of the documentation for the accreditation review. It is typically delivered to the department and the review team by the commencement of the on-site review, and is included in the materials submitted to each member of FRSAC at the conclusion of the on-site review.

On-Site Accreditation Review Procedures

1. The review team conducts the on-site review following a general outline of procedures to be performed to allow for uniformity in the evaluation process among the states. In addition, an NAIC staff representative is an observer on each site visit to help ensure uniformity and consistency in the on-site reviews. Before the on-site review, there is an initial meeting of the team members to discuss comments and concerns from review of the self-evaluation guide and supporting documentation.
2. The on-site review consists of the following:
    - Discussion with financial solvency senior management and the commissioner regarding its role in financial solvency oversight.
    - Review of examination reports and supporting work papers and analytical reviews.
    - Inspection of financial analysis and examination files for selected companies.
    - Interviews with department personnel.
    - Review of organizational and personnel practices.
    - Inspection of documentation regarding primarily licensure applications and Form A filings for selected companies.

- Walk-through of the department to gain an understating of document and communication flows.
- Meetings of the review team to discuss comments and findings from the review.
- Private meeting of the team members to develop the review team's recommendation regarding the state's accreditation and to draft the review team's report.
- Closing conference with the state to discuss findings.
- Draft copies of the Part A Report and the review team's report discussing Parts B, C and D, which includes any key areas for improvement, are provided to the state.

3. The review team's report includes an executive summary identifying the review team's recommendation, supporting rationale for the recommendation, positive attributes and key areas for improvement. The report template also includes a section for the review team's discussion which allows the team flexibility to include additional context and any information that would be valuable or meaningful to the Committee. The review team's report may include items that require a response from the department. In those instances, the department is required to provide a formal response by the date indicated by NAIC staff. This response will be included in the accreditation report package provided to the Committee for discussion during the next National Meeting.

Committee Evaluation Process

1. The Committee typically meets at the national meetings to discuss the review team's reports. The Committee also has copies of the state's self-evaluation guide and supporting documentation available. In addition, the team leader and the NAIC observer are present at the meeting. Representatives of the state are in attendance to respond to questions from the Committee, or comment upon the review team's reports and recommendation.

2. The Committee has the option to convene into a "private" session during its Regulator-to-Regulator session meeting, at the discretion of the Chair of the Committee. The individuals in the private session would typically include only members of the Committee and their representatives, applicable NAIC staff, and the team leader. This should only occur in rare and infrequent situations when the Committee must discuss or inquire regarding sensitive issues. Examples of this could include the following:

    a. Concern regarding the quality or competence of personnel employed by a state insurance department, or

    b. To confer with NAIC staff on the process and results of a contentious issue that the Committee has deliberated previously.

3. Representatives of the state are excused once the Committee has no further questions for these individuals. Based on the recommendation of the review team and as a result of this meeting, the Committee makes a decision as to whether or not the state should be accredited. If the state is already accredited, the Committee makes a decision whether the state should retain its accreditation, or whether its accreditation should be placed on probation, suspended or revoked.

4. The Committee informs the state of its decision:

    a. If the decision is to retain the state's accreditation, which includes those states granted continued accreditation although they were also placed on probation, the state receives recognition at the national meeting via inclusion in the daily newsletter.

    b. For those states not currently accredited: If the decision is unfavorable, the state has three options: withdraw its request for accreditation; ask the Committee to hold its decision in abeyance pending legislative or other corrective action to bring the state into compliance with the standards; or appeal the decision of the Committee.

c. For those states currently accredited:

- If the decision is to place a state's accredited status on probation, a letter setting forth the conditions of the probation should be sent to the state as soon as possible after the Committee meeting. The state does not have the option to appeal the decision of the Committee.
- If the decision is to suspend a state's accreditation, a letter setting forth the conditions of the suspension should be sent to the state as soon as possible after the Committee meeting. The state may either accept the decision or choose to appeal the decision of the Committee. In the case of an appeal, the state retains its full accredited status during the appeals process. Public acknowledgement that a state's accreditation has been suspended should only occur after the opportunity to appeal has lapsed and the state has not chosen to do so, or if the decision by the Committee to suspend accreditation is upheld by the appeal hearing panel.
- If the decision is to revoke a state's accreditation, the state may either accept the decision or choose to appeal the decision of the Committee. In the case of an appeal, the state retains its full accredited status during the appeals process. Public acknowledgement that a state's accreditation has been revoked should only occur after the opportunity to appeal has lapsed and the state has not chosen to do so, or if the decision by the Committee to revoke accreditation is upheld by the appeal hearing panel.

5. Accreditation is for a five-year period, subject to annual reviews of the state's self-evaluation guide. Once accredited, a state is subject to a full accreditation review every five years. If information comes to the attention of the Committee that suggests that a state may no longer meet the standards, a special review may be conducted. If the Committee concludes that the state's accreditation should be placed on probation, suspended or revoked, the specific reasons are documented in a report to the state. The state would have the right to appeal a suspension or revocation decision of the Committee utilizing the procedures outlined in the section entitled, "Appeal Procedures for the NAIC Financial Regulation Standards and Accreditation Program."

Interim Annual Reviews

1. Annually, on the anniversary of the state's accreditation, the state shall submit an updated self-evaluation guide (interim annual reviews) to the NAIC Central Office.
2. The state's report in the first year after an on-site accreditation review shall also provide an updated response to all recommendations made in the review team's report, including the progress on addressing each of the recommendations. Additional updates may also be required in subsequent years to address any outstanding concerns.
3. NAIC staff will review the interim annual review report and supporting documentation submitted by the state and summarizes the information for presentation to the Committee.
4. After hearing the report from the NAIC staff, the Committee will determine whether the state remains in compliance with the standards. (The Committee may request that a representative of the state be present to answer questions, if desired.)
5. If the Committee finds the state to be out of compliance with the standards, the specific reasons will be documented in a letter to the state and the state's accreditation will be placed on probation, suspended or revoked. The state would have the right to appeal a suspension or revocation decision of the Committee utilizing the procedures outlined in the following section entitled, "Appeal Procedure for the NAIC Financial Regulation Standards and Accreditation Program." A state cannot appeal a decision by the Committee to place its accreditation on probation.

A Closer Look at the Standards

The Standards have been divided into four major categories: laws and regulations (Part A); regulatory practices and procedures (Part B); organizational and personnel practices (Part C); and organization, licensing and change of control of domestic insurers (Part D).

Part A: Laws and Regulations –Excluding RRGs

Preamble

Purpose of the Part A Standards

The purpose of the Part A: Laws and Regulations standards are to assure that an accredited state has sufficient authority to regulate the solvency of its multi-state domestic insurance industry in an effective manner. The Part A standards are the product of laws and regulations that are considered to be basic building blocks for effective financial solvency regulation. A state may demonstrate compliance with a Part A standard through a law, a regulation, or an administrative practice that implements the general authority granted to the commissioner, or any combination thereof, which achieves the objective of the standard. The term "state" as used herein is intended to include any NAIC member jurisdiction, including U.S. territories. The term "commissioner" means commissioners, directors, superintendents or other officials who by law are charged with the principal responsibility of supervising the business of insurance within each state.

Scope of the Part A Standards (Excluding Risk Retention Groups Organized as Captives)

Life/Health and Property/Casualty Insurers

The following Part A standards apply to the regulation of a state's domestic insurers licensed and/or organized under its life/health and property/casualty statutes (life/health or property/casualty insurer), but only if the insurer is a multi-state insurer. NOTE: This section does not apply to a state's domestic insurers licensed and/or organized under its captive or special purpose vehicle statutes or any other similar statutory construct. For purposes of Part A, a life/health or property/casualty insurer that meets any of the following conditions is considered to be a multi-state insurer and subject to the Part A standards:

1. A property/casualty or life/health domestic insurer that is licensed in at least one state other than its state of domicile.

2. A property/casualty or life/health domestic insurer that is operating in at least one state other than its state of domicile.

3. A property/casualty or life/health domestic insurer that is accredited or certified as a reinsurer in at least one state other than its state of domicile.

4. A property/casualty or life/health domestic insurer that is reinsuring business covering risks residing in at least two states.

5. A property/casualty domestic insurer that is accepting business on an exported basis as an excess or surplus line insurer in at least one state other than its state of domicile.

<u>Captive Reinsurers</u>
The following Part A standards apply to the regulation of a state's domestic insurers licensed and/or organized under its captive or special purpose vehicle statutes or any other similar statutory construct (captive insurer) that reinsure business covering risks residing in at least two states, but only with respect to the following lines of business:

1. Policies that are required to be valued under Sections 6 or 7 of the *Valuation of Life Insurance Policies Model Regulation* (Model #830) (commonly referred to as XXX/AXXX policies). The application of this provision is intended to have a prospective-only effect, so that regulation of captive insurers, special purpose vehicles and any other entities that reinsure these types of policies will not be subject to the Part A standards if the policies assumed were both (1) issued prior to Jan. 1, 2015, and (2) ceded so that they were part of a reinsurance arrangement as of Dec. 31, 2014. [Drafting Note: This paragraph of the Preamble became effective Jan. 1, 2016]

2. Variable annuities valued under Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43). [Drafting Note: This paragraph of the Preamble is not yet effective. Effective date for compliance to be determined.]

3. Long term care insurance valued under the *Health Insurance Reserves Model Regulation* (Model #10). [Drafting Note: This paragraph of the Preamble is not yet effective. Effective date for compliance to be determined.]

The NAIC Executive (EX) Committee adopted the XXX/AXXX Reinsurance Framework, and the NAIC is currently in the process of adopting actions necessary for its full implementation. With regard to a captive insurer, special purpose vehicle, or any other entity assuming XXX/AXXX business, regulation of the entity is deemed to satisfy the Part A accreditation requirements if the applicable reinsurance transaction satisfies the XXX/AXXX Reinsurance Framework requirements adopted by the NAIC.

[Drafting Note: The Part A standards with respect to entities assuming variable annuities and long term care reinsurance business are intended to be effective with respect to both currently in-force and future business. However, the effective dates for variable annuities and long term care insurance are not yet determined, and their application to in-force business need further discussion].

<u>Other Types of Insurers</u>
For clarity purposes, the scope of the Part A standards excludes regulation of those insurers licensed as fraternal orders and title insurers. The scope of the Part A standards also excludes regulation of health organizations, except that compliance with the "Capital and Surplus Requirement" standard is required for entities licensed as health organizations (including health maintenance organizations, limited health service organizations, dental or vision plans, hospital, medical and indemnity or service corporations, or other managed care organizations) to the extent the insurance department regulates such entities. This definition does not include an organization that is licensed as either a life/health insurer or a property/casualty insurer, which are subject to the full Part A accreditation standards.

1. Examination Authority

The department should have authority to examine companies whenever it is deemed necessary. Such authority should include complete access to the company's books and records and, if necessary, the records of any affiliated company, agent, and/or managing general agent. Such authority should extend not only to inspect books and records but also to examine officers, employees, and agents of the company under oath when deemed necessary with respect to transactions directly or indirectly

related to the company under examination. The NAIC *Model Law on Examinations* or substantially similar provisions shall be part of state law.

2. **Capital and Surplus Requirement**
The department should have the ability to require that insurers have and maintain a minimum level of capital and surplus to transact business. The department should have the authority to require additional capital and surplus based upon the type, volume and nature of insurance business transacted. The *Risk Based Capital (RBC) for Insurers Model Act* and the *Risk-Based Capital for Health Organizations Model Act* or provisions substantially similar shall be included in state laws or regulations.

3. **NAIC Accounting Practices and Procedures**
The department should require that all companies reporting to the department file the appropriate NAIC annual statement blank, which should be prepared in accordance with the NAIC's instructions handbook and follow those accounting procedures and practices prescribed by the NAIC's *Accounting Practices and Procedures Manual*, utilizing the version effective January 1, 2001 and all subsequent revisions adopted by the Financial Regulation Standards and Accreditation (F) Committee.

4. **Corrective Action**
State law should contain the NAIC's *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition* or a substantially similar provision, which authorizes the department to order a company to take necessary corrective action or cease and desist certain practices that, if not corrected, could place the company in a hazardous financial condition.

5. **Valuation of Investments**
The department should require that securities owned by insurance companies be valued in accordance with those standards promulgated by the NAIC's Capital Markets and Investment Analysis Office. Other invested assets should be required to be valued in accordance with the procedures promulgated by the NAIC's Financial Condition (E) Committee.

6. **Insurance Holding Company Systems**
State law should contain the NAIC *Insurance Holding Company System Regulatory Act* or an Act substantially similar, and the department should have adopted the NAIC's model regulation relating to this law.

7. **Risk Limitation**
State law should prescribe the maximum net amount of risk to be retained by a property and liability company for an individual risk based upon the company's capital and surplus. This limitation should be no larger than 10% of the company's capital and surplus.

8. **Investment Regulations**
State statute should require a diversified investment portfolio for all domestic insurers both as to type and issue and include a requirement for liquidity. Foreign companies should be required to substantially comply with these provisions.

9. **Liabilities and Reserves**
State statute should prescribe minimum standards for the establishment of liabilities and reserves resulting from insurance contracts issued by an insurer; including life reserves, active life reserves and unearned premium reserves, and liabilities for claims and losses unpaid and incurred but not reported claims. The NAIC's *Standard Valuation Law, Actuarial Opinion and Memorandum Regulation* and *Property and Casualty Actuarial Opinion Model Law* or substantially similar provisions shall be in place.

10. Reinsurance Ceded
State law should contain the NAIC *Credit for Reinsurance Model Law*, the NAIC's *Credit for Reinsurance Model Regulation* and the NAIC *Life and Health Reinsurance Agreement Model Regulation* or substantially similar laws.

11. CPA Audits
State statute or regulation should contain a requirement for annual audits of domestic insurance companies by independent certified public accountants that is substantially similar to the NAIC's *Annual Financial Reporting Model Regulation*.

12. Actuarial Opinion
State statute or regulation should contain a requirement for an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist on an annual basis for all domestic insurance companies.

13. Receivership
State law should set forth a receivership scheme for the administration, by the insurance commissioner, of insurance companies found to be insolvent as set forth in the NAIC's *Insurer Receivership Model Act*.

14. Guaranty Funds
State law should provide for a regulatory framework such as that contained in the NAIC's model acts on the subject, to ensure the payment of policyholders' obligations subject to appropriate restrictions and limitations when a company is deemed insolvent.

15. Filings with NAIC
State statute, regulation or practice should mandate filing of annual and quarterly statements with the NAIC in a format acceptable to the NAIC except that states may exempt from this requirement those companies that operate only in their state of domicile.

16. Producer Controlled Insurers
States should provide evidence of a regulatory framework, such as that contained in the NAIC's *Business Transacted with Producer Controlled Property/Casualty Insurer Act* or similar provisions.

17. Managing General Agents Act
States should provide evidence of a regulatory framework, such as that contained in the NAIC's *Managing General Agents Act* or similar provisions.

18. Reinsurance Intermediaries Act
States should provide evidence of a regulatory framework, such as that contained in the NAIC's *Reinsurance Intermediary Model Act* or similar provisions.

19. Regulatory Authority
State law should provide for a regulatory framework for the organization, licensing and change of control of domestic insurers.

20. **Risk Management and Own Risk and Solvency Assessment**
State law should contain the NAIC *Risk Management and Own Risk and Solvency Assessment Model Act* (#505), or a substantially similar law.

(Note: If a state can provide evidence that none of the entities contemplated in above standards 14, 16, 17 or 18, is either present or allowed to operate in the state, it will not need to demonstrate compliance with that standard.)

Part A: Laws and Regulations – Risk Retention Groups

Scope of the Part A Standards (Risk Retention Groups Organized as Captives

The following Part A standards apply to regulation of a state's domestic RRGs incorporated as captive insurers, but only if the RRG is a multi-state insurer. For purposes of Part A, an RRG that meets any of the following conditions is considered to be a multi-state insurer and subject to the Part A standards:

1. An RRG domestic insurer that is registered in a least one state other than its state of domicile.
2. An RRG domestic insurer that is operating in at least one state other than its state of domicile.
3. An RRG domestic insurer that is reinsuring business covering risks residing in at least two states.

This scope includes RRGs that are chartered in the accredited state and registered or operating in at least one other state.

1. Examination Authority

The department should have authority to examine RRGs organized as captive insurers whenever it is deemed necessary. Such authority should include complete access to the RRG's books and records and, if necessary, the records of any affiliated company, agent, and/or managing general agent. Such authority should extend not only to inspect books and records but also to examine officers, employees, and agents of the RRG under oath when deemed necessary with respect to transactions directly or indirectly related to the RRG under examination. The NAIC *Model Law on Examinations* or substantially similar provisions shall be part of state law.

2. Capital and Surplus Requirement

The department should have the ability to require that RRGs have and maintain a minimum level of capital and surplus to transact business. The department should have the authority to require additional capital and surplus based upon the type, volume, and nature of insurance business transacted. The *Risk-Based Capital for Insurers Model Act* or provisions substantially similar should be included in state laws or regulations.

3. NAIC Accounting Practices and Procedures

The department should require that RRGs reporting to the department file the appropriate NAIC Annual Statement Blank which should be prepared in accordance with the NAIC's Instructions Handbook, as applicable. The RRGs should follow those accounting procedures and practices prescribed by the NAIC *Accounting Practices and Procedures Manual* or another basis of accounting as permitted or prescribed by state law or regulation.

4. Corrective Action

State law should contain the NAIC's *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition* or a substantially similar provision which authorizes the department to order a RRG to take necessary corrective action or cease and desist certain practices which, if not corrected, could place the RRG in a hazardous financial condition.

5. Valuation of Investments

The department should require that securities owned by RRGs be valued in accordance with those standards promulgated by the NAIC's Capital Markets and Investment Analysis Office or, if a basis of accounting other than SAP is used, the state must have authority to determine the valuation of securities. For RRGs that use SAP, other invested assets should be required to be valued in accordance with the procedures promulgated by the NAIC's Financial Condition (E) Committee. For RRGs that use another basis of accounting, the state must have authority to determine valuation of securities.

6. **Insurance Holding Company Systems**
   State law should contain the NAIC *Insurance Holding Company Systems Regulatory Act* or an act substantially similar and the department should have adopted the NAIC's model regulation relating to this law.

7. **Risk Limitation**
   State law should provide the state insurance department with clear authority in statute or regulation to limit the net amount of risk retained for an individual risk.

8. **Investment Regulations**
   State statute should require a diversified investment portfolio for RRGs both as to type and issue and include a requirement for liquidity.

9. **Liabilities and Reserves**
   State statute should prescribe minimum standards for the establishment of liabilities and reserves resulting from insurance contracts issued by an RRG; including unearned premium reserves and liabilities for claims and losses unpaid and incurred but not reported claims.

10. **Reinsurance Ceded**
    State law should contain the NAIC *Model Law on Credit for Reinsurance*, the NAIC's *Credit for Reinsurance Model Regulation* or substantially similar laws.

11. **CPA Audits**
    State statute or regulation should contain a requirement for annual audits of domestic RRGs by independent certified public accountants that is substantially similar to the NAIC *Annual Financial Reporting Model Regulation*.

12. **Actuarial Opinion**
    State statute or regulation should contain a requirement for an opinion on loss and loss adjustment expense reserves by a qualified actuary or specialist annually for all domestic RRGs.

13. **Receivership**
    State law should set forth a receivership scheme for the administration, by the insurance commissioner, of RRGs found to be insolvent similar to the NAIC's *Insurer Receivership Model Act*.

14. **Filings with NAIC**
    State statute, regulation or practice should mandate filing of annual and quarterly statements with the NAIC in a format acceptable to the NAIC except that states may exempt from this requirement those RRGs that operate only in their state of domicile.

15. **Producer Controlled Insurers**
    States should provide evidence of a regulatory framework, such as that contained in the NAIC's *Business Transacted with Producer Controlled Property/Casualty Insurer Act* or similar provisions.

16. **Managing General Agents Act**
    States should provide evidence of a regulatory framework, such as that contained in the NAIC's *Managing General Agents Act* or similar provisions.

17. **Reinsurance Intermediaries Act**
    States should provide evidence of a regulatory framework, such as that contained in the NAIC's *Reinsurance Intermediary Model Act* or similar provisions.

18. Governance

State statue or regulation should contain a requirement for governance standards of domestic RRGs that is substantially similar to the NAIC *Model Risk Retention Act*.

(Note: If a state can provide evidence that none of the entities contemplated in above standards 15, 16, or 17, is either present or allowed to operate in the state (in relation to RRGs), it will not need to demonstrate compliance with that standard.)

Part B: Regulatory Practices and Procedures

Preamble

Purpose of the Part B Standards

The purpose of Part B is to identify base-line regulatory practices and procedures required to supplement and support enforcement of the states' financial solvency laws in order for the states to attain substantial compliance with the core standards established in Part A. Part B identifies standards that are to be applied in the regulation of all forms of multi-state insurers as discussed below. The term "state" as used herein is intended to include any NAIC member jurisdiction, including U.S. territories.

Part B sets out standards required to ensure adequate solvency regulation of multi-state insurers. Each state must make an appropriate allocation of its available resources to effectively address its regulatory priorities. In addition to a domestic state's examination and analysis activities, other checks and balances exist in the regulatory environment. These include other states' regulation of licensed foreign companies, the appropriate application of FAST and IRIS ratios, the analyses by NAIC's staff, the NAIC Financial Analysis Working Group, the NAIC Analyst Team System project, and to some extent the evaluation by private rating agencies.

Scope of the Part B Standards

The scope of Part B is broader than the scope of Part A as Part B encompasses nearly all forms of insurers domiciled or chartered in the accredited state, but only if the insurer is a multi-state insurer. The term "insurer" in Part B includes regulation of a state's domestic insures licensed and/or organized under its life/health and property/casualty statutes, those insurers licensed as fraternal orders and title insurers, risk retention groups organized as captive insurers, those insurers licensed as health organizations (including health maintenance organizations, limited health service organizations, dental or vision plans, hospital, medical and indemnity or service corporations or other managed care organizations, but only to the extent the insurance department regulates such entities), and other entities organized under other statutory schemes. Although this scope includes risk retention groups organized as a captive insurer, it does not include any other type of captive insurer. While the unique organizational characteristics of some of these entities may require specialized laws, their multi-state activity demands solvency oversight that employs the base-line regulatory practices and procedures identified in Part B. For purposes of Part B, an insurer (other than a non-RRG captive insurer) that meets any of the following conditions is considered to be a multi-state insurer subject to the Part B standards:

1. A domestic insurer that is licensed in a least one state other than its state of domicile.

2. A domestic insurer that is registered in at least one state other than its state of domicile.

3. A domestic insurer that is operating in a least one state other than its state of domicile.

4. A domestic insurer that is accredited or certified as a reinsurer in at least one state other than its state of domicile.

5. A domestic insurer that is reinsuring business covering risks residing in at least two states.

6. A domestic insurer that is accepting business on an exported basis as an excess or surplus line insurer in at least one state other than its state of domicile.

The accreditation program recognizes that complete standardization of practices and procedures across all states may not be practical or desirable because of the unique situations each state faces. States differ with respect to staff and technology resources that are available as well as the characteristics of the domestic industry regulated. For example, states may choose to emphasize automated analysis over manual or vice

versa. Reliable results may be obtained using alternative, yet effective, financial solvency oversight methodologies. The accreditation program should not emphasize form over substance in its evaluation of the states' solvency regulation.

(<u>NOTE</u>: FRSAC has adopted Review Team Guidelines that provide detailed guidance to the review teams regarding how compliance with the Part B, Regulatory Practices and Procedures Standards should be assessed. These guidelines can also assist states in preparing for the accreditation review of their department.)

1. <u>Financial Analysis</u>

a. Sufficient Qualified Staff and Resources
The department should have the appropriate staff and resources to review effectively and timely review the financial condition of all domestic insurers.

b. Communication of Relevant Information to/from Financial Analysis Staff
The department should ensure that all relevant information and data obtained that may assist in the financial analysis process is provided to the financial analysis staff. The department should ensure that findings of the financial analysis staff are communicated to the appropriate person(s) within the department.

c. Appropriate Supervisory Review
The department's internal financial analysis process should provide for appropriate supervisory review and comment. Supervisory review may be conducted by the analyst's supervisor or a senior level analyst whose job functions include such review duties.

d. Priority-Based Analysis
The department's financial analysis procedures should be priority-based to ensure that potential problem companies are reviewed promptly. The prioritization scheme should follow the guidelines and classifications outlined in the *Financial Analysis Handbook* and utilize appropriate factors to assist in the consistent determination of priority designations.

e. Documented Analysis Procedures
The department should generally follow the risk-focused financial analysis process outlined in the *Financial Analysis Handbook* to ensure that appropriate analysis procedures are performed on each domestic insurer and insurance holding company system, as applicable to either the domestic regulator or lead state depending on the filing..

f. Appropriate Depth and Quality of Review
The department's financial analysis should ensure that domestic insurers and insurance holding company systems for which the department serves as the lead state receive a high quality review at an appropriate depth commensurate with their financial strength and position, and risk profile.

g. Reporting of and Action on Material Adverse Findings
The department's procedures should require that all material adverse findings be promptly presented to the commissioner or an appropriate designee for determination and implementation of appropriate regulatory action. Upon the reporting of any material adverse findings from the financial analysis staff, the department should take timely action in response to such findings or adequately demonstrate the determination that no action was required.

2. Financial Examinations

a. Sufficient Qualified Staff and Resources
The department should have the resources to effectively examine all domestic insurers on a periodic basis in a manner commensurate with the financial strength and position of each insurer.

b. Communication of Relevant Information to/from Examination Staff
The department should ensure that all relevant information and data obtained that may assist in the financial examination process is provided to the financial examination staff. The department should ensure that findings of the financial examination staff are communicated to the appropriate person(s).

c. Use of Specialists
The department's examination staff should include specialists with appropriate training and/or experience or otherwise have available qualified specialists, which will permit the department to effectively examine any insurer. These specialists should be utilized where appropriate given the complexity of the examination or identified financial concerns.

d. Appropriate Supervisory Review
The department's procedures for examinations should provide for supervisory review of examination workpapers and reports to ensure that the examination procedures and findings are appropriate and complete and that the examination was conducted in an efficient and timely manner.

e. General Examination Procedures
The department's policies and procedures for the conduct of examinations should generally follow those set forth in the NAIC *Financial Condition Examiners Handbook*. Appropriate variations in methods and scope should be commensurate with the financial strength and position of the insurer.

f. Risk Assessment and Testing
The department's performance and documentation of risk-focused examinations should generally follow the guidance set forth in the NAIC *Financial Condition Examiners Handbook*. Appropriate variations in method and scope should be commensurate with the financial strength and position of the insurer.

g. Scheduling of Examinations
In scheduling financial examinations, the department should follow procedures such as those set forth in the NAIC *Financial Condition Examiners Handbook* that provide for the periodic examination of all domestic companies on a timely and coordinated basis. This system should accord priority to companies that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. Communication of Examination Results
The department's reports of examination should be prepared in accordance with the format adopted by the NAIC and should be sent to other states in which the insurer transacts business in a timely fashion.

i. Reporting of and Action on Material Adverse Findings
The department's procedures should require that all material adverse findings be promptly presented to the commissioner or an appropriate designee for determination and implementation of appropriate regulatory action. Upon the reporting of any material adverse findings from the financial examination staff, the department should take timely action in response to such findings or adequately demonstrate the determination that no action was required

3. **Department Procedures and Oversight**

   a. **Information Sharing**
   States should have the authority to share confidential information with other state, federal, and international regulatory agencies and law enforcement authorities, and the NAIC. States should have the authority to maintain the confidentiality of information received from these parties. Further, the states should demonstrate the willingness to act on this authority to share confidential information.

   b. **Procedures for Troubled Companies**
   The department should generally follow and observe procedures set forth in the NAIC *Troubled Insurance Company Handbook*. Appropriate variations in application of procedures and regulatory requirements should be commensurate with the identified financial concerns and operational problems of the insurer.

   c. **Department Oversight**
   Department management should be involved in solvency monitoring activities for its domestic industry to ensure appropriate oversight of staffing, company interactions and key solvency issues with the ability and willingness to take action as deemed appropriate.

Part C: Organizational and Personnel Practices

1. **Professional Development**
   The department should recognize and provide necessary training needs for staff involved with financial surveillance and regulation. The department should also have a policy that encourages professional development through job-related college courses, professional programs, and/or other training programs.

2. **Minimum Educational and Experience Requirements**
   The department should establish minimum educational and experience requirements for all professional employees and contractual staff positions in the financial regulation and surveillance area, which are commensurate with the duties and responsibilities of the position.

3. **Retention of Personnel**
   The department should have the ability to attract and retain qualified personnel for those positions involved with financial surveillance and regulation.

4. **Use of Contract Personnel**
   A department that utilizes contract personnel to assist in financial surveillance and regulation should ensure that those hired in the capacity of a contractor are subject to standards that are comparable to or exceed those standards applicable to employees of the state.

Part D: Organization, Licensing and Change of Control of Domestic Insurers

Preamble

The focus of the Part D standards is on strengthening financial regulation and the prevention of unlicensed or fraudulent activities. The scope of this section only includes the licensing of new companies and Form A filings. The section applies to only traditional life/health and property/casualty companies, and this scope is narrower than that of Part B in that it does not include entities such as health maintenance organizations, health service plans, and captive insurers (including captive risk retention groups). These standards only deal with the department's analysis of domestic companies and do not include foreign or alien insurers. The initial company licensing process does not consider the "multi-

state" concept since the company is in its initial licensing phase. The standards regarding Form A filings deal with only filings submitted related to multi-state insurers, as that term is defined in the Part B Preamble.

1. **Sufficient Staff and Resources**
   The department should have the appropriate staff and resources to effectively and timely review applications for primary licensure and Form A filings for all domestic insurers.

2. **Scope and Performance of Procedures for Primary Applications**
   The department should have documented licensing procedures to provide for consistency in the review process and to ensure that appropriate procedures are performed on all primary applications.

3. **Scope of Performance of Procedures for Form A Filings**
   The department should have documented procedures for the Form A filings to provide for consistency in the review process and to ensure that appropriate procedures are performed on all Form A reviews.

Evolving Standards: The Impact of Changes in the Financial Regulation Standards

As insurance industry practices evolve, so must solvency regulation. Therefore, the NAIC has anticipated that the standards outlined above will not be static but will be dynamic.

What is the process to add to or modify the Standards?

In March 1998, the NAIC adopted a more flexible process when adding new standards or modifying the existing Standards. The process seeks extensive input from public officials, consumers, academics, regulators and industry representatives when changes in the Financial Regulation Standards and Accreditation Program are considered.

The procedures identify three ways in which the solvency standards may be modified:

1. The development of new models or amendment of existing models;
2. Additional or more specific requirements to Parts B, C and D of the standards; or
3. Indirect modification of current requirements through changes in manuals or books incorporated by reference in the standards, such as modification of the NAIC *Annual Statement Blank* required to be filed by all companies.

The process uses a set schedule to complete the deliberation process, which allows all interested parties to clearly understand the decision timetable.

With regard to the development of new models or the amendment of existing models, the proposal would be discussed at the spring national meeting by the Committee with public testimony taken at the summer national meeting. The Committee will notify all interested parties including all regulators, industry, consumer groups, the National Conference of State Legislatures (NCSL), National Governors' Association (NGA), National Conference of Insurance Legislators (NCOIL), and others, both of the potential change in the model and the process for public comment.

Additionally, any suggested addition or change to the accreditation standards will be accompanied by the following:

1. A statement and explanation of how the standard is directly related to solvency surveillance and why the proposal should be included in the standards.
2. A statement as to why ultimate adoption by every jurisdiction may be desirable.

3. A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date.
4. A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have "substantially similar" language or rather a regulatory framework. If it is being proposed that "substantially similar" language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements.
5. An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable.

After consideration of the testimony, the Committee will determine whether the proposal should be exposed as a potential standard. At the fall national meeting, Executive Committee and Plenary will vote on the proposal.

If the proposal is adopted by Plenary, a one-year exposure period, commencing the following January 1, for laws and regulations standards will commence during which time all interested parties will evaluate the effectiveness of the proposal.

After the exposure period has ended, the Committee will review the proposal at the spring national meeting to see what action, if any, should be taken to formally adopt the new proposal. At the summer national meeting, a public hearing will be held and the Committee will decide whether to add the proposal to the standards with a 60% majority vote needed to adopt. At the fall national meeting, Executive Committee and Plenary would also take action with 60% required to adopt. Once adopted by Plenary, the standard will become effective two years immediately following the next January 1. This provides a total of at least four full years for all parties to consider amendments or additions to the laws and regulations standards.

For additional or more specific requirements to Parts B, C and D of the standards or indirect modification of current requirements through changes in manuals or books incorporated by reference in the standards, no seasoning period is required, and these changes become effective as deemed appropriate.

If the Committee determines that a waiver of the above procedures is necessary to expeditiously consider modification or alteration of the standards, it may upon a three-fourths (3/4) majority vote, move to recommend adoption of changes or modifications to the Executive Committee. The Report of the Committee shall fully explain the necessity for expeditious action and attempt to summarize in an objective manner, the positions of the various interested parties. The Executive Committee and Plenary would vote on the Report, with a 60% majority required for adoption.

Changes to the Program

~~***Effective January 1, 2018***~~

- ~~The F Committee has adopted a new Part A Standard that requires the adoption of Risk Management and Own Risk and Solvency Assessment Model (#505) on a substantially similar basis. The Model requires insurers above a specified premium threshold to submit a confidential annual ORSA Summary Report.~~

- ~~The F Committee also adopted revisions to the Part B: Financial Analysis and Financial Examination guidelines related to review of the ORSA reports. The guidelines focus on assuring the ORSA report is reviewed by the lead state and pertinent information is incorporated into the analysis or examination work performed.~~

- ~~Effective beginning with the annual 2017 analysis, the Committee adopted revisions to the Part B: Financial Analysis and Financial Examination guidelines and related self evaluation guide/interim annual review to incorporate risk focused analysis revisions. The revisions to the guidelines and self-evaluation guide/interim annual review align with the recent revisions to the Financial Analysis Handbook to adopt a risk focused approach to analysis.~~

Effective January 1, 2019

- The 2011 Revisions related to the certified reinsurer provisions were previously included as an optional standard, but will now be required as an accreditation standard. Therefore, all accredited jurisdictions will need to adopt the 2011 revisions to the *Credit for Reinsurance Model* #*Law* (#785) and #*Credit for Reinsurance Model Regulation* (#786~~,~~), if they have not already done so. In conjunction with making the certified reinsurer provisions a required standard, three significant elements were updated which include: 1) Concentration Risk; 2) Catastrophe Recoverables Deferral; and 3) Passporting. Previously, adoption of these specific provisions was optional, even when a state adopted the certified reinsurer provisions. The Committee agreed that these three provisions should be mandatory for all accredited jurisdictions.

- The F Committee also adopted two revisions to Part B. 1) If a department utilizes a contractor to perform the primary supervisory review of financial analysis, an additional level of review is required on the Insurer Profile Summary and/or Group Profile Summary by a qualified department employee. 2) For examinations that have a substantial amount of business subject to principle-based reserve (PBR) calculations or exclusion tests, a credentialed actuary must be used.

Effective January 1, 2020

- The 2009 revisions to the *Standard Valuation Law* (#820), which authorize a principle-based reserving (PBR) methodology for life, annuity and accident and health contracts. The significant elements for these revisions will be included in the Part A, Liabilities and Reserves standard. In addition to the life companies already encompassed in the Part A accreditation standards, the PBR elements, as adopted, are designed to apply to fraternal benefit societies. Since fraternals are currently excluded from the scope of Part A, an update to the Preamble to include them in the scope for this standard is expected prior to the effective date of the standard.

- The 2014 revisions to the *Annual Financial Reporting Model* ~~Regulations~~*Regulation* (#205), which relate to new requirements for an internal audit function is being added as a new significant element in the CPA Audits standard.

- The *Corporate Governance Annual Disclosure Model Act* (#305) and the *Corporate Governance Annual Disclosure Model Regulation* (#306). These models require an insurer (or group of insurers) to provide a confidential disclosure regarding its corporate governance practices to the lead state and/or domestic regulator annually by June 1.

- Updates to Part B regarding timing of the review of Own Risk and Solvency Assessment (ORSA) Summary Reports. Reports for groups that include multiple insurers domiciled in various states should be reviewed and shared by the lead state within 120 days of receipt. Legal entity ORSA Summary Reports (which don't cover insurers domiciled in various states) should be reviewed within 180 days of receipt.

What the Future Holds: A Strong System of Solvency Regulation

The regulation of the insurance industry for solvency stands as a unique example of how an effective regulatory system can be built. The strength of that system resides in the interdependence of independent state regulators, each responsible to his or her own constituencies, yet jointly responsible for the financial health of an entire industry. At every step along the way, state insurance regulators bear in mind their duty to safeguard consumers.

Governors, legislators and state insurance regulators, not content to rest on past success, have devised in the Financial Regulation Standards and Accreditation Program, a powerful means of achieving the necessary degree of consistency among states without sacrificing the multi-state diversity that has been instrumental to that success. Since 1990, every state, the District of Columbia and Puerto Rico have adopted legislative packages designed to bring their departments of insurance into compliance with the Standards. The partnership among state government officials has been key to the success of the accreditation program, solvency regulation, and effective consumer protection.