

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

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

For $T=0$

$${}_i\text{Paid Claims}_{i_y} \times v^0 + {}_i\text{Case Reserve}_{i_y} \times v^0 + {}_i\text{IBNR}_{i_y} \times v^0 + {}_i\text{Transferred Reserve}_{i_y} \times v^0$$

For $T>0$

$${}_i\text{Paid Claims}_{i_y} \times v^0 + {}_{i+1}\text{Paid Claims}_{i_y} \times v^1 + {}_{i+2}\text{Paid Claims}_{i_y} \times v^2 + \dots + {}_{i+T}\text{Paid Claims}_{i_y} \times v^T + {}_{i+1}\text{Case Reserve}_{i_y} \times v^{T+0} + ({}_{i+1}\text{IBNR}_{i_y} \times v^{T+0}) + {}_i\text{Transferred Reserve}_{i_y} \times v^{T+0}$$

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

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

INSTRUCTIONS FOR FORM 4

OVERVIEW

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

DEFINITIONS AND FORMULAS

Current

Current calendar year of reporting.

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

Prior

The year immediately prior to the year of reporting.

Example: 2009

2nd Prior

Two years prior to the year of reporting.

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

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Example: Data from 2001 through 2009.

Column 1 – Number of Policies In Force

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

Column 2 – Number of Certificates

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

Column 3 – Death Claims

The total number of death claims for a calendar year.

Column 4 – Long-Term Care Accelerated Claims

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

Column 5 – Total Reserves

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

INSTRUCTIONS FOR FORM 5

OVERVIEW

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

DEFINITIONS AND FORMULAS

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

Column 1 – Earned Premiums

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

Grand Total Page:

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

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

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

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

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

Column 2 – Incurred Claims

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

Grand Total Page:

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

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

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

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

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

Column 3 – In Force Count End of Year

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

Grand Total Page:

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

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

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

Column 4 – Lives In force End of Year

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

Not for Distribution

SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1, 2 AND 3

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

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

Run-Off and Reinsurance Business

Similarly, insurers in run-off (major medical claims incurred with zero major medical earned premiums) or that only has assumed and no direct written major medical business in any of the states are not required to complete this supplement. However, 100% assumption reinsurance with novation (or 100% indemnity reinsurance for administration of a block of business entered into prior to March 23, 2010 – see HHS Reg. 158.150 (a)(3)) is treated as direct business for purposes of this supplement (included as direct business for the assuming reinsurer and excluded from direct business for the ceding insurer). Otherwise, the reinsurance data required in this supplement is only for use if an insurer writes direct major medical business and also assumes and/or cedes such insurance.

If an insurer has direct earned premiums to include in Columns 1 through 9 or 12 of Part 1, but also has some business in run-off (major medical claims incurred for 2019 policy year and prior, with zero major medical earned premiums or no coverage in place), the run-off claims and expenses results should be reported in Part 1, Columns 1 through 9 or 12. (If an insurer files the supplement and has a state in which the only Columns 1 through 9 or 12 business is run-off business as defined above, the insurer can report the run-off business for that state as if it was other health business; i.e., because the MLR is meaningless to that state, report zero for Columns 1 through 9 or 12 and include the run-off business along with any other health insurance reported in the Other Health Business columns of Parts 1 and 2.)

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

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

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

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

Not for Distribution

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

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

Column 1	–	Comprehensive Health Coverage – Individual
	Include:	Health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes group conversion policies.
Column 2	–	Comprehensive Health Coverage – Small Group Employer
		All policies issued to small group employers.
		Include small group health plans. “Small group health plan” means a health plan offered in the small group market as such term is defined in state law, consistent with the group’s state of situs reporting, in accordance with the Public Health Service Act.
Column 3	–	Comprehensive Health Coverage – Large Group Employer
		All policies issued to large group employers (including Federal Employees Health Benefit Plan and similar insured state and local fully insured programs).
	Include:	TRICARE plans.
Column 4	–	Mini-med plans – Individual
Column 5	–	Mini-med plans – Small Group Employer
Column 6	–	Mini-med plans – Large Group Employer
		Include “mini-med” plans, also referred to as “limited benefit indemnity health insurance plans” in Section 158.120(d)(3) of the MLR Interim Final Rule for policies that have a total annual limit of \$250,000 or less.
		The definition of individual, small group employer and large group employer is the same definition as used for Comprehensive Health Coverage (Columns 1 through 3) above.
Column 7	–	Expatriate plans – Small Group
Column 8	–	Expatriate plans – Large Group
		Include expatriate plans referenced in Section 158.120(d)(4) of the MLR Interim Final Rule as policies that provide coverage for employees, substantially all of whom are: working outside their country of citizenship, working outside of their country of citizenship and outside the employer’s country of domicile, or non-U.S. citizens working in their home country.
		These policies can be reported on a nationwide, aggregated basis, in the respective small group/large group columns. The amounts should be reported on the appropriate, domiciliary state page.
Column 9	–	Student Health Plans
		Include student health plans referenced in Section 147.145(a) of the MLR Interim Final Rule
		These policies can be reported on a nationwide, aggregated basis. The amounts should be reported on the appropriate, domiciliary state page.

Column 10 – Government Business (Excluded by Statute)

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

Column 11 – Other Health Business

Other Business (Excluded by Statute):

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

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

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

For insurers that assume health business via aggregate stop-loss reinsurance or other reinsurance that applied to a reinsured entity’s or group of entities’ entire business that would not be allocable to comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student plans in Columns 1 through 9 of Parts 1 and 2 of the supplement: report such assumed reinsurance on Line 5.0 (premiums) and Line 5.1 (claims) in Column 11 (Other Health Business) for the state page corresponding to the ceding insurer’s state of domicile.

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

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

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

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1

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

Column 14 – Uninsured Plans

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

Line 1.1 – Health Premiums Earned

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

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

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

Line 1.2 – Federal High-Risk Pools

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

Line 1.3 – State High-Risk Pools

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

Exclude: Items included on Line 2.4.

Line 1.5 – Federal Taxes and Federal Assessments

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

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

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

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

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

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

Guaranty fund assessments.

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

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

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

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

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

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

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

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

Line 1.6a – Community Benefit Expenditures (informational only)

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

EITHER*:

- a. Payments to a state, by health plans, of premium tax exemption values in lieu of state premium taxes;
- b. Payments by health plans for community benefit expenditures.** These payments must be state-based requirements to qualify for inclusion in this line item;

OR

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

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

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

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

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

Line 1.7 – Regulatory Authority Licenses and Fees

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

Exclude: Fines and penalties of regulatory authorities.

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

Line 1.9 – Net Assumed Less Ceded Reinsurance Premiums Earned

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

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

Line 1.10 – Other Adjustments Due to MLR Calculations – Premiums

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

Line 1.11 – Risk Revenue

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

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

Health Statement:

Column 13 should equal Statement of Revenue and Expense, Line 9, Column 2.

Line 2 – Claims

Health Statement:

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

Line 2.1 – Incurred Claims Excluding Prescription Drugs

Include: Direct Paid Claims during the Year

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

Change in Unpaid Claims

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

Change in Incurred but not Reported

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

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

Include: MLR rebates paid during the year.

Prescription drugs reported in Line 2.2.

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

Medical incentive pools and bonuses.

- Line 2.2 – Prescription Drugs
- Include: Expenses for prescription drugs and other pharmacy benefits covered by the reporting entity.
- Exclude: Prescription drug charges that are included in a hospital billing that should be classified as Hospital/Medical Benefits on Line 2.1.
- Line 2.3 – Pharmaceutical Rebates
- Refer to *SSAP No. 84—Health Care and Government Insured Plan Receivables* for accounting guidance.
- Line 2.4 – State Stop Loss, Market Stabilization and Claim/Census Based Assessment (Informational Only)
- Any market stabilization payments or receipts by insurers that are directly related to claims incurred and other claims based on census based assessments.
- State subsidies based on a stop-loss payment methodology.
- Unsubsidized state programs designed to address distribution of health risks across health insurers via charges to low risk-carriers that are distributed to high risk carriers.
- Refer to *SSAP No. 35R—Guaranty Fund and Other Assessments* for accounting guidance.
- Line 3 – Incurred Medical Incentive Pools and Bonuses
- Arrangements with providers and other risk-sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments to providers to promote quality improvements as defined in the PHSA (Section 2717).
- Should agree to Supplemental Health Care Exhibit, Part 2, Line 2.11, for each column.
- Health Statement:
- Column 15 should equal Underwriting and Investment Exhibit, Part 2, Line 13, Column 1 minus 10.
- Line 4 – Deductible Fraud and Abuse Detection/Recovery Expenses
- This amount is the lesser of the expense reported in Part 3, Column 7, Lines 1.11, 2.11, 3.11, 4.11, 5.11, 6.11, 7.11, 8.11 and 9.11, and the fraud and abuse recoveries reported in Part 2, Line 3, Columns 1, 2, 3, 4, 5, 6, 7, 8 and 9, respectively.
- Line 5.0 – Total Incurred Claims (Lines 2.1 + 2.2 – 2.3 + 3)
- Should agree with Supplemental Health Care Exhibit, Part 2, Line 2.15.
- Line 5.1 – Net Assumed Less Ceded Reinsurance Claims Incurred
- Assumed reinsurance claims paid plus the change in the assumed reinsurance claims liability and aggregate assumed reinsurance claims reserve less the ceded reinsurance claims paid plus the change in the ceded reinsurance claims liability and aggregate ceded reinsurance claims reserve less the change in claims related reinsurance recoverables.
- Should agree with Supplemental Health Care Exhibit, Part 2, Line 2.16 plus Line 2.17, less Line 2.18, for each column.

- Line 5.2 – Other Adjustments Due to MLR Calculation – Claims
- Any amounts excluded from claims in Part 2 for MLR calculation purposes.
- Deduct: MLR rebated incurred included in Line 5.0
- Line 5.3 – Rebates Paid
- MLR Rebates paid during the year.
- Columns 1 through 3 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(8), Columns 1 through 3, respectively.
- Sum of Columns 4 through 9 plus 12 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(8), Column 4.
- Line 5.4 – Estimated Rebates Unpaid at the End of the Prior Year
- Should equal Line 5.5 from the prior year.
- Columns 1 through 3 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(3), Columns 1 through 3, respectively.
- Sum of Columns 4 through 9 plus 12 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(3), Column 4.
- Line 5.5 – Estimated Rebates Unpaid at the End of the Current Year
- MLR rebates estimated but unpaid as of the reporting period.
- Columns 1 through 3 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(9), Columns 1 through 3, respectively.
- Sum of Columns 4 through 9 plus 12 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(9), Column 4.
- This cross-check is for the year-end annual statement accrual for the Public Health Service Act rebates to Supplemental means Case Exhibit, Part 1 April 1 filing. This amount may differ from the final payment made in accordance with the HHS filing.
- Line 5.6 – Fee-for-Service and Co-Pay Revenue (net of expenses)
- Includes: Revenue recognized by the reporting entity for collection of co-payments from members and revenue derived from health services rendered by reporting entity providers that are not included in member policies.
- Deduct: Medical expenses associated with fee-for-service business.

Line 6.1 – Improve Health Outcomes

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

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

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

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

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

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

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

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

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

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

Line 6.2 – Activities to Prevent Hospital Readmissions

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

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

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

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

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

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

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

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

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

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

Line 6.3 – Improve Patient Safety and Reduce Medical Errors

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

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

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

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

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

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

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

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

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

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

Line 6.4 – Wellness and Health Promotion Activities

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

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

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

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

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

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

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

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

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

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

Line 6.5 – Health Information Technology Expenses related to Health Improvement

Include expenses meeting the definition of HIT Expenses for Health Care Quality Improvements in Part 3, Column 5 that are health information technology expenses.

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

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

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

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

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

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

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

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

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

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

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

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

Utilization review;

Detection and prevention of payment for fraudulent requests for reimbursement;

Expenses for internal and external appeals processes; and

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

Line 8.2 – All Other Claims Adjustment Expenses

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

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

Examples of other claim adjustment expenses are:

Estimating the amounts of losses and disbursing loss payments;

Maintaining records, general clerical and secretarial;

Office maintenance, occupancy costs, utilities and computer maintenance;

Supervisory and executive duties; and

Supplies and postage.

- Line 10 – General and Administrative Expenses
General and Administrative Expenses not Included in Line 6.6 or Line 8.3.
- Line 10.1 – Direct Sales Salaries and Benefits
Compensation (including, but not limited, to salaries and benefits) to employees of the company engaged in the activity of soliciting and generating sales to policyholders for the company.
- Line 10.2 – Agents and Brokers Fees and Commissions
All expenses incurred by the company payable to a licensed agent, broker or producer who is not an employee of the issuer in relation to the sale and solicitation of policies for the company.
- Line 10.3 – Other Taxes (Excluding Taxes on Lines 1.5 through 1.7 above and Line 14 below)
Include: Taxes of Canada or of any other foreign country not specifically provided for elsewhere.
Sales taxes, other than state sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.
- Line 10.4a – Community Benefit Expenditures (informational only; already reported in line 10.4)
Community benefit expenditures excluded from Line 1.6a due to tax rate limitation.
- Line 16 – ICD-10 Implementation Expenses (Informational only; already included in Line 8.2 and Line 10.4)
Costs associated the implementation of ICD-10, including the total cost of conversion, claims adjudication, maintenance and quality improvement allowance.
- Line 16a – ICD-10 Implementation Expenses (Informational only; already included in Line 10.4)
Include: Quality Improvement ICD-10 conversion costs incurred up to .3% of earned premium in the relevant state market. (Refer to 45 CFR 158.150 of PPACA.)

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OTHER INDICATORS

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

Line 1 – Number of Certificates / Policies

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

Column 15 should equal Accident and Health Policy Experience Exhibit Column 2, Line D2 – D1.

Line 2 – Number of Covered Lives

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

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

Line 3 – Number of Groups

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

Line 4 – Member Months

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

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

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ACA RECEIPTS, PAYMENTS, RECEIVABLES and PAYABLES TABLE

Permanent ACA Risk Adjustment Program

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

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

Transitional ACA Reinsurance Program

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

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

Temporary ACA Risk Corridors Program

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

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

The amounts from the lines below for Column 1, Individual Plans and Column 2, Small Group Employer Plans, are included in the amount reported on Line 1.5 of Part 2:

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

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2

Column 13 – Total

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

- Column 13, Line 1.16 (Net Premiums Earned) should equal the Accident and Health Policy Experience Exhibit, Part 4, Column 1, Line 6 (Total) minus Line 2 (Other Forms Direct Business).
- Column 13, Line 1.11 (Total Direct Premiums Earned) minus Line 1.5 (Paid Rate Credits) minus Line 1.8 (Change in Reserve for Rate Credits) plus Line 1.15 (Other Adjustments Due to MLR Calculation – Premiums) should equal the Accident and Health Policy Experience Exhibit, Part 4, Column 1, Line 1 (U.S. Forms Direct Business).
- Column 13, Line 2.20 (Net Incurred Claims) minus Line 2.11 (Incurred Medical Incentive Pools and Bonuses) should equal the Accident and Health Policy Experience Exhibit, Part 4, Columns 2 plus 3, Line 6 (Total) minus Line 2 (Other Forms Direct Business).
- Column 13, Line 2.15 (Total Incurred Claims) minus Line 2.5 (Paid Rate Credits) minus Line 2.9 (Reserve for Rate Credits Current Year) plus Line 2.10 (Reserve for Rate Credits Prior Year) minus Line 2.11 (Incurred Medical Incentive Pools and Bonuses) plus Line 2.19 (Other Adjustments Due to MLR Calculation – Claims) should equal the Accident and Health Policy Experience Exhibit, Part 4, Columns 2 plus 3, Line 1 (U.S. Forms Direct Business).

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

Lines 1.1 – Direct Premiums Written

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

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

Line 1.5 – Paid Rate Credits

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

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

- Line 1.6 – Reserve for Rate Credits Current Year
- Report experience-rated refund liabilities less receivables under retrospectively rated contracts.
- Include: MLR rebates accrued, premium stabilization reserves and risk corridor liabilities less receivables.
- Line 1.9 – Premium Balances Written Off
- Include: Agents' or premium balances determined to be uncollectible and written off as losses. Also include recoveries during the current year on balances previously written off. Include actual write offs, not reserves for bad debt or statutory nonadmitted amounts.
- Line 1.10 – Group Conversion Charges
- If Line 1.1 has been reduced or increased by the amount of any conversion charges associated with group conversion privileges between group and individual lines of business in the annual statement accounting, enter the reverse of these charges on this line in the appropriate columns.
- Line 1.11 – Total Direct Health Premiums Earned
- Include: Direct written premium plus the change in unearned premium reserves.
- Line 1.12 – Assumed Premium Earned from Non-affiliates
- Include: Premiums assumed from ceding entity per SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance.
- Line 1.13 – Net Assumed Less Ceded Premiums Earned from Affiliates
- Include: Premiums received from ceding entity and ceded premium per SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance.
- Line 1.14 – Ceded Premium Earned to Non-affiliates
- Include: Assessments payable for reinsurance for issuers of individual policies per SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act and ceded premium per SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance.
- Line 1.15 – Other Adjustments Due to MLR Calculation – Premiums
- Include: Any amounts excluded from premium for MLR calculation purposes that are normally included in premiums for financial statement purposes.
- Do not include: MLR rebates or any other premium adjustment related to retrospectively rated contracts as those amounts are to be reported on Part 2 Line 1.5 through Line 1.8.

Hospital/Medical Benefits

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

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

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

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

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

The cost of utilizing skilled nursing and intermediate care facilities.

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

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

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

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

Other Professional Services

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

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

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

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

Outside Referrals

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

Emergency Room and Out-of-Area

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

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

Aggregate Write-ins for Other Hospital and Medical

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

Line 2.1 Paid Claims during the Year

Report payments net of risk share amount collected.

Line 2.2 – Direct Claim Liability Current Year

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

Include: Unpaid Claims

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

Incurred but not Reported

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

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

- Line 2.4 – Direct Claim Reserves Current Year
- Report reserves related to health care services for present value of amounts not yet due on claims and the claims related portion for reserve for future contingent benefits.
- Include: Amounts for the reserve for rate credits for the current year.
- The direct claims related portion of lawsuit reserves as reported on the Liabilities Page 3, Line 2 (Life Statement), Line 7 (Health Statement) and Line 1 (Property Statement).
- Line 2.6 – Direct Contract Reserve Current Year
- Report the amount of reserves required when due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim liabilities and claim reserves. Refer to *SSAP No. 54R—Individual and Group Accident and Health Contracts* for guidance.
- Include: Contract reserves and other claims related reserves.
- Exclude: Premium deficiency reserves.
- Line 2.8 – Paid Rate Credits
- Report experience-rated premium refunds paid or received during the reporting year for retrospectively rated contracts.
- Include: MLR rebates paid, risk corridor for premiums paid or received, and all other premium refunds paid or received related to retrospectively rated contracts.
- Line 2.9 – Reserve for Rate Credits Current Year
- Report experience-rated refund liabilities less receivables under retrospectively rated contracts.
- Include: MLR rebates accrued, premium stabilization reserves, and risk corridor liabilities less receivables.
- Line 2.11 – Incurred Medical Incentive Pools and Bonuses
- Arrangements with providers and other risk-sharing arrangements whereby the reporting entity agrees to share savings with contracted providers.
- Line 2.12 – Net Health Care Receivables
- Report the change between prior year health care receivables and current year health care receivables. The amounts on this line are the gross health care receivable assets, not just the admitted portion. This amount should not include those health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.
- Line 2.13 – Group Conversion Charges
- If Line 1.1 has been reduced or increased by the amount of any conversion charges associated with group conversion privileges between group and individual lines of business in the annual statement accounting, enter the reverse of these charges on this line. Otherwise, if group conversion charges were reported separately from premiums and claims on the annual statement, enter these charges on this line in the appropriate columns.

Line 2.14 – Multi-option Coverage Blended Rate Adjustment

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

Line 2.15 – Total Incurred Claims

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

Line 2.19 – Other Adjustments Due to MLR Calculation – Claims

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

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

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

Include collected recoveries on paid claims only.

Footnote (a)

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

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SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

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

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

The definitions of Individual, Small Group and Large Group are found in the instructions for Part 1 and 3 of this supplement exhibit.

Improving Health Care Quality Expenses – General Definition:

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

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

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

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

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

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

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

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

This category can include costs for associated activities such as:

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

Column 2 – Activities to Prevent Hospital Readmission

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

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

Column 3 – Improve Patient Safety and Reduce Medical Errors

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

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

Column 4 – Wellness & Health Promotion Activities

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

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

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

Column 5 – HIT Expenses for Health Care Quality Improvements

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

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

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended).

NOTE:

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

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

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

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

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

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

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

Life/Fraternal Statement:

Exhibit 2, Line 2 Salaries and wages
Exhibit 2, Line 3.11 Contributions for benefit plans for employees
Exhibit 2, Line 3.12 Contributions for benefit plans for agents
Exhibit 2, Line 3.21 Payments to employees under non-funded benefit plans
Exhibit 2, Line 3.22 Payments to agents under non-funded benefit plans
Exhibit 2, Line 3.31 Other employee welfare
Exhibit 2, Line 3.32 Other agent welfare

Health Statement:

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

P/C Statement:

U&I Part 3, Line 8.1 Salaries
U&I Part 3, Line 9 Employee relations and welfare
U&I Part 3, Line 11 Directors' fees

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

Include:

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

Life/Fraternal Statement:

Exhibit 2, Line 4.5 Expense of investigation and settlement of policy claims
Outsourced portion of Exhibit 2, Line 7.1 Agency expense allowance

Health Statement:

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

P/C Statement:

Outsourced portion of U&I Part 3, Line 1.4 Net claim adjustment services
Outsourced portion of U&I Part 3, Line 2.8 Net commission/brokerage
Outsourced portion of U&I Part 3, Line 3 Allowances to manager and agents

Exclude:

Services provided by affiliates under management agreements.

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

Life/Fraternal Statement:

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

Health Statement:

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

P/C Statement:

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

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

Life/Fraternal Statement:

Exhibit 2, Line 5.6 Rental of equipment

Equipment amounts from Exhibit 2, Line 5 Cost or depreciation of furniture/equipment

Health Statement:

U&I Part 3, Line 12 Equipment

P/C Statement:

U&I Part 3, Line 14 Equipment

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

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

Life/Fraternal Statement:

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

Health Statement:

U&I Part 3, Line 5 Certification and Accreditation

P/C Statement:

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

Exclude: Rating agencies and other similar organizations.

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

Include: Any additional expenses not included in another category.

Life/Fraternal Statement:

Exhibit 2, Line 1 Rent
Exhibit 2, Line 4.1 Legal fees and expenses
Exhibit 2, Line 4.2 Medical examination fees
Exhibit 2, Line 4.3 Inspection report fees
Exhibit 2, Line 4.4 Fees of public accountants and consulting actuaries
Exhibit 2, Line 5.1 Traveling expenses
Exhibit 2, Line 5.2 Advertising
Exhibit 2, Line 5.3 Postage, express, telegraph and telephone
Exhibit 2, Line 5.4 Printing and stationery
Furniture portion of Exhibit 2, Line 5.5 Cost or depreciation of furniture/equipment
Exhibit 2, Line 6.1 Books and periodicals
Non-accreditation portion of Exhibit 2, Line 6.2 Bureau and association fees
Exhibit 2, Line 6.3 Insurance, except on real estate
Exhibit 2, Line 6.4 Miscellaneous losses
Exhibit 2, Line 6.5 Collection and bank service charges
Exhibit 2, Line 6.6 Sundry general expenses
In house portion of Exhibit 2, Line 7.1 Agency expense allowance
Exhibit 2, Line 7.2 Agents' balances charged off (less \$__ recovered)
Exhibit 2, Line 7.3 Agency conferences other than local meetings
Exhibit 2, Line 9.1 Real estate expenses
Exhibit 2, Line 9.2 Investment expenses not included elsewhere
Exhibit 2, Line 9.3 Aggregate write-ins for expenses

Health Statement:

U&I Part 3, Line 1 Rent
U&I Part 3, Line 3 Commissions
U&I Part 3, Line 4 Legal fees
U&I Part 3, Line 6 Auditing, actuarial and other consulting
U&I Part 3, Line 7 Traveling expenses
U&I Part 3, Line 8 Marketing and advertising
U&I Part 3, Line 9 Postage, express and telephone
U&I Part 3, Line 10 Printing and office supplies
U&I Part 3, Line 11 Occupancy, depreciation and amortization
U&I Part 3, Line 15 Boards, bureaus and association fees
U&I Part 3, Line 16 Insurance, except real estate
U&I Part 3, Line 17 Collection and bank service charges
U&I Part 3, Line 18 Group service and administration fees
U&I Part 3, Line 21 Real estate expenses
U&I Part 3, Line 24 Investment expenses not included elsewhere
U&I Part 3, Line 25 Aggregate write-ins

P/C Statement:

In house portion of U&I Part 3, Line 1.4 Net claim adjustment services
In house portion of U&I Part 3, Line 2.8 Net commission/brokerage
In house portion of U&I Part 3, Line 3 Allowances to manager and agents
U&I Part 3, Line 4 Advertising
Non-accreditation portion of U&I Part 3, Line 5 Boards, bureaus and associations
U&I Part 3, Line 6 Surveys and underwriting reports
U&I Part 3, Line 7 Audit of assured's records
U&I Part 3, Line 10 Insurance
U&I Part 3, Line 12 Travel and travel items
U&I Part 3, Line 13 Rent and rent items
U&I Part 3, Line 16 Printing and stationery
U&I Part 3, Line 17 Postage, telephone and telegraph, exchange and express
U&I Part 3, Line 18 Legal and auditing
U&I Part 3, Line 21 Real estate expenses
U&I Part 3, Line 24 Aggregate write-ins

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

Life Statement:

Exhibit 2, Line 6.7 Group service and administration fees

Exhibit 2, Line 6.8 Reimbursements by uninsured plans

Health Statement:

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

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

P/C Statement:

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

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

Life/Fraternal Statement:

Exhibit 3, Line 1 Real estate taxes

Exhibit 3, Line 2 State insurance or fraternal licenses and fees

Exhibit 3, Line 3 State taxes on premiums

Exhibit 3, Line 4 Other state taxes (incl S__ for employee benefits)

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

Exhibit 3, Line 6 All other taxes

Health Statement:

U&I Part 3, Line 22 Real Estate Taxes

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

U&I Part 3, Line 23.2 State premium taxes

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

U&I Part 3, Line 23.4 Payroll taxes

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

P/C Statement:

U&I Part 3, Line 8.2 Payroll taxes

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

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

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

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

U&I Part 3, Line 22 Real estate taxes

Lines 1.11, 2.11,
3.11, 4.11, 5.11,
6.11, 7.11, 8.11
& 9.11 –

Total Fraud and Abuse Detection/Recovery Expenses Included in Column 7 (Informational Only)

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

Not for Distribution

EXPENSE ALLOCATION SUPPLEMENTAL FILING

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

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

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

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

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

Not for Distribution

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

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

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

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

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

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

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

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

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

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

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

Introduction

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

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

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

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

Base Reconciliation Exhibit

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

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

Modifications to Premiums, Considerations and Deposits

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

- Line 2 – Enter any life, annuity or health premiums, deposit-type contract funds and other considerations received by your company that were not reported on Schedule T or the Exhibit of Premiums and Losses and, therefore, not included in Line 1 above. The total of Line 2 should equal Line 2.1 + Line 2.2. Such amounts should be reported in the appropriate column based on whether such amounts relate to life insurance, annuity, accident and health, or annuity and deposit-type business. Include all amounts received for insurance contracts, Guaranteed investment contract receipts, universal life insurance deposits and any other amounts received by the company for covered contracts that were not reported on the company's Schedule T or the Exhibit of Premiums and Losses (sometimes referred to as FASB 97 deposit reporting) must be reported on Line 2. Annuity amounts entered on Lines 1 and 2 must include, but are not limited to, amounts received for immediate or deferred annuity contracts, structured settlement agreements, lottery contracts, group annuity contracts, guaranteed interest or investment contracts, deposit administration contracts and allocated or unallocated funding obligations. In addition, allocate by state and include on Line 2 amounts reported on the applicable Schedule T as Company Contributions for Employee Benefit Plans (Line 60 (Health blank) or 90 (Life blank) of Schedule T), Dividends Applied to Purchase Paid-up Additions and Annuities, Dividends Applied to Shorten Endowment or Premium-Paying Period, Premium or Annuity Considerations Waived Under Disability or Other Contract Provisions, and Aggregate Other Amounts Not Allocable by State.
- Line 2.1 – Enter fees and charges for investment management, administration and contract guarantees from the Separate Account associated with variable contracts reduced by any contractholder dividends representing a return of such fees and charges. Specifically, in the case of variable annuity products, those portions of fees and charges paid to the general account with respect to living and death benefit guarantees, M&E charges and annual contract charges. In the case of variable life products with guaranteed death benefits, the portion of fees/charges paid to the general account would include the cost of insurance in addition to M&E charges and annual contract charges. Because the fees and charges are reportable by state, a reporting entity may use either a seriatim, i.e., specific contract identification, or state an allocation method. An appropriate allocation method would be to calculate a ratio of fee income to total variable premium for the product line and multiply the ratio by the state specific variable premium.
- Line 2.2 – Enter any other life, annuity or health premiums, deposit-type contract funds and other considerations received by your company that were not reported on Schedule T or the Exhibit of Premiums and Losses.

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

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

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

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

(Millions of Dollars)

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

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

(Millions of Dollars)

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

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

(Millions of Dollars)

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

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

(Millions of Dollars)

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

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

(Millions of Dollars)

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

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

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

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

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

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

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

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

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

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

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

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

Lines 6.01 –
6.99

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

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

Lines 7.1 –
7.4

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

Line 7.1

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

Line 7.2

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

Line 7.3

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

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

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

Model Act Base

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

Not for Distribution

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

To be filed on or before April 1.

Introduction

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

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

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

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

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

Adjustments to the Base Reconciliation Exhibit

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

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

- Line 1 – Model Act Base
- The amount from Line 11 of the Base Reconciliation Exhibit should be transferred to Line 1 of the Adjustments Exhibit.
- Line 2 – All 403(b) annuities are included in Column 4 (Unallocated Annuity and Other Unallocated Fund Deposits) on the Base Reconciliation Exhibit and must be transferred to Column 2 (Allocated Annuity and Other Allocated Fund Deposits) for certain states that have not adopted the most recent Model #520 in its entirety. The amount to be transferred from Column 4 to Column 2 represents the amount of 403(b) annuity premiums included in Line 1 of the Adjustments Exhibit, regardless of whether it was originally reported in Column 2 or Column 4 of the Base Reconciliation Exhibit. Those companies that originally reported 403(b) premiums in Column 4 of the Base Reconciliation Exhibit must transfer such amounts to Column 2 even though no original transfer was required on Line 4.1 of the Base Reconciliation Exhibit.
- Lines 3.1 and 3.2 – Companies that have unallocated funding obligations that are not issued for or in connection with a specific employee, union or association of natural persons benefit plan or government lottery (Line 7.1 of the Base Reconciliation Exhibit) must report such amounts on Lines 3.1 and 3.2. Line 3.2 should include any amounts reported on Line 3.1.
- Lines 4.1, 4.2, 4.3 and 4.5 – Companies that have unallocated funding obligations issued to fund government lotteries or employee, union or association of natural persons benefit plans that are NOT: (a) governmental retirement plans established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code, or (b) protected by the Federal Pension Benefit Guaranty Corporation must report such amounts on Lines 4.1, 4.2 and 4.3. Line 4.4 equals the sum of Lines 4.1, 4.2 and 4.3. Lines 4.1, 4.2 and 4.3 are mutually exclusive. Line 4.5 needs to be completed for Minnesota business only.
- Lines 5.1, 5.2, 5.3 and 5.4 – Companies that have unallocated funding obligations issued to fund governmental retirement plans established under Sections 401 and 403(b) of the U.S. Internal Revenue Code must report such amounts on Lines 5.1, 5.2 and 5.3. Line 5.2 should include the amounts reported on Line 5.1. Line 5.3 needs to be completed for New Jersey business only. Line 5.4 needs to be completed for Minnesota business only.
- Lines 6.1, 6.2, 6.4 and 6.5 – Companies that have unallocated funding obligations issued to fund governmental retirement plans established under Section 403(b) of the U.S. Internal Revenue Code must report such amounts on Lines 6.1 and 6.2. Line 6.3 equals the sum of Lines 6.1 and 6.2. Lines 6.1 and 6.2 are mutually exclusive. Line 6.4 needs to be completed for New Jersey business only. Line 6.5 needs to be completed for Minnesota business only.
- Lines 7.1, 7.2 and 7.3 – Companies that have unallocated annuity contracts issued to an employee benefit plan protected by the Federal Pension Benefit Guaranty Corporation (Line 7.2 of the Base Reconciliation Exhibit) must report such amounts on Lines 7.1 and 7.2. Line 7.2 should include the amounts reported on Line 7.1. Line 7.3 needs to be completed for New Jersey business only.
- Line 8 – Companies that have unallocated funding obligations issued to fund government lotteries must report such amounts up to \$5 million per contract holder. This line should be completed for New Jersey business only.

- Line 9 – Companies that have unallocated funding obligations that fund employee or association of natural persons benefit plans in New Jersey in excess of \$2 million need to report receipts up to \$5 million per contract. This line should be completed for New Jersey business only.
- Line 10 – Aggregate Write-ins for Other Deductions
- Enter the total of the write-ins listed in schedule “Details of Write-ins Aggregated at Line 10 for Other Deductions.”
- Line 11 – Represents the preliminary assessment base calculation for those states that have not adopted the most recent Model #520.

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

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

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

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

Not for Distribution

Not for Distribution

LIFE SUPPLEMENT
TO THE HEALTH ANNUAL STATEMENT

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

EXHIBIT 5 – AGGREGATE RESERVES FOR LIFE CONTRACTS

To be filed on or before March 1.

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

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

Column 1 – Valuation Standard

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

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

Mortality and Morbidity

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

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

Interest

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

Valuation Method

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

Age Basis

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

Other

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

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

LIFE INSURANCE: NLP ANB CRF unless otherwise indicated

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

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

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

Column 5 – Credit (Group and Individual)

Include: Business not exceeding 120 months.

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

Life Insurance

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

Accidental Death Benefits

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

Disability – Active Lives

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

Disability – Disabled Lives

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

Miscellaneous Reserves

Classification by mortality and interest split basis not required.

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

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

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

EXHIBIT 5 – INTERROGATORIES

To be filed on or before March 1.

Interrogatories 1 and 2

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

The following interrogatories deal with dividends or refunds:

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

INSTRUCTIONS FOR ACTUARIAL OPINION

Process of Dividend or Refund Determination

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

Description of Experience Factors

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

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

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

Actuarial Interrogatories

- I. Has the contribution principle been followed in determining dividends or refunds? If not, describe.
- II. Has any material change occurred with respect to the determination of contract factors? If yes, describe.
- III. Have there been any changes in the scales of dividends or refunds on new or existing business authorized for illustration by the reporting entity? If yes, describe in general the changes that were made.
- IV. Have there been any changes in the scales of dividends or refunds apportioned for payment? If yes, describe in general the changes that were made.
- V. For each major block of business, indicate when the dividend or refund scale was last changed (including changes described in IV, above), and indicate the extent of such change in terms of the percentage by which dividends or refunds payable under the new scale exceeded or were less than those that would have been paid in the year of change had the scale not been changed.
- VI. Does the dividend or refund scale incorporate the use of projections or forecasts of experience factors for any period in excess of two years beyond the effective date of the scale? If yes, describe.
- VII. In the basis of determining investment income experience factors, state whether the reporting entity uses (a) a portfolio average approach, (b) an investment generation approach, or (c) a combination of the two approaches. If (b) or (c), describe the general basis used, including the issue year groupings.

VIII. With respect to contract loan provisions:

Describe how differences in such provisions affect dividends or refunds.

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

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

- a. Are they payable on death, surrender, and maturity?
- b. Are they payable or credited either upon the commencement of nonforfeiture insurance or upon termination thereof by death, surrender, or maturity?
- c. Do they reflect the incidence, size, and growth of amounts that may be attributable to the contracts in question?

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

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

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

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

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

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

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

ACTUARIAL OPINION

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

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

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

Signature of Actuary

Date

Interrogatory 3

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

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

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

1. Single and periodic premium deferred annuities.
2. Universal Life contracts providing for fixed and/or flexible premiums.
3. Adjustable periodic premium life contracts, also known as indeterminate premium life contracts.
4. Single and periodic premium life contracts.
5. Renewable and convertible term insurance contracts which do not guarantee the premiums payable upon renewal, or which provide for renewal on the then current premium basis.

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

INSTRUCTIONS FOR ACTUARIAL OPINION

Determination Procedures

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

Actuarial Interrogatories

- I. Since this statement was last filed, have there been any changes in the values of nonguaranteed elements on new or existing business authorized for illustration by the reporting entity? If yes, describe the changes that were made.
- II. Since this statement was last filed, have there been any changes in the values of nonguaranteed elements actually charged or credited? If yes, describe the changes that were made.
- III. Indicate to what extent any change described in 1 or 2 varies from the contract and/or general methods and procedures last reported for the affected contracts.
- IV. Are the anticipated experience factors underlying any nonguaranteed elements different from current experience? If yes, describe in general terms the ways in which future experience is anticipated to differ from current experience and the nonguaranteed element factors that are affected by such anticipation.
- V. State whether anticipated investment income experience factors are based on: (a) a portfolio average approach, (b) an investment generation approach, or (c) other. If (b) or (c), describe the general basis used, including the investment generation groupings.
- VI. Describe how the reporting entity allocates anticipated experience among its various classes of business.
- VII. Does the undersigned believe there is a substantial probability that illustrations authorized by the reporting entity to be presented on new and existing business cannot be supported by currently anticipated experience? If yes, indicate which classes and explain.

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

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

ACTUARIAL OPINION

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

- i. Paid, credited, charged or determined in (year of statement); and
- ii. Authorized by the Reporting Entity to be illustrated on new and existing business during (year of statement).

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

Signature of Actuary

Date

Interrogatory 7

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

Interrogatory 8

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

Interrogatory 9

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

EXHIBIT 7 – DEPOSIT-TYPE CONTRACTS

To be filed on or before March 1.

This exhibit is intended to capture information about the activity, before and after any reinsurance, for deposit-type contracts as defined in *SSAP No. 52—Deposit-Type Contracts*.

Column 2	–	Guaranteed Interest Contracts (Without Life Contingencies)
	Include:	Contracts that do not subject the reporting entity to any mortality or morbidity risk.
Column 3	–	Annuities Certain
	Include:	Amounts settled under contracts without any mortality or morbidity risk, e.g., certain immediate annuity contracts, amounts associated with lottery payouts, structured settlements, income settlement options or other amounts where payments are for a fixed period or amount.
Column 4	–	Supplemental Contracts (Without Life Contingencies)
	Include:	Amounts resulting from proceeds settled under a settlement option provision of a life or annuity contract without any mortality or morbidity risk.
Column 5	–	Dividend Accumulations, or Refunds
	Include:	Amounts held on accounts related to contracts without any mortality or morbidity risk.
Column 6	–	Premium and Other Deposit Funds
	Include:	Amounts not reported elsewhere in this exhibit for contracts that do not incorporate any mortality or morbidity risk.
Line 2	–	Deposits Received During the Year
	Include:	Considerations or amounts from contract holders that increased the fund balance. The amounts reported should be consistent with those reported on the Cash Flow page.
Line 3	–	Investment Earnings Credited to the Account
	Include:	Amounts earned and/or credited to the account.
Line 4	–	Other Net Changes in Reserves
	Include:	The net difference between periods when the reserve amount held differs from the accumulated account balance, including income accumulations less withdrawal and applicable surrender charges.
	Exclude:	Interest earned and/or credited to the account reported in Line 3.

- Line 5 – Fees and Other Charges Assessed
- Include: Any fees or assessments to the account that reduce the balance and are reported as income by the company.
- Line 6 – Surrender Charges
- Include: Charges assessed for contract surrenders or withdrawals, e.g., early withdrawal penalties.
- Line 7 – Net Surrender or Withdrawal Payments
- Include: The net proceeds paid or payable (after deduction for surrender charges) to the contract holder.
- The amounts reported should be consistent with those reported on the Cash Flow page.
- Line 14 – Net Balance at the End of the Current Year After Reinsurance
- The amounts reported should be consistent with those reported on the Liability page.

Not for Distribution

SCHEDULE S – REINSURANCE

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

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

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

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

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

Illustration for reporting MODCO activity

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

Index to Schedule S

- ** Part 1, Section 1 – Reinsurance Assumed Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits
 - * Part 1, Section 2 – Reinsurance Assumed Accident and Health Insurance
 - * Part 2 – Reinsurance Recoverable on Paid and Unpaid Losses
 - ** Part 3, Section 1 – Reinsurance Ceded Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits
 - * Part 3, Section 2 – Reinsurance Ceded Accident and Health Insurance
 - * Part 4 – Reinsurance Ceded to Unauthorized Companies
 - * Part 5 – Reinsurance Ceded to Certified Reinsurers
 - * Part 6 – Five-Year Exhibit of Reinsurance Ceded Business
 - * Part 7 – Restatement of Balance Sheet to Identify Net Credit for Ceded Reinsurance
- * These parts of Schedule S are included as part of the Health Annual Statement
- ** These parts of Schedule S are included as part of the Life Supplement to the Health Annual Statement

Due Date

To be filed on or before March 1.

ID Number

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

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

Use of Federal Employer Identification Number

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

Alien Insurer Identification Number (AIIN)

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

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

Pool and Association Numbers

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

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

Certified Reinsurer Identification Number (CRIN)

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

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

NAIC Company Code

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

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

Domiciliary Jurisdiction

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

Lloyd's of London

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

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

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

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

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

Dates

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

Determination of Authorized Status

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

Captive Affiliate Line Category

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

Definition of Affiliated Non-Traditional Insurer/Reinsurer

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

1. An affiliated insurance or reinsurance company licensed, authorized or otherwise granted the authority to operate in a single United States jurisdiction under any captive insurer law, special purpose insurer law, or other similar law separate from those applicable to traditional insurers and/or reinsurers.
2. An affiliated insurance or reinsurance company licensed, authorized or otherwise granted the authority to operate in any jurisdiction outside the United States under any captive insurer law, special purpose insurer law, or other similar law separate from those applicable to traditional insurers and/or reinsurers in that non-United States jurisdiction.
3. Any other affiliated insurance or reinsurance company that by law, regulation, or order, or contract is authorized to insure or reinsure only risks from its parent or affiliate.

SCHEDULE S – PART 1 – SECTION 1

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

To be filed on or before March 1.

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

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

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

Column 2 – ID Number

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

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

Column 5 – Domiciliary Jurisdiction

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

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

Column 6 – Type of Reinsurance Assumed

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

Abbreviations:

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

REINSURANCE TYPES

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

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

Column 7 – Type of Business Assumed

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

Abbreviations:

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

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

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

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

XXX Life Other: Used to describe the actuarial reserves required to be held under Section 6 of the Model #30 for risk assumed from a ceding insurer for policies described under Section 6F, Section 6G, Section 6H or to the portion of the reserve pursuant to YRT Reinsurance under Section 6E, which is commonly referred to as Regulation XXX (or, more simply, XXX).

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

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

Column 8 – Amount of In Force at End of Year

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

- Column 10 – Premiums
To agree with Underwriting and Investment Exhibit, Part 1, Line 10, Column 2.
For deposit funds and other liabilities without life or disability contingencies, leave this Column blank.
- Column 11 – Reinsurance Payable on Paid and Unpaid Losses
For deposit funds and other liabilities without life or disability contingencies, leave this Column blank.
- Column 12 – Modified Coinsurance Reserve
Report the amount of reserves held by the ceding company under modified coinsurance contracts. Include separate accounts modified coinsurance reserves. See examples for MODCO transactions contained in the general instructions for Schedule S.
- Column 13 – Funds Withheld Under Coinsurance
Report the amount of funds withheld by the ceding company on coinsurance contracts.

Not for Distribution

SCHEDULE S – PART 3 – SECTION 1

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

To be filed on or before March 1.

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

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

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

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

Certified

Affiliates

U.S.

Captive.....	5799999
Other	5899999
Total.....	5999999

Non-U.S.

Captive.....	6099999
Other	6199999
Total.....	6299999

Total Certified Affiliates.....6399999

Non-Affiliates

U.S. Non-Affiliates.....6499999

Non-U.S. Non-Affiliates.....6599999

Total Certified Non-Affiliates.....6699999

Total Separate Accounts Certified.....6799999

Total Separate Accounts Authorized, Unauthorized and Certified.....6899999

Total U.S. (Sum of 0399999, 0899999, 1499999, 1999999, 2599999, 3099999, 3799999, 4399999, 4899999, 5399999, 5999999 and 6499999)..... 6999999

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

Total (Sum of 3499999 and 6899999)..... 9999999

Column 2 – ID Number

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

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

Column 5 – Domiciliary Jurisdiction

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

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

Column 6 – Type of Reinsurance Ceded

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

Abbreviations:

I	Individual	}	All Reinsurance Types should be followed by /I or /G.
G	Group		
<u>REINSURANCE TYPES</u>			
CO	Coinsurance	YRT	Yearly renewable term
COFW	Coinsurance with funds withheld	YRTFW	Yearly renewable term with funds withheld
MCO	Modified coinsurance	COMB	Combination coinsurance/modified coinsurance
MCOFW	Modified coinsurance with funds withheld	COMBFW	Combination coinsurance/modified coinsurance with funds withheld
CAT	Catastrophe	ORI	Other reinsurance

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

Column 7 – Type of Business Ceded

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

Abbreviations:

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

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

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

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

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

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

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

- Column 8 – Amount in Force at End of Year
- Report the ceded amount of the basic life insurance policy only.
- For catastrophe-reinsurance (CAT), disability reinsurance (DIS), accidental death benefit reinsurance (ADB) and annuity reinsurance (ACO and AMCO), leave this Column blank.
- Column 9 – Reserve Credit Taken Current Year
- To agree with appropriate lines in Exhibit 5 (life supplement) and Exhibit 7 (life supplement). See examples for modco transactions contained in the general instructions for Schedule S.
- Column 11 – Premiums
- Amounts included in this Column should represent reinsurance ceded premiums on an incurred basis, to agree with Line 10 of Underwriting and Investment Exhibit, Part 1, Column 3.
- For deposit funds and other liabilities without life or disability contingencies, leave this Column blank.
- Columns 12 – Outstanding Surplus Relief – Current Year and
Columns 13 – Outstanding Surplus Relief – Prior Year }
- Outstanding surplus relief means the amount of surplus not yet reported as income in Commissions and Expense Allowance on Reinsurance Ceded, attributable to reinsurance agreements described in SSAP No. 67—*Life, Deposit-Type and Accident and Health Reinsurance*.
- Report the amount of initial commissions and expense allowance not yet recovered by the reinsurer for the following types of treaties (individual or group): CO, ACO, MCO, AMCO, COFW, ACOFW, MCOFW, AMCOFW, COMB or ACOMB. This Column does not apply to CAT, DIS, ADB, YRT or other non-proportional reinsurance treaties.
- Increase the outstanding surplus resulting from reinsurance of separate accounts business.
- Column 14 – Modified Coinsurance Reserve
- Report the amount of reserves held under modified coinsurance contracts. Include separate accounts modified coinsurance reserves.
- Column 15 – Funds Withheld Under Coinsurance
- Report the amount of funds withheld on coinsurance contracts.

STATE PAGE

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

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

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

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

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

Column 2 – Credit Life (Group and Individual)

Include: Business not exceeding 120 months duration.

Column 5 – Total

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

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

} and }

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

Line 3 – Deposit-type Contracts Paid

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

Line 4 – Other Considerations

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

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

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

} and }

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

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

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

Lines 24
to 26

– Accident and Health Insurance

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

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

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

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

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

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

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

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ANALYSIS OF ANNUITY OPERATIONS BY LINES OF BUSINESS

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

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

Definitions:

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

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

Include: Market Value Adjusted Annuities

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

Exclude: Market Value Adjusted Annuities

Line 34 – Policies/certificates in force end of year

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

ANALYSIS OF INCREASE IN ANNUITY RESERVES DURING THE YEAR

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

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

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

Definitions:

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

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

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

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

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

Column 2	-	Individual Fixed Annuities and	}
Column 7	-	Group Fixed Annuities	
		Include:	Market Value Adjusted Annuities
Column 6	-	Individual Other Annuities and	}
Column 11	-	Group Other Annuities	
		Exclude:	Market Value Adjusted Annuities

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APPENDIX

INSTRUCTIONS FOR USE OF BARCODES

It is the responsibility of the company to prepare and utilize barcodes correctly.

The upper right-hand corner of the jurat page, and other pages and forms as identified on the Document Identifier Codes listing, will be the location of a 17-digit barcode symbol. The barcode standard to be utilized is the 3 of 9 (or 39) methodology. The barcode should be printed using at least a 24-point font. In addition to the barcode symbols, the name of the reporting entity, the year, and the document code should be printed on the barcode label. When the barcode is printed as part of the page rather than an affixed label, the reporting entity's name need not be printed above the barcode.

The barcode consists of the entity identifier (5 digits), the year (YYYY-4 digits), the document identifier (3 digits), the state code (2 digits), if state specific page, the data indicator (1 digit) and a filing type identifier (1 digit).

This 17th digit should utilize the following codes:

- 0 to represent the annual filings
- 1 to represent the March quarterly filing
- 2 to represent the June quarterly filing
- 3 to represent the September quarterly filing
- 4 to represent the Health Maintenance Organization's fourth quarter filing
- 5 to represent amended annual filings
- 6 to represent amended March quarterly filing
- 7 to represent amended June quarterly filing
- 8 to represent amended September quarterly filing

For filings of a reporting entity, the entity identifier is the NAIC company code number.

The year is represented as the last four digits of the filing year. For the 2019 annual statement due March 1, 2020, the year would be 2019.

The document identifier represents what page, schedule, exhibit, etc., is being filed. The respective identifiers for those documents requiring a barcode are included on the document identifier listing.

The state code represents the document identifier can be filed for each individual state (e.g., the state business pages). The two-digit code would be the same as used on Schedule T. If it is not a state-specific form, the state code is 00. The state code Other is 58, and the code for Grand Total is 59. If the reporting entity has nothing to report on any state-specific supplemental schedule or exhibit, the barcode included in the Supplemental Exhibits and Schedules Interrogatories should contain a state code of 59.

The data indicator represents if the document contains data. For filings containing data place a one (1) in this field. If the document is a NONE, place a zero (0) in this field.

The filing type identifier is used to indicate the filing of NAIC filing components or state mandated (state specific) filing requirements other than those required by the NAIC. For NAIC filing requirements, the type code is 0. For state filing requirements, the type code is 1.

If forms which are required to have a separate barcode as identified on the Document Identifier Codes listing are bound in the statement, these forms **MUST** have the barcode affixed to them. If a reporting entity submits with the March 1 filing a page requiring a barcode and that page has not been completed due to a later filing date, the barcode should not be affixed for the March filing. If the filing includes a page listing none schedules (and the state in which you are filing permits such a filing) and any of these schedules fall within that listing that requires a barcode, the barcode must be placed to the right of the name of the page, exhibit or schedule. On those forms which are completed on a by-state basis and are marked none because the company does not write that type of business or that particular state page is none, place the appropriate identifier with the data indicator of zero (0). State pages which have values reported must use the appropriate state barcode identifier from Schedule T. If any state requires the filing of a none “by-state basis” page, the name of the appropriate state must still be printed on the hard copy after “For the State of _____.”

A listing of the Document Identifier Codes can be found at www.naic.org/cmtc_e_app_blanks.htm.

The reporting entity is required to affix the appropriate barcode next to the respective Supplemental Interrogatory using the document identifier code provided. Note that it is only Supplemental Interrogatories to which the reporting entity has responded “NO” that it does not have to file a particular exhibit or form, and for which the physical page or form is marked none that the appropriate barcode be affixed. For supplements that are state specific, the only instance a barcode should be affixed is when that type of business is not written at all in any state.

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COUNTRY OF DOMICILE

APPENDIX OF ABBREVIATIONS

This is a comprehensive list of ISO Alpha 3 country abbreviations: Please note the following exception. Use NAT for Native American Tribes.

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

HUN	-	Hungary	NCL	-	New Caledonia
ISL	-	Iceland	NZL	-	New Zealand
IND	-	India	NIC	-	Nicaragua
IDN	-	Indonesia	NER	-	Niger
IRN	-	Iran, Islamic Republic of	NGA	-	Nigeria
IRQ	-	Iraq	NIU	-	Niue
IRL	-	Ireland	NFK	-	Norfolk Island
IMN	-	Isle of Man	MNP	-	Northern Mariana Islands
ISR	-	Israel	NOR	-	Norway
ITA	-	Italy	OMN	-	Oman
JAM	-	Jamaica	PAK	-	Pakistan
JPN	-	Japan	PLW	-	Palau
JEY	-	Jersey	PSE	-	Palestinian Territory, Occupied
JOR	-	Jordan	PAN	-	Panama
KAZ	-	Kazakhstan	PNG	-	Papua New Guinea
KEN	-	Kenya	PRY	-	Paraguay
KIR	-	Kiribati	PER	-	Peru
PRK	-	Korea, Democratic People's Republic of	PHL	-	Philippines
			PCN	-	Pitcairn
KOR	-	Korea, Republic of	POL	-	Poland
KWT	-	Kuwait	PRT	-	Portugal
KGZ	-	Kyrgyzstan	PRI	-	Puerto Rico
LAO	-	Lao PDR	QAT	-	Qatar
LVA	-	Latvia	REU	-	Réunion
LBN	-	Lebanon	ROU	-	Romania
LSO	-	Lesotho	RUS	-	Russian Federation
LBR	-	Liberia	RWA	-	Rwanda
LBY	-	Libyan Arab Jamahiriya	BLM	-	Saint-Barthélemy
LIE	-	Liechtenstein	SMN	-	Saint Helena
LTU	-	Lithuania	KNA	-	Saint Kitts and Nevis
LUX	-	Luxembourg	LCA	-	Saint Lucia
MAC	-	Macao, Special Administrative Region of China	MAF	-	Saint-Martin (French part)
			SPM	-	Saint Pierre and Miquelon
MKD	-	Macedonia, Republic of	VCT	-	Saint Vincent and Grenadines
MDG	-	Madagascar	WSM	-	Samoa
MWI	-	Malawi	SMR	-	San Marino
MYS	-	Malaysia	STP	-	Sao Tome and Principe
MDV	-	Maldives	SAU	-	Saudi Arabia
MLI	-	Mali	SEN	-	Senegal
MLT	-	Malta	SRB	-	Serbia
MHL	-	Marshall Islands	SYC	-	Seychelles
MTQ	-	Martinique	SLE	-	Sierra Leone
MRT	-	Mauritania	SGP	-	Singapore
MUS	-	Mauritius	SVK	-	Slovakia
MYT	-	Mayotte	SVN	-	Slovenia
MEX	-	Mexico	SLB	-	Solomon Islands
FSM	-	Malaysia, Federated States of	SOM	-	Somalia
MDA	-	Moldova	ZAF	-	South Africa
MCO	-	Monaco	SGS	-	South Georgia and the South Sandwich Islands
MNG	-	Mongolia			
MNE	-	Montenegro	SSD	-	South Sudan
MSR	-	Montserrat	ESP	-	Spain
MAR	-	Morocco	LKA	-	Sri Lanka
MOZ	-	Mozambique	SDN	-	Sudan
MMR	-	Myanmar	SUR	-	Suriname *
NAM	-	Namibia	SJM	-	Svalbard and Jan Mayen Islands
NRU	-	Nauru	SWZ	-	Swaziland
NPL	-	Nepal	SWE	-	Sweden
NLD	-	Netherlands	CHE	-	Switzerland

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

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DEFINITIONS OF LINES OF BUSINESS

Riders/Endorsements/Floaters:

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

Comprehensive (Hospital & Medical):

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

Medicare Supplement:

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

Dental-Only:

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

Vision-Only:

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

Federal Employees Health Plans (FEHBP):

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

Medicare Cost:

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

Medicare Risk:

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

Medicare Other:

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

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

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

Medicaid Cost:

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

Medicaid Risk:

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

Self-Funded:

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

Self-Funded Members:

Persons covered under Administrative Services Only or Administrative Services Contracts. See SSAP No. 47—*Uninsured Plans*.

PRODUCT LINES:

HMO (Health Maintenance Organization):

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

There are four basic HMO models:

- a. Group Model
- b. Individual Practice Association
- c. Network Model
- d. Staff Model

An entity must have three characteristics to be an HMO:

1. An organized system for providing health care or otherwise assuring health care delivery in a geographic area.
2. An agreed upon set of basic and supplemental health maintenance and treatment services.
3. A voluntary enrolled group of people.

PPO (Preferred Provider Organization):

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

POS (Point of Service):

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

There are several ways POS can be provided:

- a. An HMO may allow members to obtain limited services from non-participating providers.
- b. An HMO may provide non-participating benefits through a supplemental major medical policy.
- c. A PPO may be used to provide both participating and non-participating levels of coverage and access.

Hospital/Surgical:

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

Dental (Only):

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

Vision (Only):

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

Other (Specify):

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

Miscellaneous Definitions:

Encounter:

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

Hospital Encounter:

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

Non-hospital Encounter:

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

Physician:

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

Non-physician:

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

- a. Chiropractor
- b. Clinical Psychologist
- c. Dentist
- d. Optometrist
- e. Physical Therapist
- f. Physician Assistant
- g. Nurse Practitioner
- h. Social Worker

Inpatient:

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

Outpatient:

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

Admission:

Hospital inpatient care for any medical condition.

Hospital Day:

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

Individual:

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

Group:

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

Member:

A person who has enrolled as a subscriber or an eligible dependent of a subscriber and for whom the health organization has accepted the responsibility for the provision of health services as may be contracted for. For Administrative Services Only or Administrative Services Contracts see Self-Funded Members.

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