HEALTH

2024

RBC Risk-Based Capital Forecasting and Instructions

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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NAIC Executive Office
444 North Capitol Street, NW
Suite 700
Washington, DC 20001
202.471.3990

NAIC Central Office
1100 Walnut Street
Suite 1000
Kansas City, MO 64106
816.842.3600

NAIC Capital Markets
& Investment Analysis Office
One New York Plaza, Suite 4210
New York, NY 10004
212.398.9000

Health
Risk-Based Capital / Newsletter

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What Risk-Based Capital Pages Should Be Submitted?

For the year-end 2024 health risk-based capital (RBC) filing, submit hard copies of pages **XR001 through XR027** to any state that requests a hard copy in addition to the electronic filing. Beginning with year-end 2007, a hard copy of the RBC filings was not required to be submitted to the NAIC. Other pages, outside of pages XR001 through XR027, do not need to be submitted. Those pages would need to be retained by the company as documentation.

Modification of Fixed Income Assets – Miscellaneous (XR008) Structure for Residual Tranches or Interests

The Capital Adequacy (E) Task Force adopted proposal 2024-02-CA during its April 30 meeting to add a line in XR008 to include the total of residual tranches or interests on a standalone line with no factor proposed and, hence, deemed as structural change only.

Factor for Residual Tranches or Interests (XR008)

The Capital Adequacy (E) Task Force adopted proposal 2024-18-CA during its June 28 meeting to adopt a 20% factor for residual tranches or interests in XR008.

Modification to the Affiliated Investment Blanks (XR002)

The Capital Adequacy (E) Task Force adopted proposal 2024-08-CA during its April 30 meeting to remove the reference to "H0 Component" from the Column (12) heading on page 2 XR002. The "H0" references are misleading in that only affiliate

In This Issue:

types 1, 2, 5, and 6 flow into H0, while affiliate types 3, 4, 7, 8, and 9 flow into H1.

In addition, the Task Force adopted proposal 2023-12-CA during its Dec. 2, 2023, meeting to adopt an editorial change made to remove the word "Common" in the heading of Column (13) of XR002 (Details for Affiliated Stocks). A corresponding change was made to XR010 (Equity Assets) and XR024 (Calculation of Total Risk-Based Capital After Covariance) by removing the word "Common" in line "Market Value in Excess Affiliated Stocks." This line includes the affiliated amounts for both preferred and common stock.

Receivable for Securities Factor (XR008)

The Capital Adequacy (E) Task Force adopted proposal 2024-13-CA during its June 28 meeting, determining the factor for the Receivables for Securities (Line (11), Page XR008) to remain unchanged.

Underwriting Risk Annual Statement Source (XR014)

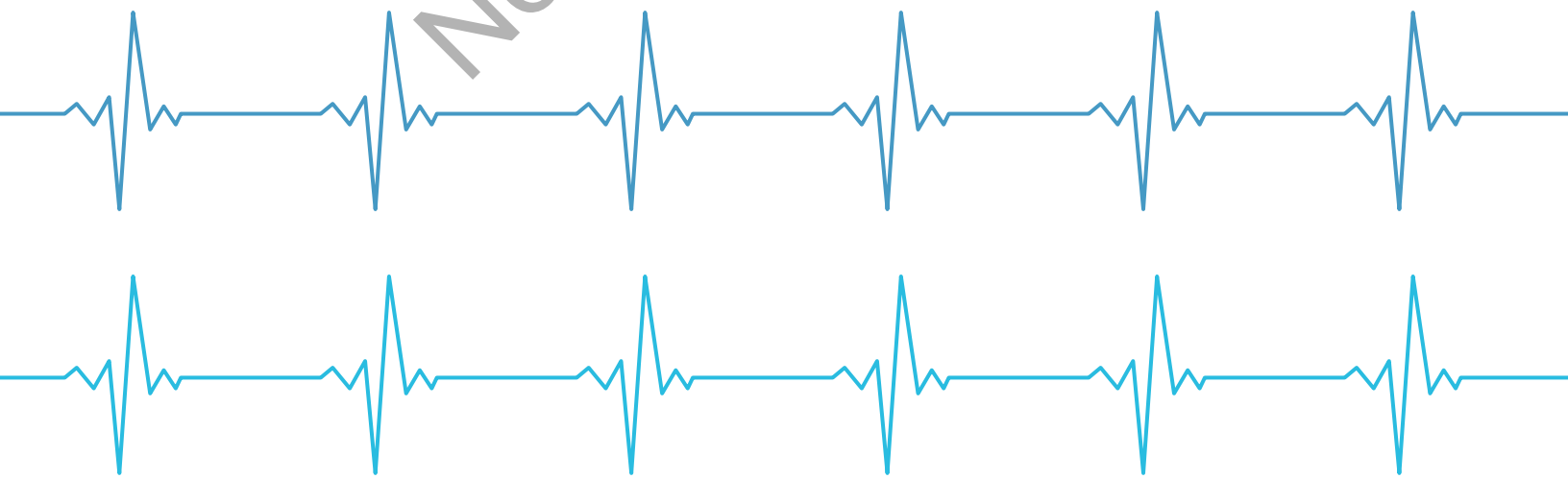
The Capital Adequacy (E) Task Force adopted proposal 2023-11-H during its Dec. 2, 2023, meeting. The proposal adopted an editorial change made to the Annual Statement Source column on page XR014 for the following:

a. Column (1), Line (4) Other Health Risk Revenue was updated to reference "Pg. 7, Col. 2+3+8+9, Line 4."

b. Column (1), Line (10) Fee-For-Service Offset was updated to reference "Pg. 7, Col. 2+3+8+9, Line 3."

Health Care Receivables (XR021) Factor Changes

The Capital Adequacy (E) Task Force adopted proposal 2024-12-H (MOD) during its June 28 meeting. The modified proposal updated the factor for Pharmaceutical Health Care Receivables (line 26.1) to 20% on the first $5 million and 3% on the amount over $5 million. For non-pharmaceutical health care receivables (lines 26.2 through 26.6), tier factors are applied to those lines in the aggregate, with 40% applied on the first $10 million and 5% on the amount over $10 million.



Underwriting Risk Factors (XR013) – Investment Income Adjustment

The Capital Adequacy (E) Task Force adopted proposal 2024-09-CA during its June 28 meeting. This proposal updated the comprehensive medical, Medicare supplement, and dental and vision factors to include a 5.5% investment yield adjustment. The revised factors are:

	Comprehensive Medical	Medicare Supplement	Dental & Vision
$0–$3 Million	0.1427	0.0973	0.1143
$3–$25 Million	0.1427	0.0596	0.0706
Over $25 Million	0.0832	0.0596	0.0706

Risk-Based Capital Forecasting and Instructions

The Health RBC forecasting spreadsheet calculates RBC using the same formula presented in the *2024 NAIC Health Risk-Based Capital Report Including Overview & Instructions for Companies*, and it can be downloaded from the NAIC Account Manager. The *2024 NAIC Health Risk-Based Capital Report Including Overview & Instructions for Companies* publication is available for purchase in an electronic format through the NAIC Publications Department. This publication is available for purchase on or about November 1 each year. The User Guide is no longer included in the Forecasting & Instructions.

WARNING: The RBC forecasting spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted, and the RBC will not have been filed.

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Direct correspondence to: Derek Noe, RBC Newsletters, NAIC, 1100 Walnut Street, Suite 1000, Kansas City, MO 64106-2197. Phone: (816) 783-8973. Email: dnoe@naic.org.

2024 NAIC Health

Risk-Based Capital Report

Including

Forecasting and Instructions for Companies

as of December 31, 2024

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when Completed

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(816) 783-8300
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Central Office
1100 Walnut Street, Suite 1000
Kansas City, MO 64106-2197
816-842-3600

Capital Markets & Investment
Analysis Office
One New York Plaza, Suite 4210
New York, NY 10004
212-398-9000

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Risk-Based Capital
Preamble

History of Risk-Based Capital by the NAIC

A. Background

1. The NAIC, through its committees and working groups, facilitated many projects of importance to state insurance regulators, the industry and users of statutory financial information in the early 1990s. That was evidenced by the original mission statement and charges given to the Capital Adequacy (E) Task Force (CADTF) of the Financial Condition (E) Committee.

2. From the inception of insurance regulation in the mid-1800s, the limitation of insurance company insolvency risk has been a major goal of the regulatory process. The requirement of adequate capital has been a major tool in limiting insolvency costs throughout the history of insurance regulation. Initially, the states enacted statutes requiring a specified minimum amount of capital and surplus for an insurance company to enter the business or to remain in business.

3. Fixed minimum capital requirements were largely based on the judgment of the drafters of the statutes and varied widely among the states. Those fixed minimum capital and surplus requirements have served to protect the public reasonably well for more than a century. However, they fail to recognize variations in risk between broad categories of key elements of insurance, nor do they recognize differences in the amount of capital appropriate for the size of various insurers.

4. In 1992, the NAIC adopted the life risk-based capital (RBC) formula with an implementation date of year-end 1993. The formula was developed for specific regulatory needs. Four major categories were identified for the life formula: asset risk; insurance risk; interest rate risk; and all other business risk. The property/casualty and health formulas were implemented in 1994 and 1998, respectively. The focus of these two formulas is: asset risk; underwriting risk; credit risk; and business risk (health).

5. The total RBC needed by an insurer to avoid being taken into conservatorship is the Authorized Control Level RBC, which is 50% of the sum of the RBC for the categories, adjusted for covariance. The covariance adjustment is meant to take into account that problems in all risk categories are not likely to occur at the same time.

6. The mission of the CADTF was to determine the amount of capital an insurer should be required to hold to avoid triggering various specific regulatory actions. The RBC formula largely consists of a series of risk factors that are applied to selected assets, liabilities, or other specific company financial data to establish the threshold levels generally needed to bear the risk arising from that item.

7. To carry out its mission, the CADTF was charged with carrying out the following initiatives:
   - Evaluate emerging "risk" issues for referral to the RBC working groups/subgroups for certain issues involving more than one RBC formula.
   - Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
   - Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
   - Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the *Accounting Practices and Procedures Manual* and the *Valuation Manual* to ensure that model laws, publications, formulas, analysis tools, etc., supported by the CADTF continue to meet regulatory objectives.

8. The RBC forecasting, and instructions were developed and are now maintained in accordance with the mission of the CADTF as a method of measuring the threshold amount of capital appropriate for an insurance company to avoid capital specific regulatory requirements based on its size and risk profile.

B. Purpose of Risk-Based Capital

9. The purpose of RBC is to identify potentially weakly capitalized companies. This facilitates regulatory actions that, in most cases, ensure policyholders will receive the benefits promised without relying on a guaranty association or taxpayer funds. Consequently, the RBC formula calculates capital level trigger points that enable regulatory intervention in the operation of such companies.

10. RBC instructions, RBC reports and adjusted report(s) are intended solely for use by the commissioner/state in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and are considered confidential. All domestic insurers are required to file an RBC report unless exempt by the commissioner. There are no state permitted practices to modify the RBC formula and all insurers are required to abide by the RBC instructions.

11. Comparison of an insurer's TAC to any RBC level is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer and is not intended as a means to rank insurers generally. Therefore—except as otherwise required under the provisions of *Risk-Based Capital (RBC) for Insurers Model Act* (#312) or the *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315)—the making, publishing, disseminating, circulation or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or place before the public, in a newspaper, magazine or other publication, or in a form of a notice, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any insurer or of any component derived in the calculation by any insurer is prohibited

C. Objectives of Risk-Based Capital Reports

12. The primary responsibility of each state insurance department is to regulate insurance companies in accordance with state laws, with an emphasis on solvency for the protection of policyholders. The ultimate objective of solvency regulation is to ensure that policyholder, contract holder and other legal obligations are met when they come due and that companies maintain capital and surplus at all times and in such forms as required by statute.

    To support this role, the RBC reports identify potentially weakly capitalized companies in that each insurer must report situations where the actual TAC is below a threshold amount for any of the several RBC levels. This is known as an "RBC event" and reporting is mandatory. The state regulatory response is likely to be unique to each insurer, as each insurer's risk profile will have some differences from the average risk profile used to develop the RBC formula factors and calculations.

    There are several RBC levels with different levels of anticipated additional regulatory oversight following the reporting of an RBC event. Company Action Level (CAL) has the least amount of additional regulatory oversight, as it envisions the company providing to its regulator a plan of action to increase capital or reduce risk or otherwise satisfy the regulator of the adequacy of its capital. Regulatory Action Level (RAL) is the next higher level, where the regulator is more directly involved in the development of the plan of action. Authorized Control Level (ACL) anticipates an even higher amount of regulatory action in implementing the plan of action.

D. Critical Concepts of Risk-Based Capital

13. Over the years, various financial models have been developed to try to measure the "right" amount of capital that an insurance company should hold.[1] "No single formula or ratio can give a complete picture of a company's operations, let alone the operation of an entire industry. However, a properly designed formula will help in the early identification of companies with inadequate capital levels and allow corrective action to begin sooner. This should ultimately lower the number of company failures and reduce the cost of any failures that may occur."

14. Because the NAIC formula develops threshold levels of capitalization rather than a target level, it is impractical to use the RBC formula to compare the RBC ratio developed by one insurance company to the RBC ratio developed by another. Comparisons of amounts that exceed the threshold standards do not provide a definitive assessment of their relative financial strength. For this reason, Model #312 and Model #315 prohibit insurance companies, their agents and others involved in the business of insurance using the company's RBC results to compare competitors.

15. The principal focus of solvency measurement is the determination of financial condition through an analysis of the financial statements and RBC. However, protection of the policyholders can only be maintained through continued monitoring of the financial condition of the insurance enterprise. Operating performance is another indicator of an enterprise's ability to maintain itself as a going concern.

16. The CADTF and its RBC working groups are charged with evaluating refinements to the existing NAIC RBC formula and considering improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity (when it is determined to be necessary); and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified.

17. The CADTF and its RBC working groups will monitor and evaluate changes to the annual financial statement blanks and the *Purposes and Procedure Manual of the NAIC Investment Analysis Office* to determine if assets or, specifically, investments evaluated by the NAIC Securities Valuation Office are relevant to the RBC formula in determining the threshold capital and surplus for all insurance companies or whether reporting available to the regulator is a more appropriate means to addressing the risk. The CADTF will consider different methods of determining whether a particular risk should be added as a new risk to be studied and selected for a change to the applicable RBC formula, but due consideration will be given to the materiality of the risk to the industry, as well as the very specific purpose of the RBC formulas to develop regulatory threshold capital levels.

[1] Report of the Industry Advisory Committee to the Life Risk-Based Capital (E) Working Group, p. 6; Nov. 17, 1991.

Overview of the NAIC Health Risk-Based Capital Report

INTRODUCTION

Risk-based capital (RBC) is a method of measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile. It provides an elastic means of setting the capital requirement in which the degree of risk taken by the insurer is the primary determinant. The five major categories of risks involved are:

Insurance Affiliates And Misc. Other	H–0	This is the risk from declining value of insurance subsidiaries as well as risk from off-balance sheet and other misc. accounts (e.g., DTAs).
Asset Risk – Other	H–1	This is the risk of assets' default of principal and interest or fluctuation in market value.
Underwriting Risk	H–2	This is the risk of underestimating liabilities from business already written or inadequately pricing business to be written in the coming year.
Credit Risk	H–3	This is the risk of recovering receivable amounts from creditors.
Business Risk	H–4	This is the risk of general business.

A company's risk-based capital is calculated by applying factors to various asset, premium and reserve items. The factor is higher for those items with greater underlying risk and lower for less risky items. The adequacy of a company's actual capital can then be measured by a comparison to its risk-based capital as determined by the formula.

Risk-based capital standards will be used by regulators to set in motion appropriate regulatory actions relating to insurers that show indications of weak or deteriorating conditions. It also provides an additional standard for minimum capital requirements that companies should meet to avoid being placed in rehabilitation or liquidation.

PURPOSE OF THIS REPORT

This report presents the NAIC Health Risk-Based Capital formula in an instructional format that should be helpful to anyone responsible for submitting data. This formula is an extremely important tool for regulators. Determining accurate and timely data is an important part of this process. This is most likely to occur when everyone, from the company CEO to the individual preparing the data, has a basic understanding of the formula. While this report provides this understanding in a concise package, it is strongly recommended that the person or persons compiling and entering the information be senior company officials with a good understanding of the financial aspects of health business. It is also recommended that companies seek the assistance of their independent accountants and/or actuaries when preparing this report. Please complete the Jurat signature requirements in accordance with the requirements of the domiciliary state. Direct any questions concerning signature requirements to that state.

WHAT'S IN THE REPORT

Certain terms relating to risk-based capital used in this report are defined in the NAIC *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315).

Generally, each narrative page discusses a different segment of each risk classification (i.e., there is a narrative for Bonds, Mortgages, Preferred and Common Stocks, etc. within the Asset Risk section). The formula is presented in worksheet form following the narrative section.

Most narrative pages have a brief background summary of the development of the factors called the "Basis of the Factors." Development of certain factors require sophisticated modeling techniques, but the basic concepts are not complicated.

Many of the sections have a narrative page on "Specific Instructions for Application of the Formula." This section should serve as a guideline for those who assemble the data or analyze the results. It includes definitions and explanations for specific items that should be calculated, clarification on structural intent of certain sections of the formula, and instructions on reconciliation of certain totals.

Annual statement sources referred to in this report do not use parentheses, i.e., a reference to the current year's total Administrative Expenses on the income statement will read "Page 4, Col 2, Line 21." Annual statement references will begin with a page number only for Pages 2, 3, 4 and 7. Otherwise, the reference will be a schedule letter (e.g., Schedule D or Sch D) or a name of an exhibit or schedule (e.g., Underwriting and Investment Exhibit or UI).

Risk-based capital references in this report will use parentheses around the line and column number. For example, a reference to XR022 – Business Risk, Column 2, Line 20 in this report will read, "XR022, Column (2), Line (20)."

Negative values can sometimes appear in the value column or RBC Subtotal column of this report. These negative values are retained to facilitate crosschecking of amounts reported in the annual statement against amounts reported in the RBC filing. However, when a negative number appears in the value column, that value will be converted to zero before determining the RBC Requirement. For example, a negative $10,000 for cash [XR008, Col (1), Line (1)] will produce a zero ($0 times 0.003) in Column (2), RBC Requirement, rather than a negative $30 (-$10,000 times 0.003).

MANAGEMENT'S DISCUSSION AND ANALYSIS

Each company has the opportunity to prepare a written analysis of their company's risk-based capital results. This analysis is not a requirement. A company may explain special situations as it deems necessary. Companies should also give explanations where line items do not reconcile with amounts referenced to annual statement sources. However, modification of the risk-based capital formula is not acceptable. Factors, RBC Amounts that go to the Calculation of Total Risk-Based Capital After Covariance page (H0, H1, H2, H3, H4) and the Total Adjusted Capital Amount should not be overwritten. This written analysis should not be construed as the "RBC Plan" required in the NAIC *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315).

APPLICABILITY OF NAIC HEALTH RBC REPORT

The NAIC Health RBC Report has been developed for companies who file the NAIC Health annual statement "orange blank."

CHANGES TO THE FORMULA

Changes to the formula may be made by annual statement presentation, accounting procedures and refinement of the formula. All such changes will be determined by the NAIC Capital Adequacy (E) Task Force.

HOW TO SUBMIT DATA

Printed RBC reports and electronic submissions should be submitted as specified in the individual state filing checklists. **The electronic submission is due March 1**. There may be places where the screen display of the RBC program and the printout format vary slightly from the booklet. In those instances, the booklet should explain the differences; however, the overall calculation will be the same.

WORKPAPERS

Workpapers needed to prepare this report should be retained and available for examination in accordance with record retention requirements of the domestic state laws or regulations.

QUESTIONS

Contact **Derek Noe at 816-783-8973 or *dnoe@naic.org*** for RBC formula questions. The NAIC Financial Reporting Questions Help Line can also be contacted at 816-783-8400 for formula and reporting questions.

AFFILIATED/SUBSIDIARY STOCKS
XR002–XR004

There are nine categories of affiliated/subsidiary investments that are subject to Risk-Based Capital requirements for common stock and preferred stock holdings. Those nine categories are:

1. Directly Owned U.S. Insurance Affiliates/Subsidiaries Subject to a Risk-Based Capital (RBC)-Look-Through Calculation
    a. Health Insurance Company or Health Entity
    b. Property and Casualty Insurance Company
    c. Life Insurance Company
2. Indirectly Owned U.S. Insurance Affiliates/Subsidiaries Subject to RBC-Look-Through Calculation
    a. Health Insurance Company or Health Entity
    b. Property and Casualty Insurance Company
    c. Life Insurance Company
3. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries
4. Investment Subsidiaries
5. Directly Owned Alien Insurance Affiliates/Subsidiaries
    a. Health Insurance Company or Health Entity
    b. Property and Casualty Insurance Company
    c. Life Insurance Company
6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries
    a. Health Insurance Company or Health Entity
    b. Property and Casualty Insurance Company
    c. Life Insurance Company
7. Investments in Upstream Affiliate (Parent)
8. Directly Owned U.S. Insurance Affiliates/Subsidiaries Not Subject to RBC
    a. Health Insurance Companies and Health Entities Not Subject to RBC
    b. Property and Casualty Insurance Companies Not Subject to RBC
    c. Life Insurance Companies Not Subject to RBC
9. Non-Insurance Affiliates/Subsidiaries Not Subject to RBC
    a. Entities with a capital requirement imposed by a regulatory body
    b. Other Financial Entities without regulatory capital requirements
    c. Other Non-financial entities

Enter applicable items for each affiliate/subsidiary in the Details for Affiliated Stocks worksheet. The program will automatically calculate the risk-based capital charge for each affiliate/subsidiary. When the data is uploaded to the NAIC database, it will be crosschecked, and the company will be required to correct any discrepancies and refile a corrected version with the NAIC and/or any state that requires the company to file RBC with its department. The RBC report will display the number of affiliates/subsidiaries. These numbers should be reviewed to ensure that all affiliates/subsidiaries are appropriately reported.

The total of all reported affiliate/subsidiary stock should equal the amounts reported on Schedule D, Part 2, Section 1, Line 4409999999 plus Schedule D, Part 2, Section 2, Line 5979999999 and should also equal Schedule D, Part 6, Section 1, Line 0999999 plus Line 1899999.

Affiliated/Subsidiary investments fall primarily into two broad categories: (a) Insurance Affiliates/Subsidiaries that are Subject to risk-based capital; and (b) Affiliates/Subsidiaries that are Not Subject to risk-based capital. The risk-based capital for these two broad groups differs. A third category of Affiliates/Subsidiaries, publicly traded insurance affiliates/subsidiaries held at market value, has characteristics of both broader categories. As a result, it has a two-part RBC calculation. The general treatment for each is explained below.

Directly owned insurance and health entity affiliates/subsidiaries are affiliates/subsidiaries in which the reporting company owns the stock of the affiliate/subsidiary. Indirectly owned insurance affiliates/subsidiaries and health entities are those where the reporting company owns stock in a holding company, which in turn owns the stock of the insurance affiliate/subsidiary or health entity. Note that there could be multiple holding companies that control the downstream insurance company.

Enter the book/adjusted carrying value of: the common stock in Column (5), the preferred stock in Column (9), the total outstanding common stock in Column (7) and the total outstanding preferred stock of that affiliate/subsidiary in Column (10) of the appropriate worksheet. The percentage of ownership is calculated by summing the book/adjusted carrying values of the owned preferred and common stock and dividing that amount by the sum of all outstanding preferred and common stock.

Insurance Affiliates/Subsidiaries that are Subject to RBC

1. Directly Owned U.S. Affiliates/Subsidiaries:

The risk-based capital requirement for the reporting company for those insurance affiliates/subsidiaries that are subject to a risk-based capital requirement is based on the Total Risk-Based Capital After Covariance of the subsidiary, prorated for the percent of ownership of that affiliate/subsidiary.

For purposes of Affiliate/Subsidiary Risk all references to Total Risk-Based Capital After Covariance of the affiliate/subsidiary means:

a. For a Health affiliate/subsidiary RBC filing, Total Risk-Based Capital After Covariance before Basic Operational Risk (XR025, Line (41)).
b. For a P/C affiliate/subsidiary RBC filing, Total Risk-Based Capital After Covariance before Basic Operational Risk (PR032, Line (60)).
c. For a Life affiliate/subsidiary RBC filing, the sum of
    i. Total Risk-Based Capital After Covariance before Basic Operational Risk (LR031, Line (69); and
    ii. Primary Security shortfalls for all cessions covered by Actuarial Guideline XLVIII (AG 48) multiplied by two (LR031, Line (73)).

For RBC purposes, the reporting insurer must determine the carrying value and the RBC requirement of a directly owned RBC filing affiliate/subsidiary company, even if the RBC filing affiliate/subsidiary is non-admitted for financial reporting purposes. The value reported in annual statement Schedule D, Part 6, Section 1 will be used for RBC purposes. In addition to RBC, the carrying value of the RBC filer must be reported in total adjusted capital for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on Line (6) of the Calculation of Total Adjusted Capital page to satisfy these instructions.

Equity method Insurance Affiliates/Subsidiaries: Equity method is defined in *SSAP 97—Investments in Subsidiary, Controlled and Affiliated Entities*, paragraph 8.b. as the underlying audited statutory equity of the respective entity's financial statements, adjusted for any unamortized goodwill as provided for in *SSAP No. 68—Business Combinations and Goodwill*. For those insurance affiliates/subsidiaries of the reporting company that are reported under the equity method, the H_0 charge of the ownership of the common and preferred stock in these Affiliates/Subsidiaries is limited to the lesser of:

- (a) the Total RBC After Covariance of the affiliate/subsidiary times the percentage of ownership, which is the total of common stock and preferred stock; or
- (b) the common and preferred stock book/adjusted carrying value at which the affiliate/subsidiary is carried

Market Value (including discounted market value) Insurance Affiliates/Subsidiaries (See SSAP No. 97, paragraph 8.a.): If the affiliate/subsidiary's common stock is publicly traded and the reporting company carries the affiliate/subsidiary at market value, after any "discount," there are generally two components to the reporting company's RBC generated by the affiliate/subsidiary. The prorated portion is the percentage of ownership of total common and preferred stock. The smaller of the prorated portion of the affiliate/subsidiary's own statutory surplus or the prorated portion of its RBC after covariance is added to the H_0 component of the reporting

company. **Normally,** the common and preferred stock book/adjusted carrying value of the affiliate/subsidiary exceeds the prorated portion of the larger of its statutory surplus and its RBC after covariance**, an additional charge is applied to H_1. T**he additio**nal charge** to the H_1 component is the larger of a) 22.5% of the affiliate/subsidiary's common and preferred stock book/adjusted carrying value in excess of the prorated portion of the affiliate's/subsidiary's statutory surplus or b) the prorated portion of the affiliate's/subsidiary's RBC after covariance in excess of the prorated portion of its statutory surplus. If the affiliate/subsidiary's common and preferred stock book/adjusted carrying value is less than the prorated portion of its RBC after covariance, but greater than the prorated portion of its statutory surplus, 100% of the common and preferred stock book/adjusted carrying value in excess of the prorated portion of the affiliate/subsidiary's statutory surplus is added to the reporting company's H_1 component. If the affiliate/subsidiary's common and preferred stock book/adjusted carrying value is less than the prorated portion of the affiliate/subsidiary statutory surplus, there is no addition to the H_1 component.

2. Indirectly Owned U.S. Insurance Affiliates/Subsidiaries

For Indirectly Owned U.S. Insurance Affiliates/Subsidiaries, the carrying value and RBC is calculated in the same manner as for directly owned U.S. Insurance Affiliates/Subsidiaries. The RBC for the indirect affiliates/subsidiaries must be calculated prior to completing this RBC report.

SSAP No. 97 provides guidance for the reporting and admittance requirements of SCAs. Accordingly, there may be cases where an indirectly owned RBC filer may not be separately reported in the statutory financial statements (e.g., they are captured within the carrying value of an intermediate holding company). The SSAP No. 97 guidance permits reporting SCAs at the directly owned holding company level or via look-through to the downstream entity (including where the downstream entity is an RBC filer), but an audit of the entity is required for admittance (i.e. if reporting is at the directly owned holding company level, the holding company must be audited, if the reporting is on a look-through basis then the downstream entity must be audited). Regardless of whether there is a look-through applied pursuant to Statutory Accounting Principles (SAP) for annual financial statement reporting, for RBC purposes the reporting insurer must "look-through" all intermediate holding and subsidiary companies to determine the carrying value and the RBC requirement of indirectly owned RBC filing affiliate/subsidiary companies. This involves drilling down to the first RBC filing insurance subsidiary and adjusting for percentage ownership of the intermediate entity directly owning the RBC filing affiliate/subsidiary. Both RBC and carrying value of the RBC filer must be reported for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on Line (6) of the Calculation of Total Adjusted Capital page to satisfy these instructions.

The carrying value for each indirect insurance affiliate/subsidiary is established based on company records using the statutory value of the insurer as reported in the NAIC annual financial statement blank submitted by the affiliate/subsidiary or market value when applicable, and the RBC requirement as determined in its RBC Report adjusted for the ownership percentages (both the percentage of the indirectly owned RBC filing affiliate/subsidiary that is owned by the directly held downstream holding company and the reporting insurer's ownership percentage in that downstream entity). The value reported by the downstream holding company for the U.S. RBC filing insurer is the same as the statutory value established for the insurer on a look-through basis.

3. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries

The carrying value of a U.S. Insurance Affiliate/Subsidiary that is subject to RBC is deducted from the value of the directly held holding company or other entity that in turn directly owns the U.S. Insurance Affiliate/Subsidiary that is subject to RBC, based on the value reported for each insurance subsidiary on the downstream immediate holding company or non-insurance owner's balance sheet. That value is prescribed by the NAIC Accounting Practices and Procedures Manual (SSAP No. 97, paragraph 22.a.). A similar exercise is required for each RBC filing insurer and each non-U.S. insurer in order to determine the remaining excess value of the holding company.

The remaining value of the directly held holding company is then subject to a charge that is calculated in accordance with the instructions for Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries as specified in the RBC formula. If the holding company is not admitted, report the excess carrying value as zero and the corresponding RBC charge will also be zero. If a negative excess value for the downstream holding company results from removing the value of U.S. RBC filing insurers from the downstream holding company's reported value, then the value of that holding company will be floored at zero and the corresponding RBC charge will also be zero.

The following hypothetical Balance Sheet indicates the view of a Holding Company - Holder, Inc. which is 100% owned by MEGA Health Insurance Company (it assumes that the value reported by the downstream holding company for the U.S. RBC filing insurer is the same as the statutory value established for the insurer on a look-through basis):

	Balance Sheet Holder, Inc. 12/31/XXXX				
Cm Stk:	ABC Life Company	10,000,000		Long Term Debt	5,000,000
	XYZ Casualty Company	15,000,000		Other Liabilities	2,000,000
	ANH Health Company	3,000,000			
	Other Common Stock	17,000,000		Total Liabilities	7,000,000
	Cash	7,000,000			
	Other Assets	5,000,000		Equity	50,000,000
	Total Assets	57,000,000		Total Liabilities & Equity	57,000,000

The RBC calculation for Holder, Inc.'s value in excess of the indirectly owned insurance affiliates/subsidiaries is as follows:

Company	**Stat. Book Value**	**Source:**
Holder, Inc.	50,000,000	MEGA Health Sch D - Part 6, Section 1
Holder, Inc. aff/subs subject to RBC		
ABC Life Company	10,000,000	Holder, Inc. Stat. balance sheet
XYZ Casualty Company	15,000,000	Holder, Inc. Stat. balance sheet
ANH Health Company	3,000,000	Holder, Inc. Stat. balance sheet
Subtotal	28,000,000	
Holder, Inc. excl. RBC aff/subs	22,000,000	*(amount subject to the 30.0% factor for Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries)*

The following table shows the XR002 entries that MEGA Health Insurance Company (which owns 100% owns of Holder, Inc.) would report for the indirectly owned insurance affiliates/subsidiaries under Holder, Inc. This table assumes that Holder, Inc. owns 40%, 50% and 25% of ABC Life, XYZ Casualty, and ANH Health, respectively. The table also assumes that the RBC values shown for these affiliates/subsidiaries at the 100% level are the correct RBC After Covariance but Before Operational Risk.

		XR002 Column					
		4	5	7	8	11	12
Affiliates/Subsidiaries	**Affiliates/Subsidiaries Type**	**100% RBC**	**Book Adjusted Carrying Value**	**Total Value of Affiliates/Subsidiaries**	**Statutory Surplus of Affiliates/Subsidiaries**	**% Owned**	**RBC Required**
ABC Life Company	Indirect U.S. Life Aff/Sub	5,000,000	10,000,000	25,000,000	25,000,000	40%	2,000,000
XYZ Casualty Company	Indirect U.S. P&C Aff/Sub	12,000,000	15,000,000	30,000,000	30,000,000	50%	6,000,000
ANH Health Company	Indirect U.S. Health Aff/Sub	6,000,000	3,000,000	12,000,000	12,000,000	25%	1,500,000

The risk-based capital charge for the parent insurer preparing the calculation is a 30% charge against the holding company value in excess of the indirectly owned insurance affiliates/subsidiaries as calculated in the prior example. Enter information in the appropriate columns of the worksheet, omitting those columns that do not apply (Column (3) – NAIC Company Code or Alien ID Number and Column (4) Affiliate's RBC After Covariance).

Affiliates/Subsidiaries that are Not Subject to RBC

4. Investment Subsidiaries

An investment subsidiary is a subsidiary that exists only to invest the funds of the parent company. The term investment subsidiary is defined in the annual statement instructions as any subsidiary, other than a holding company, engaged or organized primarily to engage in the ownership and management of investments for the insurer. An investment subsidiary shall not include any broker-dealer or a money management fund managing funds other than those of the parent company. The risk-based capital for an investment in an investment subsidiary is 30% of the carrying value of the common and preferred stock.

5. Directly Owned Alien Insurance Affiliates/Subsidiaries

For purposes of this formula, the Risk-Based Capital (RBC) of each directly owned alien insurance affiliate/subsidiary is the annual statement book adjusted carrying value of the reporting company's interest in the affiliate multiplied by 1.000. Enter information for any non-U.S. insurance affiliate/subsidiary: life, property and casualty, and health insurers.

For each affiliate/subsidiary, enter the following information:

- Company Name,
- Alien Insurer Identification Number,
- Book Adjusted carrying value of common and preferred stock,
- Total Outstanding value of common and preferred stock,
- Book/adjusted carrying value of the common and preferred stock from Schedule D, Part 6, Section 1, Line 1499999 and 0599999. If no value is reported in the Total Value of Affiliate's common and preferred stock columns (7) and (10), the program will assume 100% ownership.

6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries

For Indirectly Owned Alien Insurance Affiliates/Subsidiaries, the carrying value and RBC charge is calculated in a similar manner as for directly owned Alien Insurance Affiliates/Subsidiaries.

SSAP No. 97 provides guidance for the reporting and admittance requirements of SCAs. Accordingly, there may be cases where an indirectly owned Alien insurer may not be separately reported in the statutory financial statements (e.g., they are captured within the carrying value of an intermediate holding company). The SSAP No. 97 guidance permits reporting SCAs at the directly owned holding company level or via look-through to the downstream entity (including where the downstream entity is an

Alien insurer), but an audit of the entity is required for admittance (i.e. if reporting is at the directly owned holding company level, the holding company must be audited, if the reporting is on a look-through basis then the downstream entity must be audited). Regardless of whether there is a look-through applied pursuant to Statutory Accounting Principles (SAP) for annual financial statement reporting, for RBC purposes the reporting insurer must "look-through" all intermediate holding and subsidiary companies to determine the carrying value and the RBC charge that would be imposed had the Alien insurance affiliate/subsidiary companies been directly held by the reporting insurer. This involves looking down to the first alien insurer affiliate/subsidiary, unless there is an RBC filer in between, and adjusting for percentage ownership of the intermediate entity directly owning the RBC filing affiliate/subsidiary. Both the RBC charge and carrying value of the alien insurer must be reported for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on Line (6) of the Calculation of Total Adjusted Capital page to satisfy these instructions.

The carrying value of an alien insurance affiliate/subsidiary is deducted from the value of the directly held holding company or other entity that in turn directly owns the U.S. Insurance Affiliate/Subsidiary that is subject to RBC, based on the value reported for each insurance subsidiary on the downstream immediate holding company or non-insurance owner's balance sheet. That value is prescribed by the NAIC Accounting Practices and Procedures Manual (SSAP No. 97, paragraph 22.a.). A similar exercise is required for each RBC filing insurer and each non-U.S. insurer in order to determine the remaining excess value of the holding company.

The RBC charge to be applied to each indirectly owned alien insurance affiliate/subsidiary is the annual statement book adjusted carrying value of the reporting company's interest in the affiliate/subsidiary multiplied by 1.0 and adjusted to reflect the reporting company's ownership on the holding company. For example, assume NEWBIE Insurance Company acquired 100% shares of Holder (a holding company), and Holder owns an Alien Life Insurance Company, which represents 50% of the book adjusted carrying value of Holder. If Holder has a book adjusted carrying value of $20,000,000, NEWBIE Insurance Company would enter $10,000,000 (1/2 of $20,000,000) as the carrying value of the Alien Life Insurance Company and the RBC charge for the indirect ownership of the alien insurance affiliate/subsidiary would be $10,000,000 (1.000 times $10,000,000). The risk-based capital charge for the parent insurer preparing the calculation is a 30% charge against the holding company value in excess of the indirectly owned insurance affiliates/subsidiaries.

XR002 Columns			
(1)	(2)	(5)	(12)
Affiliate/Subsidiary	Affiliate/Subsidiary Type	Book Adjusted Carrying Value (Statement Value) of Affiliate's Common Stock	RBC Required
Alien Life Insurance Company	6c	10,000,000	10,000,000
Holder Holding Company	3	10,000,000	3,000,000

If NEWBIE Insurance Company only acquired 50% shares of Holder, NEWBIE Insurance Company would enter $5,000,000 (50% of 1/2 of $20,000,000) as the carrying value of the Alien Life Insurance Company and the RBC charge for the indirect ownership of the alien insurance affiliate/subsidiary would be $5,000,000 (1.0 times $5,000,000). Enter information for any indirectly owned alien insurance subsidiaries.

XR002 Columns			
(1)	(2)	(5)	(12)
Affiliate/Subsidiary	Affiliate/Subsidiary Type	Book Adjusted Carrying Value (Statement Value) of Affiliate's Common Stock	RBC Required
Alien Life Insurance Company	6c	5,000,000	5,000,000
Holder Holding Company	3	5,000,000	1,500,000

For each affiliate/subsidiary enter the following information:

- Company Name,
- Alien Insurer Identification Number,

- Book Adjusted carrying value of common and preferred stock,
- Book/adjusted carrying value of the common and preferred stock from Schedule D, Part 6, Section 1, Line 1499999 and 0599999. If no value is reported in the Total Value of Affiliate's Common and preferred stock column (7) and (10), the program will assume 100% ownership.

7. Investment in Upstream Affiliate (Parent)

The risk-based capital (RBC) for an investment in an upstream parent is 30.0% of the book/adjusted carrying value of the common and preferred stock, regardless of whether that upstream parent is subject to RBC. Report the appropriate information from Schedule D, Part 6, Section 1, Lines 0199999 and 1099999 in Columns (1) through (10).

For each affiliate, enter the following information:

- Company Name,
- Affiliate Type Code,
- NAIC Company Code,
- Book Adjusted carrying value of common stock
- Book Adjusted carrying value of preferred stock,
- Total Outstanding value of common and preferred stock.

8. Directly Owned U.S. Insurance Affiliates/Subsidiaries Not Subject to RBC
   a. Health Insurance Companies and Health Entities Not Subject to RBC
   b. Property and Casualty Insurance Companies Not Subject to RBC, such as title insurers, monoline financial guaranty insurers, and monoline mortgage guarantee insurers
   c. Life Insurance Companies Not Subject to RBC, such as life insurance subsidiary exempted from RBC

The risk-based capital for insurers not subject to RBC is based on the underlying statute, regulation, or rule governing capital requirements for such entities. If not otherwise specified by statute regulation or rule, the risk-based capital for an investment in a U.S. insurer that is not required to file an RBC formula is 30% of the book/adjusted carrying value of the common and preferred stock.

9. Non-Insurance Affiliates/Subsidiaries Not Subject to RBC
   a. Financial entities with a capital requirement imposed by a regulatory body (e.g., a bank)
   b. Other financial entities without regulatory capital requirements
   c. Other non-financial entities

The risk-based capital for entity types a, b, and c is 30% of the book/adjusted carrying value of the common and preferred stock. The affiliate/subsidiary code for Non-Insurer Affiliates/Subsidiaries Not Subject to RBC is "9". Reported amounts use Schedule D, Part 6, Section 1, Line 0899999, and Line 1799999 as the basis of reporting.

OFF-BALANCE SHEET AND OTHER ITEMS

XR005

Off-balance sheet items, such as contingent liabilities, pose a risk to insurers. A 1% factor was chosen on a judgment basis to allow for this risk. For securities lending programs, a reduced charge may apply to certain programs that meet the criteria as outlined below.

Specific Instructions for Application of the Formula

Line (1)
Securities lending programs that have all of the following elements are eligible for a lower off-balance sheet charge:

1. A written plan adopted by the Board of Directors that outlines the extent to which the insurer can engage in securities lending activities and how cash collateral received will be invested.
2. Written operational procedures to monitor and control the risk associated with securities lending. Safeguards to be addressed should, at a minimum, provide assurance of the following:
    a. Documented investment guidelines between lender and investment manager with established procedure for review of compliance.
    b. Investment guidelines for cash collateral that clearly delineate liquidity, diversification, credit quality, and average life/duration requirements.
    c. Approved borrower lists and limits to allow for adequate diversification.
    d. Holding excess collateral with margin percentages in line with industry standards, which are currently 102% (or 105% for cross currency loans).
    e. Daily mark-to-market of lent securities and obtaining additional collateral needed to maintain a margin of 102% of market.
    f. Not subject to any automatic stay in bankruptcy and may be closed out and terminated immediately upon the bankruptcy of any party.
3. A binding securities lending agreement (standard "Master Securities Lending Agreement" from Securities Industry and Financial Markets Association) in writing between the insurer, or its agent on behalf of the insurer, and the borrowers.
4. Acceptable collateral is defined as cash, cash equivalents, direct obligations of, or securities that are fully guaranteed as to principal and interest by the government of the United States or any agency of the United States, or by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and NAIC 1-rated securities. Affiliate-issued collateral would not be deemed acceptable. In all cases the collateral held must be permitted investments in the state of domicile for the respective insurer.

Collateral included in General Interrogatories Part 1, Line 25.04 of the annual statement should be included on Line (1).

Line (2) – Collateral from all other securities lending programs should be reported in General Interrogatories Part 1, Line 25.05 and included in Line (2).

Lines (3) through (14) – Non-controlled assets are any assets reported on the balance sheet that are not exclusively under the control of the company, or assets that have been sold or transferred subject to a put option contract currently in force. For Lines (12) and (13), include assets pledged as collateral reported in the General Interrogatories Part 1, Lines 26.30 and 26.31 other than assets related to the Federal Reserve's Term Asset Loan Facility (TALF).

Line (16) – Guarantees for Affiliates include loan guarantees or other undertakings for the benefit of an affiliate which results in a material contingent exposure of the company's or any affiliated insurer's assets. The definition of "material" exposure or financial effect is the same as for annual statement disclosure requirements.

Line (17) – Contingent liabilities include any material contingent liabilities that are disclosed in the Notes to Financial Statements. *This category includes all structured securities for which the company has not received a full release of liability from a third party*.

Line (18) – "Yes" means the entity which files the U.S. federal income tax return which includes the reporting entity is a regulated insurance company (including where the reporting entity is the direct filer of the tax return). "No" means the entity which files the U.S. Federal income tax return which includes the reporting entity is not a regulated insurance company (e.g., a non-insurance entity or holding company makes the filing). "N/A" means the entity is exempt from filing a U.S. Federal income tax return; Lines (19) and (20) should be zero in this case.

Lines (19) and (20) – Apply a 1% charge in the RBC formula, placed outside of the covariance adjustment, to admitted adjusted gross deferred tax assets (DTAs) as described in *SSAP No. 101—Income Taxes*, paragraphs 11.a. and 11.b. (lesser of paragraph 11.b(i) and 11.b(ii)). For the period for which the paragraph 11.a. component is

determined, the charge is reduced to 0.5% when the insurance company either filed its own separate U.S. Federal income tax return or it was included in a consolidated U.S. Federal income tax of which the common parent is an insurance company. The source for the DTA amounts to use in the calculation is found in the Annual Statement, Notes to Financial Statements, Note 9, Part A, Section 2, Admission Calculation Components for SSAP No. 101. Paragraph 11.a. is found in Section 2, subpart (a), Paragraph 11.b. is found in Section 2, subpart (b).

OFF-BALANCE SHEET SECURITY LENDING COLLATERAL AND SCHEDULE DL, PART 1 ASSETS

XR006

Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements and incur the related risk charges on those assets. Other entities have collateral that is not recorded on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.

The collateral in these accounts is maintained by a third party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/adjusted carrying value, and maturity date.

The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

Specific Instructions for Application of the Formula

Column (2) – Schedule DL, Part 1 Book/Adjusted Carrying Value comes from Annual Statement Schedule DL, Part 1, Column (6) Securities Lending Collateral Assets reported On-Balance Sheet (Assets Page, Line 10).

Off-balance sheet collateral included in General Interrogatories Part 1, Lines 25.04 and 25.05 of the annual statement should agree with Line (40), Column (1).

Lines (1) through (27) – Bonds – Bond factors described on page XR007 – Fixed Income Assets – Bonds.

Line (28) through (34) – Preferred Stock – Preferred stock factors described on page XR010 – Equity Assets.

Line (35) – Common Stock – Common stock factors described on page XR010 – Equity Assets.

Line (36) – Real Estate and Property and Equipment Assets – Real Estate and Property and Equipment Assets factors described on page XR011 – Property & Equipment Assets.

Line (37) – Other Invested Assets – Other invested assets factor described on page XR008 – Fixed Income Assets – Miscellaneous.

Line (38) – Mortgage Loans on Real Estate – Mortgage Loans on Real Estate factors described on page XR008 – Fixed Income Assets – Miscellaneous.

Line (39) – Cash, Cash Equivalents and Short-Term Investments – Cash, Cash Equivalents and Short-Term Investments factors described on page XR008 – Fixed Income Assets – Miscellaneous.

FIXED INCOME ASSETS
XR007 AND XR008

The RBC requirement for fixed income assets is largely driven by the default risk on those assets. There are two major subcategories: Bonds and Miscellaneous. Bonds include items that meet the definition of a bond, regardless if the bond is long-term (reported on Schedule D-1), short-term (reported on Schedule DA), or a cash equivalent (reported on Schedule E-2). Miscellaneous fixed income assets include non-bond items reported on the cash equivalent and short-term schedules, derivatives, mortgage loans, collateral loans, and other items reported on Schedule BA: Other Long-Term Invested Assets.

Bonds (XR007)

The bond factors for investment grade bonds (NAIC Designation (1.A-2.C) are based on cash flow modeling. Each bond of a portfolio was annually tested for default (based on a "roll of the dice") where the default probability varies by NAIC Designation Category and that year's economic environment. The default probabilities were based on historical data intended to reflect a complete business cycle of favorable or unfavorable credit environments. The risk of default was measured over a five-year time horizon, based on the duration of assets held for health companies.

The factors for NAIC Designation Category 3.A to 6 recognize that these non-investment grade bonds are reported at the lower of amortized cost or fair value. These bond risk factors are based on the market value fluctuation for each of the NAIC Designation Category compared to the market value fluctuation of stocks during the 2008-2009 financial crisis.

While the life and property/casualty formulas have a separate calculation for the bond size factor (based on the number of issuers in the RBC filer's portfolio), the health formula does not include a separate calculation, instead a bond size component was incorporated into the bond factors. A representative portfolio of 382 issuers was used in calculating the bond risk factors.

There is no RBC requirement for bonds guaranteed by the full faith and credit of the United States, Other U.S. Government Obligations, and securities on the NAIC U.S. Government Money Market Fund List because it is assumed that there is no default risk associated with U.S. Government issued securities.

The book/adjusted carrying value of all bonds should be reported in Columns (1), (2) or (3). The bonds are split into twenty-one different risk classifications. These risk classifications are based on the NAIC Designation Category as defined and permitted in the *Purposes and Procedures Manual of the Investment Analysis Office*. The subtotal of Columns (1), (2), and (3) will be calculated in Column (4). The RBC requirement will be automatically calculated in Column (5).

Miscellaneous Fixed Income Assets (XR008)

The factor for cash is 0.3%. It is recognized that there is a small risk related to possible insolvency of the bank where cash deposits are held. This factor was based on the original unaffiliated NAIC 01 bond risk factor prior to the increased granularity of the NAIC Designation Categories in 2021 and reflects the short-term nature of this risk. The required risk-based capital for cash will not be less than zero, even if the company's cash position is negative.

The short-term investments to be included in this section are those short-term investments not reflected elsewhere in the formula. The 0.3% factor is equal to the factor for cash. The amount reported in Line (8) reflects the total from Schedule DA: Short-Term Investments (Line (6)), less the short-term bonds (Line (7)). (The short-term bonds reported in Line (7) should equal Schedule DA, Part 1, Column 7, Line 2509999999.)

Mortgage loans (reported on Schedule B) and Derivatives (reported on Schedule DB) receive a factor of 5%, consistent with other risk-based capital formulas studied by the Working Group.

The following investment types are captured on Schedule BA: Other Long-Term Invested Assets. Specific factors have been established for certain Schedule BA assets based on the nature of the investment. Those Schedule BA assets not specifically identified below receive a 20% factor (Line (16) **and Line (22)**).

- Collateral Loans reported on Line (13) receive a factor of 5%, consistent with other risk-based capital formulas studied by the Working Group.
- Working Capital Finance Investments: The book adjusted carrying value of NAIC 01 and 02 Working Capital Finance Investments, Lines (14) and (15), should equal the Notes to Financial Statement, Lines 5M(01a) and 5M(01b), Column 3 of the annual statement.
- Low-income housing tax credit investment are reported on Column (1) in accordance with *SSAP No. 93—Low-Income Housing Tax Credit Property Investments*.
    - Federal Guaranteed Low-Income Housing Tax Credit (LIHTC) investments are to be included in Line (17). There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.
    - Federal Non-Guaranteed LIHTC investments with the following risk mitigation factors are to be included in Line (18):
        a) A level of leverage below 50%. For a LIHTC Fund, the level of leverage is measured at the fund level.
        b) There is a tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.
    - State Guaranteed LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments are to be included in Line (19).
    - State Non-Guaranteed LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments are to be included on Line (20).
    - All Other LIHTC investments, state and federal LIHTC investments that do not meet the requirements of Lines (17) through (20) would be reported on Line (21).

REPLICATION (SYNTHETIC ASSET) TRANSACTIONS AND MANDATORY CONVERTIBLE SECURITIES

XR009

A replication (synthetic asset) transaction is a derivative transaction entered into in conjunction with other investments in order to reproduce the investment characteristics of otherwise permissible investments. A derivative transaction entered into by an insurer as a hedging or income generation transaction shall not be considered a replication (synthetic asset) transaction. All replication transactions must be reviewed and approved by the NAIC Capital Markets & Investment Analysis Office and assigned an RSAT number. The transactions are disclosed in Schedule DB, Part C, Section 1.

A replication (synthetic asset) transaction increases the insurer's exposure to one type of asset, the replicated (synthetic) asset, and may reduce the insurer's exposure to the asset risk associated with the cash market components of the transaction. Both effects are captured and quantified in the worksheet for replication transactions.

A mandatory convertible security is defined as a type of convertible bond that has a required conversion or redemption feature. Either on or before a contractual conversion date, the holder must convert the mandatory convertible security into the underlying common stock. Mandatory convertible securities are subject to special reporting instructions and are therefore not assigned NAIC Designations or Unit Prices by the SVO. The balance sheet amount for mandatory convertible securities shall be reported at the lower of amortized cost or fair value during the period prior to conversion. This reporting method is not impacted by NAIC designation or information received from credit rating providers (CRPs). Upon conversion, these securities will be subject to the accounting guidance of the SSAP that reflects their revised characteristics. For further guidance regarding mandatory convertible securities refer to *SSAP No. 26R—Bonds*. This worksheet adjusts the RBC requirement upward if the security that results from the conversion is more risky than the original security.

This worksheet should contain a line for each replicated (synthetic) asset and each cash instrument component of all replication (synthetic asset) transactions undertaken by the insurer. It should also contain a line for each mandatory convertible security and a line for the security that will result from the conversion. The assets should be sorted first by the RSAT number, next by type (replicated assets first, then cash instruments, then mandatory convertible securities, and the security that results from the conversion) and finally by CUSIP.

Column (1): The RSAT number for each transaction should be that used in Schedule DB, Part C, Section 1. Leave this column blank for mandatory convertible securities.

Column (2): Enter an R (for replicated asset) if the line describes one of the replicated (synthetic) assets, a CW (for cash instrument with RBC credit) if the line describes one of the cash instruments constituting the transaction and the transaction either (1) is a swap of prospectively determined interest rates or (2) eliminates the asset risk associated with the cash instrument, and a CN (for cash instrument with no RBC credit) if the line describes one of the cash instruments constituting the transaction and the transaction does not eliminate the insurer's exposure to the asset risk associated with the instrument. Enter an MC for a mandatory convertible security and an MCC for the security that will result from the conversion.

Column (3): Show the CUSIP for all cash instruments that are securities and all mandatory convertible securities and all securities that will result from a mandatory conversion.

Column (4): Give the description of the replicated (synthetic) asset(s) or cash instruments as found on Schedule DB, Part C, Section 1. Leave blank for mandatory convertible securities.

Column (5): Give the NAIC designation or other description that will best identify the asset risk of the asset. For replications (synthetic assets) this is contained in Columns 3 or 14 of Schedule DB, Part C, Section 1.

Column (6): Give the book/adjusted carrying value of the asset. For replications (synthetic assets) this is contained in Columns 5, 10 or 15 of Schedule DB, Part C, Section 1.

Column (7): For replicated (synthetic) assets and for the securities that will result from the conversion of a mandatory convertible security, multiply the risk-based capital factor appropriate to the asset designation of the asset times the book/adjusted carrying value contained in Column (6). For cash instrument components that qualify for an RBC credit and for mandatory convertible securities, the amount contained in this column is the product of:

(a) The risk-based capital factor appropriate to the asset designation of the cash instrument or mandatory convertible security, but not higher than the average risk-based capital factor for the replicated (synthetic) asset(s) or the securities that result from the conversion of the mandatory convertible security, times
(b) The book/adjusted carrying value contained in Column 6, times
(c) –1.

For other cash instrument components, this column should contain a zero.

EQUITY ASSETS
XR010

Unaffiliated Preferred Stocks

Detailed information on unaffiliated preferred stock reported in Column (1) are found in Schedule D, Part 2, Section 1 not including affiliated preferred stock. The preferred stocks must be broken out by asset designation (NAIC 01 through NAIC 06) and these individual groups are to be entered in the appropriate lines. The total

amount of unaffiliated preferred stock reported should equal annual statement Page 2, Column 3, Line 2.1, less any affiliated preferred stock in Schedule D Summary by Country, Column 1, Line 18.

Unaffiliated Common Stock

Federal Home Loan Bank Stock has characteristics more like a fixed income instrument rather than common stock. A 2.3% factor was chosen. The factor for other unaffiliated common stock is based on studies which indicate that a 10% to 12% factor is needed to provide capital to cover approximately 95% of the greatest losses in common stock over a one-year future period. The higher factor of 15% contained in the formula reflects the increased risk when testing a period in excess of one year. This factor assumes capital losses are unrealized and not subject to favorable tax treatment at the time of loss in market value.

ASSET RISK – PROPERTY & EQUIPMENT
XR011

There are five subcategories of "Property & Equipment Assets": (1) Properties Occupied by the Company; (2) Properties Held for the Production of Income; (3) Properties Held for Sale; (4) Furniture and Equipment; and (5) EDP Equipment and Software.

Encumbrances have been included in the real estate bases since the value of the property subject to loss would include encumbrances.

Classify Furniture and Equipment into: (1) the portion used to deliver health care that is subject to statutory accounting depreciation limits; and (2) all other. Category (1) should include only that furniture and equipment which has had its depreciation period limited to no more than three years pursuant to *SSAP No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities*. Category (2) should include all other furniture and equipment, or that furniture and equipment whose depreciation periods are not limited by SSAP No. 73, i.e., the depreciation period is based on useful life. If the filing entity's state of domicile has a permitted practice that preempts SSAP No. 73, all furniture and equipment should be classified in Category (2).

ASSET CONCENTRATION
XR012

The purpose of the asset concentration calculation is to reflect the additional risk of high concentrations of certain types of assets in single exposures, termed "issuers." An issuer is a single entity, such as IBM or the Ford Motor Company. When the reporting entity has a large portion of its asset portfolio concentrated in only a few issuers, there is a heightened risk of insolvency if one of those issuers should default. An issuer may be represented in the reporting entity's investment portfolio by a single security designation, such as a large block of NAIC Designation Category 2.A bonds, or a combination of various securities, such as common stocks, preferred stocks, and bonds. The additional RBC for asset concentration is applied to the ten largest issuers.

Concentrated investments in certain types of assets are not expected to represent an additional risk over and above the general risk of the asset itself. Therefore, prior to determining the ten largest issuers, you should exclude those assets that are exempt from the asset concentration factor. Asset types that are excluded from the calculation include: NAIC 06 bonds and unaffiliated preferred stock; affiliated common stock; affiliated preferred stock; property and equipment; U.S. government full faith and credit, Other U.S. government obligations, and NAIC U.S. government money market fund list securities; NAIC 01 bonds and unaffiliated preferred stock; any other asset categories with risk-based capital factors less than 1%**,** and investment companies (mutual funds) and common trust funds that are diversified within the meaning of the federal Investment Company Act of 1940 [Section 5(b) (1)]. The pro rata share of individual securities within an investment company (mutual fund) or common trust fund are to be included in the determination of concentrated investments, subject to the exclusions identified.

With respect to investment companies (mutual funds) and common trust funds, the reporting entity is responsible for maintaining the appropriate documentation as evidence that such is diversified within the meaning of the federal Investment Company Act and providing this information upon request of the Commissioner, Director or

Superintendent of the Department of Insurance. The reporting entity is also responsible for maintaining a listing of the individual securities and corresponding book/adjusted carrying values making up its investment companies (mutual funds) and common trust funds portfolio, in order to determine whether a concentration charge is necessary. This information should be provided to the Commissioner, Director or Superintendent upon request.

The assets that **ARE INCLUDED** in the calculation when determining the 10 largest issuers are as follows:

NAIC Designation Category 2.A-2.C Bonds
NAIC Designation Category 3.A-3.C Bonds
NAIC Designation Category 4.A-4.C Bonds
NAIC Designation Category 5.A-5.C Bonds
Collateral Loans
Mortgage Loans
NAIC 02 Unaffiliated Preferred Stock
NAIC 03 Unaffiliated Preferred Stock
NAIC 04 Unaffiliated Preferred Stock
NAIC 05 Unaffiliated Preferred Stock
Other Long-Term Assets
NAIC 02 Working Capital Finance Investments
Federal Guaranteed Low-Income Housing Tax Credits
Federal Non-Guaranteed Low-Income Housing Tax Credits
State Guaranteed Low-Income Housing Tax Credits
State Non-Guaranteed Low-Income Housing Tax Credits
All Other Low-Income Housing Tax Credits
Unaffiliated Common Stock

The concentration factor basically doubles the risk-based capital factor (up to a maximum of 30%) for assets held in the 10 largest issuers. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, this factor itself only serves to add an additional risk-based capital requirement on these assets.

The name of each of the largest 10 issuers is entered at the top of the table and the appropriate statement amounts are entered in Column (2), Lines (1) through (26). Aggregate all similar asset types before entering the amount in Column (2). To determine the 10 largest issuers, first pool all of the assets subject to the concentration factor. From this pool, aggregate the various securities by issuer. The aggregate book/adjusted carrying values for the assets are computed, and the 10 largest are subject to the concentration factor. For example, an organization might own $6,000,000 in NAIC Designation Category 2.A bonds of IBM plus $4,000,000 in NAIC Designation Category 2.C plus $5,000,000 of common stock. The total investment in that issuer is $15,000,000. If that is the largest issuer, then the identifier (“IBM Corporation”) would be entered in the space allowed for the first Issuer Name, and the $6,000,000 would be entered under the book/adjusted carrying value column for Line (1) (NAIC Designation Category 2.A bonds), $4,000,000 would be entered on Line (3) (NAIC Designation Category 2.C Bonds) and the $5,000,000 would be entered on Line (22) (unaffiliated common stock).

Replicated assets other than synthetically created indices should be included in the asset concentration calculation in the same manner as other assets.

UNDERWRITING RISK - L(1) THROUGH L(21)
XR013

Underwriting Risk is the largest portion of the risk-based capital charge for most reporting entities. The Underwriting Risk page generates the RBC requirement for the risk of fluctuations in underwriting experience. The credit that is allowed for managed care in this page comes from the Managed Care Credit Calculation page.

Underwriting risk is present when the next dollar of unexpected claim payments comes directly out of the reporting entity's capital and surplus. It represents the risk that the portion of premiums intended to cover medical expenses will be insufficient to pay such expense. For example, a reporting entity may charge an individual $100 in premium in exchange for a guaranty that all medical costs will be paid by that reporting entity. If the individual incurs $101 in claims costs, the reporting entity's surplus will decline because it did not charge a sufficient premium to pick up the additional risk for that individual.

There are other arrangements where the reporting entity is not at risk for excessive claims payments, such as when an HMO agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claim costs, so the risk of excessive claims experience is borne by the self-insured employer, not the reporting entity. The underwriting risk section of the formula, therefore, requires some adjustments to remove non-underwriting risk business (both premiums and claims) before the RBC requirement is calculated. Appendix 1 contains commonly used terms for general types of health insurance. Refer to INT 05-05: Accounting for Revenue under Medicare Part D Cover for terms specifically used with respect to Medicare Part D coverage of prescription drugs.

Claims Experience Fluctuation

The RBC requirement for claims experience fluctuation is based on the greater of the following calculations:

A. Underwriting risk revenue, times the underwriting risk claims ratio, times a set of tiered factors. The tiered factors are determined by the underwriting risk revenue volume.

or

B. An alternative risk charge that addresses the risk of catastrophic claims on any single individual. The alternative risk charge is equal to multiple of the maximum retained risk on any single individual in a claims year. The maximum retained risk (level of potential claim exposure) is capped at $750,000 per individual and $1,500,000 total for medical coverage; $25,000 per individual and $50,000 total for all other coverage except Medicare Part D coverage and $25,000 per individual and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (e.g., writing more than one coverage type), the alternative risk charge for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive (hospital & medical) individual & group (with a cap of $1,500,000) and dental (with a cap of $50,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).

For RBC reports to be filed by a health organization commencing operations in this reporting year, the health organization shall estimate the initial RBC levels using operating (revenue and expense) projections (considering managed care arrangements) for its first full year (12 months) of managed care operations. The projections, including the risk-based capital requirement, should be the same as those filed as part of a comprehensive business plan that is submitted as part of the application for licensure. The Underwriting, Credit (capitation risk only), and Business Risk sections of the first RBC report submitted shall be completed using the health organization's actual operating data for the period from the commencement of operations until year-end, plus projections for the number of months necessary to provide 12 months of data. The affiliate, asset and portions of the credit risk section that are based on balance sheet information shall be reported using actual data. For subsequent years' reports, the RBC results for all of the formula components shall be calculated using actual data.

L(1) through L(21)

There are six lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive (Hospital & Medical) individual & group; (2) Medicare Supplement; (3) Dental/Vision; (4) Stand-Alone Medicare Part D Coverage; (5) Other Health; and (6) Other Non-Health. Each of these lines of business has its own column in the Underwriting Risk – Experience Fluctuation Risk table. The categories listed in the columns of this page include all risk revenue and risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

Column (1) – Comprehensive (Hospital & Medical) Individual & Group. Includes policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare Supplement), and Medicaid risk coverage. This category DOES NOT include administrative services contracts (ASC), administrative services only (ASO) contracts, or any non-underwritten business. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Plan (FEHBP) or TRICARE, which are handled in Line 24 of this section. Medicaid Pass-Through Payments reported as premiums should also be excluded from this category and should be reported in Line 25.2 of this section. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed $1,500,000. Prescription drug benefits included in major medical insurance plans (including Medicare Advantage plans with prescription drug coverage) should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

Column (2) – Medicare Supplement. This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement and includes Medicare Select. Medicare risk business is reported under Comprehensive (Hospital & Medical) Individual & Group.

Column (3) – Dental & Vision. This is limited to policies providing for dental-only or vision-only coverage issued as a stand-alone policy or as a rider to a medical policy, which is not related to the medical policy through deductibles or out-of-pocket limits.

Column (4) – Stand-Alone Medicare Part D Coverage. This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D (benefits in excess of the standard benefit design) are addressed separately on page XR015. Employer-based Part D coverage that is in an uninsured plan as defined in *SSAP No. 47—Uninsured Plans* is not to be included here.

Column (5) – Other Health Coverages. This includes other health coverages such as other stand-alone prescription drug benefit plans, that have not been specifically addressed in Columns (1) through (4) listed above and those lines of business addressed separately on page XR015, such as stop loss. Stop-loss premiums are addressed separately in Line (25) on page XR015.

Column (6) – Other Non-Health Coverages. This includes life and property and casualty coverages.

The following paragraphs explain the meaning of each line of the table for computing the experience fluctuation underwriting risk RBC.

Line (1) Premium. This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Nor does it include federal employees health benefit programs (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns should come directly from Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. For Stand-Alone Medicare Part D Coverage the premium includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D payment demonstration amounts and risk corridor payment adjustments. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. It does not include revenue received for reinsurance payments or low-income subsidy (cost-sharing portion), which are considered funds received for uninsured plans in

accordance with Emerging Accounting Issues Working Group (EAIWG) INT. No. 05-05. Also exclude the beneficiary premium (supplemental benefit portion) for Stand-Alone Medicare Part D coverage.

> **NOTE**: Where premiums are paid on a monthly basis, they are generally fully earned at the end of the month for which coverage is provided. In cases where the mode of payment is less frequent than monthly, a portion of the premium payment will be unearned at the end of any given reporting period.

Line (2) Title XVIII Medicare. This is the earned amount of money charged by the reporting entity (net of reinsurance) for Medicare risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the beneficiary premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement.

Line (3) Title XIX Medicaid. This is the earned amount of money charged by the reporting entity for Medicaid risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicaid subscribers. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. Stand-Alone Medicare Part D coverage of low-income enrollees is not included in this line.

Line (4) Other Health Risk Revenue. This is earned amounts charged by the reporting entity as a provider or intermediary for specified medical (e.g., full professional, dental, radiology, etc.) services provided to the policyholders, or members of another insurer or health entity. Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or health entity to the reporting entity in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation as underwriting risk revenue and are included in the calculation of managed care credits. Exclude fee-for-service revenue received by the reporting entity from another reporting entity. This revenue is reported in the Business Risk section of the formula as non-underwritten and limited risk revenue. The amounts reported in the individual columns will come directly from Page 7, Line 4 of the annual statement.

Line (5) Medicaid Pass-Through Payments Reported as Premiums. Medicaid Pass-Through Payments that are included as premiums in the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 should be reported in this line.

Line (6) Underwriting Risk Revenue. The sum of Lines (1) through (4) minus Line (5).

Line (7) Net Incurred Claims. Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or Federal Employees Health Benefits Program (FEHBP) and TRICARE claims. These amounts are found on Page 7, Line 17 of the annual statement.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in INT 05-05: Accounting for Revenue under Medicare Part D Coverage). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claims liabilities should reflect expected recoveries from the reinsurance coverage, for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS. Exclude the beneficiary incurred claims (supplemental benefit portion) for Stand-Alone Medicare Part D coverage and report the incurred claims amount (supplemental benefit portion) on Line (25.1) of page XR015.

Line (8) Medicaid Pass-Through Payments Reported as Claims. Medicaid Pass-Through Payments that are included as claims in the Analysis of Operations by Lines of Business, Page 7, Line 17 should be reported in this line.

Line (9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims. Line (7) minus Line (8).

Line (10) Fee-for-Service Offset. Report fee for service revenue that is directly related to medical expense payments. The fee for service line does not include revenue where there is no associated claim payment (e.g., fees from non-member patients where the provider receives no additional compensation from the reporting entity) and when such revenue was excluded from the pricing of medical benefits. The amounts reported in the individual columns should come directly from Page 7, Line 3 of the annual statement.

Line (11) Underwriting Risk Incurred Claims. Line (9) minus Line (10).

Line (12) Underwriting Risk Claims Ratio. For Columns (1) through (5), Line (11)/Line (6). If either Line (6) or Line (11) is zero or negative, Line (12) is zero.

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column (1) through (3) have incorporated an investment income yield of 5.**5**%.

	$0 – $3 Million	$3 – $25 Million	Over $25 Million
Comprehensive (Hospital & Medical)	0.14**27**	0.14**27**	0.083**2**
Individual & Group			
Medicare Supplement	0.09**73**	0.0**596**	0.0**596**
Dental & Vision	0.114**3**	0.07**06**	0.07**06**
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

The investment income yield was incorporated into the Comprehensive (Hospital & Medical) individual & group, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month U.S. Treasury bond. Each year, the Working Group will identify the yield of the 6-month U.S. Treasury bond (U.S. Department of the Treasury) on each Monday through the month of January and determine if further modification to the 5.**5**% adjustment is needed. Any adjustments will be rounded up to the nearest 0.5%.

Line (14) Base Underwriting Risk RBC. Line (6) x Line (12) x Line (13).

Line (15) Managed Care Discount. For Comprehensive (Hospital & Medical) individual & group, Medicare Supplement (including Medicare Select) and Dental/Vision, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (17) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three categories is used for all three.

For Stand-Alone Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in uncertainty about future claims payments attributable to federal risk arrangements. The discount factor is from Column (4), Line (17) of the Managed Care Credit Calculation page.

There is no discount given for the Other Health and Other Non-Health lines of business.

Line (16) RBC After Managed Care Discount. Line (14) x Line (15).

Line (17) Maximum Per-Individual Risk After Reinsurance. This is the maximum after-reinsurance loss for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

- Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than $750,000 per member, the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and $750,000.

- Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity's participation in the stop-loss layer (up to $750,000 less retention).

If there is no specific stop-loss or reinsurance in place, enter $9,999,999.

Examples of the calculation are presented below:

EXAMPLE 1 (Reporting entity provides Comprehensive Care):

Highest Attachment Point (Retention)	$100,000
Reinsurance Coverage	90% of $500,000 in excess of $100,000
Maximum reinsured coverage	$600,000 ($100,000 + $500,000)
Maximum Ret. Risk =	$100,000 deductible
	+ $150,000 ($750,000 – $600,000)
	+ $ 50,000 (10% of ($600,000 – $100,000) coverage layer)
	= $300,000

EXAMPLE 2 (Reporting entity provides Comprehensive Care):

Highest Attachment Point (Retention)	$75,000
Reinsurance Coverage	90% of $1,000,000 in excess of $75,000
Maximum reinsured coverage	$1,075,000 ($75,000 + $1,000,000)
Maximum Ret. Risk =	$ 75,000 deductible
	+ 0 ($750,000 – $1,075,000)
	+ $ 67,500 (10% of ($750,000 –$75,000)) coverage layer)
	= $142,500

Line (18) Alternate Risk Charge. This is twice the amount in Line (17) for columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (17), subject to a maximum of $1,500,000 for Column (1), $50,000 for Columns (2), (3) and (5) and $150,000 for Column (4). Column (6) is excluded from this calculation.

Line (19) Alternate Risk Adjustment. This line shows the largest value in Line (18) for the column and all columns left of the column. Column (6) is excluded from this calculation.

Line (20) Net Alternate Risk Charge. This is the amount in Line (18), less the amount in the previous column of Line (19), but not less than zero. Column (6) is excluded from this calculation.

Line (21) Net Underwriting Risk RBC. This is the maximum of Line (16) and Line (20) for each of columns (1) through (5). This is the amount in Line (14), Column (6). The amount in Column (7) is the sum of the values in Columns (1) through (6).

OTHER UNDERWRITING RISK – L(22) THROUGH L(45)

XR015–XR017

In addition to the general risk of fluctuations in the claims experience, there is an additional risk generated when reporting entities guarantee rates for extended periods beyond one year. If rate guarantees are extended between 15 and 36 months from policy inception, a factor of 0.024 is applied against the direct premiums earned for those guaranteed policies. Where a rate guaranty extends beyond 36 months, the factor is increased to 0.064. This calculation only applies to those lines of accident and health business, which include a medical trend risk, (i.e., Comprehensive (Hospital & Medical) individual & group, Medicare Supplement, Dental/Vision, Stand-Alone Medicare Part D Coverage, Supplemental benefits within Medicare Part D Coverage, Stop-Loss, and Minimum Premium). Premiums entered should be earned premium for the current calendar year period and not for the entire period of the rate guarantees. Premium amounts should be shown net of reinsurance only when the reinsurance ceded premium is also subject to the same rate guarantee.

A separate risk factor has been established to recognize the reduced risk associated with safeguards built into the Federal Employees Health Benefit Program (FEHBP) created under Section 8909(f)(1) of Title 5 of the United States Code and TRICARE business. Claims incurred are multiplied by 2% to determine total underwriting RBC on this business.

The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive (Hospital & Medical) individual & group or Other Health Coverages (Page XR013). It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop-Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35% will be applied to the first $25,000,000 in premium and a factor of 25% will be applied to premium in excess of $25,000,000. Stop-loss premiums should be reported on a net basis.

Line (25.1) Supplemental Benefits within Stand-Alone Medicare Part D Coverage. A separate risk factor has been established to recognize the different risk (as described in INT 05-05: Accounting for Revenue under Medicare Part D Coverage) for the incurred claims associated with the beneficiaries for these supplemental drug benefits.

Line (25.2) Medicaid Pass-Through Payments Reported as Premium. The treatment of Medicaid Pass-Through Payments varies from state to state, and in some instances is treated as premium. The Health Risk-Based Capital (E) Working Group, however, determined that the risk associated with these payments is more administrative in nature and similar to uninsured plans. As such, the Working Group determined that the charge should follow that of the uninsured plans (ASC and ASO) and apply a 2% factor charge to those Medicaid Pass-Through Payments reported as premiums. This amount should be equal to the amount reported on page XR013, Column (1), Line (5).

Lines (26) through (32) Disability Income. Disability Income Premiums are to be separately entered depending upon category (Individual and Group). For Individual Disability Income, a further split is between noncancellable (NC) or other (guaranteed renewable, etc.). For Group Disability Income, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below $50,000,000 for similar types. In determining the premiums subject to the higher factors, Individual Disability Income NC and Other are combined. All types of Group and Credit Disability Income are combined in a different category from Individual.

STOP-LOSS ELECTRONIC-ONLY TABLES

The Health Risk-Based Capital (E) Working Group revised the stop-loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop-loss factors as a result of the changes to life-time maximum amounts included in the Federal Affordable Care Act.

Electronic Table 1 – Stop-Loss Interrogatories

The interrogatories are designed to gather the information by product type and will be reviewed on a go-forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end 2019, will reflect the incurred data for calendar year 2018 run-out through December 31, 2019.

For those insurers where the stop-loss gross premium written is both under $2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

Product Type

Specific Stop Loss (including aggregating specific) = This coverage was included in the 1998 to 2008 factor development.
Aggregate Stop Loss = This coverage was included in the 1998 to 2008 factor development.
HMO Reinsurance = Specific reinsurance of an HMO's commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.
Provider Excess = Specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.
Medical Excess Reinsurance = Specific reinsurance of an insurance company's medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

Do not include quota share or excess reinsurance written on stop-loss business.

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed, e.g., the RBC report filed for 2019 should provide experience information for calendar year 2018 with run-out through December 31, 2019. If the contract year does not follow a calendar year (e.g. 7/1-6/30), the impact on the interrogatories would be spread across two years in the same manner it would be reported in two annual statements (i.e., half of premium and the applicable portion of the liability/expense would hit the first year, the remainder would hit the second year). Report based on the calendar year even if the calendar year includes two separate contracts (For example: Contract 1 started on 7/1/2017 and ran through 6/30/2018. Contract 2 started on 7/1/2018 and ran through 6/30/2019. The 2018 calendar year experience information would be comprised of the experience information in Contract 1 from 1/1/2018 through 6/30/2018 AND Contract 2 from 7/1/2018 to 12/31/2018.). Contracts that do not follow a calendar year should NOT be excluded.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.

Total Gross Claims + Expenses =

Total Gross Claims – These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability.

+

Expenses – These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio – This is equal to (Total Gross Claims + Expenses)/Total Gross Premium.

Premiums Net of Reinsurance – This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =

Total Net Claims – These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.

+

Expenses – These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio – This is equal to (Total Net Claims + Expenses)/Premiums Net of Reinsurance.

Electronic Table 2a – Calendar Year Specific Stop-Loss Contracts by Group Size and Table 2b – Calendar Year Aggregate Stop-Loss Contracts by Group Size

For those insurers where the stop-loss gross premium written is both under $2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 2.

Table 2a should reflect the specific stop-loss data and Table 2b should reflect the aggregate stop-loss data.

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31st of the calendar (reporting) year. If the contract does not follow a calendar year (e.g. 7/1-6/30), report the policies written during the year of the annual statement and in effect at the end of the calendar year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, total number of lives insured, including dependents).

Number of Groups – list the number of groups for each stop-loss contract based on the number of covered lives in the group.

Average Specific Attachment Point (Table 2a) – The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Example: Average Specific Attachment Point ($) (Table 2a, 50-99 Covered Lives in Group) =
(Sum of Specific Attachment Points X Reported Lives)/(Sum of Reported Lives)

Insured Group	Specific Att Point ($)	Aggregate Att (%)	Number of Lives	Include Exclude	Reason to Exclude
1	$200,000	115%	90	Include	
2	$100,000	120%	60	Include	
3	$50,000	140%	40	Exclude	Not in Group Size Band
4	$120,000	N/A	50	Include	
Calculation:	(200,000 x 90 + 100,000 x 60 + 120,000 x 50)/(90 + 60 + 50) = $150,000				

Average Aggregate Attachment Percentage (Table 2b) – Is based on expected claims. Subgroups that have separate stop-loss contracts should be aggregated in terms of determining the group size. The average should be weighted by expected claims in the respective group size bracket, excluding the expected claims within the denominator where aggregate coverage was not provided.

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) =
(Sum of Expected Claims x Attachment Percentage %)/(Sum of Expected Claims)

Insured Group	Specific Att Point ($)	Aggregate Att (%)	Expected Claims	Number of Lives	Include Exclude	Reason to Exclude
1	$200,000	115%	$ 500,000	90	Include	
2	$100,000	120%	$ 300,000	60	Include	
3	$50,000	140%	$ 200,000	40	Exclude	Not in Group Size Band
4	$120,000	N/A	$ 400,000	50	Exclude	Aggregate not purchased by group
Calculation:	(500,000 x 115% + 300,000 x 120%)/(500,000 + 300,000) = 116.7%					

Footnote – The number of covered lives for stop-loss coverage is reported in the Accident and Health Policy Experience Exhibit for Year (April 1st filing) in Column 13, Section C. Other Business, Line 2.

If stop-loss policies are sold on a Per Employee Per Month basis and the actual number of covered lives is unknown, it would be reasonable to estimate the number of covered lives if the exact information is not administratively available to the reporting entity. This method of estimation may be similar to estimations provided for the Accident and Health Policy Experience Exhibit for Year. If estimated, an explanation of the method used to estimate the number of covered lives should be provided in the footnote.

Lines (33) through (41) Long Term Care. Long-Term Care Insurance (LTCI) Premiums are used to determine both a rate risk and the morbidity risk. The rate risk relates to all Noncancellable LTCI premiums. The morbidity risk is partially applied directly to premium with a higher factor (10%) applied to amounts up to $50,000,000 and a lower factor (3%) applied to premiums in excess of $50,000,000. In addition, the earned premiums and incurred claims for the last two years are used to determine an average loss ratio (incurred claims divided by earned premiums). This average loss ratio times the current year's premium is called Adjusted LTCI Claims for RBC. A higher factor (25%) is applied to claims up to $35,000,000 and a lower factor (8%) is applied to claims above $35,000,000. In certain situations where loss ratios cannot

be used because one of the values is zero or negative, the current year's incurred claims are used. In a situation where the current year's premium is not positive, higher factors are applied to current year's incurred claims to reflect the lack of a premium-based RBC. The RBC for LTCI is the sum of these three calculations.

Line (42) Limited Benefit Plans. There is a factor for certain types of Limited Benefit coverage (Hospital Indemnity, which includes a per diem for intensive care facility stays, and Specified Disease) which includes both a percent of earned premium on such insurance (3.5%) and a flat dollar amount ($50,000) to reflect the higher variability of small amounts of business.

Line (43) Accidental Death and Dismemberment. There is a factor for Accidental Death and Dismemberment (AD&D) insurance (where a single lump sum is paid) which depends on several items:

1. Three times the maximum amount of retained risk for any single claim;
2. $300,000 if 3 times the maximum amount of retained risk is larger than $300,000;
3. 5.5% of earned premium to the extent the premium for AD&D is less than or equal to $10,000,000; and
4. 1.5% of earned premium in excess of $10,000,000.

There are places for reporting the total amount of earned premium and maximum retained risk on any single claim. The actual RBC amount will be calculated automatically as the lesser of 1 and 2. That result is then added to 3 and 4.

Line (44) Other Accident. There is a factor for Other Accident coverage that provides for any accident-based contingency other than those contained in Line 43. For example, this line should contain all the premium for policies that provide coverage for accident only disability or accident only hospital indemnity. The premium for policies that contain AD&D in addition to other accident only benefits should be shown on this line.

Line (45) Premium Stabilization Reserves. Premium stabilization reserves are funds held by the company in order to stabilize the premium a group policyholder must pay from year to year. Usually experience-rating refunds are accumulated in such a reserve so that they can be drawn upon in the event of poor future experience. This reduces the insurer's risk.

For health insurance, 50% of the premium stabilization reserves held in the annual statement as a liability (not as appropriated surplus) are permitted as an offset up to the amount of risk-based capital. The 50% factor was chosen to approximate the portion of premium stabilization reserves that would be an appropriate offset if the formula were applied on a contract-by-contract basis, and the reserve offset were limited to the amount of risk-based capital required for each contract.

Companies must list each group having 5% or more of the total premium stabilization reserve of the reporting entity. All other groups may be summarized on one line and labeled as various.

No credit is given here for premium stabilization reserves held for FEHBP and TRICARE coverage, because that coverage is already subject to a lesser percentage of premium in the underwriting risk calculation to reflect its reduced level of risk. Similarly, no credit is given here for any amounts held in connection with stand-alone Medicare Part D Coverage (i.e., amounts held as liabilities to the federal government under the risk-corridor mechanism), since Medicare Part D Coverage premium is already subject to a lesser factor in the underwriting risk calculation to reflect the reduced net level of risk. Amounts held as prepayments from the federal government for reinsurance coverage or low-income subsidy (cost-sharing portion) under Medicare Part D Coverage are not considered premium stabilization reserves as they relate to an uninsured plan.

As such, the company must exclude all amounts relating to FEHBP, TRICARE or stand-alone Medicare Part D Coverage in determining the amount of reserves to be reported here.

UNDERWRITING RISK – MANAGED CARE CREDIT
XR018

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between health entities and pure indemnity carriers. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claim payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the formula, other than for Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase, or new arrangements may be added to the existing categories. The managed care categories are:

* Category 0 – Arrangements not Included in Other Categories
* Category 1 – Contractual Fee Payments
* Category 2 – Bonus and/or Incentives/Withhold Arrangements
* Category 3 – Capitation
* Category 4 – Non-Contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future, no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care "buckets" to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claim payments may fit into more than one category. If that occurs, enter the claim payments into the highest applicable category. CLAIM PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claim payments reported in the Managed Care Credit Calculation page should equal the total year's paid claims.

Line (1) – Category 0 – Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:

- Fee for service (charges).
- Discounted FFS (based upon charges).
- Usual Customary and Reasonable (UCR) Schedules.
- Relative Value Scales (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
- Stop-loss payments by a health entity to its providers that are capitated or subject to withhold/incentive programs.
- Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
- Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).

This amount should equal Exhibit 7, Part 1, Column 1, Line 5 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (2) – Category 1 – Payments Made According to Contractual Arrangements. There is a 15% managed care credit for payments included in this category:

- Hospital per diems, DRGs or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- RVS where the payment base and RV factor are fixed by contract for more than one year.
- Ambulatory payment classifications (APCs).

This amount should equal Exhibit 7, Part 1, Column 1, Line 6 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (3) - Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives With No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentives/withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25%. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year's Category 2a managed care credit factor. Bonus and/or incentives payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

EXAMPLE – **2019** Reporting Year

2018 withhold/bonus/incentive payments	750,000
2018 withholds/bonuses/incentives available	1,000,000
A. MCC Factor Multiplier	75% – Eligible for credit
2018 withholds/bonuses/incentives available	1,000,000
2018 claims subject to withhold - gross*	5,000,000
B. Average Withhold Rate	20%
Category 2 Managed Care Credit Factor (A x B)	15%

The resulting factor is multiplied by claim payments subject to withhold - net** in the current year.

*** These are amounts due before deducting withhold or paying bonuses and/or incentives.**
**** These are actual payments made after deducting withhold or paying bonuses and/or incentives.**

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements. This amount should equal Exhibit 7, Part 1, Column 1, Line 7 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (4) – Category 2b – Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentives/withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claim payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25%. The minimum of Category 2b managed care credit is 15% (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1. This amount should equal Exhibit 7, Part 1, Column 1, Line 8 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (5) – Category 3a – Capitated Payments Directly to Providers. There is a managed care credit of 60% for claims payments in this category, which includes:

- All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claim payments paid DIRECTLY to licensed providers on a capitated basis. This amount should equal Exhibit 7, Part 1, Column 1, Line 1 + Line 3 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (6) – Category 3b – Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60% for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries. An *intermediary* is a person, corporation or other business entity (not licensed as a medical provider) that arranges, by contracts with physicians and other licensed medical providers, to deliver health services for a health entity and its enrollees via a separate contract between the intermediary and the health entity. This includes affiliates of a health entity that are not subject to RBC, except in those cases where the health entity qualifies for a higher managed care credit because the capitated affiliate employs providers and pays them non-contingent salaries, and where the affiliated intermediary has a contract only with the affiliated health entity. A *Regulated Intermediary* is an intermediary (affiliated or not) subject to state regulation and files the Health RBC formula with the state.

Line (7) – Category 3c – Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60% for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers. (Subject to a 5% limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5% limitation should be reported in Category 0.)

Enter the amount of medical expense capitations paid to non-regulated intermediaries.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 1 for a provider, and for an intermediary at the greater of category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive

revisions either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 0 for both providers and intermediaries.

Line (8) – Category 4 – Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75% for claim payments in this category. Once claim payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on line 7 in the Underwriting Risk section should be deducted before applying the managed care credit factor. This category includes:

- Non-contingent salaries to persons directly providing care.
- The portion of payments to affiliated entities, which is passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with its affiliated health entity.
- All facilities related medical expenses and other non-provider medical costs generated within a health facility that is owned and operated by the health entity.
- Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as “medical expense” payments (paid claims) rather than administrative expenses. The "aggregate cost" method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services, and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

This amount should equal Exhibit 7, Part 1, Column 1, Line 9 + Line 10 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (9) – Sub-Total Paid Claims. The total of paid claims for Comprehensive Medical, Medicare Supplement and Dental [should equal the total claims paid for the year as reported in Exhibit 7, Part 1, Column 1, Line 13 less Line 11 of the annual statement and the sum of Lines (8.3), (12) and (13) on page XR018 – Underwriting Risk – Managed Care Credit.

Line (10) – Category 0 – No Federal Reinsurance or Risk Corridor Protection. Category 0 for Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (11) – Category 1 – Federal Reinsurance but no Risk Corridor Protection. Category 1 for Medicare Part D Coverage would be all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (12) – Category 2a – No Federal Reinsurance but Risk Corridor Protection. Category 2a for Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (13) – Category 3a – Federal Reinsurance and Risk Corridor Protection. Category 3a for Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (14) – Sub-Total Paid Claims. The total paid claims for Medicare Part D Coverage, excluding supplemental benefits.

Line (16) – Weighted Average Managed Care Discount. These amounts are calculated by dividing the total weighted claims by the comparable sub-total claim payments. For Column (3), this is Column (3), Line (9) divided by Column (2), Line (9). For Column (4), this is Column (4) Line (14) divided by Column (2), Line (14).

Line (17) – Weighted Average Managed Care Risk Adjustment Factor**.** These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount values in Line (16).

Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year's discount factor. These do not apply to Medicare Part D coverage.

Line (18) – Withhold & Bonus/Incentive Payments***, prior year*****.** Enter the prior year's actual withhold and bonus/incentive payments.

Line (19) –Withhold & Bonuses/Incentives Available***, prior year*****.** Enter the prior years withholds and bonuses/incentives that were available for payment in the prior year.

Line (20) – MCC Multiplier – Average Withhold Returned**.** Divides Line (18) by Line (19) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (21) – Withholds & Bonuses/Incentives Available, ***prior year*****.** Equal to Line (19) and is automatically pulled forward.

Line (22) – Claims Payments Subject to Withhold, ***prior year*****.** Claim payments that were subject to withholds and bonuses/incentives in the prior year. Equal to L(3) + L(4) of the managed care credit claims payment table FOR THE PRIOR YEAR.

Line (23) – Average Withhold Rate, ***prior year*****.** Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24) – MCC Discount Factor, Category 2**.** Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the health entitities withhold/bonus/incentive program in the prior year.

CREDIT RISK
XR020

Reinsurance Ceded – L(1) through L(17)

There is a credit risk associated with recoverability of amounts due from reinsurers. However, reinsurance with wholly owned subsidiaries is exempt from RBC requirements because affiliate risk is addressed elsewhere in the health RBC formula. The RBC requirement is 0.5% of the annual statement value of recoverables, unearned premiums, and other reserve credits.

The annual statement references for reinsurance recoverables (paid and unpaid) come from Schedule S, Part 2. The annual statement references for unearned premiums and other reserve credits are in Schedule S, Part 3.

Capitations – L(18) through L(24)

Credit risk arises from capitations paid directly to providers or to intermediaries. The risk is that the health entity will pay the capitation but will not receive the agreed-upon services and will encounter unexpected expenses in arranging for alternative coverage. The credit risk RBC requirement for capitations paid directly to providers is 2% of the amount of capitations reported as paid claims in the Managed Care Credit Calculation page. This amount is roughly equal to two weeks of paid capitations.

However, a health entity can also make arrangements with its providers that mitigate the credit risk, such as obtaining acceptable letters of credit or withholding funds. Where the health entity obtains these protections for a specific provider, the amount of capitations paid to that provider are exempted from the credit risk charge. A separate Capitations worksheet is provided to calculate this exemption, but a health entity is not obligated to complete the worksheet.

The credit risk RBC requirement for capitations to intermediaries is 4% of the annual statement amount of the capitated payments reported as paid claims in the Managed Care Credit Calculation page. However, as with capitations paid directly to providers, the regulated health entity can eliminate some or all of the credit risk that arises from capitations to intermediaries by obtaining acceptable letters of credit or withheld funds. There is no credit risk for any portion of the managed care discount factor for Medicare Part D Coverage.

Line (18) – Total Capitations Paid Directly to Providers. This is the amount reported in the Managed Care Credit Calculation page, Line (5).

Line (19) – Less Secured Capitations to Providers. Computed from the Capitations worksheet, this includes all capitations to providers that are secured by funds withheld or by acceptable letters of credit equal to 8% of annual claims paid to the provider. If lesser protection is provided (e.g., an acceptable letter of credit equal to 2% of annual claims paid to that provider), then the amount of capitation is prorated. The exemption is calculated separately for each provider and intermediary. The worksheet to calculate the exemption is shown following these instructions (and is to be filed electronically if any data is included).

Line (20) – Capitations to Providers Subject to Credit Risk Charge. Line (18) minus Line (19).

Line (21) – Total Capitations to Intermediaries. From Line (6) and Line (7) of the Managed Care Credit Calculation page, this includes all capitation payments to intermediaries.

Line (22) – Less Secured Capitations to Intermediaries. Computed from the Capitations worksheet, this includes all capitations to providers that are secured by funds withheld or by acceptable letters of credit equal to 16% of annual claims paid to the provider. If lesser protection is provided (e.g., an acceptable letter of credit equal to 5% of annual claims paid to that provider), then the amount of capitation is prorated. The exemption is calculated separately for each provider and intermediary. The worksheet to calculate the exemption is shown below these instructions (and is to be filed electronically if any data is included).

CAPITATIONS TO PROVIDERS AND INTERMEDIARIES
CREDIT RISK EXEMPTION WORKSHEET

CAPITATIONS PAID DIRECTLY TO PROVIDERS

Number	Name of Provider	A Paid Capitations During Year	B Letter of Credit Amount	C Funds Withheld	D=(B+C)/A Protection Percentage	E=A*Min(1,D/8%) Exempt Capitations
1	Sally Smith	125,000	5,000	0	4%	62,500
2	Jim Jones	50,000	5,000	0	10%	50,000
3	Dr. Doolittle	750,000	5,000	50,000	7%	687,500
4	Dr. Clements	25,000	0	0	0%	0
5	All others	2,500,000				0
19999	Total to Providers	3,450,000	xxx	xxx	xxx	800,000

CAPITATIONS PAID TO UNREGULATED INTERMEDIARIES

Number	Name of Provider	A Paid Capitations During Year	B Letter of Credit Amount	C Funds Withheld	D=(B+C)/A Protection Percentage	E=A*Min(1,D/16%) Exempt Capitations
1	Mercy Hospital	2,500,000	200,000	300,000	20%	2,500,000
2	Chicago Hope	1,000,000	100,000	0	10%	625.000
3	Bill's Clinic	4,500,000	0	500,000	11%	3,125,000
4	Joe's HMO	3,500,000	0	0	0%	0
5	All others	2,500,000				0
29999	Total to Unregulated Intermed	14,000,000	xxx	xxx	xxx	6,250,000

CAPITATIONS PAID TO REGULATED INTERMEDIARIES

Number	Name of Provider	Paid Capitations During Year	Domiciliary State			Exempt Capitations
1	Fred's HMO	2,500,000	NY			2,500,000
2	Blue Cross of Guam	50,000	GU			50,000
39999	Total to Regulated Intermed	2,550,000	xxx	xxx	xxx	2,550,000
99999	Total	20,000,000	xxx	xxx	xxx	9,600,000

Divide the "Protection Percentage" by 8% (providers) or by 16% (unregulated intermediaries) to obtain the percentage of the capitation payments that are exempt. If the protection percentage is greater than 100%, the entire capitation payment amount is exempt. All capitations to regulated intermediaries qualify for the exemption.

The "Exempt Capitation" amount from Line 19999 of $800,000 would be reported on *L(19) Less Secured Capitations to Providers* in the Credit Risk page. The total of the "Exempt Capitation" amount from Line 29999 plus Line 39999 ($6,250,000+$2,550,000=$8,800,000) would be reported on L(22) *Less Secured Capitations to Intermediaries* in the Credit Risk page.

Line (23) – Capitations to Intermediaries Subject to Credit Risk Charge. L(21) minus L(22).

Line (24) – Capitation Credit Risk RBC. Sum of L(20) and L(23).

Other Receivables – L(25) through L(31)

There is an RBC requirement of 1% of the annual statement amount of investment income receivable and an RBC requirement of 5% of the annual statement amount for amounts due from parents, subsidiaries, and affiliates, and aggregate write-ins for other than invested assets. **The RBC requirement for pharmaceutical rebate receivables is 20% of the first $5 million and a 3% charge will be applied to the amount in excess.** An RBC requirement of **40% is applied to the first $10 million of the aggregated annual statement amount and 5% will be applied to the amounts in excess of the $10 million** for all other health care receivables reported in Lines (26.2) through (26.6) **in aggregate**. Enter the appropriate value in Lines (25) through (31).

Line (26.1). Pharmaceutical rebates are arrangements between pharmaceutical companies and reporting entities in which the reporting entities receive rebates based upon the drug utilization of its subscribers at participating pharmacies. These rebates are sometimes recorded as receivables by reporting entities using estimates based upon historical trends which should be adjusted to reflect significant variables involved in the calculation, such as number of prescriptions written/filled, type of drugs prescribed, use of generic vs. brand-name drugs, etc. In other cases, the reporting entity determines the amount of the rebate due based on the actual use of various prescription drugs during the accumulation period and then bills the pharmaceutical company. Oftentimes, a pharmacy benefits management company may determine the amount of the rebate based on a listing (of prescription drugs filled) prepared for the reporting entity's review. The reporting entity will confirm the listing and the pharmaceutical rebate receivable. Pharmaceutical rebates may relate to insured plans or uninsured plans. Only the receivable amount related to the insured plans should be reported on this line. Amount comes from annual statement Exhibit 3, Column 7, Line 0199999.

Line (26.2). Claim overpayments may occur as a result of several events, including but not limited to claim payments made in error to a provider. Reporting entities often establish receivables for claim overpayments. Amount comes from annual statement Exhibit 3, Column 7, Line 0299999.

Line (26.3). A health entity may make loans or advances to large hospitals or other providers. Such loans or advances are supported by legally enforceable contracts and are generally entered into at the request of the provider. In many cases, loans or advances are paid monthly and are intended to represent one month of fee-for-service claims activity with the respective provider. Amount comes from annual statement Exhibit 3, Column 7, Line 0399999.

Line (26.4). A capitation arrangement is a compensation plan used in connection with some managed care contracts in which a physician or other medical provider is paid a flat amount, usually on a monthly basis, for each subscriber who has elected to use that physician or medical provider. In some instances, advances are made to a provider under a capitation arrangement in anticipation of future services. Amount comes from annual statement Exhibit 3, Column 7, Line 0499999.

Line (26.5). Risk sharing agreements are contracts between reporting entities and providers with a risk sharing element based upon utilization. The compensation payments for risk sharing agreements are typically estimated monthly and settled annually. These agreements can result in receivables due from the providers if annual utilization is different than that used in estimating the monthly compensation. Amount comes from annual statement Exhibit 3, Column 7, Line 0599999.

Line (26.6). Any other health care receivable not reported in Lines (26.1) through (26.5). Amount comes from annual statement Exhibit 3, Column 7, Line 0699999.

Line (27). Only include on this line amounts receivable related to pharmaceutical rebates on uninsured plans that are in excess of the liability estimated by the reporting entity for the portion of such rebates due to the uninsured accident and health plans.

BUSINESS RISK
XR022

There are four major subcategories found in the Business Risk section of the formula: Administrative Expense Risk; Non-Underwritten and Limited Risk Business; Guaranty Fund Assessment Risk; and Excessive Growth Risk.

Administrative Expense Risk – L(1) through L(7) and L(20) through L(26)

There is a risk associated with the fluctuation of administrative expenses relative to the premium needed to pay those expenses. Estimates of administrative expense ratios are built into the price of providing medical care to subscribers, just as claims expenses are built into the rates. Like claim expenses, administrative expenses are subject to misestimation, and therefore, generate an RBC requirement, but lower than the RBC requirement for claim fluctuations.

Administrative Expense Risk encompasses both Claims Adjustment Expenses and General Administrative Expenses as separate items that should be reported on Lines (1) and (2), respectively.

The ASC and ASO revenues and expenses that are included in the Administrative Expenses reported in Lines (1) and (2) should be removed from those lines by reporting the net amount of expenses to the revenues on Lines (3) and (4). If the revenues are greater than the expenses for the ASC or ASO business, then a negative amount will be reported on these lines in order to add back the net income from the ASC or ASO business. Keep in mind that only the ASC and ASO revenues and expenses that are included in the administrative expenses will be reported on lines (3) and (4).

ASC/ASO commissions that are reported within the Underwriting and Investment Exhibit, Part 3 of the annual statement should be included in Line (5).

Lines (20) through (26) calculate the RBC risk factor for administrative expense risk as a weighted average, using underwriting risk revenue as the weight. The factor is 7% of the first $25 million of underwriting risk revenue plus 4% of the underwriting risk revenues in excess of $25 million, divided by total underwriting risk revenues. The weighted average factor is then multiplied by the administrative expenses excluding administrative expenses associated with ASC/ASO business, premium taxes and commission payments. The ending charge is then prorated for administrative expenses related only to the managed care lines of business.

Non-Underwritten and Limited Risk – L(8) through L(11)

The risks associated with administrative services only (ASO) arrangements and administrative services contracts (ASC) are different than the risks of underwritten business. Therefore, the administrative expenses for these contracts are netted out of the total administrative risk category before applying a risk factor. However, there is still some risk that the administrative expenses for these contracts are insufficient to absorb the full outlay required and for the recovery of ASC claims payments. While the risk associated with these expenses is lower than that of general operating expense risk, it is still greater than zero.

ASO administrative fees, and reimbursements under ASC contracts for both administrative fees and the medical costs paid (ASC only), are included in the Non-Underwritten and Limited Risk Base. Any commissions associated with ASC and ASO business should be included in Line (8) and Line (9) due to the risk of costs to the insurer in administering ASC and ASO plans.

> **NOTE**: The claim payments under ASC contracts SHOULD NOT be included in the Underwriting Risk section; they are reported in the Non-Underwritten and Limited Risk section only.

The RBC requirement for administrative expenses on non-underwritten and limited risk business is 2% of both ASC administrative expense and ASO administrative expenses. The RBC requirement for claims payments paid though ASC arrangements is 1% of the medical expense payments [not including Medicare Part D reinsurance payment or low-income subsidy (cost sharing portion].

The RBC requirement for fee-for service revenues received from other reporting entities is also 1%.

Guaranty Fund Assessment Risk – L(12)

If the reporting entity is subject to guaranty fund assessments in any state, there is an RBC requirement of 0.5% of the direct earned premiums subject to assessment in that state. Premiums subject to guaranty fund assessments that are reported in Schedule T should be aggregated and reported in Line (12).

Excessive Growth Risk – L(13) through L(19)

Excessive growth risk is an important element of the health RBC formula. Several recommendations for recognizing growth risk were considered, including growth in underwriting risk RBC by line of business, growth in premium, and growth in enrollment. However, these various measurements did not discriminate between reporting entities that had controlled growth with no accompanying increase in underwriting risk and those that were growing in both volume and risk. Additionally, the working group wanted to avoid imposing a growth charge that would unfairly discriminate against start-up companies where high growth rates were the norm. Start-up health companies may consider use of their first-year projected amounts (included in the projected RBC within the approved proforma) upon approval from their domiciliary state.

The risk charge for excessive growth is set as a function of both growth in underwriting risk revenue and in underwriting risk RBC. A "safe harbor" level of growth is established as the growth rate in premiums plus 10%. Therefore, if the reporting entity had an increase in underwriting risk revenue volume of 30%, its underwriting risk RBC could grow up to 40% before any additional growth risk RBC is generated. That way, an entity that doubles its volume without more than doubling its RBC will not be subject to the excessive growth RBC charge. However, an entity that doubles its RBC without doubling its underwriting risk revenue volume can be expected to trigger the excessive growth charge.

To calculate excessive growth risk RBC in future years, enter the prior year's underwriting risk revenue [Prior Year Underwriting Risk – Experience Fluctuation Risk page, Column (7), Line (6)] in Line (13). The prior year's Net Underwriting Risk RBC [Prior Year Underwriting Risk – Experience Fluctuation Risk page, C(7), L(21)] is entered on Line (15). For start-up companies report the first twelve months projected Underwriting Risk Revenue on Line (13) and the projected Net Underwriting Risk RBC on Line (15). The current year values are pulled automatically into Lines (14) and (16). The growth rate in underwriting risk revenue plus 10% is multiplied times the prior year's Net Underwriting Risk RBC in Line (15) to establish the safe harbor level for the current year**.**

If there has been a merger or divestiture during the period, the values must be restated to reflect either the combination or division as if it had been in place at the beginning of the period. For example, if a merger takes place during 2019, the end-of-year 2018 underwriting risk revenue and the end-of-year 2018 net underwriting risk RBC must both be adjusted to include the merged entity as if it had been owned in the prior year.

As long as the current year's Net Underwriting Risk RBC in Line (16) is lower than the safe harbor amount in Line (17), there is no excessive growth risk charge. If the current year's Net Underwriting Risk RBC is greater than the safe harbor amount, then the excess over the safe harbor value appears in Line (18). The excessive growth risk charge in Line (19) is one half of the value in Line (18).

FEDERAL ACA RISK ADJUSTMENT SENSITIVITY TEST
XR023

The federal ACA Risk Adjustment Sensitivity Test is used to adjust TAC for the risk adjustment receivable or payable. The sensitivity test identifies the potential impact to an insurer's RBC ratio due to the risk of misestimation of the ACA risk adjustment by the insurer. The sensitivity test looks at both the risk of overestimation and underestimation by the insurer for both receivables and payables. Lines (1) through (8) look at the risk of overestimation while Lines (9) through (16) look at the risk of underestimation by decreasing and increasing the amount reported in the Notes to Financial Statement by 25%. The sensitivity test provides a "what if" scenario that has no effect on the risk-based capital amounts reported in the annual statement. The Health Risk-Based Capital (E) Working Group determined that a 25% change in the annual statement amount and a 50% factor should be used to calculate the effect of the misestimation of the risk adjustment receivable and payable on the RBC ratio. The company can provide an explanation in the footnote if the company believes the factors are not appropriate, with an explanation as to why the factors are inappropriate.

Line (1) and Line (9) – Premium Adjustments Receivable Due to ACA Risk Adjustment. This is the amount reported in the annual statement Notes to Financial Statement 24E2a1. Column (2) would equal Column (1) multiplied by the sensitivity amount.

Line (2) and Line (10) – Premium Adjustments Payable Due to ACA Risk Adjustment. This is the amount reported in the annual statement Notes to Financial Statement 24E2a3. Column (2) would equal Column (1) multiplied by the sensitivity amount.

Line (3) and Line (11) – Total ACA Risk Adjustments Receivable and Payable. Line (3) would be equal to Line (2) minus Line (1) and Line (11) would be equal to Line (10) minus Line (9).

Line (4) and Line (12) – Total Risk Adjustment. The absolute value of Line (4), Column (3) is equal to Line (3). The absolute value of Line (12), Column (3) is equal to Line (11).

Line (5) and Line (13) – Page XR026, Total Adjusted Capital, Post Deferred Tax. Line (7).

Line (6) and Line (14) – Total Adjusted Capital Stressed for Risk Adjustments. Line (6) is equal to Line (5) minus Line (4) and Line (14) is equal to Line (13) minus Line (12).

Line (7) and Line (15) – Authorized Control Level RBC. Page XR027 – Comparison of Total Adjusted Capital to Risk-Based Capital Line (4).

Line (8) and Line (16) – ACA Risk Adjusted ACL RBC Ratio. Line (8) is equal to Line (6) divided by Line (7) and Line (16) is equal to Line (14) divided by Line (15). Footnote - If it is the belief of the company that the factors are not appropriate, provide an explanation as to why the factors are inappropriate. Provide an explanation as why the company believes that the factors are inappropriate.

COVARIANCE CALCULATION
XR024–XR025

The purpose of the Health RBC formula is to estimate the minimum risk-based capital required to absorb losses that can be caused by a series of catastrophic financial events. However, it is extremely unlikely that all such losses will occur simultaneously. The covariance formula adjusts the combined effect of the H0, H1, H2, H3, and H4 risks so that the combination of risks is less than the sum of the parts. Statistically, this assumes that the H1, H2, H3 and H4 risks are uncorrelated. The H0 risk of subsidiaries is added to the total under the assumption that the risk of the subsidiaries is highly correlated with the risk of the parent, so that if the parent were to experience severe financial distress, the subsidiaries would also be adversely affected.

The components of the RBC after Covariance Formula are:

H0 – Insurance Affiliates and Misc. Other
H1 – Asset Risk – Other
H2 – Underwriting Risk
H3 – Credit Risk
H4 – Business Risk

The covariance formula is applied before adding operational risk on Line (41) on XR025:

RBC after Covariance Before Operational Risk = Square Root of ($H1^2 + H2^2 + H3^2 + H4^2$) + H0

Operational Risk:
Operational risk is defined as the risk of financial loss resulting from operational events, such as the inadequacy or failure of internal systems, personnel, procedures or controls, as well as external events. Operational risk includes legal risk but excludes reputational risk and risk arising from strategic decisions. Operational risk has been identified as a risk that should be explicitly addressed in the RBC formulas. The Operational Risk charge is intended to account for operational risks that are not already reflected in existing risk categories.

An operational risk charge will be reported on Line (42) using a percentage of RBC or "add-on" approach that will apply a risk factor of 3.00% to the amount reported in Line (41) - RBC after Covariance Before Operational Risk reported on page XR025. A reduction to the operational risk charge equal to the sum of the C-4a offset amounts reported by the direct Life RBC filing insurance subsidiaries (Page LR031, Lines (65 + 71)), adjusted for the percentage of ownership in the direct life insurance subsidiary, will be reported on Page XR025 in Line (43), and the Net Basic Operational Risk charge will be reported in Line (44), but not to produce a charge that is less than zero.

Total RBC After Covariance including Operational Risk will be reported in Line (45) as the sum of lines (41) and (44).

Authorized Control Level RBC is computed from the RBC after Covariance and is set at 50% of RBC after Covariance including Operational Risk.

Company Action Level RBC is 200% of Authorized Control Level RBC. Regulatory Action Level RBC is 150% of Authorized Control Level RBC. Mandatory Control Level RBC is 70% of Authorized Control Level RBC.

TOTAL ADJUSTED CAPITAL
XR026

Total Adjusted Capital (TAC) includes the statutory capital and surplus/total net worth of the reporting entity plus adjustments. Adjustments are made in recognition of statutory accounting conventions that tend to understate the actual capital and surplus that a company possesses in case of liquidation.

There are additions to TAC for the Asset Valuation Reserve and half of the dividend liability of any Life/Health subsidiary. These reserves understate the surplus of the subsidiary and must be added back to the parent's TAC. The annual statement amount of any Life/Health subsidiary's AVR should be reported on Line (2), prorated for percent of ownership. Dividend liability for life insurance subs should be reported on Line (3). The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

Subsidiary amounts are included, as appropriate, recognizing that the subsidiary's surplus is included within the surplus of the parent. For Property and Casualty subsidiaries, there is a reduction in TAC equal to non-tabular discounts and medical discounts reported as tabular that the subsidiary may claim. Discounting of loss reserves is not widely practiced in Property/Casualty accounting. Therefore, any of these discounts being used by a Property/Casualty subsidiary to bolster the subsidiary's surplus must be removed to ensure a level playing field among companies subject to RBC. If the reporting entity owns a Property/Casualty subsidiary that has non-tabular discounts or medical discounts reported as tabular, the full amount of the reserve discount should be entered on Lines (4) and (5). Nontabular reserve discounts reported in Line (5) come from the subsidiary's Schedule P Part 1. Tabular reserves in Line (4) come from the Notes to the Financial Statement of the affiliate's annual statement.

Lines (8) through (12) are used for a sensitivity test. The sensitivity test provides a "what if" scenario eliminating deferred tax assets and deferred tax liabilities from the calculation of Total Adjusted Capital. The sensitivity test has no effect on the risk-based capital amounts reported in the annual statement.

DTA should include only the admitted portion of the DTA inside amount, for Line (8). Line (10) should only include the admitted portion of insurance subsidiaries deferred tax assets that are subject to RBC and whose RBC formula excludes DTAs and DTLs from the TAC calculation.

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL

XR027

As long as the Total Adjusted Capital (TAC) shown on Line (1) of Comparison of Total Adjusted Capital to Risk-Based Capital section exceeds the Company Action Level Risk-Based Capital (CALRBC) shown on Line (2), the reporting entity has passed the minimum capital adequacy test of the Health RBC formula. However, that does not necessarily mean that the reporting entity is financially sound. The RBC formula is just one of many regulatory tools used by regulators to evaluate the financial health of regulated entities. Although healthy companies rarely fail the RBC test, weak companies often do pass the RBC test, although weak companies will eventually fail the test if their problems continue.

Those organizations that do trigger one of the RBC action levels are generally subject to regulatory action by the state of domicile, or by a non-domiciliary state where the reporting entity does business, under the provisions of state law. The NAIC *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315) provides for an increasingly stringent regulatory response for companies that trigger one of the RBC action levels. Those action levels are (1) Company Action Level, (2) Regulatory Action Level, (3) Authorized Control Level and (4) Mandatory Control Level.
The four RBC action levels trigger an increasingly stringent level of regulatory response for those companies that trigger one of the action levels. Lines (2) through (6) will be calculated automatically by the program. One of the following action levels will appear on Line (6).

- Company Action Level (TAC is between 150% and 200% of the Authorized Control Level RBC).
- Regulatory Action Level (TAC is between 100% and 150% of the Authorized Control Level RBC).
- Authorized Control Level (TAC is between 70% and 100% of the Authorized Control Level RBC).
- Mandatory Control Level (TAC less than 70% of the Authorized Control Level RBC).

Company Action Level requires the reporting entity to prepare and submit to the insurance commissioner a comprehensive financial plan. The plan identifies the conditions that contributed to the company's financial condition, contains proposals to correct the company's financial problems, and provides projections of the company's financial condition, both with and without the proposed corrections.

Regulatory Action Level requires the reporting entity to submit a comprehensive financial plan. In addition, the insurance commissioner may perform any examinations or analysis of the reporting entity's business and operations that it deems necessary and issue any appropriate corrective orders to address the company's financial problems.

Authorized Control Level authorizes the insurance commissioner to take whatever regulatory actions considered necessary to protect the best interest of the policyholders and creditors of the reporting entity which may include the actions necessary to cause the insurer to be placed under regulatory control (i.e., rehabilitation or liquidation).

Mandatory Control Level requires the insurance commissioner to place the reporting entity under regulatory control.

Trend Test

A company whose RBC ratio is between 200% and 300% and combined ratio is greater than 105% could trigger a Company Action Level RBC regulatory action per the Trend Test.

APPENDIX 1 – COMMONLY USED TERMS

The Definitions of Commonly Used Terms are frequently duplicates from the main body of the text. If there are any inconsistencies between the definitions in this section and the definitions in the main body of the instructions, the main body definition should be used.

Administrative Expenses – Costs associated with the overall management and operations of the reporting entity that are not directly related to, or in direct support of providing medical services. Expenses to administer ASC, ASO business, and related revenue must be identified separately from underwritten business. Commission payments and premium taxes are excluded for RBC calculation purposes.

Administrative Services Contract (ASC) – A contract where the reporting entity agrees to provide administrative services such as claims processing for a third party that is at risk, and accordingly, the administrator has not issued an insurance policy, regardless of whether an identification card is issued. The administrator may arrange for provision of medical services through a contracted or employed provider network. The plan (whether insured by another reporting entity or self-insured) bears all of the insurance risk, and there is not possibility of loss or liability to the administrator caused by claims incurred related to the plan. Claims are paid from the reporting entity's own bank accounts, and only subsequently receives reimbursement from the uninsured plan sponsor. No arrangement where the reporting entity receives a capitated payment for providing medical services to a third party shall qualify as an uninsured plan.

ASC Reimbursements – Funds received by the reporting entity under an ASC contract as reimbursement for claims payments and for expenses associated with administering the contract.

Administrative Services Only (ASO) – A contract where the reporting entity agrees to provide administrative services such as claims processing for a third party that is at risk, and accordingly, the administrator has not issued an insurance policy, regardless of whether an identification card is issued. The administrator may arrange for provision of medical services through a contracted or employed provider network. The plan (whether insured by another reporting entity or self-insured) bears all of the insurance risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. Claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the reporting entity, but only after the reporting entity has received funds from the uninsured plan sponsor that are adequate to fully cover the claim payments. No arrangement where the reporting entity receives a capitated payment for providing medical services to a third party shall qualify as an uninsured plan.

ASO Reimbursements – Funds received by the reporting entity under an ASO contract as a fee for expenses associated with administering the contract.

Admitted Assets – Assets recognized and accepted by a state commissioner, director or superintendent in determining the solvency of the reporting entity.

Affiliate – A person or entity that directly, or indirectly through one or more other persons or entities, controls, is controlled by, or is under common control with the reporting entity.

Aggregate Cost Payments – The "aggregate cost" method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

Claims – Payments made for medical services arranged for or provided by the health entity to its members, including payments for direct support of medical services arranged or provided by the health entity, less fee-for-service revenue directly related to such payments. Payments for services rendered to non-members of a health entity are excluded from claims, and associated fee for service revenue may not be deducted from claims, except in cases where non-contingent salaries are paid to employee providers regardless of whether they provide care to members or non-members of the health entity.

Health Care Delivery Assets – Land, buildings, equipment and supplies used directly to deliver health care to members as defined by SSAP No. 73.

Health Care Receivable – Fee-for-service, coordination of benefits and subrogation, co-payments, and other health balances. For RBC purposes, exclude ASC reimbursements due and reinsurance recoveries.

Health Entity – Any issuer of a policy or contract providing or offering to provide a plan of Comprehensive Medical and Hospital; Medicare Supplement; Dental/Vision; Stand-Alone Medicare Part D Coverage or Other health benefits through individual or group plans and which files the Health Annual Statement blank. The term Health Entity was previously expanded and replaced MCO beginning in the 2015 instructions.

Hospital Indemnity Coverage – Coverage that provides a pre-determined, fixed benefit or daily indemnity for contingencies based on a stay in a hospital or intensive care facility.

Incentives, Withhold and Bonus Amounts – Are amounts to be paid to providers by the health entity as an incentive to achieve goals such as effective management of care. An incentive arrangement may involve paying an agreed-on amount for each claim (e.g. provider agrees to practice in an underserved area). While a bonus arrangement may be paid at the end of a contact period after specific goals have been met. Withhold arrangements can involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

Intermediary – A person, corporation or other business entity (not licensed as a medical provider) that arranges, by contracts with physicians and other licensed medical providers, to deliver health services for a reporting entity and its enrollees via a separate contract between the intermediary and the reporting entity.

Managed Care Organization (MCO) – Any person, corporation or other entity which enters into arrangements or agreements with licensed medical providers or intermediaries for the purpose of providing or offering to provide a plan of health benefits directly to individuals or employer groups in consideration for an advance periodic charge (premium) per member covered.

Maximum Retained Risk – The maximum level of potential claim exposure (capped at $750,000 for medical coverage and $25,000 for all other coverage) resulting from coverage on a single member of a reporting entity. Maximum retained risk for reporting entities providing "professional component" (non-hospital) coverage will be capped at $375,000. Where specific stop-loss reinsurance protection is in place, this is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than $750,000 per member ($375,000 for reporting entities providing "professional component" coverage only), the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and $750,000.

Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity's participation in the stop-loss layer (up to $750,000 less retention).

Non-Admitted Assets – Assets that are not accepted by a state commissioner or superintendent in determining the solvency of the reporting entity.

Non-Contingent Salaries – Salaries paid to providers of medical care which cannot be adjusted based upon utilization of services (e.g., # of patients seen or the intensity of the illnesses treated).

Premiums – This is the amount of money charged by the reporting entity for the specified benefit plan. It is the prepaid (usually on a per member per month basis) payments made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization.

Professional Services – Health care services provided by a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law.

Provider Stop-Loss – Coverage afforded to a provider via the risk-sharing mechanisms within the reporting entity's contract with such provider in exchange for a reduced payment to the provider. Also includes insurance (not reinsurance) purchased by the provider (or an intermediary) directly from a licensed insurer.

Regulated Intermediary – An intermediary (affiliated or not) subject to state regulation and files the Health RBC formula with the state. (see also Intermediary)

Reinsurance – An agreement between a reporting entity and a licensed (re)insurer whereby the reinsurer agrees, in exchange for a premium, to indemnify the reporting entity on a proportional or non-proportional basis, against a specified part of the cost of providing a plan of health benefits to its enrolled groups and individuals.

Risk Revenue – Amounts charged by the reporting entity as a provider or intermediary for specified medical services provided to the policyholders or members of another insurer or health entity. Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or health entity to the reporting entity in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation at the same factor as premiums and are subject to the same managed care credit categories. *NOTE: RISK REVENUE IS VERY SIMILAR TO REINSURANCE ASSUMED.*

Specified Disease Coverage – Coverage that provides primarily pre-determined benefits for expenses for the care of cancer and/or other specified diseases.

Stop-Loss Coverage – Coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product. Coverage may apply on a specific basis, an aggregate basis or both. Specific coverage means that the stop-loss carrier's risk begins after a minimum of at least $5,000 of claims for any one covered Life has been covered by the group plan, provider/provider group or direct writer. Aggregate coverage means that the stop-loss carrier's risk begins after the group plan, provider/provider group or direct writer has retained at least 90% of expected claims, or the economic equivalent.

APPENDIX 2 – COMMONLY USED TERMS FOR MEDICARE PART D COVERAGE

The U.S. Centers for Medicare and Medicaid Services (CMS) oversees the Medicare Part D prescription drug coverage, including both coverage provided through a stand-alone Prescription Drug Plan (PDP) and coverage provided as part of a Medicare Advantage plan. The terms are defined in INT 05-05: Accounting for Revenue under Medicare Part D Coverage.

APPENDIX 3 – EXAMPLE USED FOR AFFILIATED/SUBSIDIARY STOCKS

To determine the value of total outstanding common stock or total outstanding preferred stock, divide the book/adjusted carrying value of the investment (found in Schedule D - Part 6 Section 1, Column 7) by the percentage of ownership (found in Schedule D – Part 6 – Section 1, Column 11). For example:

Subsidiary Insurance Company	Owner's Book/Adjusted Carrying Value	Percentage Ownership	Total Stock Outstanding
Subsidiary #1	$1,000,000	100%	$1,000,000
Subsidiary #2	$1,000,000	75%	$1,333,333
Subsidiary #3	$1,000,000	50%	$2,000,000
Subsidiary #4	$1,000,000	25%	$4,000,000
Subsidiary #5	$1,000,000	10%	$10,000,000

Affix Bar Code Here

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COMPANY INFORMATION PAGE (JURAT)
Health Risk-Based Capital
For the Year Ending December 31, 2024

(A) Company Name _____

(B) NAIC Group _____ (C) NAIC Company Code _____ (D) Employer's ID Number _____

(E) Organized under the Laws of the State of _____

Contact Person for Health Risk-Based Capital:

(F) First Name (G) Middle (H) Last Name

(I) Mail Address of Contact Person
(Street and Number or P.O. Box)

(J) City (K) State (L) Zip

(M) Phone Number of RBC Contact Person Extension

(N) Email Address of RBC Contact Person

(O) Date Prepared _____

(P) Preparer (if different than Contact)
First Middle Last

(Q) Is this an Original, Amended, or Refiling?

(Q1) If Amended, Amendment Number:

(R) Were any items that come directly from the annual statement entered manually to prepare this filing? (Yes/No)

(S) Was the entity in business for the entire reporting year?

Officers: Name

Title

Each says that they are the above described officers of the said insurer, and that this risk-based capital report is a true and fair representation of the company's affairs and has been completed in accordance with the NAIC instructions, according to the best of their information, knowledge and belief, respectively.

_____ _____ _____
(Signature) (Signature) (Signature)

Denotes items that must be manually entered on filing software.

DETAILS FOR AFFILIATED STOCKS

	(1) Name of Affiliate	(2) Affil Type	(3) NAIC Company Code or Alien ID Number	(4) Affiliate's RBC after Covariance Before Basic Operational Risk XR025 Line (41) PR032 Line (60) LR031 Line (69) + (73)	(5) Book/Adjusted Carrying Value (Statement Value) of Affiliate's Common Stock	(6) Valuation Basis of Col (5) M - Market Value after any "discount" A - All Other	(7) Total Value of Affiliate's Outstanding Common Stock	(8) Statutory Surplus of Affiliate Subject to RBC (Adjusted for % Owned)	(9) Book/Adjusted Carrying Value (Statement Value) of Affiliate's Preferred Stock	(10) Total Value of Affiliate's Outstanding Preferred Stock	(11) Percent Owned *	(12) RBC Required	(13) Market Value Excess Component Affiliated Stocks RBC Required (H1 Component)
(01)													
(02)													
(03)													
(04)													
(05)													
(06)													
(07)													
(08)													
(09)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													
(9999999)	Total	XXX	XXX			XXX					XXX		

Denotes items that must be manually entered on filing software.

Remark: Subcategory 8a, 8b and 8c are referring to the directly owned insurance affiliates not subject to RBC look-through
Indirectly owned insurance affiliate not subject to RBC will be included Category 4

* Only applies to Affiliate Type 1 and 2

SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS

	Affiliate Type	Type Code	Basis	(1) Number of Companies	(2) Total RBC Required
(1)	Directly Owned Health Insurance Companies or Health Entities	1a	Sub's RBC After Covariance		
(2)	Directly Owned Property and Casualty Insurance Affiliates	1b	Sub's RBC After Covariance		
(3)	Directly Owned Life Insurance Affiliates	1c	Sub's RBC After Covariance		
(4)	Indirectly Owned Health Insurance Companies or Health Entities	2a	Sub's RBC After Covariance		
(5)	Indirectly Owned Property and Casualty Insurance Affiliates	2b	Sub's RBC After Covariance		
(6)	Indirectly Owned Life Insurance Affiliates	2c	Sub's RBC After Covariance		
(7)	Holding Company in Excess of Indirect Subs	3	0.300		
(8)	Investment Subsidiary	4	0.300		
(9)	Directly Owned Alien Health Insurance Companies or Health Entities	5a	1.000		
(10)	Directly Owned Alien Property and Casualty Insurance Affiliates	5b	1.000		
(11)	Directly Owned Alien Life Insurance Affiliates	5c	1.000		
(12)	Indirectly Owned Alien Health Insurance Companies or Health Entities	6a	1.000		
(13)	Indirectly Owned Alien Property and Casualty Insurance Affiliates	6b	1.000		
(14)	Indirectly Owned Alien Life Insurance Affiliates	6c	1.000		
(15)	Investment in Upstream Affiliate (Parent)	7	0.300		
(16)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	8a	0.300		
(17)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	8b	0.300		
(18)	Directly Owned Life Insurance Companies Not Subject to RBC	8c	0.300		
(19)	Non-Insurance Entities with a Capital Requirement Imposed by a Regulatory Body	9a	0.300		
(20)	Non-Insurance Other Financial Entities without Regulatory Capital Requirements	9b	0.300		
(21)	Other Non-Financial Entities	9c	0.300		
(22)	Total				

SUMMARY FOR SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS FOR CROSS-CHECKING STATEMENT VALUES

	Affiliated Preferred Stock Schedule D Part 6 Section 1 C7	Annual Statement Line Number	(1) Annual Statement Total Preferred Stock	(2) Total From RBC Report	(3) Difference
(1)	Parent	0199999			
(2)	U.S. P&C Insurer	0299999			
(3)	U.S. Life Insurer	0399999			
(4)	U.S. Health Insurer	0499999			
(5)	Alien Insurer	0599999			
(6)	Non-Insurer Which Controls Insurer	0699999			
(7)	Investment Subsidiary	0799999			
(8)	Other Affiliates	0899999			
(9)	Subtotal	0999999			

	Affiliated Common Stock Schedule D Part 6 Section 1 C7	Annual Statement Line Number	(1) Annual Statement Total Common Stock	(2) Total From RBC Report	(3) Difference
(10)	Parent	1099999			
(11)	U.S. P&C Insurer	1199999			
(12)	U.S. Life Insurer	1299999			
(13)	U.S.Health Insurer	1399999			
(14)	Alien Insurer	1499999			
(15)	Non-Insurer Which Controls Insurer	1599999			
(16)	Investment Subsidiary	1699999			
(17)	Other Affiliates	1799999			
(18)	Subtotal	1899999			

OFF-BALANCE SHEET AND OTHER ITEMS

		Annual Statement Source	(1) Bk/Adj Carrying Value	(2) Factor	(3) RBC Requirement	(4) Yes/No Response
	Noncontrolled Assets					
(1)	Loaned to Others - Conforming Securities Lending Programs	General Interrogatories Part 1 Line 25.04		0.002		
(2)	Loaned to Others - Securities Lending Programs - Other	General Interrogatories Part 1 Line 25.05		0.010		
(3)	Subject to Repurchase Agreements	General Interrogatories Part 1 Line 26.21		0.010		
(4)	Subject to Reverse Repurchase Agreements	General Interrogatories Part 1 Line 26.22		0.010		
(5)	Subject to Dollar Repurchase Agreements	General Interrogatories Part 1 Line 26.23		0.010		
(6)	Subject to Reverse Dollar Repurchase Agreements	General Interrogatories Part 1 Line 26.24		0.010		
(7)	Placed Under Option Agreements	General Interrogatories Part 1 Line 26.25		0.010		
(8)	Letter Stock or Securities Restricted as to Sale - Excluding FHLB Capital Stock	General Interrogatories Part 1 Line 26.26		0.010		
(9)	FHLB Capital Stock	General Interrogatories Part 1 Line 26.27		0.010		
(10)	On Deposit with States	General Interrogatories Part 1 Line 26.28		0.010		
(11)	On Deposit with Other Regulatory Bodies	General Interrogatories Part 1 Line 26.29		0.010		
(12)	Pledged as Collateral - Excluding Collateral Pledged to an FHLB	General Interrogatories Part 1 Line 26.30		0.010		
(13)	Pledged as Collateral to FHLB (Including Assets Backing Funding Agreements)	General Interrogatories Part 1 Line 26.31		0.010		
(14)	Other	General Interrogatories Part 1 Line 26.32		0.010		
(15)	Total Noncontrolled Assets	Sum of Lines (1) through (14)				
(16)	Guarantees for Affiliates	Notes to Financial Statements 14A(03C1), Column 2		0.010		
(17)	Contingent Liabilities	Notes to Financial Statements 14A(1), Column 2		0.010		
(18)	Is the entity responsible for filing the U.S. Federal income tax return for the reporting insurer a regulated insurance company?	"Yes", "No" or "N/A" in Column (4)				
(19)	SSAP No. 101 Paragraph 11a Deferred Tax Assets	Notes to Financial Statements, Item 9A2(a), Column 3		†		
(20)	SSAP No. 101 Paragraph 11b Deferred Tax Assets	Notes to Financial Statements, Item 9A2(b), Column 3		0.010		
(21)	Total Miscellaneous Off-Balance Sheet and Other Items	Lines (15) + (16) + (17) + (19) + (20)				

† If Line (18) Column (4) is "Yes", then the factor is 0.005. If Line (18) Column (4) is "No", then the factor is 0.010. If Line (18) Column (4) is "N/A", then the factor is 0.000.

Denotes items that must be manually entered on filing software.

OFF-BALANCE SHEET SECURITY LENDING COLLATERAL AND SCHEDULE DL, PART 1 ASSETS

Asset Category	Annual Statement Source	(1) Off-Balance Sheet Collateral Book/Adjusted Carrying Value	(2) Schedule DL, Part 1 Book/Adjusted Carrying Value	(3) Subtotal	Factor	(4) RBC Requirement
Fixed Income Assets						
Bonds						
(1) NAIC 1.A - U.S. Government - Full Faith and Credit, Other U.S. Government Obligations, and NAIC U.S. Government Money Market Fund List (Refer to A/S Instructions)	Company Records				0.000	
(2) NAIC Designation Category 1.A Bonds	Company Records				0.003	
(3) NAIC Designation Category 1.B Bonds	Company Records				0.005	
(4) NAIC Designation Category 1.C Bonds	Company Records				0.008	
(5) NAIC Designation Category 1.D Bonds	Company Records				0.011	
(6) NAIC Designation Category 1.E Bonds	Company Records				0.014	
(7) NAIC Designation Category 1.F Bonds	Company Records				0.016	
(8) NAIC Designation Category 1.G Bonds	Company Records				0.019	
(9) Total NAIC 01 Bonds	Sum of Lines (1) through (8)					
(10) NAIC Designation Category 2.A Bonds	Company Records				0.022	
(11) NAIC Designation Category 2.B Bonds	Company Records				0.025	
(12) NAIC Designation Category 2.C Bonds	Company Records				0.031	
(13) Total NAIC 02 Bonds	Sum of Lines (10) through (12)					
(14) NAIC Designation Category 3.A Bonds	Company Records				0.069	
(15) NAIC Designation Category 3.B Bonds	Company Records				0.076	
(16) NAIC Designation Category 3.C Bonds	Company Records				0.083	
(17) Total NAIC 03 Bonds	Sum of Lines (14) through (16)					
(18) NAIC Designation Category 4.A Bonds	Company Records				0.089	
(19) NAIC Designation Category 4.B Bonds	Company Records				0.097	
(20) NAIC Designation Category 4.C Bonds	Company Records				0.110	
(21) Total NAIC 04 Bonds	Sum of Lines (18) through (20)					
(22) NAIC Designation Category 5.A Bonds	Company Records				0.123	
(23) NAIC Designation Category 5.B Bonds	Company Records				0.137	
(24) NAIC Designation Category 5.C Bonds	Company Records				0.151	
(25) Total NAIC 05 Bonds	Sum of Lines (22) through (24)					
(26) Total NAIC 06 Bonds	Company Records				0.300	
(27) Total Bonds	Line (9) + (13) + (17) + (21) + (25) + (26)					
Equity Assets						
Preferred Stock - Unaffiliated						
(28) NAIC 01 Unaffiliated Preferred Stock	Company Records				0.003	
(29) NAIC 02 Unaffiliated Preferred Stock	Company Records				0.010	
(30) NAIC 03 Unaffiliated Preferred Stock	Company Records				0.020	
(31) NAIC 04 Unaffiliated Preferred Stock	Company Records				0.045	
(32) NAIC 05 Unaffiliated Preferred Stock	Company Records				0.100	
(33) NAIC 06 Unaffiliated Preferred Stock	Company Records				0.300	
(34) Total Unaffiliated Preferred Stock	Sum of Lines (28) through (33)					
(35) Unaffiliated Common Stock	Company Records				0.150	
(36) Real Estate and Property & Equipment Assets	Company Records				0.100	
(37) Other Invested Assets	Company Records				0.200	
(38) Mortgage Loans on Real Estate	Company Records				0.050	
(39) Cash, Cash Equivalents and Short-Term Investments (Not reported on Bonds above)	Company Records				0.003	
(40) Total	Lines (27) + (34) + (35) + (36) + (37) + (38) + (39)					

Denotes items that must be manually entered on the filing software.

FIXED INCOME ASSETS - BONDS

		Annual Statement Source	(1) Long-Term Bonds Schedule D, Part 1 Book/Adjusted Carrying Value L(3) thru (26) = Sch D Pt 1F	(2) Short-Term Investments Schedule DA, Part 1 Book/Adjusted Carrying Value L(3) thru (26) = Sch DA Pt 1F	(3) Cash Equivalents Schedule E, Part 2 Book/Adjusted Carrying Value L(3) thru (26) = Sch E Pt 2F	(4) Subtotal C(1) + C(2) + C(3)	Factor	(5) RBC Requirement
BONDS								
(1)	NAIC 1.A - U.S. Government - Full Faith and Credit, Other U.S. Government Obligations, and NAIC U.S. Government Money Market Fund List (Refer to A/S Instructions)	C(1) = Sch D, Pt 1, C11, L0109999999 C(2) = Sch DA, Pt 1, C7, L0109999999 C(3) = Sch E, Pt 2, C7, L0109999999 + L8209999999					0.000	
(2)	NAIC Designation Category 1.A Bonds	C(1)=Footnote Amt 1 L000001A - L(1) C(2)=Footnote Amt 1 L000001A - L(1) C(3)=Footnote Amt 1 L000001A - SCE, Pt2, C7 L0109999999					0.003	
(3)	NAIC Designation Category 1.B Bonds	Footnote Amt 2 L000001A					0.005	
(4)	NAIC Designation Category 1.C Bonds	Footnote Amt 3 L000001A					0.008	
(5)	NAIC Designation Category 1.D Bonds	Footnote Amt 4 L000001A					0.011	
(6)	NAIC Designation Category 1.E Bonds	Footnote Amt 5 L000001A					0.014	
(7)	NAIC Designation Category 1.F Bonds	Footnote Amt 6 L000001A					0.016	
(8)	NAIC Designation Category 1.G Bonds	Footnote Amt 7 L000001A					0.019	
(9)	Total NAIC 01 Bonds	Sum of Lines (1) through (8)						
(10)	NAIC Designation Category 2.A Bonds	Footnote Amt 1 L000001B					0.022	
(11)	NAIC Designation Category 2.B Bonds	Footnote Amt 2 L000001B					0.025	
(12)	NAIC Designation Category 2.C Bonds	Footnote Amt 3 L000001B					0.031	
(13)	Total NAIC 02 Bonds	Sum of Lines (10) through (12)						
(14)	NAIC Designation Category 3.A Bonds	Footnote Amt 1 L000001C					0.069	
(15)	NAIC Designation Category 3.B Bonds	Footnote Amt 2 L000001C					0.076	
(16)	NAIC Designation Category 3.C Bonds	Footnote Amt 3 L000001C					0.083	
(17)	Total NAIC 03 Bonds	Sum of Lines (14) through (16)						
(18)	NAIC Designation Category 4.A Bonds	Footnote Amt 1 L000001D					0.089	
(19)	NAIC Designation Category 4.B Bonds	Footnote Amt 2 L000001D					0.097	
(20)	NAIC Designation Category 4.C Bonds	Footnote Amt 3 L000001D					0.110	
(21)	Total NAIC 04 Bonds	Sum of Lines (18) through (20)						
(22)	NAIC Designation Category 5.A Bonds	Footnote Amt 1 L000001E					0.123	
(23)	NAIC Designation Category 5.B Bonds	Footnote Amt 2 L000001E					0.137	
(24)	NAIC Designation Category 5.C Bonds	Footnote Amt 3 L000001E					0.151	
(25)	Total NAIC 05 Bonds	Sum of Lines (22) through (24)						
(26)	Total NAIC 06 Bonds	Footnote Amt 1 L000001F					0.300	
(27)	Total Bonds RBC	Lines (9) + (13) + (17) + (21) + (25) + (26)						

FIXED INCOME ASSETS - MISCELLANEOUS

		Annual Statement Source	(1) Bk/Adj Carrying Value	Factor	(2) RBC Requirement
(1)	Cash	Page 2, Line 5, inside amount 1		0.0030	
(2)	Cash Equivalents	Page 2, Line 5, inside amount 2			
(3)	Less: Cash Equivalents, Total Bonds	Schedule E, Part 2, Column 7, Line 2509999999			
(4)	Less: Exempt Money Market Mutual Funds as Identified by SVO	Schedule E, Part 2, Column 7, Line 8209999999			
(5)	Net Cash Equivalents	Lines (2) - (3) - (4)		0.0030	
(6)	Short-Term Investments	Page 2, Line 5, inside amount 3			
(7)	Short-Term Bonds	Schedule DA, Part 1, Column 7, Line 2509999999			
(8)	Total Other Short-Term Investments	Lines (6) - (7)		0.0030	
(9)	Mortgage Loans - First Liens	Page 2, Column 3, Line 3.1		0.0500	
(10)	Mortgage Loans - Other Than First Liens	Page 2, Column 3, Line 3.2		0.0500	
(11)	Receivable for Securities	Page 2, Column 3, Line 9		0.0240	
(12)	Aggregate Write-Ins for Invested Assets	Page 2, Column 3, Line 11		0.0500	
(13)	Collateral Loans	Included in Page 2, Column 3, Line 8		0.0500	
(14)	NAIC 01 Working Capital Finance Investments	Notes to Financial Statement 5M(01a), Column 3		0.0038	
(15)	NAIC 02 Working Capital Finance Investments	Notes to Financial Statement 5M(01b), Column 3		0.0125	
(16)	Other Long-Term Invested Assets Excluding Collateral Loans, **Residual Tranches or Interests** and Working Capital Finance Investments	Included in Page 2, Column 3, Line 8		0.2000	
(17)	Federal Guaranteed Low Income Housing Tax Credits	Schedule BA Part 1, Column 12 Lines 3599999 + 3699999		0.0014	
(18)	Federal Non-Guaranteed Low Income Housing Tax Credits	Schedule BA Part 1, Column 12 Lines 3799999 + 3899999		0.0260	
(19)	State Guaranteed Low Income Housing Tax Credits	Schedule BA Part 1, Column 12 Lines 3999999 + 4099999		0.0014	
(20)	State Non-Guaranteed Low Income Housing Tax Credits	Schedule BA Part 1, Column 12 Lines 4199999 + 4299999		0.0260	
(21)	All Other Low Income Housing Tax Credits	Schedule BA Part 1, Column 12 Lines 4399999 + 4499999		0.1500	
(22)	**Total Residual Tranches or Interests**	**Schedule BA, Part 1, Column 12 Lines 4699999 + 4799999 + 4899999 + 4999999 + 5099999 + 5199999 + 5299999 + 5399999 + 5499999 + 5599999 + 5699999 + 5799999**		**0.2000**	
(23)	Total Other Long-Term Invested Assets (Page 2, Column 3, Line 8)	Lines (13) + (14) + (15) + (16) + (17) + (18) + (19) + (20) + (21) **+ (22)**			
(24)	Derivatives	Page 2, Column 3, Line 7		0.0500	
(25)	Total Miscellaneous Fixed Income Assets RBC	Lines (1) + (5) + (8) + (9) + (10) + (11) + (12) + (23) + **(24)**			

Denotes items that must be manually entered on filing software.

REPLICATION (SYNTHETIC ASSET) TRANSACTIONS AND MANDATORY CONVERTIBLE SECURITIES

	(1) RSAT Number	(2) Type	(3) CUSIP	(4) Description of Asset(s)	(5) NAIC Designation or Other Description of Asset	(6) Value of Asset	(7) RBC Requirement
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							
(19)							
(20)							
(21)							
(22)							
(23)							
(24)							
(25)							
(26)							
(27)							
(28)							
(29)							
(30)							
(31)							
(32)							
(33)							
(34)							
(35)							
(9999999)	XXX	XXX	XXX	Total	XXX		

Denotes items that must be manually entered on filing software.

EQUITY ASSETS

		Annual Statement Source	(1) Bk/Adj Carrying Value	Factor	(2) RBC Requirement
PREFERRED STOCK - UNAFFILIATED					
(1)	NAIC 01 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.003	
(2)	NAIC 02 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.010	
(3)	NAIC 03 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.020	
(4)	NAIC 04 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.045	
(5)	NAIC 05 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.100	
(6)	NAIC 06 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.300	
(7)	Total - Unaffiliated Preferred Stock	Sum of Lines (1) through (6)			
(Should equal Page 2, Column 3, Line 2.1 less Sch D Sum, Column 1, Line 18)					
COMMON STOCK - UNAFFILIATED					
(8)	Federal Home Loan Bank Stock	Company Records		0.023	
(9)	Total Common Stock	Schedule D, Summary, Column 1, Line 25			
(10)	Affiliated Common Stock	Schedule D, Summary, Column 1, Line 24			
(11)	Other Unaffiliated Common Stock	Lines (9) - (8) - (10)		0.150	
(12)	Market Value Excess Affiliated Stocks	XR002 C(13) L(9999999)			
(13)	Total Unaffiliated Common Stock **and Market Value Excess Affiliated Stocks**	Lines (8) + (11) + (12)			

Denotes items that must be manually entered on filing software.

PROPERTY & EQUIPMENT ASSETS

		Annual Statement Source	(1) Bk/Adj Carrying Value	Factor	(2) RBC Requirement
(1)	Properties Occupied by the Company	Page 2, Column 3, Line 4.1		0.100	
(2)	Encumbrances (Property Occupied by the Company)	Page 2, Line 4.1, inside amount		0.100	
(3)	Properties Held for the Production of Income	Page 2, Column 3, Line 4.2		0.100	
(4)	Encumbrances (Property Held for Production of Income)	Page 2, Line 4.2, inside amount		0.100	
(5)	Properties Held for Sale	Page 2, Column 3, Line 4.3		0.100	
(6)	Encumbrances (Property Held for Sale)	Page 2, Line 4.3, inside amount		0.100	
(7)	Furniture and Equipment	Lines (7.1) + (7.2) (should equal Page 2, Column 3, Line 21)			
(7.1)	HC Delivery Subject to Statutory Acct Depreciation Limits	Company Records		0.100	
(7.2)	All Other Furniture and Equipment	Company Records		0.100	
(8)	EDP Equipment and Software	Page 2, Column 3, Line 20		0.100	
(9)	Total Property and Equipment	Lines (1) + (2) + (3) + (4) + (5) + (6) + (7.1) + (7.2) + (8)			

Denotes items that must be manually entered on filing software.

ASSET CONCENTRATION

Issuer Name

	(1)	(2) Bk/Adj Carrying Value	Factor	(3) Additional RBC
(1)	NAIC Designation Category 2.A Bonds		0.0220	
(2)	NAIC Designation Category 2.B Bonds		0.0250	
(3)	NAIC Designation Category 2.C Bonds		0.0310	
(4)	NAIC Designation Category 3.A Bonds		0.0690	
(5)	NAIC Designation Category 3.B Bonds		0.0760	
(6)	NAIC Designation Category 3.C Bonds		0.0830	
(7)	NAIC Designation Category 4.A Bonds		0.0890	
(8)	NAIC Designation Category 4.B Bonds		0.0970	
(9)	NAIC Designation Category 4.C Bonds		0.1100	
(10)	NAIC Designation Category 5.A Bonds		0.1230	
(11)	NAIC Designation Category 5.B Bonds		0.1370	
(12)	NAIC Designation Category 5.C Bonds		0.1490	
(13)	Collateral Loans		0.0500	
(14)	Mortgages		0.0500	
(15)	NAIC 02 Unaffiliated Preferred Stock		0.0100	
(16)	NAIC 03 Unaffiliated Preferred Stock		0.0200	
(17)	NAIC 04 Unaffiliated Preferred Stock		0.0450	
(18)	NAIC 05 Unaffiliated Preferred Stock		0.1000	
(19)	Other Long-Term Invested Assets		0.1000	
(20)	NAIC 02 Working Capital Finance Investments		0.0125	
(21)	Federal Guaranteed Low Income Housing Tax Credits		0.0014	
(22)	Federal Non-Guaranteed Low Income Housing Tax Credits		0.0260	
(23)	State Guaranteed Low Income Housing Tax Credits		0.0014	
(24)	State Non-Guaranteed Low Income Housing Tax Credits		0.0260	
(25)	All Other Low Income Housing Tax Credits		0.1500	
(26)	Unaffiliated Common Stock		0.1500	
(27)	Total of Issuer = Lines (1) through (26)			

Note: Ten issuer sections and a grand total page will be available on the filing software. The grand total page is calcuated as the sum of issuers 1-10 by asset type.

Denotes items that must be manually entered on filing software.

UNDERWRITING RISK

Experience Fluctuation Risk

		Line of Business	(1) Comprehensive (Hospital & Medical) - Individual & Group	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
(1)	†	Premium							
(2)	†	Title XVIII-Medicare		XXX	XXX	XXX	XXX	XXX	
(3)	†	Title XIX-Medicaid		XXX	XXX	XXX	XXX	XXX	
(4)	†	Other Health Risk Revenue		XXX				XXX	
(5)		Medicaid Pass-Through Payments Reported as Premiums		XXX	XXX	XXX	XXX	XXX	
(6)		Underwriting Risk Revenue = Lines (1) + (2) + (3) + (4) - (5)							
(7)	†	Net Incurred Claims						XXX	
(8)		Medicaid Pass-Through Payments Reported as Claims		XXX	XXX	XXX	XXX	XXX	
(9)		Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = Lines (7) - (8)						XXX	
(10)	†	Fee-For-Service Offset		XXX				XXX	
(11)		Underwriting Risk Incurred Claims = Lines (9) - (10)						XXX	
(12)		Underwriting Risk Claims Ratio = For Column (1) through (5), Line (11)/(6)						1.000	XXX
(13)		Underwriting Risk Factor*					0.130	0.130	XXX
(14)		Base Underwriting Risk RBC = Lines (6) x (12) x (13)							
(15)		Managed Care Discount Factor						XXX	XXX
(16)		RBC After Managed Care Discount = Lines (14) x (15)						XXX	
(17)	†	Maximum Per-Individual Risk After Reinsurance						XXX	XXX
(18)		Alternate Risk Charge **						XXX	XXX
(19)		Alternate Risk Adjustment						XXX	XXX
(20)		Net Alternate Risk Charge***						XXX	
(21)		Net Underwriting Risk RBC (MAX{Line (16), Line (20)}) for Columns (1) through (5), Column (6), Line (14)							

TIERED RBC FACTORS*						
	Comprehensive (Hospital & Medical) - Individual & Group	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
$0 - $3 Million	**0.1427**	**0.0973**	**0.1143**	0.251	0.130	0.130
$3 - $25 Million	**0.1427**	**0.0596**	**0.0706**	0.251	0.130	0.130
Over $25 Million	**0.0832**	**0.0596**	**0.0706**	0.151	0.130	0.130

ALTERNATE RISK CHARGE**						
** The Line (18) Alternate Risk Charge is calculated as follows:						
LESSER OF:	$1,500,000 or 2 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	$150,000 or 6 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	N/A

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR014.

* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision managed care discount factor.

*** Limited to the largest of the applicable alternate risk adjustments, prorated if necessary.

† Annual Statement Source

	Line of Business	(1) Comprehensive (Hospital & Medical) - Individual & Group	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
(1)	Premium	Page 7, Columns 2 & 3, Lines 1 + 2	Page 7, Column 4, Line 1 + 2	Page 7, Columns 6 & 5, Line 1 + 2			Page 7, Column 14, Lines 1 + 2	
(2)	Title XVIII-Medicare	Page 7, Column 8, Lines 1 + 2	XXX	XXX	XXX	XXX	XXX	Page 7, Column 8, Lines 1 + 2
(3)	Title XIX-Medicaid	Page 7, Column 9, Lines 1 + 2	XXX	XXX	XXX	XXX	XXX	Page 7, Column 9, Lines 1 + 2
(4)	Other Health Risk Revenue	Page 7, Columns 2 + 3 + **8** + **9**, Line 4	XXX	Page 7, Columns 6 & 5, Line 4			XXX	
(7)	Net Incurred Claims	Page 7, Columns 2 + 3 + 8 + 9, Line 17	Page 7, Column 4, Line 17	Page 7, Columns 6 & 5, Line 17			XXX	
(10)	Fee-For-Service Offset	Page 7, Columns 2 + 3 + **8** + **9**, Line 3	XXX	Page 7, Columns 6 & 5 , Line 3			XXX	
(17)	Maximum Per-Individual Risk After Reinsurance	Gen Int Part 2, Lines 5.31 + 5.32	Gen Int Part 2 Line 5.33	Gen Int Part 2 Line 5.34			XXX	XXX

Denotes items that must be manually entered on filing software.

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Other Underwriting Risk					
(22)	Business with Rate Guarantees Between 15-36 Months - Direct Premium Earned	Gen Int Part 2 Line 9.21		0.024	
(23)	Business with Rate Guarantees Over 36 Months - Direct Premium Earned	Gen Int Part 2 Line 9.22		0.064	
(24)	FEHBP and TRICARE Claims Incurred	UI, Part 2, Column 7, Line 12.4		0.020	
(25)	Stop Loss and Minimum Premium	Company Records		*	
(25.1)	Supplemental Benefits within Stand-Alone Medicare Part D Coverage (Claims Incurred)	Company Records		0.500	
(25.2)	Medicaid Pass-Through Payments Reported as Premiums	XR013, Column (1), Line (5)		0.020	
(25.3)	Total Other Underwriting Risk	Sum of Lines (22) through (25.2)			
Disability Income Premium					
(26)	Noncancellable Disability Income - Individual Morbidity	Company Records			
(26.1)	First $50 Million Earned Premium of Line (26)			0.350	
(26.2)	Over $50 Million Earned Premium of Line (26)			0.150	
(26.3)	Total Noncancellable Disability Income - Individual Morbidity	Lines (26.1) + (26.2)			
(27)	Other Disability Income - Individual Morbidity	Company Records			
(27.1)	Earned Premium in Line (27) [up to $50 Million less Premium in Line (26.1)]			0.250	
(27.2)	Earned Premium in Line (27) not included in Line (27.1)			0.070	
(27.3)	Total Other Disability Income - Individual Morbidity	Lines (27.1) + (27.2)			
(28)	Disability Income - Credit Monthly Balance Plans	Company Records			
(28.1)	First $50 Million Earned Premium of Line (28)			0.200	
(28.2)	Over $50 Million Earned Premium of Line (28)			0.030	
(28.3)	Total Disability Income - Credit Morbidity	Lines (28.1) + (28.2)			
(29)	Disability Income - Group Long-Term	Company Records			
(29.1)	Earned Premium in Line (29) [up to $50 Million less Premium in Line (28.1)]			0.150	
(29.2)	Earned Premium in Line (29) not included in Line (29.1)			0.030	
(29.3)	Total Disability Income - Group Long-Term	Lines (29.1) + (29.2)			
(30)	Disability Income - Credit Single Premium with Additional Reserves	Company Records			
(30.1)	Additional Reserves for Credit Disability Plans	Company Records			
(30.2)	Additional Reserves for Credit Disability Plans, Prior Year	Company Records			
(30.3)	Sub-Total Disability Income - Credit Single Prem w/Addl Reserves	Lines (30) - (30.1) + (30.2)			
(30.4)	Earned Premium in Line (30.3) [up to $50 Million less Premium in Lines (28.1) + (29.1)]			0.100	
(30.5)	Earned Premium in Line (30.3) not included in Line (30.4)			0.030	
(30.6)	Total Disability Income - Credit Single Premium with Additional Reserves	Lines (30.4) + (30.5)			
(31)	Disability Income - Credit Single Premium without Additional Reserves	Company Records			
(31.1)	Earned Prem in Line (31) [up to $50 Million less Prem in Lines (28.1) + (29.1) + (30.4)]			0.150	
(31.2)	Earned Premium in Line (31) not included in Line (31.1)			0.030	
(31.3)	Total Disability Income - Credit Single Premium without Additional Reserves	Lines (31.1) + (31.2)			
(32)	Disability Income - Group Short-Term	Company Records			
(32.1)	Earned Prem in Line (32) [up to $50 Million less Prem in Lines (28.1) + (29.1) + (30.4) + (31.1)]			0.050	
(32.2)	Earned Premium in Line (32) not included in Line (32.1)			0.030	
(32.3)	Total Disability Income - Group Short-Term	Lines (32.1) + (32.2)			

Denotes items that must be manually entered on filing software.

* A factor of .350 will be applied to the first $25,000,000 in Column (1), Line (25) and a factor of .250 will be applied to the remaining premium in excess of $25,000,000.

Long-Term Care (LTC) Insurance Premium		**Annual Statement Source**	(1) Amount	Factor		(2) RBC Requirement
(33)	Noncancellable LTC Premium - Rate Risk	Company Records		0.100	*	
(34)	All LTC Premium - Morbidity Risk (to $50 Million)	Line (37.1) Column (1) up to $50 Million		0.100		
(35)	LTC Premium (over $50 Million) - Morbidity Risk	Remainder of Line (37.1) Column (1) over $50 Million		0.030		
(36)	Premium-Based RBC	Column (2), Lines (33) + (34) + (35)				

Historical Loss Ratio Experience		**Annual Statement Source**	(1) Premiums	(2) Incurred Claims	(3) Column (2)/(1) Loss Ratio §	(4) RBC Requirement
(37.1)	Current Year	Company Records				
(37.2)	Immediate Prior Year	Company Records				
(37.3)	Average Loss Ratio	If loss ratios are used, [Column (3), Line (37.1) + Line (37.2)/2, otherwise zero]				
(38)	Adjusted LTC Claims for RBC	If Column (3) Line (37.3) <> 0, then [Column (1), Line (34) + Line (35)] x Column (3), Line (37.3), else Column (2) Line (37.1)				
(38.1)	Claims (to $35 Million) - Morbidity Risk	Lower of Column (2), Line (38) and $35 Million			0.370 †	
(38.2)	Claims (over $35 Million) - Morbidity Risk	Excess of Column (2), Line (38) over $35 Million			0.120 ‡	
(39)	LTC Claims Reserves	Company Records			0.050	
(40)	Claims-Based RBC	Column (4), Lines (38.1) + (38.2)				
(41)	LTC RBC	Column (2), Line (36) + Column (4), Lines (39) + (40)				

* The factor applies to all Noncanellable premium.

† If Column (1), Line (37.1) is positive, then a factor of 0.250 is used. Otherwise, a higher factor of 0.370 is used

‡ If Column (1), Line (37.1) is positive, then a factor of 0.080 is used. Otherwise, a higher factor of 0.120 is used

§ If Column (1), Line (37.1) or (37.2) are less than or equal to zero or if Column (2), Line (37.1) or (37.2) are less than zero, the loss ratios are not used and Column (3), Line (37.3) is set to zero.

Denotes items that must be manually entered on filing software.

Limited Benefit Plans (Individual and Group Combined)		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
(42)	Hospital Indemnity and Specified Disease	Included in Page 7, Column 13, Line 1 and 2, in part		0.035	
(42.1)	$50,000 if Line (42) is Greater Than Zero				
(42.2)	Total Hospital Indemnity and Specified Disease	Lines (42) + (42.1)			
(43)	Accidental Death & Dismemberment	Included in Page 7, Column 13, Line 1 and 2, in part			
(43.1)	First $10 Million Earned Premium of Line (43)			0.055	
(43.2)	Over $10 Million Earned Premium of Line (43)			0.015	
(43.3)	Maximum Retained Risk for Any Single Claim	Company Records			
(43.4)	Three Times Line (43.3)				
(43.5)	Lesser of Line (43.4) or $300,000				
(43.6)	Total AD&D	Lines (43.1) + (43.2) + (43.5)			
(44)	Other Accident	Included in Page 7, Column 13, Line 1 and 2, in part		0.050	
(45)	Premium Stabilization Reserves	Included in U&I, Part 2D, Column 1, Line 4		-0.500 Φ	
(46)	Total Other Underwriting Risk	Lines (25.3) + (26.3) + (27.3) + (28.3) + (29.3) + (30.6) + (31.3) + (32.3) + (41) + (42.2) + (43.6) + (44) + (45)			

Φ This is limited to the Total Net Underwriting RBC on XR013, Column (7), Line (21) Less Column (4), and XR015, Column (2), Lines (25.3), (26.3), (27.3), (28.3), (29.3), (30.6), (31.3), (32.3), XR016 Column (2), Line (36) and XR017 Column (2), Lines (42.2), (43.6), and (44).

Denotes items that must be manually entered on filing software.

UNDERWRITING RISK - Managed Care Credit Calculation

Managed Care Claims Payments	Annual Statement Source	(1) Factor	(2) Paid Claims	(3) Weighted Claims†	(4) Part D Weighted Claims‡
(1) Category 0 - Arrangements not Included in Other Categories	Exhibit 7, Part 1, Column 1, Line 5, in part §	0			
(2) Category 1 - Payments Made According to Contractual Arrangements	Exhibit 7, Part 1, Column 1, Line 6, in part §	0.150			
(3) Category 2a - Subject to Withholds or Bonuses/Incentives - Otherwise Category 0	Exhibit 7, Part 1, Column 1, Line 7, in part §	*			
(4) Category 2b - Subject to Withholds or Bonuses/Incentives - Otherwise Category 1	Exhibit 7, Part 1, Column 1, Line 8, in part §	*			
(5) Category 3a - Capitated Payments Directly to Providers		0.600			
(5.1) Capitation Payments - Medical Group - Category 3a	Exhibit 7, Part 1, Column 1, Line 1, in part §				
(5.2) Capitation Payments - All Other Providers - Category 3a	Exhibit 7, Part 1, Column 1, Line 3, in part §				
(6) Category 3b - Capitated Payments to Regulated Intermediaries	Included in Exhibit 7, Part 1, Column 1, Line 2 §	0.600			
(7) Category 3c - Capitated Payments to Non-Regulated Intermediaries	Included in Exhibit 7, Part 1, Column 1, Line 2 §	0.600			
(8) Category 4 - Medical & Hospital Expense Paid as Salary to Providers		0.750			
(8.1) Non-Contingent Salaries - Category 4	Exhibit 7, Part 1, Column 1, Line 9, in part §				
(8.2) Aggregate Cost Arrangements - Category 4	Exhibit 7, Part 1, Column 1, Line 10, in part §				
(8.3) Less Fee For Service Revenue from ASC or ASO	Company Records				
(9) Sub-Total Paid Claims	Exhibit 7, Part 1, Column 1, Lines 13 - 11 - (8.3) - (12) - (13)				
Stand-Alone Medicare Part D Coverage Claim Payments					
(10) Category 0 - No Federal Reinsurance or Risk Corridor Protection	Company Records	XXX	XXX		XXX
(11) Category 1 - Federal Reinsurance but no Risk Corridor Protection	Company Records	XXX	XXX		XXX
(12) Category 2a - No Federal Reinsurance but Risk Corridor Protection	Company Records	0.667			
(13) Category 3a - Federal Reinsurance and Risk Corridor Protection Apply	Company Records	0.767			
(14) Sub-Total Paid Claims	Sum of Lines (10) through (13)				
(15) Total Paid Claims	Sum of Lines (9) and (14)				
(16) Weighted Average Managed Care Discount					
(17) Weighted Average Managed Care Risk Adjustment Factor					

† This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision Managed Care Discount factor.
‡ This column is for the Medicare Part D Managed Care Discount factor.
§ Stand-Alone Medicare Part D business reported in Lines (12) and (13) would be excluded from these amounts.
* The factor is calculated on page XR019.

Denotes items that must be manually entered on filing software.

		Annual Statement Source	(1) Amount
*** Calculation of Category 2 Managed Care Factor**			
(18)	Withhold & Bonus/Incentives Payments, ***Prior Year***	Company Records	
(19)	Withhold & Bonuses/Incentives Available, ***Prior Year***	Company Records	
(20)	MCC Multiplier - Average Withhold Returned [Line (18)/(19)]		
(21)	Withholds & Bonuses/Incentives Available, ***Prior Year***	Company Records	
(22)	Claims Payments Subject to Withhold, ***Prior Year***	Company Records	
(23)	Average Withhold Rate, Prior Year [Line (21)/(22)]		
(24)	MCC Discount Factor, Category 2 Min{.25,[Lines (20) x (23)]}		

* The factor is pulled into Lines (3) and (4) on page XR018.

Denotes items that must be manually entered on filing software.

CREDIT RISK

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Reinsurance Ceded					
(1)	Recoverables on Paid Losses - 100% Owned Affiliates	Included in Schedule S, Part 2, Column 6, Line 1899999			
(2)	Recoverables on Paid Losses - Other Affiliates	Included in Schedule S, Part 2, Column 6, Line 1899999		0.005	
(3)	Recoverables on Paid Losses - Non-Affiliates	Schedule S, Part 2, Column 6, Line 2199999		0.005	
(4)	Total Recoverables on Paid Losses	Lines (1) + (2) + (3) (Schedule S, Part 2, Column 6, Line 2299999)			
(5)	Recoverables on Unpaid Losses - 100% Owned Affiliates	Included in Schedule S, Part 2, Column 7, Line 1899999			
(6)	Recoverables on Unpaid Losses - Other Affiliates	Included in Schedule S, Part 2, Column 7, Line 1899999		0.005	
(7)	Recoverables on Unpaid Losses - Non-Affiliates	Schedule S, Part 2, Column 7, Line 2199999		0.005	
(8)	Total Recoverables on Unpaid Losses	Lines (5) + (6) + (7) (Schedule S, Part 2, Column 7, Line 2299999)			
(9)	Unearned Premiums - 100% Owned Affiliates	Included in Schedule S, Part 3, Section 2, Column 9, Lines 0799999+ 1899999 + 2999999 + 4099999			
(10)	Unearned Premiums - Other Affiliates	Included in Schedule S, Part 3, Section 2, Column 9, Lines 0799999 + 1899999 + 2999999 + 4099999		0.005	
(11)	Unearned Premiums - Non-Affiliates	Included in Schedule S, Part 3, Section 2, Column 9, Lines 1099999 + 2199999 + 3299999 + 4399999		0.005	
(12)	Total Unearned Premiums	Lines (9) + (10) + (11)			
(13)	Other Reserve Credits - 100% Owned Affiliates	Included in Schedule S, Part 3, Section 2, Column 10, Lines 0799999 + 1899999 + 2999999 + 4099999			
(14)	Other Reserve Credits - Other Affiliates	Included in Schedule S, Part 3, Section 2, Column 10, Lines 0799999 + 1899999 + 2999999 + 4099999		0.005	
(15)	Other Reserve Credits - Non-Affiliates	Included in Schedule S, Part 3, Section 2, Column 10, Lines 1099999 + 2199999 + 3299999 + 4399999		0.005	
(16)	Total Other Reserve Credits	Lines (13) + (14) + (15)			
(17)	Total Reinsurance RBC	Lines (4) + (8) + (12) + (16)			
Capitations to Intermediaries					
(18)	Total Capitations Paid Directly to Providers	XR018, Column (2), Line (5)			
(19)	Less Secured Capitations to Providers	Company Records			
(20)	Capitations to Providers Subject to Credit Risk Charge	Lines (18) - (19)		0.020	
(21)	Total Capitations to Intermediaries	XR018, Column (2), Lines (6) + (7)			
(22)	Less Secured Capitations to Intermediaries	Company Records			
(23)	Capitations to Intermediaries Subject to Credit Risk Charge	Lines (21) - (22)		0.040	
(24)	Capitation Credit Risk RBC	Lines (20) + (23)			

Denotes items that must be manually entered on filing software.

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Other Receivables					
(25)	Investment Income Receivable	Page 2, Column 3, Line 14		0.010	
(26)	Health Care Receivables	Exhibit 3, Column 7, Line 0799999			
(26.1)	Pharmaceutical Rebate Receivables	Exhibit 3, Column 7, Line 0199999		*	
(26.2)	Claim Overpayment Receivables	Exhibit 3, Column 7, Line 0299999		**	
(26.3)	Loan and Advances to Providers	Exhibit 3, Column 7, Line 0399999		**	
(26.4)	Capitation Arrangement Receivables	Exhibit 3, Column 7, Line 0499999		**	
(26.5)	Risk Sharing Receivables	Exhibit 3, Column 7, Line 0599999		**	
(26.6)	Other Health Care Receivables	Exhibit 3, Column 7, Line 0699999		**	
(27)	Amounts Receivable Relating to Uninsured Accident and Health Plans	Included in Page 2, Column 3, Line 17		0.050	
(28)	Amounts Due from Parents, Subs, and Affiliates	Page 2, Column 3, Line 23		0.050	
(29)	Aggregate Write-Ins For Other Than Invested Assets	Page 2, Column 3, Line 25		0.050	
(30)	Total Other Receivables RBC	Line (25) + Sum Lines (26.1) through (29)			
(31)	Total Credit RBC	Lines (17) + (24) + (30)			

*** Line (26.1) Pharmaceutical Rebates - A factor of 0.200 will be applied to the first $5,000,000 in Column (1), and a factor of 0.030 will be applied to the remaining amount in excess of $5,000,000.**

****Lines (26.2)-(26.6) Non-Pharmaceutical Rebates - These lines are aggregated first and a factor of 0.400 will be applied to the first $10,000,000 in Column (1) and a factor of 0.050 will be applied to the remaining amount in excess of $10,000,000**

Denotes items that must be manually entered on filing software.

BUSINESS RISK

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Administrative Expense Risk					
(1)	Claims Adjustment Expenses	Page 4, Column 2, Line 20			
(2)	General Administrative Expenses	Page 4, Column 2, Line 21			
(3)	Less the Net Amount of ASC Revenue and Expenses Included in Lines 1 and 2	Company Records			
(4)	Less the Net Amount of ASO Revenue and Expenses Included in Lines 1 and 2	Company Records			
(5)	Less Admin Expenses for Commission & Premium Taxes	Underwriting & Investment Exhibit Part 3, Line 3, in part			
(6)	Administrative Expenses Base RBC	Lines (1) + (2) - (3) - (4) - (5)		*	
(7)	Proration of Admin Expense to Experience Fluctuation Risk	Lines (6) x (20)/(Lines (21) + (22))			
Non-Underwritten and Limited-Risk					
(8)	Administrative Expenses for ASC Arrangements	Company Records		0.020	
(9)	Administrative Expenses for ASO Arrangements	Company Records		0.020	
(10)	Medical Costs Paid Through ASC Arrangements (Including Fee-for Service Received From Other Health Entities)	Company Records		0.010	
(11)	Non-Underwritten and Limited Risk Business RBC				
Guaranty Fund Assessment Risk					
(12)	Premiums Subject to Guaranty Fund Assessment	Included in Sch T - Company Records		0.005	
Excessive Growth Risk					
(13)	UW Risk Revenue, Prior Year	**2023** XR013, Column (7), Line (6) *(manual entry)* †			
(14)	UW Risk Revenue, Current Year	**2024** XR013, Column (7), Line (6)			
(15)	Net UW Risk RBC, Prior Year	**2023** XR013, Column (7), Line (21) *(manual entry)* †			
(16)	Net UW Risk RBC, Current Year	**2024** XR013, Column (7), Line (21)			
(17)	RBC Growth Safe Harbor	[Lines (14)/(13)+.10] x Line (15)			
(18)	Excess of RBC Growth Over Safe Harbor	Max{0, Lines (16) - (17)}			
(19)	Excessive Growth Risk RBC	.5 x Line (18)			

			Premium	Weight	Weighted Premium
(20)	Experience Fluctuation Risk Revenue	XR013, Column (7), Line (6)			
(21)	Premiums Earned	Page 4, Column 2, Lines 2 + 3			
(22)	Risk Revenue	Page 4, Column 2, Line 5			
(23)	Tier 1 - $0 to $25 Million of Line (20)			0.070	
(24)	Tier 2 - Amount Over $25 Million of Line (20)			0.040	
(25)	Total Experience Fluctuation Risk Revenue	Lines (23) + (24)			
(26)	Administrative Expenses Base RBC Factor	Column (2), Line (25) / Column (1), Line (25)			

* The factor for the Administrative Expenses Base RBC is calculated as a weighted average, based on premium volume from XR013.

† For start-up health companies using projected amounts from the domicile state approved proforma, complete Footnote 1.

Denotes items that must be manually entered on filing software.

Footnote 1: If your company is a start-up health company that has received approval from your domiciliary state to use projected amounts in Lines (13) and (15), please explain the projections used.

FEDERAL ACA RISK ADJUSTMENT SENSITIVITY TEST

			(1)		(2)		(3)	(4)
	Overestimation of 25%	Annual Statement Source	Amount	Sensitivity Percentage	Subtotal Column (1) * Column (2)	Factor	RBC Result	Adjusted Capital
(1)	Premium Adjustments Receivable Due to ACA Risk Adjustment	Notes to Financial Statement 24E2a1		0.75		0.500		
(2)	Premium Adjustments Payable Due to ACA Risk Adjustment	Notes to Financial Statement 24E2a3		0.75		0.500		
(3)	Total ACA Risk Adjustments Payable Less Receivable	Line (2) - (1)						
(4)	Total Risk Adjustment	Absolute Value of Line (3)						
(5)	Total Adjusted Capital, Post-Deferred Tax	XR026, Column (2), Line (7)						
(6)	Total Adjusted Capital Stressed for Risk Adjustments	Line (5) - (4)						
(7)	Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)						
(8)	ACA Risk Adjusted ACL RBC Ratio	Line (6)/(7)						
	Underestimation of 25%							
(9)	Premium Adjustments Receivable Due to ACA Risk Adjustment	Column (1), Line (1)		1.25		0.500		
(10)	Premium Adjustments Payable Due to ACA Risk Adjustment	Column (1), Line (2)		1.25		0.500		
(11)	Total ACA Risk Adjustments Payable Less Receivable	Line (10) - (9)						
(12)	Total Risk Adjustment	Absolute Value of Line (11)						
(13)	Total Adjusted Capital, Post-Deferred Tax	XR026, Column (2), Line (7)						
(14)	Total Adjusted Capital Stressed for Risk Adjustments	Line (13) - (12)						
(15)	Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)						
(16)	ACA Risk Adjusted ACL RBC Ratio	Line (14)/(15)						

Footnote: If it is the belief of the company that the factors are not appropriate, provide an explanation as to why the factors are inappropriate. _____

_____

CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

			(1) RBC Amount
H0 - INSURANCE AFFILIATES AND MISC. OTHER AMOUNTS			
(1)	Off-Balance Sheet Items	XR005, Off-Balance Sheet Page, Line (21)	
(2)	Directly Owned Health Insurance Companies or Health Entities	XR003, Affiliates Page, Column (2), Line (1)	
(3)	Directly Owned Property and Casualty Insurance Affiliates	XR003, Affiliates Page, Column (2), Line (2)	
(4)	Directly Owned Life Insurance Affiliates	XR003, Affiliates Page, Column (2), Line (3)	
(5)	Indirectly Owned Health Insurance Companies or Health Entities	XR003, Affiliates Page, Column (2), Line (4)	
(6)	Indirectly Owned Property and Casualty Insurance Affiliates	XR003, Affiliates Page, Column (2), Line (5)	
(7)	Indirectly Owned Life Insurance Affiliates	XR003, Affiliates Page, Column (2), Line (6)	
(8)	Affiliated Alien Insurers - Directly Owned	XR003, Affiliates Page, Column (2), Line (9) + (10) + (11)	
(9)	Affiliated Alien Insurers - Indirectly Owned	XR003, Affiliates Page, Column (2), Line (12) + (13) + (14)	
(10)	Total H0	Sum Lines (1) through (9)	
H1 - ASSET RISK - OTHER			
(11)	Holding Company in Excess of Indirect Subs	XR003, Affiliates Page, Column (2), Line (7)	
(12)	Investment Subsidiary	XR003, Affiliates Page, Column (2), Line (8)	
(13)	Investment in Upstream Affiliate (Parent)	XR003, Affiliates Page, Column (2), Line (15)	
(14)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	XR003, Affiliates Page, Column (2), Line (16)	
(15)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	XR003, Affiliates Page, Column (2), Line (17)	
(16)	Directly Owned Life Insurance Companies Not Subject to RBC	XR003, Affiliates Page, Column (2), Line (18)	
(17)	Affiliated Non-Insurer	XR003, Affiliates Page, Column (2), Line (19) + (20) + (21)	
(18)	Fixed Income Assets	XR006, Off-Balance Sheet Collateral, Lines (27) + (37) + (38) + (39) + XR007, Fixed Income Assets - Bonds, Line (27) + XR008, Fixed Income Assets - Miscellaneous, Line **(25)**	
(19)	Replication & Mandatory Convertible Securities	XR009, Replication/MCS Page, Line (9999999)	
(20)	Unaffiliated Preferred Stock	XR006, Off-Balance Sheet Collateral, Line (34) + XR010, Equity Assets Page, Line (7)	
(21)	Unaffiliated Common Stock & **Market Value Excess Affiliated Stocks**	XR006, Off-Balance Sheet Collateral, Line (35) + XR010, Equity Assets Page, Line (13)	
(22)	Property & Equipment	XR006, Off-Balance Sheet Collateral, Line (36) + XR011, Prop/Equip Assets Page, Line (9)	
(23)	Asset Concentration	XR012, Grand Total Asset Concentration Page, Line (27)	
(24)	Total H1	Sum Lines (11) through (23)	
H2 - UNDERWRITING RISK			
(25)	Net Underwriting Risk	XR013, Underwriting Risk Page, Line (21)	
(26)	Other Underwriting Risk	XR015, Underwriting Risk Page, Line (25.3)	
(27)	Disability Income	XR015, Underwriting Risk Page, Lines (26.3) + (27.3) + (28.3) + (29.3) + (30.6) + (31.3) + (32.3)	
(28)	Long-Term Care	XR016, Underwriting Risk Page, Line (41)	
(29)	Limited Benefit Plans	XR017, Underwriting Risk Page, Lines (42.2) + (43.6) + (44)	
(30)	Premium Stabilization Reserve	XR017, Underwriting Risk Page, Line (45)	
(31)	Total H2	Sum Lines (25) through (30)	

Denotes items that must be manually entered on filing software.

CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

			(1) RBC Amount
H3 - CREDIT RISK			
(32)	Total Reinsurance RBC	XR020, Credit Risk Page, Line (17)	
(33)	Intermediaries Credit Risk RBC	XR020, Credit Risk Page, Line (24)	
(34)	Total Other Receivables RBC	XR021, Credit Risk Page, Line (30)	
(35)	Total H3	Sum Lines (32) through (34)	
H4 - BUSINESS RISK			
(36)	Administrative Expense RBC	XR022, Business Risk Page, Line (7)	
(37)	Non-Underwritten and Limited Risk Business RBC	XR022, Business Risk Page, Line (11)	
(38)	Premiums Subject to Guaranty Fund Assessments	XR022, Business Risk Page, Line (12)	
(39)	Excessive Growth RBC	XR022, Business Risk Page, Line (19)	
(40)	Total H4	Sum Lines (36) through (39)	
(41)	RBC after Covariance Before Basic Operational Risk	H0 + Square Root of ($H1^2 + H2^2 + H3^2 + H4^2$)	
(42)	Basic Operational Risk	0.030 x Line (41)	
(43)	C-4a of U.S. Life Insurance Subsidiaries	Company Records	
(44)	Net Basic Operational Risk	Line (42) - (43) (not less than zero)	
(45)	RBC After Covariance Including Basic Operational Risk	Lines (41) + (44)	
(46)	Authorized Control Level RBC	.50 x Line (45)	

Denotes items that must be manually entered on filing software.

CALCULATION OF TOTAL ADJUSTED CAPITAL

		Annual Statement Source	(1) Amount	Factor	(2) Adjusted Capital
Company Amounts					
(1)	Capital and Surplus	Page 3, Column 3, Line 33	$0	1.000	
Subsidiary Adjustments					
(2)	AVR - Life Subsidiaries	Affiliate's Statement §		1.000	
(3)	Dividend Liability - Life Subsidiaries	Affiliate's Statement		0.500	
(4)	Tabular Discounts - P&C Subsidiaries	Affiliate's Statement		-1.000	
(5)	Non-Tabular Discounts - P&C Subsidiaries	Affiliate's Statement		-1.000	
(6)	Carrying Value of Non-Admitted Insurance Affiliates	Included in XR002 Column (5) and Column (9)		1.000	
(7)	Total Adjusted Capital, Post-Deferred Tax				
Sensitivity Test					
(8)	DTA Value for Company	Page 2, Column 3, Line 18.2		1.000	
(9)	DTL Value for Company	Page 3, Column 3, Line 10.2		1.000	
(10)	DTA Value for Insurance Subsidiaries	Company Records		1.000	
(11)	DTL Value for Insurance Subsidiaries	Company Records		1.000	
(12)	Total Adjusted Capital, Pre-Deferred Tax (Sensitivity)	Lines (7) - (8) + (9) - (10) + (11)			
Ex DTA ACL RBC Ratio Sensitivity Test					
(13)	Deferred Tax Asset	Page 2, Column 3, Line 18.2		1.000	
(14)	Total Adjusted Capital Less Deferred Tax Asset	Line (7) less (13)			
(15)	Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)			
(16)	Ex DTA ACL RBC Ratio	Line (14)/(15)			0.000%

§ The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

Denotes items that must be manually entered on filing software.

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL

		Abbreviation	(1) Amount	(2) Result
(1)	Total Adjusted Capital, Post Tax			
(2)	Company Action Level = 200% of Authorized Control Level	CAL		
(3)	Regulatory Action Level = 150% of Authorized Control Level	RAL		
(4)	Authorized Control Level = 100% of Authorized Control Level	ACL		
(5)	Mandatory Control Level = 70% of Authorized Control Level	MCL		
(6)	Level of Action, if Any			

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE-YEAR HISTORY ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	
Authorized Control Level Risk-Based Capital on Line 15 of the Five-Year Historical Data Page	

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8		
(8)	Underwriting Deductions	Page 4, Line 23		
(9)	Combined Ratio	Line (8)/(7)	0.000%	
(10)	RBC Ratio	Line(1)/(4)	0.000%	
(11)	Trend Test Result	If Line (10) is between 200% and 300% and Line (9) > 105%, then "Yes," otherwise "No"		
(12)	Level of Action, if any, including Trend Test			

Denotes items that must be manually entered on filing software.

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