FINANCIAL SERVICES COMMISSION
Office of Insurance Regulation
Materials Available on the Web at:
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July 25, 2019

MEMBERS
Governor Ron DeSantis
Attorney General Ashley Moody
Chief Financial Officer Jimmy Patronis
Commissioner Nicole "Nikki" Fried

Contact: **Caitlin Murray**
(850-413-5005)

9:00 A.M.
LL-03, The Capitol
Tallahassee, Florida

ITEM	SUBJECT	RECOMMENDATION

1. Request for Approval of Minutes of the Financial Services Commission for March 12, 2019.

   http://www.myflorida.com/myflorida/cabinet/agenda19/0312/Transcript.pdf

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Publication of Rule 69N-121.003; Organizational Structure of the Office

   The deputy commissioner for business development and market research is deleted from the rule. The title for the deputy commissioner of life and health is amended to delete the reference to "and for specialty."

   (ATTACHMENT 2) **APPROVAL FOR PUBLICATION**

3. Request for Approval for Publication of Rule 69O-137.002; Annual Audited Financial Reports

   The rule is amended to add a section for internal audits and defines "internal audit function."

   (ATTACHMENT 3) **APPROVAL FOR PUBLICATION**

4. Request for Approval for Publication of Rule 69O-143.046; Registration of Insurers

   This rule is amended to update forms previously adopted.

   (ATTACHMENT 4) **APPROVAL FOR PUBLICATION**

5. Request for Approval for Publication of Rules 69O-156.003, .0075, .0086; Definitions; Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or

Certificates Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010; Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Newly Eligible Medicare Beneficiaries and with an Effective Date for Coverage on or After January 1, 2020

Chapter 69O-156 is amended to allow for a new product generation by adopting revisions to the NAIC Model Regulation.

(ATTACHMENT 5) **APPROVAL FOR PUBLICATION**

6. Request for Approval for Publication of Rule 69O-167.007; Supplementary Payment of Defense Costs

   Repeal of the rule due to the rule being obsolete or unnecessary.

   (ATTACHMENT 6) **APPROVAL FOR PUBLICATION**

7. Request for Approval for Publication of Rule 69O-189.003; Workers' Compensation: Application and Audit Procedures

   The rule is amended to reference section 92.525, FS, for sworn statements. The rule is amended remove notarization requirements in portions of the rule. A sentence allowing the acceptance of electronic notarization is deleted due to the notary requirement being removed.

   (ATTACHMENT 7) **APPROVAL FOR PUBLICATION**

8. Request for Approval for Final Adoption of Rules 69O-149.005, .006; Reasonableness of Benefits in Relation to Premiums; Actuarial Memorandum

   69O-149.005 is amended to allow an insurer to issue multiple year guarantee or rating cap provisions from 24 months to 60 months for accident only, accidental death and dismemberment, dental, hearing, hospital indemnity, hospital/surgical medical expense, intensive care, and vision plans. Rule 69O-149.006 is amended to update the experience on the form requirements and the actuarial certification requirements.

   (ATTACHMENT 8) **APPROVAL FOR FINAL ADOPTION**

9. Request for Approval for Final Adoption of Rule 69O-154.202; Definitions

   Rule 69O-154.202 is amended to update the definition of Commonly Accepted Actuarial Practice.

   (ATTACHMENT 9) **APPROVAL FOR FINAL ADOPTION**

10. Request for Final Adoption of Rules 69O-163.009, .011; Determination of Reasonableness of Benefits in Relation to Premium Charge; Credit Disability Insurance Rates

    Rule 69O-163.009 is amended to require the filing of Form OIR-B2-2213 to provide numerical and written justification when there is a deviation from prima facie rates. The maximum credit disability insurance premium rates are amended in Rule 69O-163.011.

(ATTACHMENT 10) **APPROVAL FOR FINAL ADOPTION**

11. Request for Approval for Final Adoption of Rules 69O-191.074, .076, .078; Records Retention; Corrective Action Plans; Subscriber Grievance Procedure

    Rule 69O-191.074 is amended to update and delete out of date references to government agencies and update the manner to retain records. Rule 69O-191.076 is amended to incorporate a form for filing a pro forma projection of an anticipated program. Rule 69O-191.078 is amended to delete references to the Statewide Subscriber Assistance Panel due to the repeal of section 408.7056, F.S.

    (ATTACHMENT 11) **APPROVAL FOR FINAL ADOPTION**

OFFICE OF INSURANCE REGULATION

GOVERNOR DESANTIS: Insurance Regulation. Commissioner Altmaier, you're up.

COMMISSIONER ALTMAIER: Good morning, Governor, Attorney General, CFO, Commissioner. It's good to see you each this morning.

We have, obviously, an agenda in front of you this morning.

The first item up is approval of the minutes from our December the 4th, 2018 meeting. And we respectfully request your approval of those minutes.

GOVERNOR DESANTIS: Is there a motion?

CFO PATRONIS: So move.

GOVERNOR DESANTIS: Second?

ATTORNEY GENERAL MOODY: Second.

COMMISSIONER FRIED: Second.

GOVERNOR DESANTIS: Any objections?

(NO RESPONSE).

GOVERNOR DESANTIS: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Excellent. Thank you.

Governor and Cabinet, if it's okay with you, Agenda Items 2, 3, 4 and 5 can likely be bundled

together. We're taking the same action on each of those rules.

Those are rules that we are publishing for input from stakeholders. And for the most part, most of those are clarifying in nature. We're updating manuals that have been updated that those rules reference.

No interested stakeholder requested a workshop on these, and so the process now is to publish those for additional feedback. And in light of the feedback that we do or don't receive, we will bring these back to the Cabinet for final adoption at a later date.

GOVERNOR DESANTIS: Is there a motion on these items?

CFO PATRONIS: Move 2, 3, 4 --

GOVERNOR DESANTIS: Second?

ATTORNEY GENERAL MOODY: Second.

GOVERNOR DESANTIS: Any objections?

(NO RESPONSE).

GOVERNOR DESANTIS: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

And similarly, Governor and Cabinet, if there are no objections, Items Number 6, 7, 8, 9 and 10

can also likely be bundled together. We're taking the same action on those rules.

They have -- these are rules that have been here already previously. They have been noticed; they have been published. We have not received any feedback on those.

Three of those are simply conforming these rules to amended statutes. Two of them are just simply updating manuals that are referenced by the rules, so noncontroversial events there.

We'd respectively ask for your approval on those agenda items.

GOVERNOR DESANTIS: Is there a motion on the items.

COMMISSIONER FRIED: So moved.

GOVERNOR DESANTIS: Second?

ATTORNEY GENERAL MOODY: Second.

GOVERNOR DESANTIS: Any objections?

(NO RESPONSE).

GOVERNOR DESANTIS: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

And then, finally, we have included in your materials our second quarter report for the fiscal year 2018/'19.

I'll allow you to look through that at your pleasure. I hope that you find it helpful. The only thing that I will mention is that what we have primarily been working on, as you can imagine, is the insurance industry's response to Hurricane Michael.

We have been publishing every couple of weeks claims information on our website. The most up-to-date information as of this morning is about 143,000 filed claims. That number has stabilized generally over the past four to six weeks.

The amount of insured losses, estimated insured losses is approximately 5.8 billion. That's a number that we do expect to continue to fluctuate upwards as the claims settlement process continues. We're obviously working very hard with our insurance industry.

We've appreciated the partnership, CFO Patronis, with the Department of Financial Services as we work with your Consumer Services Division. I know you've been very active in the community. We appreciate that, and we look forward to working with each of you as we continue to see to it that the insurance industry makes good on the promises that they've made to these consumers in that area.

With that, Governor and Cabinet, I'm available for any questions.

GOVERNOR DESANTIS: On the report, is there a motion to approve the report?

CFO PATRONIS: So move.

GOVERNOR DESANTIS: Second?

ATTORNEY GENERAL MOODY: Second.

GOVERNOR DESANTIS: All right. Any objections?

(NO RESPONSE).

GOVERNOR DESANTIS: Hearing none, the motion carries.

Do you have some questions?

CFO PATRONIS: Just a comment. Governor, I just wanted to brag on David, the efforts that he's been pushing forward with AOB reform this past legislative session. It's not easy.

He comes from a perspective where he's got to fight for the consumer and also fight for what is fair in making sure that we have a robust, healthy, you know, competitive market in the State of Florida. And he has been really working his tail off.

So, David, thank you for everything you're doing.

COMMISSIONER ALTMAIER: Thank you, CFO. I appreciate those comments. And likewise, thank you for your partnership. And to each of your offices, thank you for your availability to us as we work those tough issues.

GOVERNOR DESANTIS: Any other questions or comments.

(NO RESPONSE).

GOVERNOR DESANTIS: Okay. Thank you, Commissioner. Appreciate it.

COMMISSIONER ALTMAIER: Thank you. Have a great day.

* * * *

M E M O R A N D U M

DATE: July 2, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel

SUBJECT: Cabinet Agenda for July 25, 2019
Request for Approval to Publish Amendments to
Rule 69N-121.003
Assignment # 242192-19

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before July 17, 2019, and to the Financial Services Commission on July 25, 2019, with a request to approve for publication the proposed rule.

The Deputy commissioner for business development and market research is deleted from the rule. The title for the deputy commissioner of life and health is amended to delete the reference to "and for specialty." This rule is being amended to reflect the current organization of the Office of Insurance Regulation.

Sections 20.121(3)(b), F.S., is the rulemaking authority and laws implemented for this rule. Michael Lawrence, Jr. is the attorney handling this rule. Attached is the proposed rule.

Approved for signature:

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier, Commissioner
Office of Insurance Regulation

69N-121.003 Organizational Structure of the Office.

(1) Under the Commissioner of the Office are hereby established a chief of staff, a general counsel, and two ~~three~~ deputy commissioners as follows:

~~(a) Deputy commissioner for business development and market research;~~

(a)~~(b)~~ Deputy commissioner for property and casualty; and,

(b)~~(c)~~ Deputy commissioner for life and health ~~and for specialty~~.

(2) No change.

Rulemaking Authority 20.121(3)(b) FS. Law Implemented 20.121(3)(b) FS. History–New 12-22-05, Amended _____.

M E M O R A N D U M

DATE: July 2, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel

SUBJECT: Cabinet Agenda for July 25, 2019
Request for Approval to Publish Amendments to
Rule 69O-137.002
Assignment # 238076-18

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before July 17, 2019, and to the Financial Services Commission on July 25, 2019, with a request to approve for publication the proposed rule.

The rule is amended to add a section for internal audits and defines "internal audit function" to comply with revisions to NAIC model rule 205.

Sections 624.308(1); 624.4085; 624.424(8)(e), 624.307(1); 624.324; 624.424(8), F.S., are the rulemaking authority and laws implemented for this rule.

Michael Lawrence, Jr. is the attorney handling this rule. Attached is the proposed rule.

Approved for signature:

Anoush Brangaccio

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier

David Altmaier, Commissioner
Office of Insurance Regulation

69O-137.002 Annual Audited Financial Reports.

(1) through (2) No change.

(3) Definitions.

(a) through (b) No change.

(c) “Audit committee” means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or Group of insurers, the Internal audit function of an insurer or Group of insurers (if applicable), and external audits of financial statements of the insurer or Group of insurers. The Audit committee of any entity that controls a Group of insurers may be deemed to be the Audit committee for one or more of these controlled insurers solely for the purposes of this regulation at the election of the controlling person. Refer to paragraph (14)(e), for exercising this election. If an Audit committee is not designated by the insurer, the insurer’s entire board of directors shall constitute the Audit committee.

(d) through (h) No change.

(i) “Internal audit function” means a person or persons that provide independent, objective, and reasonable assurance designed to add value and improve an organization’s operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

(j)~~(i)~~ “Internal control over financial reporting” means a process effected by an entity’s board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in subparagraphs (5)(b)2. through 7. of this regulation, and includes those policies and procedures that:

1. through 3. No change.

(k)~~(j)~~ “Office” means the Office of Insurance Regulation.

(l)~~(k)~~ “SEC” means the United States Securities and Exchange Commission.

(m)~~(l)~~ “Section 404” means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC’s rules and regulations promulgated thereunder.

(n)~~(m)~~ “Section 404 Report” means management’s report on “internal control over financial reporting” as defined by the SEC and the related attestation report of the independent certified public accountant as described in paragraph (3)(a).

(o)~~(n)~~ "SOX Compliant Entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (i) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); (ii) the Audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and (iii) the Internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

(p)~~(o)~~ "Section 16 Report" means a Management's Report of Internal Control over Financial Reporting provided in subsection (16) of this rule.

(4) through (8) No change.

(9) Scope of Audit and Report of Independent Certified Public Accountant. Financial statements furnished pursuant to subsection (5), above, shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, *Consideration of Internal Control in a Financial Statement Audit*, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU 319, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to subsection (17) ~~(16)~~, the independent certified public accountant should consider (as that term is defined in AU Section 120 of the Professional Standards of the AICPA, *Defining Professional Requirements in Statements on Auditing Standards*) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration should also be given to the other procedures illustrated in the Financial Condition Examiner's Handbook promulgated by the National Association of Insurance Commissioners (incorporated by reference in rule 69O-138.001, F.A.C.) as the independent Certified Public Accountant deems necessary.

(10) through (13) No change.

(14) Requirements for Audit Committee.

This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.

(a) No change.

(b) The Audit committee of an insurer or Group of insurers shall be responsible for overseeing the insurer's Internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by subsection 15 of this Regulation.

(c)~~(b)~~ Each member of the Audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to paragraphs (f) ~~(e)~~ and (3)(c).

(d)~~(c)~~ In order to be considered independent for purposes of this section, a member of the Audit committee may not, other than in his or her capacity as a member of the Audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof.

(e)~~(d)~~ If a member of the Audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an Audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(f)~~(e)~~ To exercise the election of the controlling person to designate the Audit committee for purposes of this regulation, the ultimate controlling person shall provide written notice to the Office of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the Office by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(g)~~(f)~~1. The Audit committee shall require the accountant that performs for an insurer any audit required by this regulation to timely report to the Audit committee in accordance with the requirements of AU Section 380 of the Professional Standards of the AICPA, *Communication with Audit Committees*, including:

a. through c. No change.

2. If an insurer is a member of an insurance holding company system, the reports required by subparagraph (g)1., ~~(f)1.,~~ may be provided to the Audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the Audit committee.

(h)~~(g)~~ The proportion of independent Audit committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0 – 300,000,000	Over $300,000,000 – 500,000,000	Over 500,000,000

No minimum requirements. See also Notes A and B.	Majority (50% or more) of members shall be independent. See also Notes A and B.	Supermajority of members (75% or more) shall be independent. See also Note A.

Note A: The Office has authority afforded by Section 624.4085, F.S., to require the entity's board to enact improvements to the independence of the Audit committee membership if the insurer is in a Risk Based Capital action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than $500,000,000 in prior year direct written and assumed premiums are encouraged to structure their Audit committees with at least a supermajority of independent Audit committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

(i)~~(h)~~ An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may make application to the Office for a waiver from the subsection (14), requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from subsection (14), with the states that it is licensed in or doing business in and the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

(15) Internal Audit Function Requirements

(a) Exemption – An insurer is exempt from the requirements of this section if:

1. The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; and,

2. If the insurer is a member of a Group of insurers, the group has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

(b) Note: An insurer or Group of insurers exempt from the requirements of subsection (15) is encouraged, but not required, to conduct a review of the insurer business type, sources of capital, and other risk factors to determine whether an Internal audit function is warranted. The potential benefits of an Internal audit function should be assessed and compared against the estimated costs.

(c) Function – The insurer or Group of insurers shall establish an Internal audit function providing independent, objective, and reasonable assurance to the Audit committee and insurer management regarding the insurer's governance, risk management, and internal controls. This assurance shall be provided by performing general and specific audits, reviews, and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

(d) Independence – In order to ensure that internal auditors remain objective, the Internal audit function must be organizationally independent. Specifically, the Internal audit function will not defer ultimate judgment on audit matters to others, and shall appoint an individual to head the Internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

(e) Reporting – The head of the Internal audit function shall report to the Audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the Internal audit function's independence or effectiveness, material findings from completed audits, and the appropriateness of corrective actions implemented by management as a result of audit findings.

(f) Additional Requirements – If an insurer is a member of an insurance holding company system or included in a Group of insurers, the insurer may satisfy the Internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level.

(16)~~(15)~~ Conduct of Insurer in Connection with the Preparation of Required Reports and Documents.

(a) through (c) No change.

(17)~~(16)~~ Management's Report of Internal Control over Financial Reporting.

(a) through (e) No change.

(18)~~(17)~~ Exemptions and Effective Dates.

(a) through (e) No change.

(f) The requirements of subsection (17), ~~(16),~~ and other modified sections, except for subsection (14), covered above, are effective beginning with the reporting period ending December 31, 2010, and each year thereafter. An insurer or Group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file a report. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements.

(g) If an insurer or Group of insurers that has been exempt from the subsection 15 requirements no longer qualifies for that exemption, it shall have one year after the year the threshold is exceeded to comply with the requirements of this rule.

(19)~~(18)~~ Canadian and British Companies.

(a) through (b) No change.

(20)~~(19)~~ Severability Provision.

If any section or portion of this rule or its applicability to any person or circumstance is held invalid by a court, the remainder of the rule or the applicability of the provision to other persons or circumstances shall not be affected.

(21)(20) Standards Incorporated by Reference.

(a) through (b) No change.

Rulemaking Authority 624.308(1), 624.4085, 624.424(8)(e) FS. Law Implemented 624.307(1), 624.324, 624.424(8) FS. History–New 3-31-92, Amended 3-14-94, 8-17-98, 4-4-01, 8-14-02, Formerly 4-137.002, Amended 11-3-05, 9-21-10, _____.

M E M O R A N D U M

DATE: July 2, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel

SUBJECT: Cabinet Agenda for July 25, 2019
Request for Approval to Publish Amendments to
Rule 69O-143.046
Assignment # 219351-17

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before July 17, 2019, and to the Financial Services Commission on July 25, 2019, with a request to approve for publication the proposed rule.

The Office of Insurance Regulation is amending this rule to update forms previously adopted. Sections 624.308, 628.801, 624.307(1), 624.317, 624.424, 628.251, 628.461, F.S., are the rulemaking authority and laws implemented for this rule.

Michael Lawrence, Jr. is the attorney handling this rule. Attached are: 1) the proposed rule; and 2) the forms incorporated by reference.

Approved for signature:

Anoush Brangaccio

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier

David Altmaier, Commissioner
Office of Insurance Regulation

69O-143.046 Registration of Insurers.

(1) through (2) No change.

(3) Every insurer subject to registration shall file a registration statement on a Form OIR-D0-516, incorporated by reference in paragraph 69O-143.046(15)(a), F.A.C. ~~http://www.flrules.org/Gateway/reference.asp?No=Ref-08291, "Form B – Insurance Company Holding System Registration Statement," rev. 5/16.~~ The form shall provide current information about:

(a) through (g) No change.

(4) All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement filed on a Form OIR-A1-2116, incorporated by reference in paragraph 69O-143.046(15)(b), F.A.C. ~~"Form C – Summary of Changes to Registration Statement," new 5/16, http://www.flrules.org/Gateway/reference.asp?No=Ref-06550.~~

(6) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on an amended Form OIR-D0-516, incorporated by reference in paragraph 69O-143.046(15)(a), F.A.C., within fifteen calendar days after the end of the month in which it learns of each such change or addition. The amended Form OIR-D0-516 should only address those items which are being amended, and should include at the top of the cover page "Amendment No. [insert number] to Form B for [insert year]." Notwithstanding the provisions of this paragraph, dividends and other distributions to shareholders are to be reported to the Office pursuant to section 628.371, F.S.

(7) In addition to the registration statement required in subsection (3), each registered insurer, except foreign insurers subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in this rule and rule 69O-143.047, F.A.C., shall also provide on Form OIR-A1-2118, incorporated by reference in paragraph 69O-143.046(15)(c), F.A.C., ~~"Form F – Enterprise Risk Report, "new 5/16, http://www.flrules.org/Gateway/reference.asp?No=Ref-06552,~~ the information required under section 628.801(2), F.S.

(8) through (14) No change.

(15) The following forms are hereby ~~adopted and~~ incorporated by reference: ~~and are available at www.floir.com:~~

(a) Form OIR-D0-516, "Form B – Insurance Company Holding System Registration Statement," effective 09/18, available at www.flrules.org/XXXXX; ~~rev. 5/16; http://www.flrules.org/Gateway/reference.asp?No=Ref-06549;~~

(b) Form OIR-A1-2116, "Form C – Summary of Changes to Registration Statement," effective 09/18, available at www.flrules.org/XXXXX; ~~new 5/16; http://www.flrules.org/Gateway/reference.asp?No=Ref-06550;~~ and,

(c) Form OIR-A1-2118, "Form F – Enterprise Risk Report," effective 09/18, available at www.flrules.org/XXXXX. ~~new 5/16; http://www.flrules.org/Gateway/reference.asp?No=Ref-06552.~~

Rulemaking Authority 624.308, 628.801 FS. Law Implemented 624.307(1), 624.317, 624.424, 628.251, 628.461, 628.801 FS. History–New 12-16-70, Formerly 4-26.02, Amended 6-7-90, 1-30-91, Formerly 4-26.002, 4-143.046, Amended 5-31-16, 7-30-17, _____.

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of_____

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____, 20_____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____

_____

_____

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of control. As to each person specified in the chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system furnish the following information:

(a) Name;

(b) Home office address;

(c) Principal executive office address;

(d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;

(e) The principal business of the person;

(f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and

(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations.

ITEM 5. TRANSACTIONS AND AGREEMENTS

Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the registrant and its affiliates:

(a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(b) Purchases, sales or exchanges of assets;

(c) Transactions not in the ordinary course of business;

(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business;

(e) All management agreements, service contracts and all cost-sharing arrangements;

(f) Reinsurance agreements;

(g) Dividends and other distributions to shareholders;

(h) Consolidated tax allocation agreements; and

(i) Any pledge of the registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of Section 4 of the Act.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of 1% or less of the registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and relationship of the affiliated parties to the registrant.

ITEM 6. EMPLOYMENT CONTRACTS

Furnish the following information with regard to each employment contract entered into by the insurer and each of its affiliates with any of the other officers and/or directors of the insurer: name of employees, position held, annual remuneration, and other perquisites, and term of contact.

ITEM 7. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which the litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 8. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 9. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the Commissioner otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Commissioner. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.

Unless the Commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of the insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the *Personal Financial Statements Guide* by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or regulation Sections 4 and 6.

ITEM 10. FORM C REQUIRED

A Form C, Summary of Changes to Registration Statement (OIR-A1-2116), must be prepared and filed with this Form B.

ITEM 11. SIGNATURE AND CERTIFICATION

I have reviewed the above, and to the best of my knowledge, information and belief, it is true and correct.

_____	_____	_____
Date	Name	Position or Title

Sworn to and Subscribed before me this _____ day of _____, 20___.

_____ [SEAL]
Notary Public

FORM C

SUMMARY OF CHANGES TO REGISTRATION STATEMENT

Filed with the Insurance Department of the State of_____

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____
_____
_____
_____

Date:_____, 20_____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____
_____
_____

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description should identify the nature of the change and shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

SIGNATURE AND CERTIFICATION

I have reviewed the above, and to the best of my knowledge, information and belief, it is true and correct.

Date	Name	Position or Title

Sworn to and Subscribed before me this _____ day of _____ 19_____

_____

Notary Public (SEAL)

FORM F
ENTERPRISE RISK REPORT

Filed with the Insurance Department of the State of_____

By

_____
Name of Registrant/Applicant

On Behalf of/Related to Following Insurance Companies

Name Address

_____
_____
_____
_____

Date: _____, 20_____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____
_____
_____

ITEM 1. ENTERPRISE RISK

The Registrant/Applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in Section 628.801(2)(b), Florida Statutes, provided such information is not disclosed in the Insurance Holding Company System Annual Registration Statement filed on behalf of itself or another insurer for which it is the ultimate controlling person:

- Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;

- Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities within the insurance holding company system;

- Any changes of shareholders of the insurance holding company system exceeding ten percent (10%) or more of voting securities;

- Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system;

- Business plan of the insurance holding company system and summarized strategies for next 12 months;

- Identification of material concerns of the insurance holding company system raised by supervisory college, if any, in last year;

- Identification of insurance holding company system capital resources and material distribution patterns;

- Identification of any negative movement, or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook);

- Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and

- Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

The Registrant/Applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the Registrant/Applicant is not domiciled in the U.S., it may attach its most recent public audited financial statement filed in its country of domicile, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.

ITEM 2: OBLIGATION TO REPORT.

If the Registrant/Applicant has not disclosed any information pursuant to Item 1, the Registrant/Applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.

ITEM 3: SIGNATURE AND CERTIFICATION

SIGNATURE

Pursuant to the requirements of Section 4 of the Act, Registrant has caused this Enterprise Risk Report to be duly signed on its behalf of the City of _____ and State of _____ on the day of _____ , 20____.

(SEAL)_____
Name of Applicant

BY_____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached Enterprise Risk Report dated _____, 20___, for and on behalf of _____ (Name of Registrant); that (s)he is the _____ (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)_____

(Type or print name beneath) _____

M E M O R A N D U M

DATE: July 2, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel

SUBJECT: Cabinet Agenda for July 25, 2019
Request for Approval to Publish Amendments to
Rules 69O-156.003,.0075,.0086
Assignment # 227901-18

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before July 17, 2019, and to the Financial Services Commission on July 25, 2019, with a request to approve for publication the proposed rules.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015 and prohibits the sale of Medigap policies that cover Part B deductibles to "newly eligible" Medicare beneficiaries. On August 29, 2016, the National Association of Insurance Commissioners (NAIC) adopted revisions to the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (NAIC Model Regulation) to comply with MACRA. 69O-156.003 and 69O-156.0075 are amended and 69O-156.0086 is created to comply with amendments to the NAIC Model Regulation by NAIC.

Sections 624.308(1), 627.674(2), 627.6741(5) , 624.307(1), 627.410, 627.674, 627.6741, F.S., are the rulemaking authority and laws implemented for these rules.

Michael Lawrence, Jr. is the attorney handling these rules. Attached are: 1) the proposed rules, and 2) the form incorporated by reference.

Approved for signature:

Anoush Brangaccio

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier

David Altmaier, Commissioner
Office of Insurance Regulation

69O-156.003 Definitions.

For purposes of this rule:

(1) through (13) No change.

(14) "Newly Eligible Medicare Beneficiary" means anyone who attains age 65 on or after January 1, 2020, or who first becomes eligible for Medicare benefits due to age, disability, or end-stage renal disease on or after January 1, 2020.

(15)~~(14)~~ "Policy" as used herein is as defined in Section 627.672, F.S.

(16)~~(15)~~ "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

(17)~~(16)~~ "Pre-existing condition" shall not be defined to limit or preclude liability under a policy for a period longer than six (6) months because of a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of the coverage.

(18)~~(17)~~ "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to January 1, 1992.

(19)~~(18)~~ "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010.

(20)~~(19)~~ "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance with an effective date for coverage on or after June 1, 2010.

(21) "2020 Standardized Medicare supplement benefit plan," "2020 Standardized benefit plan," or "2020 plan" means

(a) For any eligible person, a group or individual policy of Medicare supplement insurance Plan A, B, D, G, High Deductible G, K, L, M, or N with an effective date for coverage on or after January 1, 2020; or

(b) For individuals eligible for Medicare prior to January 1, 2020, a group or individual policy of Medicare supplement insurance Plan A, B, C, D, F, High Deductible F, G, High Deductible G, K, L, M, or N with an effective date for coverage on or after January 1, 2020.

(22)~~(20)~~ "Replacement" is any transaction wherein new Medicare supplement insurance is to be purchased and it is known to the agent, broker or insurer at the time of application that, as a part of the transaction, existing accident and health insurance has been or is to be lapsed or the benefits thereof substantially reduced.

(23)~~(21)~~ "Secretary" means the Secretary of the United States Department of Health and Human Services.

Rulemaking Authority 624.308(1), 627.674(2), 627.6741(5) FS. Law Implemented 624.307(1), 627.674, 627.6741 FS. History–New 1-1-81, Formerly 4-51.03, Amended 11-7-88, 9-4-89, 12-9-90, Formerly 4-51.003, Amended 1-1-92, 7-14-96, 7-26-99, 3-4-01, Formerly 4-156.003, Amended 9-15-05, 1-4-10, Amended_____.

69O-156.0075 Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010.

The following standards are applicable to all 2010 Standardized Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of Rules 69O-156.006, 69O-156.007, and 69O-156.008, F.A.C.

(1) No change.

(2) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(a) through (f) No change.

(g) Home Health Care (Parts A & B) Medicare Approved Services: Medically necessary skilled care services and medical supplies.

(3) No change.

Rulemaking Authority 624.308(1), 627.674(2)~~(a)~~ FS. Law Implemented 624.307(1), 627.410, 627.674, 627.6741 FS. History–New 1-4-10, Amended _____.

69O-156.0086 Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Newly Eligible Medicare Beneficiaries with an Effective Date for Coverage on or After January 1, 2020.

No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to Newly Eligible Medicare Beneficiary. In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. No. 114-10, 129 Stat. 87 (2015)), all policies must comply with the following benefit standards:

(1) Benefit Requirements. The standards and requirements of this rule apply to all Medicare supplement policies or certificates delivered or issued for delivery to Newly Eligible Medicare Beneficiary. Standardized Medicare supplement benefit Plans C, F, and F with High Deductible, as defined in paragraphs 69O-156.0085(5)(c), (e), and (f), F.A.C., may not be offered to Newly Eligible Medicare Beneficiaries.

(2) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing the basic (core) benefits, as defined in paragraph (6)(a).

(3) If an issuer makes available any of the additional benefits described in paragraphs (6)(b)-(i), then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subsection (2) above, a policy form or certificate form containing either standardized Medicare supplement benefit Plan D as described in paragraph (6)(c) or standardized Medicare supplement benefit Plan G as described in paragraph (6)(d).

(4) Applicability to Certain Individuals. This rule applies only to Newly Eligible Medicare Beneficiaries who are enrolled in Medicare Part B:

(a) By reason of attaining age 65 on or after January 1, 2020; or

(b) By reason of entitlement to benefits under Part A pursuant to sections 226(b) or 226A of the Social Security Act (42 U.S.C. §§ 426(b), 426-1) or who are deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

(5)(a) Benefit plans shall conform in structure, language, designation, and format to the standard benefit plans listed in this subsection (6) and the definitions in Rule 69O-156.003, F.A.C., and must include a copy of Form OIR-B2-MSC2, Outline of Coverage, Benefit Plans, Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020, effective 01/20.

(b) Form OIR-B2-MSC2, Outline of Coverage, Benefit Plans, Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020, effective 01/20, is hereby incorporated by reference and available at www.flrules.org/XXXXX and may be printed from the Office's website: http://www.floir.com/Sections/LandH/Medicare/MedicareForms.aspx.

(6) Make-up of 2020 Standardized Benefit Plans:

(a) Standardized Medicare supplement benefit Plan A shall include only the following:

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

4. Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations.

5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

7. Home Health Care (Parts A & B) Medicare Approved Services: Medically necessary skilled care services and medical supplies.

(b) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in paragraph (6)(a), plus one hundred percent (100%) of the Medicare Part A deductible amount per benefit period.

(c) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit, as defined in paragraph (6)(a), plus one hundred percent (100%) of the Medicare Part A deductible amount per benefit period; Skilled Nursing Facility Care Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A; and Medically Necessary Emergency Care in a Foreign Country, which is Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, if such care would have been covered by Medicare if provided in the United States and if such care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.

(d) Standardized Medicare supplement [regular] Plan G shall include only the following: The basic (core) benefit as defined in paragraph (6)(a), plus one hundred percent (100%) of the Medicare Part A deductible amount per benefit period; Skilled Nursing Facility Care Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A; one hundred percent (100%) of the Medicare Part B excess charges and Medically Necessary Emergency Care in a Foreign Country, which is Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, if such care would have been covered by Medicare if provided in the United States and if such care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.

(e) Standardized Medicare supplement Plan G With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in subparagraph 2. below.

1. The basic (core) benefit and additional benefits as defined in paragraph (6)(d).

2. The annual deductible in standardized Medicare supplement Plan G With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by standardized Medicare supplement [regular] Plan G. The basis for the deductible shall be $2,240 and shall be adjusted annually from 2018 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, rounded to the nearest multiple of ten dollars ($10).

(f) Standardized Medicare supplement Plan K shall include only the following:

1. Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period.

2. Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

3. Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

4. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 11.

5. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 11.

6. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 11.

7. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) until the out-of-pocket limitation is met as described in subparagraph 11.

8. Home Health Care (Parts A & B) Medicare Approved Services: Coverage for fifty percent (50%) of medically necessary skilled care services and medical supplies.

9. Part B Cost Sharing: Coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 11.

10. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

11. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B. The basis for the out-of-pocket limitation shall be $5,240 and shall be adjusted annually from 2018 by the Secretary of the U.S. Department of Health and Human Services to reflect the appropriate inflation adjustment.

(g) Standardized Medicare supplement Plan L shall include only the following:

1. Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

2. Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

3. Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

4. Medicare Part A Deductible: Coverage for seventy-five percent (75%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 11.

5. Skilled Nursing Facility Care: Coverage for seventy-five percent (75%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 11;

6. Hospice Care: Coverage for seventy-five percent (75%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 11.

7. Blood: Coverage for seventy-five percent (75%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) until the out-of-pocket limitation is met as described in subparagraph 11.

8. Home Health Care (Parts A & B) Medicare Approved Services: Coverage for seventy-five percent (75%) of medically necessary skilled care services and medical supplies.

9. Part B Cost Sharing: Coverage for seventy-five percent (75%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 11.

10. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

11. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B. The basis for the out-of-pocket limitation shall be $5,240 and shall be adjusted annually from 2018 by the Secretary of the U.S. Department of Health and Human Services to reflect the appropriate inflation adjustment.

(h) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in paragraph (6)(a), plus fifty percent (50%) of the Medicare Part A deductible amount per benefit period; Skilled Nursing Facility Care Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A; and Medically Necessary Emergency Care in a Foreign Country, which is Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, if such care would have been covered by Medicare if provided in the United States and if such care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.

(i) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in paragraph (6)(a), plus one hundred percent (100%) of the Medicare Part A deductible amount per benefit period; Skilled Nursing Facility Care Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A; and Medically Necessary Emergency Care in a Foreign Country, which is Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, if such care would have been covered by Medicare if provided in the United States and if such care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000; and Part B coverage with co-payments in the following amounts:

1. The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists).

2. The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

For purposes of this subsection, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(7) New or Innovative Benefits: An issuer may, with the prior written approval of the Office, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals who are not a Newly Eligible Medicare Beneficiary remain subject to the requirements of Rules 69O-156.0075 and 69O-156.0085, F.A.C.

Rulemaking Authority 624.308(1), 627.674(2) FS. Law Implemented 624.307(1),627.410, 627.674, 627.6741 FS. History-New .

FLORIDA OFFICE OF INSURANCE REGULATION - LIFE & HEALTH PRODUCT REVIEW

[Company name]
OUTLINE OF COVERAGE
Benefit Plans _____ [insert letters of plans being offered]
Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020
NOTICE TO BUYER: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only+	
	A	B	D	G1	K	L	M	N	C	F1
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply3	✔	✔
Blood (first 3 pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in [2018]2					[$5,240]2	[$2,620]2				

Note: A ✓means 100% of the benefit is paid. **+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.** This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Every company must make Plan A available.

1 - Plans F and G also have a high deductible option which require first paying a plan deductible of [$2240] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible Plans F and G do not cover the separate Foreign travel emergency deductible. High deductible Plan G does not cover the Medicare Part B deductible. However, high deductible Plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 - Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 - Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

BASIC BENEFITS

Hospitalization –Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses –Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
Blood –First three pints of blood each year.
Hospice— Part A coinsurance.

PREMIUM INFORMATION

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in the state of Florida.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

NOTICE

[[for agents:] Neither [insert company's name] nor its agents are connected with Medicare.]
[[for direct response:] [insert company's name] is not connected with Medicare.]

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details. Use this outline to compare benefits and premiums among policies.

POLICY REPLACEMENT
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

COMPLETE ANSWERS ARE VERY IMPORTANT
When you fill out the application for the new policy, and it is **NOT** an "Open Enrollment or Guaranteed Issue status application," be sure to answer truthfully and completely all questions about your medical and health history. The policy is issued on the basis that the answers to all questions and all information shown in the application are correct and complete. The company may cancel your policy and refuse to pay any claims if you make misstatements, leave out or falsify important information. Review the application carefully before you sign it. Be certain that all information has been properly recorded. To review "Open Enrollment" timeframes please go to the following link on the Medicare.gov website:

https://www.medicare.gov/supplement-other-insurance/when-can-i-buy-medigap/when-can-i-buy-medigap.html

[NOTICE

Form OIR-B2-MSC2
Effective 01/20
Incorporated by Reference in Rule 69O-156.0086, F.A.C.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included here. An issuer may use additional benefit plan designations on these charts pursuant to Rule 69O-156.0085(4), F.A.C.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$0	$[1340] (Part A deductible)
61st thru 90th day	All but $[335]	$[335] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[670]	$[670] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	$0	$0
21st thru 100th day	All but $[167.50] /day	$0	Up to $[167.50] / day
101st day and after	$0	$0	All costs

PLAN A

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies			
—Durable medical equipment	100%	$0	$0
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[1340] (Part A deductible)	$0
61st thru 90th day	All but $[335]	$[335] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[670]	$[670] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility Within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	$0	$0
21st thru 100th day	All but $[167.50] /day	$0	Up to $[167.50] / day
101st day and after	$0	$0	All costs

PLAN B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies			
—Durable medical equipment	100%	$0	$0
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C+

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[1340] (Part A deductible)	$0
61st thru 90th day	All but $[335]	$[335] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[670]	$[670] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility Within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	$0	$0
21st thru 100th day	All but $[167.50] /day	Up to $[167.50] / day	$0
101st day and after	$0	$0	All costs

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN C+

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN C+

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN C+

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment First $[183] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $[183] (Part B deductible) 20%	$0 $0 $0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[1340] (Part A deductible)	$0
61st thru 90th day	All but $[335]	$[335] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[670]	$[670] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	$0	$0
21st thru 100th day	All but $[167.50] /day	Up to $[167.50] / day	$0
101st day and after	$0	$0	All costs

PLAN D

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies			
—Durable medical equipment	100%	$0	$0
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deduct.)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F+

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [$2240] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$2240]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[1340] (Part A deductible)	$0
61st thru 90th day	All but $[335]	$[335] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[670]	$[670] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	$0	$0
21st thru 100th day	All but $[167.50] /day	Up to $[167.50] / day	$0
101st day and after	$0	$0	All costs

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN F or HIGH DEDUCTIBLE PLAN F+

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN F or HIGH DEDUCTIBLE PLAN F+

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [$2240] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$2240]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $[183] of Medicare Approved Amounts*	$0	$[183] (Part B Deductible)	
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$[183] (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN F or HIGH DEDUCTIBLE PLAN F+

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
CLINICAL LABORATORY SERVICES—-TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	$0	$0
First $[183] of Medicare Approved Amounts*	$0	$[183] (Unless Part B deductible has been met)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN F or HIGH DEDUCTIBLE PLAN F+
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,]** YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2240] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[1340] (Part A deductible)	$0
61st thru 90th day	All but $[335]	$[335] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[670]	$[670] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	$0	$0
21st thru 100th day	All but $[167.50] /day	Up to $[167.50] / day	$0
101st day and after	$0	$0	All costs

PLAN G or HIGH DEDUCTIBLE PLAN G

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2240] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
CLINICAL LABORATORY SERVICES—-TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	$0	$0
-First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
-Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN G or HIGH DEDUCTIBLE PLAN G
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,]** YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[5240] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[670] (50% of Part A deductible)	$[670] (50% of Part A deductible) ♦
61st thru 90th day	All but $[335]	$[335] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[670]	$[670] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	$0	$0
21st thru 100th day	All but $[167.50] /day	Up to $[83.75] / day	Up to $[83.75] / day ♦
101st day and after	$0	$0	All costs

PLAN K

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD			
First 3 pints	$0	50%	50% ♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	50% of co-payment/ coinsurance	50% of co-payment/ coinsurance♦

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $[183] of Medicare Approved Amounts****	$0	$0	$[183] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$5240])*
BLOOD First 3 pints	$0	50%	50%♦
Next $[183] of Medicare Approved Amounts****	$0	$0	$[183] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[5240] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies			
—Durable medical equipment	100%	$0	$0
First $[183] of Medicare Approved Amounts*****	$0	$0	$[183] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN L

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[1005] (75% of Part A deductible)	$[335] (25% of Part A deductible) ♦
61st thru 90th day	All but $[335]	$[335] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[670]	$[670] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	$0	$0
21st thru 100th day	All but $[167.50] /day	Up to $[125.63] / day	Up to $[41.87] / day ♦
101st day and after	$0	$0	All costs

PLAN L

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD			
First 3 pints	$0	75%	25% ♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/ coinsurance	25% of co-payment/ coinsurance♦

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $[183] of Medicare Approved Amounts****	$0	$0	$[183] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2620])*
BLOOD First 3 pints	$0	75%	25%♦
Next $[183] of Medicare Approved Amounts****	$0	$0	$[183] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2620] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies			
—Durable medical equipment	100%	$0	$0
First $[183] of Medicare Approved Amounts*****	$0	$0	$[183] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[670] (50% of Part A deductible)	$[670] (50% of Part A deductible)
61st thru 90th day	All but $[335]	$[335] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[670]	$[670] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	$0	$0
21st thru 100th day	All but $[167.50] /day	Up to $[167.50] / day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 Pints	$0
Additional amounts	100%	$0	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$0

PLAN M

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies			
—Durable medical equipment	100%	$0	$0
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[1340] (Part A deductible)	$0
61st thru 90th day	All but $[335]	$[335] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[670]	$[670] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	$0	$0
21st thru 100th day	All but $[167.50] /day	Up to $[167.50] / day	$0
101st day and after	$0	$0	All costs

PLAN N

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 Pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies			
—Durable medical equipment	100%	$0	$0
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

M E M O R A N D U M

DATE: July 2, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel

SUBJECT: Cabinet Agenda for July 25, 2019
Request for Approval to Publish Repeal of
Rule 69O-167.007
Assignment # 238962

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before July 17, 2019, and to the Financial Services Commission on July 25, 2019, with a request to approve for publication the proposed rule.

Repeal of the rule due to the rule being obsolete or unnecessary.

Sections 624.308(1), 624.307(1), 626.9641(1)(b), F.S., are the rulemaking authority and laws implemented for this rule.

Michael Lawrence, Jr. is the attorney handling this rule. Attached is the proposed rule.

Approved for signature:

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier, Commissioner
Office of Insurance Regulation

69O-167.007 Supplementary Payment of Defense Costs.

Any insurer issuing a commercial general liability contract shall provide for defense costs in addition to the limit of liability for the contract.

(1) Defense costs may be included within coverage limits for contracts for:

(a) Professional liability where liability limits are not specified in a statute requiring such coverage,

(b) Pollution liability, and

(c) Asbestos abatement.

(2) In addition to the three exceptions in subsection (1) above, the Office shall permit other types of liability contracts to include defense costs within the limit of liability if the insurer establishes that such policy provision is in the best interests of policyholders and the public. The best interests of the public shall be determined by the Office upon consideration of the following criteria:

(a) Demand for product,

(b) Sophistication of prospective consumers,

(c) Level of defense costs generally associated with risk,

(d) Disclosure provisions, and

(e) Policy coverage limits.

(3) This rule shall not be construed as requiring an insurer to incur defense costs accruing after it has tendered policy limits.

Rulemaking Authority 624.308(1) FS. Law Implemented 624.307(1), 626.9641(1)(b) FS. History–New 8-4-92, Amended 9-19-94, Formerly 4-167.007.

69O-167.007 Supplementary Payment of Defense Costs.

~~Any insurer issuing a commercial general liability contract shall provide for defense costs in addition to the limit of liability for the contract.~~

~~(1) Defense costs may be included within coverage limits for contracts for:~~

~~(a) Professional liability where liability limits are not specified in a statute requiring such coverage,~~

~~(b) Pollution liability, and~~

~~(c) Asbestos abatement.~~

~~(2) In addition to the three exceptions in subsection (1) above, the Office shall permit other types of liability contracts to include defense costs within the limit of liability if the insurer establishes that such policy provision is in the best interests of policyholders and the public. The best interests of the public shall be determined by the Office upon consideration of the following criteria:~~

~~(a) Demand for product,~~

~~(b) Sophistication of prospective consumers,~~

~~(c) Level of defense costs generally associated with risk,~~

~~(d) Disclosure provisions, and~~

~~(e) Policy coverage limits.~~

~~(3) This rule shall not be construed as requiring an insurer to incur defense costs accruing after it has tendered policy limits.~~

Rulemaking Authority 624.308(1) FS. Law Implemented 624.307(1), 626.9641(1)(b) FS. History–New 8-4-92, Amended 9-19-94, Formerly 4-167.007, Repealed _____.

M E M O R A N D U M

DATE: July 2, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel

SUBJECT: Cabinet Agenda for July 25, 2019
Request for Approval to Publish Amendments to
Rule 69O-189.003
Assignment # 233359-18

The Office of Insurance Regulation requests that this proposed rule repeal be presented to the Cabinet aides on or before July 17, 2019, and to the Financial Services Commission on July 25, 2019, with a request to approve for publication the proposed rule.

The rule is amended to reference section 92.525, FS, for sworn statements. The rule is amended to remove notarization requirements in portions of the rule. A sentence allowing the acceptance of electronic notarization is deleted due to the notary requirement being removed. Sections 440.381, 624.308(1), 440.105(4)(b)5., 624.307, 624.424(1)(c), F.S., are the rulemaking authority and laws implemented for this rule.

Michael Lawrence, Jr. is the attorney handling this rule. Attached are: 1) the proposed rule and; 2) the form incorporated by reference.

Approved for signature:

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier, Commissioner
Office of Insurance Regulation

69O-189.003 Workers' Compensation: Application and Audit Procedures.

(1)(a) Each employer applying to a carrier in the voluntary market for workers' compensation coverage required by section 440.38, F.S., shall use Form ACORD 130 FL (rev. 2019/07) ~~Form ACORD 130 FL (rev. 2015/02)~~, ~~"~~Florida Workers~~'~~ Compensation Application,~~"~~ which is hereby adopted and incorporated by reference. The form shall be completed and submitted to the carrier with which the employer wishes to contract for coverage.

(b) A carrier wishing to use its own application form shall submit the form electronically to the Florida Office of Insurance Regulation (Office) at http://www.floir.com/iportal, and receive approval prior to its use.

1. through 2. No change.

3. The application shall contain a sworn statement by the employer which complies with section 92.525, F.S., attesting to the accuracy of the information submitted.

4. The application shall contain a sworn statement by the agent which complies with section 92.525, F.S., attesting that the agent explained to the employer or officer the classification codes that are used for premium calculations.

(c) Each employer applying for workers' compensation coverage in the Florida Workers' Compensation Joint Underwriting Association (FWCJUA) shall use Form ACORD 130 FL (2019/07) ~~ACORD Form 130 FL (rev. 2015/02)~~ unless the FWCJUA files and receives approval by the Office of Insurance Regulation to use a different application form in accordance with paragraph (1)(b). The FWCJUA shall submit any addendum to the application to the Office and receive approval prior to using. The completed application and all addenda shall be submitted to the FWCJUA at the address on the form.

(d) Form ACORD 130 FL (rev. 2019/07) is available: ~~The forms adopted in this subsection (1), may be obtained from the Office's website at: http://www.floir.com/iportal.~~

1. From ACORD at https://www.acord.org/home; and,

2. For inspection during regular business hours at the Office of Insurance Regulation, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0300.

(2)(a) No change.

(b) The employer shall sign the application. ~~The applicant's signature on the applicant form shall be notarized to the extent that such notarization complies with parts I and II of chapter 668, F.S. The carrier is authorized to require the producer's signature to be notarized to the extent that such notarization complies with parts I and II of chapter 668, F.S.~~

(c) No change.

~~(d) It is permissible for insurers to accept electronic notarizations in satisfaction of the application notarization requirements to the extent that such acceptance of electronic notarizations complies with parts I and II of chapter 668, F.S.~~

(3) through (4) No change.

Rulemaking Authority 440.381, 624.308(1) FS. Law Implemented 440.105(4)(b)5., 440.381, 624.307, 624.424(1)(c) FS. History–New 8-1-91, Formerly 4-28.007, Amended 10-3-95, 10-10-96, 1-15-98, 11-21-00, 11-5-02, 9-22-03, Formerly 4-189.003, Amended 3-29-05, 3-10-10, _____.

ACORD

FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

PRODUCER	PHONE (A/C, No, Ext): / FAX (A/C, No):	COMPANY	UNDERWRITER
		APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, ALONG WITH THEIR FEIN	
		MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES ☐ CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED	
LICENSE #: / CODE: SUB CODE:		YRS IN BUS / SIC CODE	☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORPORATION ☐ SUBCHAPTER "S" CORP ☐ OTHER:
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER	NCCI ID NUMBER / OTHER RATING BUREAU ID NUMBER

STATUS OF SUBMISSION

☐ QUOTE ☐ ISSUE POLICY

BILLING / AUDIT INFORMATION

BILLING PLAN	PAYMENT PLAN		AUDIT	
☐ AGENCY BILL	☐ ANNUAL	☐ PREM FINANCED	☐ AT EXPIRATION	☐ MONTHLY
☐ DIRECT BILL	☐ SEMI-ANNUAL	☐ OTHER:	☐ SEMI-ANNUAL	☐ OTHER:
	☐ QUARTERLY	% DOWN:	☐ QUARTERLY	

LOCATIONS -

LIST ALL PHYSICAL LOCATIONS, INCLUDING OTHER STATES, WHETHER COVERAGE IS REQUESTED OR NOT. IF APPLICANT IS A PROFESSIONAL EMPLOYER ORGANIZATION (PEO) / EMPLOYEE LEASING COMPANY, LIST ALL CLIENT COMPANIES AND THEIR LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	☐ PARTICIPATING ☐ NON-PARTICIPATING	RETRO PLAN

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLE	OTHER COVERAGES
	$ EACH ACCIDENT			☐ U.S.L. & H.
	$ DISEASE - POLICY LIMIT		COINSURANCE LIMIT	☐ VOLUNTARY COMPENSATION
	$ DISEASE - EACH EMPLOYEE			☐

DIVIDEND PLAN / SAFETY GROUP	ADDITIONAL COMPANY INFORMATION

RATING INFORMATION

☐ CHECK HERE IF LIST OF ADDITIONAL CLASS CODES ATTACHED

LOC	CLASS CODE	COM-PANY USE	CATEGORIES, DUTIES, CLASSIFICATIONS	# OF EM-PLOYEES	ACTUAL REMUNERATION PAST 12 MONTHS	ESTIMATED REMUNERATION FOR NEXT POLICY PERIOD	RATE	ESTIMATED ANNUAL PREMIUM

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS

	FACTOR	FACTORED PREMIUM
TOTAL		$
		$
		$
EXPERIENCE MODIFICATION		$
MODIFIED PREMIUM		$
PREMIUM DISCOUNT		$
EXPENSE CONSTANT	N/A	$
TOTAL ESTIMATED ANNUAL PREMIUM		$
MINIMUM PREMIUM $	DEPOSIT PREMIUM	$

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, OWNERS TO BE INCLUDED OR EXCLUDED. (REMUNERATION TO BE INCLUDED MUST BE PART OF RATING INFORMATION SECTION.) ATTACH LIST OF ADDITIONS/EXEMPTIONS, IF ANY. PROVIDE COPIES OF EVIDENCE OF EXCLUSIONS/INCLUSIONS. DISCLOSURES OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY, AS AN ALTERNATIVE, ATTACH A COPY OF EXEMPTION OR INCLUSION FORM FILED WITH THE STATE OF FLORIDA.

#	NAME	DATE OF BIRTH	SOCIAL SECURITY #	TITLE / RELATIONSHIP	OWNR-SHP %	DUTIES	INC / EXC	CLASS CODE	REMUNERATION
1									
2									
3									

PRIOR CARRIER INFORMATION / LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS ☐ LOSS RUN ATTACHED

YEAR	CARRIER & POLICY NUMBER	ACTUAL/AUDITED PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF ALL BUSINESSES, OPERATIONS AND PRODUCTS (INCLUDING OTHER STATES): MANUFACTURING - RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR - TYPE OF WORK, SUB-CONTRACTS; MERCANTILE - MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE - TYPE, LOCATION; FARM - ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS. IF CONTRACTOR, PROVIDE LICENSE NUMBER.

☐ PROFESSIONAL EMPLOYER ORGANIZATION (PEO) / EMPLOYEE LEASING COMPANY ☐ TEMPORARY EMPLOYMENT SERVICE

EMPLOYEES - ATTACH A LIST OF ADDITIONAL EMPLOYEE NAMES

NAME	CLASS CODE	SOCIAL SECURITY #	NAME	CLASS CODE	SOCIAL SECURITY #

ATTACH THE LAST FOUR (4) EMPLOYERS QUARTERLY REPORTS OR IRS FORM 941. PLEASE EXPLAIN IF THE EMPLOYERS QUARTERLY REPORTS OR 941 IS NOT AVAILABLE. DISCLOSURE OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY. AS AN ALTERNATIVE, THE LATEST EMPLOYERS QUARTERLY REPORT WITH CLASS CODES ADDED CAN BE USED IN LIEU OF A SEPARATE LISTING OF EMPLOYEE NAMES, SOCIAL SECURITY NUMBER AND CLASS CODE. ANY EMPLOYEES NOT ON THE EMPLOYERS QUARTERLY REPORT SHOULD BE SHOWN SEPARATELY.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?			16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)			17. ANY OTHER INSURANCE WITH THIS INSURER?		
			18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED (Last 3 years)?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS / SUBSIDIARY?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
6. ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			23. WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? $		
8. IS A FORMAL SAFETY PROGRAM IN OPERATION?			24. IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?		
9. ANY GROUP TRANSPORTATION PROVIDED?			**CONTACT INFORMATION**		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			**IN-SPECTION** PHONE:		
11. ANY PART TIME OR SEASONAL EMPLOYEES?			NAME:		
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?			**ACCTNG RECORD** PHONE:		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			NAME:		
14. DO EMPLOYEES TRAVEL OUT OF STATE?			**CLAIMS INFO** PHONE:		
15. ARE ATHLETIC TEAMS SPONSORED?			NAME:		

REMARKS

THE FILING OF AN APPLICATION CONTAINING FALSE, MISLEADING, OR INCOMPLETE INFORMATION PROVIDED WITH THE PURPOSE OF AVOIDING OR REDUCING THE AMOUNT OF PREMIUMS FOR WORKERS' COMPENSATION COVERAGE IS A FELONY OF THE THIRD DEGREE, PUNISHABLE AS PROVIDED IN S. 775.082, S. 775.083, OR S. 775.084.

I UNDERSTAND THAT AS THE EMPLOYER,

I MUST UPDATE THE APPLICATION MONTHLY TO REFLECT ANY CHANGE IN THE REQUIRED APPLICATION INFORMATION; (THE FLORIDA WORKERS COMPENSATION CHANGE SHEET WILL BE USED FOR THIS PURPOSE.)

IF I FILE AN APPLICATION OR APPLICATION UPDATE CONTAINING FALSE, MISLEADING, OR INCOMPLETE INFORMATION WITH THE PURPOSE OF AVOIDING OR REDUCING THE AMOUNT OF PREMIUMS FOR WORKERS COMPENSATION COVERAGE IT IS A FELONY OF THE THIRD DEGREE OR AS OTHERWISE PUNISHABLE AS PROVIDED UNDER THE LAW.

I SHALL SUBMIT TO THE CARRIER, A COPY OF THE EMPLOYERS QUARTERLY REPORT AND SELF-AUDITS SUPPORTED BY THE EMPLOYERS QUARTERLY REPORT, AS REQUIRED BY CHAPTER 443, AT THE END OF EACH QUARTER. IF I OMIT THE NAME OF AN EMPLOYEE FROM THIS EMPLOYERS QUARTERLY REPORT, FLORIDA STATUTES STATE THAT I WILL REMAIN LIABLE AND WILL REIMBURSE THE CARRIER FOR ANY WORKERS COMPENSATION BENEFITS PAID TO THIS OMITTED EMPLOYEE;

I AGREE TO MAKE AVAILABLE, ALL RECORDS NECESSARY FOR THE PAYROLL VERIFICATION AUDIT AND PERMIT THE AUDITOR TO MAKE A PHYSICAL INSPECTION OF OUR OPERATIONS. I UNDERSTAND FAILURE TO DO THIS SHALL RESULT IN A $500 PAYMENT TO THE CARRIER TO DEFRAY THE COST OF THE AUDITS;

THAT, IN ACCORDANCE WITH FLORIDA STATUTES 440.381(6), IF I (WE) UNDERSTATE OR CONCEAL PAYROLL, OR MISREPRESENT OR CONCEAL EMPLOYEE DUTIES SO AS TO AVOID PROPER CLASSIFICATION FOR PREMIUM CALCULATIONS, OR MISREPRESENT OR CONCEAL INFORMATION PERTINENT TO THE COMPUTATION AND APPLICATION OF AN EXPERIENCE RATING MODIFICATION FACTOR, I (WE) SHALL PAY A PENALTY OF TEN (10) TIMES THE AMOUNT OF THE DIFFERENCE IN PREMIUM PAID AND THE AMOUNT I (WE) SHOULD HAVE PAID, AND REASONABLE ATTORNEY'S FEES.

FORMER NAMES AND OWNERS

FOR THE LAST 5 YEARS, LIST THE CURRENT BUSINESS NAME AND ANY FORMER NAMES OR PREDECESSOR COMPANIES FOR ALL COMPANIES TO BE COVERED BY THE POLICY. INCLUDE THE FEIN FOR EACH COMPANY.

FOR EACH COVERED COMPANY, LIST ANY CURRENT OWNER WHO HAS MORE THAN 5% OWNERSHIP INTEREST. FOR EACH COVERED COMPANY OR PREDECESSOR COMPANY, LIST ANY OWNER WHO HAD MORE THAN 5% OWNERSHIP INTEREST IN THE LAST 5 YEARS.

OWNERSHIP / COMBINABILITY

DOES THIS BUSINESS OR ANY OF THE OWNERS OF THIS BUSINESS, EITHER INDIVIDUALLY OR IN COMBINATION WITH OTHER OWNERS OF THIS BUSINESS, OWN MORE THAN 50% OF ANY OTHER BUSINESS, WHICH OPERATED AT ANY TIME DURING THE FIVE YEARS PRIOR TO THIS APPLICATION?

☐ YES ☐ NO

OR, DOES THIS BUSINESS OWN A MAJORITY INTEREST IN ANOTHER ENTITY, WHICH IN TURN OWNS A MAJORITY INTEREST IN ANY ENTITY THAT OPERATED AT ANY TIME IN THE FIVE YEARS PRIOR TO THIS APPLICATION?

☐ YES ☐ NO

IF THE ANSWER TO EITHER OF THE ABOVE QUESTIONS IS YES, COMPLETE THE FOLLOWING SUPPLEMENTAL OWNERSHIP / COMBINABILITY QUESTIONS:

1. IDENTIFY BY NAME, ADDRESS, AND FEIN EACH BUSINESS WHICH IS RELATED BY COMMON OWNERSHIP TO THE APPLICANT BUSINESS.

2. SET FORTH THE DATES EACH BUSINESS WAS IN OPERATION, THE INSURANCE COMPANY THAT PROVIDED WORKERS' COMPENSATION INSURANCE, THE POLICY NUMBER AND THE EXPERIENCE MODIFICATION FACTOR APPLIED TO EACH SUCH POLICY.

3. IF THE POLICY WAS WRITTEN WITHOUT AN EXPERIENCE MODIFICATION FACTOR, PLEASE STATE.

THE APPLICANT HEREBY AUTHORIZES AND REQUESTS EACH RATING ORGANIZATION WITH EXPERIENCE RATING INFORMATION RELATED TO THE APPLICANT AND THE BUSINESS SET FORTH ABOVE TO RELEASE SUCH INFORMATION TO THE INSURER, FWCJUA, OR OTHER RATING ORGANIZATION SO THAT THE CORRECT EXPERIENCE MODIFICATION FACTOR CAN BE DETERMINED.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENTS AND PERSONALLY SWEAR THAT THE INFORMATION CONTAINED IN THE APPLICATION IS ACCURATE. THAT I, AS AN OWNER / OFFICER, AM FULLY AUTHORIZED TO SIGN THIS APPLICATION ON BEHALF OF THE APPLICANT AND TO BIND THE APPLICATION.	AS AGENT / PRODUCER I HEREBY ATTEST THAT I HAVE GIVEN THE APPLICANT/SIGNATORY THE OPPORTUNITY TO READ THE APPLICATION AND I HAVE EXPLAINED ANY AND ALL QUESTIONS REGARDING THE APPLICATION. I ALSO ATTEST THAT I HAVE EXPLAINED TO THE EMPLOYER OR OFFICER THE CLASSIFICATION CODES THAT ARE USED FOR PREMIUM CALCULATIONS PURSUANT TO SECTION 440.381 (2), FLORIDA STATUTES.
UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE READ THE FOREGOING DOCUMENT AND THAT THE FACTS STATED IN IT ARE TRUE.	UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE READ THE FOREGOING DOCUMENT AND THAT THE FACTS STATED IN IT ARE TRUE.
OWNER / OFFICER SIGNATURE **DATE**	**PRODUCER'S SIGNATURE** **DATE**
PRINT NAME	

M E M O R A N D U M

DATE: July 2, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel

SUBJECT: Cabinet Agenda for July 25, 2019
Request for Final Approval to Adopt Amendments to
Rules 69O-149.005, .006
Assignment # 214277-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or July 17, 2019, and to the Financial Services Commission on July 25, 2019, with a request to approve for publication the proposed rule.

The notice of proposed rules was published on March 21, 2019, in Volume 45, No. 56, of the *Register*. A hearing was held on June 26, 2019.

69O-149.005 is amended to allow an insurer to issue multiple year guarantee or rating cap provisions from 24 months to 60 months for accident only, accidental death and dismemberment, dental, hearing, hospital indemnity, hospital/surgical medical expense, intensive care, and vision plans. 69O-149.006 is amended to update the Experience on the Form requirements in subparagraph (3)(b)23. The amendments clarify that remaining reserves could be reflected in the experience exhibits, as well as separate new sales from the experience projections. The actuarial certification requirements in subparagraph (3)(b)28 are updated.

Sections 624.308(1), 627.410(6)(b), (d), (e), 626.9541(1), 627.410(1), (2), (6), 627.410(7), 627.411(1)(a), (e), 627.9175 F.S., are the rulemaking authority and laws implemented for these rules.

Michael Lawrence, Jr. is the attorney handling these rules. Attached are: 1) the proposed rules; and 2) the form incorporated by reference.

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

69O-149.005 Reasonableness of Benefits in Relation to Premiums.

(1) through (13) No change.

(14) An insurer may issue multiple year rate guarantee or rating cap provisions subject to the following:

(a) The coverage is for annually rated group health insurance policies for which filing of rates is exempted by section 627.410(6), F.S., and excluding disability income policies:

(b) The provision may not apply for greater than 24 months unless otherwise exempted by the Office ;

(c) The rate for the entire rating period reflects the increased risk of a rate guarantee with an increased premium or other consideration is actuarially sound, includes claim costs projected at trend levels at least as high as those applicable to other groups with similar benefit structures in the rating area covered under the form(s) and is reasonably anticipated to meet the target loss ratio for the group;

(d) The provision is available to groups on a nondiscriminatory basis as determined by the insurer's underwriting standards; and,

(e) The insurer uses experience rating in determining the group's rate consistently based on its rating and underwriting practices without regard to whether the rate is issued with or without a rate guarantee.

(15) Accident only, accidental death and dismemberment, dental, hearing, hospital indemnity, hospital/surgical medical expense, intensive care, and vision plans issued by an insurer are exempt from the requirement of paragraph (14)(b). This provision may not apply for greater than 60 months for accident only, accidental death and dismemberment, dental, hearing, hospital indemnity, hospital/surgical medical expense, intensive care, and vision plans issued by an insurer.

Rulemaking Authority 624.308(1), 627.410(6)(b), (d), (e) FS. Law Implemented 626.9541(1), 627.410(6)(d), (e), 627.410(7), 627.411(1)(a), (e), 627.9175 FS. History–New 7-1-85, Formerly 4-58.05, 4-58.005, Amended 4-18-94, 11-20-02, Formerly 4-149.005, Amended 5-18-04, 11-2-06, 6-18-07, 10-1-08,_____.

69O-149.006 Actuarial Memorandum.

(1) and (2) No change.

(3) Descriptions.

(a) No change.

(b) The descriptions, by item number, of the terms listed above in subsection (2), follow:

1. through 22. No change.

23. Experience on the Form (Past and Future Anticipated): This section shall display the actual experience on the form and that expected for the future.

a. Past Experience: Experience from inception (or the last 3 years for annually rated group coverages) shall be displayed, although, with proper interest adjustment, the experience for calendar years more than 10 years in the past may be combined. Excluding annually rated group policy forms, earned premiums, actual incurred and expected claims experience shall also be displayed, for each policy year or issue year, within the calendar year. The following information shall be displayed (A sample experience exhibit is illustrated in Appendix A, Illustrative Experience Exhibit (2/04), which is hereby incorporated by reference):

(I) and (II) No change.

(III) Claims incurred and paid, ~~Paid claims,~~ for past periods only;

(IV) Remaining claim liability and reserve, ~~Change in claim liability and reserve,~~ for past periods only. These reserves shall be updated to reflect actual claim runoff as it develops;

(V) through (XI) No change.

b. Future periods where the projected values are based on inforce experience:

(I) through (VI) No change.

(VII) Two projections will be required to be submitted to the Office. Projections shall be based on existing inforce business with and without ~~no~~ new sales assumed during the projection period.

(VIII) No change.

c. Projections for new forms or otherwise not based on experience shall:

(I) Two projections will be required to be submitted to the Office. Project an initial assumed cohort of new business with and without ~~no~~ new sales assumed during the projection period; and,

(II) No change.

d. No change.

24. through 27. No change.

28. Actuarial Certification:

a. Certification by a qualified actuary that to the best of the actuary's knowledge and judgment:

(I) No change.

(II) Complies with the Commonly Accepted Actuarial Practice as defined in subsection 69O-154.202(28), F.A.C. ~~all applicable Actuarial Standards of Practice~~; and,

(III) No change.

b. In making the certification:

(I) No change.

(II) The actuary's opinion shall comply with the Commonly Accepted Actuarial Practice as defined in subsection 69O-154.202(28), F.A.C. ~~The applicable Actuarial Standards of Practice, incorporated in subsection 69O-154.202(27), F.A.C., are as provided in the Applicability Guidelines for Actuarial Standards of Practice, second edition, as developed by the Council on Professionalism of the American Academy of Actuaries, August 1999, which standard is hereby adopted and incorporated by reference.~~

~~c. A copy of the Applicability Guidelines for Actuarial Standards of Practice may be obtained from the Bureau of Life and Health Forms and Rates, Office of Insurance Regulation, Larson Building, Tallahassee, FL 32399-0328.~~

c.~~d.~~ A qualified actuary is one who is a member of the Society of Actuaries or the American Academy of Actuaries, and who is qualified in the area of health insurance.

d.~~e.~~ If the actuary is unable to provide the certification without qualification, a detailed explanation and reason for the qualification shall be provided as part of the certification.

Rulemaking Authority 624.308(1), 627.410(6)(b), (e) FS. Law Implemented 627.410(1), (2), (6), 627.411(1)(e) FS. History–New 7-1-85, Formerly 4-58.06, 4-58.006, Amended 4-18-94, 4-9-95, 11-20-02, 6-19-03, Formerly 4-149.006, Amended 5-18-04, 11-2-06, 10-1-08, _____.

M E M O R A N D U M

DATE: July 2, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel

SUBJECT: Cabinet Agenda for July 25, 2019
Request for Final Approval to Adopt Amendments to
Rule 69O-154.202
Assignment # 217496-17

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before July 17, 2019, and to the Financial Services Commission on July 25, 2019, with a request to approve for publication the proposed rule.

The notice of proposed rule was published on March 21, 2019, in Volume 45, No. 56, of the *Register*. Notice of Change was published on April 4, 2019, on Volume 45, No. 66 of the *Register*. A hearing was held on June 26, 2019.

The rule is being amended to update the definition of Commonly Accepted Actuarial Practice. The current standards of practice established by the Actuarial Standards Board are incorporated by reference.

Sections 624.308(1), 625.121(14), 625.081, 624.307(1), 625.081, 625.121 F.S., are the rulemaking authority and laws implemented for this rule.

Michael Lawrence, Jr. is the attorney handling this rule. Attached are: 1) the proposed rules; 2) correspondence with JAPC; and 3) the filed Notice of Change.

Approved for signature:

Anoush Brangaccio

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier

David Altmaier, Commissioner
Office of Insurance Regulation

69O-154.202 Definitions.

As used in this rule chapter, the following terms have the following meaning:

(1) through (27) No change.

(28) Commonly Accepted Actuarial Practice.

(a) Practices consistent with standards of practice established by the Actuarial Standards Board. ~~as of December 31, 2002 as embodied in "Actuarial Standards of Practice" which are hereby incorporated herein by reference.~~

(b) The following standards of practice are hereby adopted and incorporated by reference:

1. Actuarial Standard of Practice No. 1 Introductory Actuarial Standard of Practice, effective 03/13, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10519;

2. Actuarial Standard of Practice No. 2 Nonguaranteed Charges or Benefits for Life Insurance Policies and Annuity Contracts, effective 05/11 available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10520;

3. Actuarial Standard of Practice No. 3 Continuing Care Retirement Communities, effective 01/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10521;

4. Actuarial Standard of Practice No. 4 Measuring Pension Obligations and Determining Pension Plan Costs or Contributions, effective 12/13, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10522;

5. Actuarial Standard of Practice No. 5 Incurred Health and Disability Claims, effective 03/17, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10523;

6. Actuarial Standard of Practice No. 6 Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Actuarially Determined Contributions, effective 05/14, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10525;

7. Actuarial Standard of Practice No. 7 Analysis of Life, Health, or Property/Casualty Insurer Cash Flows, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10526;

8. Actuarial Standard of Practice No. 8 Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits, effective 03/14, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10547;

9. Actuarial Standard of Practice No. 9 Documentation and Disclosure in Property and Casualty Insurance Ratemaking, Loss Reserving, and Valuations, effective 03/13, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10528;

10. Actuarial Standard of Practice No. 10 Methods and Assumptions for Use in Life Insurance Company Financial Statements Prepared in Accordance with U.S. GAAP, effective 01/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10529;

11. Actuarial Standard of Practice No. 11 Financial Statement Treatment of Reinsurance Transactions Involving Life or Health Insurance, effective 01/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10530;

12. Actuarial Standard of Practice No. 12 Risk Classification (for All Practice Areas), effective 01/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10531;

13. Actuarial Standard of Practice No. 13 Trending Procedures in Property/Casualty Insurance, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10532;

14. Actuarial Standard of Practice No. 14 When to Do Cash Flow Testing for Life and Health Insurance Companies, effective 03/13, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10533;

15. Actuarial Standard of Practice No. 15 Dividends for Individual Participating Life Insurance, Annuities, and Disability Insurance, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10534;

16. Actuarial Standard of Practice No. 16 Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans, effective 04/07, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10535;

17. Actuarial Standard of Practice No. 17 Expert Testimony by Actuaries, effective 06/18, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10538;

18. Actuarial Standard of Practice No. 18 Long-Term Care Insurance, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10539;

19. Actuarial Standard of Practice No. 19 Appraisals of Casualty, Health, and Life Insurance Businesses, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10540;

20. Actuarial Standard of Practice No. 20 Discounting of Property/Casualty Unpaid Claim Estimates, effective 09/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10541;

21. Actuarial Standard of Practice No. 21 Responding to or Assisting Auditors or Examiners in Connection with Financial Audits, Financial Reviews, and Financial Examination, effective 09/16, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10542;

22. Actuarial Standard of Practice No. 22 Statement of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers, effective 12/12, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10543;

23. Actuarial Standard of Practice No. 23 Data Quality, effective 12/16, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10544;

24. Actuarial Standard of Practice No. 24 Compliance with the NAIC Life Insurance Illustrations Model Regulation, effective 12/16, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10545;

25. Actuarial Standard of Practice No. 25 Credibility Procedures, effective 12/13, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10546;

26. Actuarial Standard of Practice No. 26 Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10548;

27. Actuarial Standard of Practice No. 27 Selection of Economic Assumptions for Measuring Pension Obligations, effective 09/13, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10554;

28. Actuarial Standard of Practice No. 28 Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets, effective 12/12, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10550;

29. Actuarial Standard of Practice No. 29 Expense Provisions in Property/Casualty Insurance Ratemaking, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10551;

30. Actuarial Standard of Practice No. 30 Treatment of Profit and Contingency Provisions and the Cost of Capital in Property/Casualty Insurance Ratemaking, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10552;

31. Actuarial Standard of Practice No. 31 Documentation in Health Benefit Plan Ratemaking, effective 06/09, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10553;

32. Actuarial Standard of Practice No. 32 Social Insurance, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10555;

33. Actuarial Standard of Practice No. 33 Actuarial Responsibilities with Respect to Closed Blocks in Mutual Life Insurance Company Conversions, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10556;

34. Actuarial Standard of Practice No. 34 Actuarial Practice Concerning Retirement Plan Benefits in Domestic Relations Actions, effective 06/15, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10557;

35. Actuarial Standard of Practice No. 35 Selection of Demographic and Other Noneconomic Assumptions for Measuring Pension Obligations, effective 09/14, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10558;

36. Actuarial Standard of Practice No. 36 Statements of Actuarial Opinion Regarding Property/Casualty Loss and Loss Adjustment Expense Reserves, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10559;

37. Actuarial Standard of Practice No. 37 Allocation of Policyholder Consideration in Mutual Life Insurance Company Demutualizations, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10560;

38. Actuarial Standard of Practice No. 38 Using Models Outside the Actuary's Area of Expertise (Property and Casualty), effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10561;

39. Actuarial Standard of Practice No. 39 Treatment of Catastrophe Losses in Property/Casualty Insurance Ratemaking, effective 03/13, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10562;

40. Actuarial Standard of Practice No. 40 Compliance with the NAIC Valuation of Life Insurance Policies Model Regulation with Respect to Deficiency Reserve Mortality, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10563;

41. Actuarial Standard of Practice No. 41 Actuarial Standard of Practice, effective 12/10, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10564;

42. Actuarial Standard of Practice No. 42 Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims, effective 03/18, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10565;

43. Actuarial Standard of Practice No. 43 Property/Casualty Unpaid Claim Estimates, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10566;

44. Actuarial Standard of Practice No. 44 Selection of Asset Valuation Methods for Pension Valuations, effective 05/11, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10567;

45. Actuarial Standard of Practice No. 45 The Use of Health Status Based Risk Adjustment Methodologies, effective 01/12, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10568;

46. Actuarial Standard of Practice No. 46 Risk Evaluation in Enterprise Risk Management, effective 09/12, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10569;

47. Actuarial Standard of Practice No. 47 Risk Treatment in Enterprise Risk Management, effective 12/12, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10570;

48. Actuarial Standard of Practice No. 48 Life Settlements Mortality, effective 12/13, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10571;

49. Actuarial Standard of Practice No. 49 Medicaid Managed Care Citation Rate Development and Certification, effective 03/15, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10582;

50. Actuarial Standard of Practice No. 50 Determining Minimum Value and Actuarial Value under the Affordable Care Act, effective 09/15, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10583;

51. Actuarial Standard of Practice No. 51 Assessment and Disclosure of Risk Associated with Measuring Pension Obligations and Determining Pension Plan Contributions, effective 09/17, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10574;

52. Actuarial Standard of Practice No. 52 Principle-Based Reserves for Life Products under the NAIC *Valuation Manual*, effective 09/17, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10575;

53. Actuarial Standard of Practice No. 53 Estimating Future Costs for Prospective Property/Casualty Risk Transfer and Risk Retention, effective 12/17, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10576; and

54. Actuarial Standard of Practice No. 54 Pricing of Life Insurance and Annuity Products, effective 06/18, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10577.

(c) A copy of the standards of practice may be obtained from the Actuarial Standards Board at http://www.actuarialstandardsboard.org/standards-of-practice/.

(29) through (33) No change.

Rulemaking Authority 624.308(1), 625.121(14), 625.081 FS. Law Implemented 624.307(1), 625.081, 625.121 FS. History–New 4-14-99, Formerly 4-154.202, Amended 3-1-04, 1-25-16, Amended _____.

M E M O R A N D U M

DATE: July 2, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel

SUBJECT: Cabinet Agenda for July 25, 2019
Request for Final Approval to Adopt Amendments to
Rules 69O-163.009, .011
Assignment # 207469-17

The Office of Insurance Regulation ("Office") requests that these proposed rule amendments be presented to the Cabinet aides on or before July 17, 2019, and to the Financial Services Commission on July 25, 2019, with a request to approve for publication the proposed rule.

The notice of proposed rules was published on March 21, 2019, in Volume 45, No. 56, of the *Register*. A hearing was held on June 26, 2019.

69O-163.009 is amended to require the filing of Form OIR-B2-2213 to provide numerical and written justification when there is a deviation from prima facie rates. The form is created to indicate what information must be submitted to the Office. 69O-163.011 is amended to reduce the maximum credit disability insurance premium rates that may be charged.

Sections 624.308(1), 627.678, 624.307(1), 627.678, 627.6785, 627.682 F.S., are the rulemaking authority and laws implemented for these rules.

Michael Lawrence, Jr. is the attorney handling these rules. Attached are: 1) the proposed rules; and 2) the form incorporated by reference.

Approved for signature:

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier, Commissioner
Office of Insurance Regulation

69O-163.009 Determination of Reasonableness of Benefits in Relation to Premium Charge.

(1) through (5) No change.

(6) Any deviation from prima facie rates shall require numerical and written justification. The numerical information shall be displayed as illustrated in Form OIR-B1-2213, Appendix A, Illustrative Experience Exhibit, effective 10/18, hereby incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10584, and submitted electronically via the Office's Filing Assembly Submission System (FASS) at https://iportal.fldfs.com/ifile/fass/default.asp.

Rulemaking Authority 624.308(1), 627.678 FS. Law Implemented 624.307(1), 627.678, 627.682 FS. History– New 5-9-82, Formerly 4-7.09, Amended 6-11-91, Formerly 4-7.009, Amended 3-15-94, 2-11-03, Formerly 4-163.009, Amended 9-30-09, Amended_____.

69O-163.011 Credit Disability Insurance Rates.

(1) Credit disability insurance premium rates for the insured portion of an indebtedness repayable in equal monthly installments, where the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment paid, shall not be greater than in paragraphs (a) and (b). Paragraphs (c), (d) and (e) refer to premium rates for other types of coverages either alone or in combination with the type of coverages applicable to paragraphs (a) and (b).

(a) If premiums are payable on a single-premium basis for the duration of the coverage:

TABLE I

No. of months in which indebtedness is repayable	14-Day Non-Retroactive	30-Day Non-Retroactive	7-Day Retroactive	14-Day Retroactive	30-Day Retroactive
6 or less	$0.65 ~~$0.81~~	$0.29 ~~$0.36~~	$1.18 ~~$1.47~~	$1.04 ~~$1.30~~	$0.84 ~~$1.05~~
7-12	0.90 ~~1.13~~	0.58 ~~0.72~~	1.41 ~~1.76~~	1.26 ~~1.58~~	1.09 ~~1.36~~
13-18	1.17 ~~1.46~~	0.86 ~~1.08~~	1.64 ~~2.05~~	1.50 ~~1.87~~	1.34 ~~1.67~~
19-24	1.42 ~~1.78~~	1.15 ~~1.44~~	1.87 ~~2.34~~	1.73 ~~2.16~~	1.58 ~~1.97~~
25-30	1.69 ~~2.11~~	1.44 ~~1.80~~	2.11 ~~2.64~~	1.96 ~~2.45~~	1.82 ~~2.28~~

31-36	1.94 ~~2.43~~	1.73 ~~2.16~~	2.34 ~~2.93~~	2.19 ~~2.74~~	2.06 ~~2.58~~
37-48	2.27 ~~2.84~~	2.16 ~~2.70~~	2.67 ~~3.34~~	2.48 ~~3.10~~	2.38 ~~2.97~~
49-60	2.53 ~~3.16~~	2.38 ~~2.97~~	2.95 ~~3.69~~	2.70 ~~3.38~~	2.62 ~~3.28~~
61-72*	2.74 ~~3.43~~	2.62 ~~3.27~~	3.18 ~~3.97~~	2.90 ~~3.62~~	2.82 ~~3.53~~
73-84*	2.89 ~~3.61~~	2.78 ~~3.47~~	3.34 ~~4.18~~	3.03 ~~3.79~~	2.96 ~~3.70~~
85-96*	3.01 ~~3.76~~	2.91 ~~3.64~~	3.47 ~~4.34~~	3.14 ~~3.92~~	3.07 ~~3.84~~
97-108*	3.09 ~~3.86~~	3.00 ~~3.75~~	3.57 ~~4.46~~	3.21 ~~4.01~~	3.15 ~~3.94~~
109-120*	3.16 ~~3.95~~	3.08 ~~3.85~~	3.64 ~~4.55~~	3.27 ~~4.09~~	3.22 ~~4.02~~
Per month for terms exceeding 120 months	.0242 ~~.0303~~	.0237 ~~.0296~~	.0278 ~~.0348~~	.0246 ~~.0313~~	.0246 ~~.0308~~

(b) through (f) No Change.

(2) No change.

Rulemaking Authority 624.308(1), 627.678 FS. Law Implemented 624.307(1), 627.678, 627.6785, 627.682 FS. History–New 5-9-82, Formerly 4-7.11, Amended 6-11-91, Formerly 4-7.011, Amended 2-11-03, Formerly 4-163.011, Amended 9-30-09, Amended _____.

Form OIR-B1-2213
Appendix A, Illustrative Experience Exhibit
Effective 10/18
Incorporated by Reference in
Rules 69O-149.006 and 69O-163.009, F.A.C.

Projection Assumptions:

Rate Increase effective 07/01/2016	19.2%
Claim Trend	15.0%
Insurance Trend	1.0%
Lapse Rate	20.0%
Aging	1.00

Future premium increases equal claim trend

	Cal Year	Earned Premium	Paid Claims	Remaining Claim Liability & Reserve	Incurred Claims	Incurred Loss Ratio	Expected Incurred Claims *	Expected Loss Ratio *	A/E Claims Ratio	Active Life Reserves	Earned Premium Manual Rate Basis	Earned Premium Current Rate Basis	Past Rate Increases	
		(a)	(b)	(c)	(d)	(e) = (c) + (d)	(f) = (e) / (b)	(g)	(h)	(i)	(j)	(k)	(l)		
	2008	565,464	207,477	-	207,477	36.7%	209,222	37.0%	99.2%	-	565,464.00	715,312		
	2009	1,337,824	575,693	-	575,693	43.0%	561,946	42.0%	102.4%	-	1,337,824.20	1,692,348		
	2010	2,352,416	927,487	-	927,487	39.4%	1,075,107	45.7%	86.3%	-	2,352,416.18	2,975,806		
	2011	3,986,382	1,749,723	-	1,749,723	43.9%	1,896,723	47.6%	92.2%	-	3,986,381.86	5,042,773		
	2012	5,339,093	2,211,239	1,106	2,212,344	41.4%	2,696,178	50.5%	82.1%	-	5,339,092.79	6,753,952		
	2013	6,174,297	3,544,650	31,446	3,576,096	57.9%	3,308,434	53.6%	108.1%	-	6,174,296.66	7,810,485		
	2014	6,959,921	3,818,031	375,902	4,193,933	60.3%	3,974,882	57.1%	105.5%	-	6,959,920.78	8,394,570	10.0%	7/1/09
	2015	8,259,585	3,537,263	1,834,316	5,371,578	65.0%	4,812,170	58.3%	111.6%	-	8,259,584.83	8,857,418	15.0%	7/1/10
	2016	7,747,260			5,474,303	70.7%	5,392,577	69.6%	101.6%	-				
	2017	7,246,233			5,657,119	78.1%	5,665,512	78.2%	99.9%	-				
	2018	6,666,534			5,588,695	83.8%	5,596,987	84.0%	99.9%	-				
	2019	6,133,212			5,332,842	87.0%	5,340,754	87.1%	99.9%	-				
	2020	5,642,555			4,991,619	88.5%	4,999,025	88.6%	99.9%	-				
	2021	5,191,150			4,638,212	89.3%	4,645,094	89.5%	99.9%	-				
	2022	4,775,858			4,309,827	90.2%	4,316,221	90.4%	99.9%	-				
	2023	4,393,790			4,004,691	91.1%	4,010,633	91.3%	99.9%	-				
	2024	4,042,286			3,721,159	92.1%	3,726,680	92.2%	99.9%	-				
	2025	3,718,903			3,457,701	93.0%	3,462,831	93.1%	99.9%	-				
	2026	3,421,391			3,212,896	93.9%	3,217,663	94.0%	99.9%	-				
	2027	3,147,680			2,985,423	94.8%	2,989,852	95.0%	99.9%	-				
	2028	2,895,866			2,774,055	95.8%	2,778,171	95.9%	99.9%	-				
	2029	2,664,196			2,577,652	96.8%	2,581,476	96.9%	99.9%	-				
	2030	2,451,061			2,395,154	97.7%	2,398,708	97.9%	99.9%	-				
	2031	2,254,976			2,225,577	98.7%	2,228,879	98.8%	99.9%	-				
	2032	2,074,578			2,068,006	99.7%	2,071,074	99.8%	99.9%	-				
	2033	1,908,611			1,921,591	100.7%	1,924,442	100.8%	99.9%	-				
	2034	1,755,923			1,785,543	101.7%	1,788,192	101.8%	99.9%	-				
	2035	1,615,449			1,659,126	102.7%	1,661,588	102.9%	99.9%	-				
	2036	1,486,213			1,541,660	103.7%	1,543,947	103.9%	99.9%	-				
	2037	1,367,316			1,432,511	104.8%	1,434,636	104.9%	99.9%	-				
	2038	1,257,931			1,331,089	105.8%	1,333,064	106.0%	99.9%	-				
	2039	1,157,296			1,236,848	106.9%	1,238,683	107.0%	99.9%	-				
	2040	1,064,712			1,149,279	107.9%	1,150,984	108.1%	99.9%	-				
Past		34,974,981			18,814,331	53.8%	18,534,661	53.0%	101.5%	-	34,974,981	42,242,665		
Future		86,080,978			77,472,577	90.0%	77,497,673	90.0%	100.0%	-				
Lifetime		121,055,960			96,286,908	79.5%	96,032,334	79.3%	100.3%	-				
Interest	5.0%													
Past		39,954,527			21,162,901	53.0%	20,985,327	52.5%	100.8%	-	39,954,527	48,471,391		
Future		59,677,447			52,202,547	87.5%	52,192,316	87.5%	100.0%	-				
Lifetime		99,631,974			73,365,448	73.6%	73,177,643	73.4%	100.3%	-				

Each filing should include an exhibit with the requested increase and one without the requested increase.
Formulas (and underlying assumptions) used to determine projected values should be disclosed as part of the filing.
Assumptions disclosed should include the interest, medical trend, insurance trend, aging, lapse, shock lapse, and the effectiveness of past and proposed rate increases.

** Calendar year expected claims and expected loss ratios are taken from the durational experience exhibit. 2011 expected loss ratios are taken from the approved durational loss ratio slope one duration beyond the 2010 expected loss ratio. Each additional future value follows the approved durational loss ratio slope.*

Appendix A, Continued

Premium By Duration and Calendar Year

Ann Dur	2008	2009	2010	2011	2012	2013	2014	2015	Total
1	565,464	885,453	1,325,465	2,154,657	2,365,453	2,265,752	2,165,841	2,765,798	14,493,883
2		452,371	619,817	927,826	1,508,260	1,655,817	1,586,026	1,516,089	8,266,206
3			407,134	557,835	742,260	1,206,608	1,324,654	1,268,821	5,507,313
4				346,064	446,268	467,624	965,286	1,059,723	3,284,966
5					276,851	357,015	444,243	868,758	1,946,866
6						221,481	285,612	377,606	884,699
7							188,259	242,770	431,029
8								160,020	160,020
9									-
10									-
11									-
12									-
13									-
14									-
15									-
16									-
17									-
18									-
	565,464	1,337,824	2,352,416	3,986,382	5,339,093	6,174,297	6,959,921	8,259,585	

Durational Loss Ratio Slope

Ann Dur	2008	2009	2010	2011	2012	2013	2014	2015	mid year durational slope
1	0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.37	
2	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.444
3	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.583
4	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.696
5	0.82	0.82	0.82	0.82	0.82	0.82	0.82	0.82	0.782
6	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.840
7	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.871
8	0.89	0.89	0.89	0.89	0.89	0.89	0.89	0.89	0.886
9	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.895
10	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.904
11	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.913
12	0.93	0.93	0.93	0.93	0.93	0.93	0.93	0.93	0.922
13	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.931
14	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.940
15	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.950
16	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.959
17	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.969
18	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.979

Expected Claims By Duration and Calendar Year

Ann Dur	2008	2009	2010	2011	2012	2013	2014	2015	Total
1	209,222	327,618	490,422	797,223	875,218	838,328	801,361	1,023,345	5,362,737
2		234,328	321,065	480,614	781,279	857,713	821,562	785,334	4,281,895
3			263,619	361,198	480,614	781,279	857,713	821,562	3,565,985
4				257,688	332,303	348,205	718,776	789,096	2,446,068
5					226,765	292,426	363,874	711,589	1,594,654
6						190,483	245,638	324,757	760,878
7							165,958	214,012	379,970
8								142,475	142,475
9									-
10									-
11									-
12									-
13									-
14									-
15									-
16									-
17									-
18									-
	209,222	561,946	1,075,107	1,896,723	2,696,178	3,308,434	3,974,882	4,812,170	
Exp LR's	**37.0%**	**42.0%**	**45.7%**	**47.6%**	**50.5%**	**53.6%**	**57.1%**	**58.3%**	

M E M O R A N D U M

DATE: July 2, 2019

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Michael Lawrence, Jr., Assistant General Counsel

SUBJECT: Cabinet Agenda for July 25, 2019
Request for Final Approval to Adopt Amendments to
Rules 69O-191.074, .076, .078
Assignment # 220769-18

The Office of Insurance Regulation ("Office") requests that these proposed rule amendments be presented to the Cabinet aides on or before July 17, 2019, and to the Financial Services Commission on July 25, 2019, with a request to approve for publication the proposed rule.

The notice of proposed rules was published on March 21, 2019, in Volume 45, No. 56, of the *Register*. A Notice of Change was published for 69O-191.078 on April 4, 2019, in Volume 45, No. 66 of the *Register*. A hearing was held on June 26, 2019.

Rule 69O-191.074, FAC, is amended to update and delete out of date references to government agencies and update the manner to retain records. 69O-191.076, FAC, is amended to incorporate a form for filing a pro forma projection of an anticipated program. The form is created to indicate what information must be submitted to the Office, and to ensure consistency of projections submitted to and tracked by the Office. 69O-191.078, FAC, is amended to delete references to the Statewide Subscriber Assistance Panel due to the repeal of section 408.7056, FS.

Sections 641.36, 641.22(9), 641.23(3), 641.27, 641.31(5) F.S., are the rulemaking authority and laws implemented for these rules.

Michael Lawrence, Jr. is the attorney handling these rules. Attached are: 1) the proposed rules; 2) the forms incorporated by reference; 3) correspondence with JAPC; and 4) the filed Notice of Change.

Approved for signature:

Anoush Brangaccio

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier

David Altmaier, Commissioner
Office of Insurance Regulation

69O-191.074 Records Retention.

(1) No change.

(2) These records, either in the form of paper or electronic ~~hard~~ documents, ~~microfiche or computer diskettes,~~ shall be maintained for no less than three (3) years, unless otherwise required to be maintained for a longer period of time by the Department of Health, ~~Office of Health and Rehabilitative Services,~~ Internal Revenue Service, Centers for Medicare & Medicaid Services (CMS) ~~Health Care Financing Administration (HCFA)~~ or as otherwise specified by the Office.

Rulemaking Authority 641.36 FS. Law Implemented 641.27 FS. History–New 5-28-92, Formerly 4-191.074, Amended _____.

69O-191.076 Corrective Action Plans.

(1) through (3) No change.

(4) The Office shall approve a corrective action plan complying with section 641.23(3), F.S., if the plan meets all of the following criteria in that the plan includes:

(a) through (d) No change.

(e) A pro forma projecting the anticipated program. Pro forma projections must be submitted electronically on Form OIR-A2-2212, Pro Forma Projections, effective 09/18, hereby incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-10585, via the Office's Regulatory Electronic Filing System (REFS) at https://www.floir.com/iportal.

Rulemaking Authority 641.36 FS. Law Implemented 641.23(3) FS. History–New 5-28-92, Amended 8-15-94, Formerly 4-191.076, Amended _____.

69O-191.078 Subscriber Grievance Procedure.

Every HMO shall have a subscriber grievance procedure. A detailed description of the HMO's subscriber grievance procedure shall be included in all group and individual contracts as well as in any certificate or member handbook

provided to subscribers. This procedure shall be administered at no cost to the subscriber. An HMO subscriber grievance procedure must include the following:

(1) through (5) No change.

(6) The HMO shall process the formal written subscriber grievance in a reasonable length of time not to exceed 60 days, unless the subscriber and HMO mutually agree to extend the time frame set forth by this rule. ~~However, any mutually agreed time frame modification will not preclude the subscriber from appealing to the Statewide Subscriber Assistance Panel within the periods as established by this rule.~~ If the complaint involves the collection of information outside the service area, the HMO will have 30 additional days to process the subscriber complaint through all phases of the grievance procedure. The time limitations prescribed in this paragraph requiring completion of the grievance process within 60 days shall be tolled after the HMO has notified the subscriber, in writing, that additional information is required in order to properly complete review of the complaint. Upon receipt by the HMO of the additional information requested, the time for completion of the grievance process set forth herein shall resume. A grievance which is arbitrated pursuant to chapter 682, F.S., is permitted an additional time limitation not to exceed 210 days from the date the HMO receives a written request for arbitration from the subscriber; ~~. Arbitration provisions, if any, shall not preclude the subscriber from filing with the Statewide Subscriber Assistance Panel. At the point of the arbitration process the subscriber shall be deemed to have complied with the full formal grievance procedure for the purpose of appealing to the Statewide Subscriber Assistance Panel. Each HMO shall notify the Office of all arbitrated grievances on the quarterly grievance report required by subsection 69O-191.078(12) , F.A.C.;~~

~~(7) The subscriber grievance procedure shall state that the subscriber always has the right to appeal to the Office or the Department of Health and Rehabilitative Services. The HMO shall provide to the subscriber written notice of the right to appeal upon completion of the full grievance procedure and supply the Office with a copy of the final decision letter;~~

(7)~~(8)~~ The HMO shall have physician involvement in reviewing medically related grievances. Physician involvement in the grievance process should not be limited to the subscriber's primary care physician, but may include at least one other physician;

(8)~~(9)~~ The HMO shall offer to meet with the subscriber during the formal grievance process. The location of the meeting shall be at the administrative offices of the HMO within the service area or at a location within the service area which is convenient to the subscriber;

(9)~~(10)~~ The HMO may not establish time limits of less than one year from the date of occurrence for the subscriber to file a formal grievance;

(10)~~(11)~~ Each HMO shall maintain an accurate record of each formal grievance. Each record shall include the following:

(a) through (d) No change;

~~(12) Each HMO shall submit a quarterly report to the Office pursuant to section 641.311(1)(b), F.S., listing the number and nature of all formal subscriber grievances which have not been resolved to the satisfaction of the subscriber, after the subscriber has utilized the full grievance procedure of the HMO. This report shall be formatted as outlined in the quarterly report of subscriber grievances form incorporated herein by reference and shall be filed with the Office no later than 45 days after the end of each calendar quarter. Quarterly report of subscriber grievance forms can be obtained from the Office of Insurance Regulation's website: http://www.floir.com/iportal.~~

Rulemaking Authority 641.36 FS. Law Implemented 641.22(9), 641.31(5) FS. History–New 7-8-87, Amended 2-22-88, 10-25-89, Formerly 4-31.078, Amended 5-28-92, Formerly 4-191.078, Amended _____.

INSTRUCTIONS

Tab 'Assumptions':

Type in company name in cell D1
Choose company type from the drop down menu (HMO, PLHSO, DMPO, Health Insurance Company) in cell D2
Please show all assumptions/development that are pertinent to the pro-formas. Utilize formulas as much as possible and minimize use of hard coding.
Key assumptions will need to be sensitivity tested.

Tab 'Balance Sheet':

Input data into the applicable following cells:
year 1: columns C-N
rows 9-19, 23-34, 38-43
year 2: columns P-AA
rows 9-19, 23-34, 38-43
year 3: columns AC-AN
rows 9-19, 23-34, 38-43

Tab 'P and L':

Input ***monthly*** data into the applicable following cells:
year 1: columns C-N
rows 8-15, 19-22, 26, 28-32, 35-39, 44-46, 57, 60
cell C42
year 2: columns R-AC
rows 8-15, 19-22, 26, 28-32, 35-39, 44-46, 57, 60
year 3: columns AG-AR
rows 8-15, 19-22, 26, 28-32, 35-39, 44-46, 57, 60

Tab 'Cash Flow':

Input ***monthly*** data into the applicable following cells:
C42
year 1: columns C-N
rows 9-11, 14-18, 23, 27-31
year 2: columns R-AC
rows 9-11, 14-18, 23, 27-31
year 3: columns AG-AR
rows 9-11, 14-18, 23, 27-31

Tab 'LOB Analysis':

Input ***annual*** data into the applicable following cells:
columns: F-K
year 1: rows 8-13, 17-20, 24, 26-31
year 2: rows 44-49, 53-56, 60, 62-67
year 3: rows 80-85, 89-92, 96, 98-103

Tab 'MLR':

Input ***annual*** data into the applicable following cells:
columns: F-M
year 1: rows 8-12, 16-21, 25, 28-32
year 2: rows 43-47, 51-56, 60, 63-67
year 3: rows 78-82, 86-91, 95, 98-102

Tab 'Stress Test Summary':

Perform Relevant Sensitivity Tests - the ones listed in Column A are suggestions
Step 1: Copy the formulas from row 1 in columns C-V based on the company's initial assumptions and "Paste Special -Values" into the "Base" line
Step 2: Revise the company's input data in each tab based on the specified sensitivity test

Company Name:	Company ABC	
Type: HMO, PLHSO, DMPO	HMO	
Select One:	PLHSO	
	DMPO	
	Health Ins Co	**<==== USER INPUTS**

Show all relevant assumptions used to create the pro-formas.
Beneficial to show formulas and to link to financial statements.
Also, please set up so that relevant assumptions can be sensitivity tested

Assumptions

Company ABC
Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

	Year 1 (Monthly)												
	M1Y1	M2Y1	M3Y1	M4Y1	M5Y1	M6Y1	M7Y1	M8Y1	M9Y1	M10Y1	M11Y1	M12Y1	Total Year 1
0. Members	0	0	0	0	0	0	0	0	0	0	0	0	0
1. Member Months	0	0	0	0	0	0	0	0	0	0	0	0	0
2a. Net Premium Income (Exluding ACA Risk Adjustment Receivable)	0	0	0	0	0	0	0	0	0	0	0	0	0
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Fee for Service	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Risk Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
5. Change in Unearned Premium Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Aggregate Write-Ins for Other Health Related Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Total (L2a,b+L3+L4+L5+L6)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Hospital and Medical:													
8. Hospital/Medical Benefits	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Other Benefits & Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Prescription Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0
11. Aggregate Write-Ins for Other Hospital/Medical	0	0	0	0	0	0	0	0	0	0	0	0	0
12. Subtotal (L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less:													
13. Reinsurance Recoveries	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Total Hospital and Medical (L12 -L13)	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	0	0	0	0	0	0	0	0	0	0	0	0	0
16b. ACA Risk Adjustment User Fee Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Increase in Reserves for Accident and Health Contacts	0	0	0	0	0	0	0	0	0	0	0	0	0
18. Aggregate Write-Ins for Other Income or Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	0	0	0	0	0	0	0	0	0	0	0	0	0
20. Net Underwriting Gain or Loss (L7 -L19)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
21. Net Investment Income Earned	0	0	0	0	0	0	0	0	0	0	0	0	0
22. Federal Income Taxes	0	0	0	0	0	0	0	0	0	0	0	0	0
23. Health Insurance Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
24. Net Realized Capital Gains (Losses)	0	0	0	0	0	0	0	0	0	0	0	0	0
25. Less Capital Gains Tax	0	0	0	0	0	0	0	0	0	0	0	0	0
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
27. Prior Period Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
28. Net Income	0	0	0	0	0	0	0	0	0	0	0	0	0
29. Capital Increases	0	0	0	0	0	0	0	0	0	0	0	0	0
30. Other Increases (Decreases)	0	0	0	0	0	0	0	0	0	0	0	0	0
31. Dividends to Stockholders	0	0	0	0	0	0	0	0	0	0	0	0	0
32. End of Period Surplus (L27+L28+L29+L30-L31)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Minimum Surplus Requirement: HMO: Max[a,b,c]; PLHSO: Max[a,b]; DMPO: $150,000; Health Ins Co: Max[a,d]	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
a. HMO & Health Ins Co: $1,500,000; PLHSO & DMPO: 150,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
b. 10% of Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
c. 2% of Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
d. 4% Total Liabilities + 6% Health Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Excess (Deficit) Surplus	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**
Risk Based Capital (200% ACL)	0	0	0	0	0	0	0	0	0	0	0	0	0
Risk Based Capital	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
2% of Revenues	0	0	0	0	0	0	0	0	0	0	0	0	0

XX/XX/XXXX XX:XX XX

Company ABC
Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

	Year 2 (Monthly)												
	M1Y2	M2Y2	M3Y2	M4Y2	M5Y2	M6Y2	M7Y2	M8Y2	M9Y2	M10Y2	M11Y2	M12Y2	Total Year 2
0. Members	0	0	0	0	0	0	0	0	0	0	0	0	0
1. Member Months	0	0	0	0	0	0	0	0	0	0	0	0	0
2a. Net Premium Income (Exluding ACA Risk Adjustment Receivable)	0	0	0	0	0	0	0	0	0	0	0	0	0
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Fee for Service	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Risk Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
5. Change in Unearned Premium Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Aggregate Write-Ins for Other Health Related Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Total (L2a,b+L3+L4+L5+L6)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Hospital and Medical:													
8. Hospital/Medical Benefits	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Other Benefits & Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Prescription Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0
11. Aggregate Write-Ins for Other Hospital/Medical	0	0	0	0	0	0	0	0	0	0	0	0	0
12. Subtotal (L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less:													
13. Reinsurance Recoveries	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Total Hospital and Medical (L12 -L13)	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	0	0	0	0	0	0	0	0	0	0	0	0	0
16b. ACA Risk Adjustment User Fee Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Increase in Reserves for Accident and Health Contacts	0	0	0	0	0	0	0	0	0	0	0	0	0
18. Aggregate Write-Ins for Other Income or Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	0	0	0	0	0	0	0	0	0	0	0	0	0
20. Net Underwriting Gain or Loss (L7 -L19)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
21. Net Investment Income Earned	0	0	0	0	0	0	0	0	0	0	0	0	0
22. Federal Income Taxes	0	0	0	0	0	0	0	0	0	0	0	0	0
23. Health Insurance Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
24. Net Realized Capital Gains (Losses)	0	0	0	0	0	0	0	0	0	0	0	0	0
25. Less Capital Gains Tax	0	0	0	0	0	0	0	0	0	0	0	0	0
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
27. Prior Period Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
28. Net Income	0	0	0	0	0	0	0	0	0	0	0	0	0
29. Capital Increases	0	0	0	0	0	0	0	0	0	0	0	0	0
30. Other Increases (Decreases)	0	0	0	0	0	0	0	0	0	0	0	0	0
31. Dividends to Stockholders	0	0	0	0	0	0	0	0	0	0	0	0	0
32. End of Period Surplus (L27+L28+L29+L30-L31)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Minimum Surplus Requirement: HMO: Max[a,b,c]; PLHSO: Max[a,b]; DMPO: $150,000; Health Ins Co: Max[a,d]	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
a. HMO & Health Ins Co: $1,500,000; PLHSO & DMPO: 150,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
b. 10% of Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
c. 2% of Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
d. 4% Total Liabilities + 6% Health Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Excess (Deficit) Surplus	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**
Risk Based Capital (200% ACL)	0	0	0	0	0	0	0	0	0	0	0	0	0
Risk Based Capital	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
2% of Revenues	0	0	0	0	0	0	0	0	0	0	0	0	0

Company ABC
Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

	Year 3 (Monthly)												
	M1Y3	M2Y3	M3Y3	M4Y3	M5Y3	M6Y3	M7Y3	M8Y3	M9Y3	M10Y3	M11Y3	M12Y3	Total Year 3
0. Members	0	0	0	0	0	0	0	0	0	0	0	0	0
1. Member Months	0	0	0	0	0	0	0	0	0	0	0	0	0
2a. Net Premium Income (Exluding ACA Risk Adjustment Receivable)	0	0	0	0	0	0	0	0	0	0	0	0	0
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Fee for Service	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Risk Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
5. Change in Unearned Premium Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Aggregate Write-Ins for Other Health Related Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Total (L2a,b+L3+L4+L5+L6)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Hospital and Medical:													
8. Hospital/Medical Benefits	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Other Benefits & Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Prescription Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0
11. Aggregate Write-Ins for Other Hospital/Medical	0	0	0	0	0	0	0	0	0	0	0	0	0
12. Subtotal (L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less:													
13. Reinsurance Recoveries	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Total Hospital and Medical (L12 -L13)	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	0	0	0	0	0	0	0	0	0	0	0	0	0
16b. ACA Risk Adjustment User Fee Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Increase in Reserves for Accident and Health Contacts	0	0	0	0	0	0	0	0	0	0	0	0	0
18. Aggregate Write-Ins for Other Income or Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	0	0	0	0	0	0	0	0	0	0	0	0	0
20. Net Underwriting Gain or Loss (L7 -L19)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
21. Net Investment Income Earned	0	0	0	0	0	0	0	0	0	0	0	0	0
22. Federal Income Taxes	0	0	0	0	0	0	0	0	0	0	0	0	0
23. Health Insurance Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
24. Net Realized Capital Gains (Losses)	0	0	0	0	0	0	0	0	0	0	0	0	0
25. Less Capital Gains Tax	0	0	0	0	0	0	0	0	0	0	0	0	0
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
27. Prior Period Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
28. Net Income	0	0	0	0	0	0	0	0	0	0	0	0	0
29. Capital Increases	0	0	0	0	0	0	0	0	0	0	0	0	0
30. Other Increases (Decreases)	0	0	0	0	0	0	0	0	0	0	0	0	0
31. Dividends to Stockholders	0	0	0	0	0	0	0	0	0	0	0	0	0
32. End of Period Surplus (L27+L28+L29+L30-L31)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Minimum Surplus Requirement: HMO: Max[a,b,c]; PLHSO: Max[a,b]; DMPO: $150,000; Health Ins Co: Max[a,d]	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
a. HMO & Health Ins Co: $1,500,000; PLHSO & DMPO: 150,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
b. 10% of Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
c. 2% of Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
d. 4% Total Liabilities + 6% Health Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Excess (Deficit) Surplus	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**	**-1,500,000**
Risk Based Capital (200% ACL)	0	0	0	0	0	0	0	0	0	0	0	0	0
Risk Based Capital	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Annualized Premium	0	0	0	0	0	0	0	0	0	0	0	0	0
2% of Revenues	0	0	0	0	0	0	0	0	0	0	0	0	0

Company ABC
Pro-Forma Statutory Cash Flow Statement (Florida Experience)

	Year 1 (Monthly)												
	M1Y1	M2Y1	M3Y1	M4Y1	M5Y1	M6Y1	M7Y1	M8Y1	M9Y1	M10Y1	M11Y1	M12Y1	Total Year 1
Cash From Operations													
1. Premiums Collected Net of Reinsurance	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Benefits Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Underwriting Expenses Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Total Cash From Underwriting (L1-L2-L3)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
5. Net Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Dividends to Policyholders	0	0	0	0	0	0	0	0	0	0	0	0	0
8. Federal and Foreign Income Taxes (Paid) Recovered	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Health Insurers Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Net Cash From Operations (L4+L5+L6-L7+L8-L9)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Investments													
11. Net Cash from Investments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Financing and Misc Sources													
12. Capital and paid in Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
13. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Borrowed Funds	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Dividends	0	0	0	0	0	0	0	0	0	0	0	0	0
16. Other Cash Provided (Applied)	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Net Cash from Financing and Misc Sources (L12+L13+L14-L15+L16)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
18. Net Cash, Cash Equivalents and Short -Term Investments (L10+L11+L17)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Pro-Forma Statutory Cash Flow Statement (Florida Experience)

	Year 2 (Monthly)												
	M1Y2	M2Y2	M3Y2	M4Y2	M5Y2	M6Y2	M7Y2	M8Y2	M9Y2	M10Y2	M11Y2	M12Y2	Total Year 2
Cash From Operations													
1. Premiums Collected Net of Reinsurance	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Benefits Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Underwriting Expenses Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Total Cash From Underwriting (L1-L2-L3)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
5. Net Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Dividends to Policyholders	0	0	0	0	0	0	0	0	0	0	0	0	0
8. Federal and Foreign Income Taxes (Paid) Recovered	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Health Insurers Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Net Cash From Operations (L4+L5+L6-L7+L8-L9)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Investments													
11. Net Cash from Investments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Financing and Misc Sources													
12. Capital and paid in Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
13. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Borrowed Funds	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Dividends	0	0	0	0	0	0	0	0	0	0	0	0	0
16. Other Cash Provided (Applied)	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Net Cash from Financing and Misc Sources (L12+L13+L14-L15+L16)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
18. Net Cash, Cash Equivalents and Short -Term Investments (L10+L11+L17)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Pro-Forma Statutory Cash Flow Statement (Florida Experience)

	Year 3 (Monthly)												
	M1Y3	M2Y3	M3Y3	M4Y3	M5Y3	M6Y3	M7Y3	M8Y3	M9Y3	M10Y3	M11Y3	M12Y3	Total Year 3
Cash From Operations													
1. Premiums Collected Net of Reinsurance	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Benefits Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Underwriting Expenses Paid	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Total Cash From Underwriting (L1-L2-L3)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
5. Net Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Dividends to Policyholders	0	0	0	0	0	0	0	0	0	0	0	0	0
8. Federal and Foreign Income Taxes (Paid) Recovered	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Health Insurers Provider Fee	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Net Cash From Operations (L4+L5+L6-L7+L8-L9)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Investments													
11. Net Cash from Investments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash From Financing and Misc Sources													
12. Capital and paid in Surplus	0	0	0	0	0	0	0	0	0	0	0	0	0
13. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Borrowed Funds	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Dividends	0	0	0	0	0	0	0	0	0	0	0	0	0
16. Other Cash Provided (Applied)	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Net Cash from Financing and Misc Sources (L12+L13+L14-L15+L16)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
18. Net Cash, Cash Equivalents and Short -Term Investments (L10+L11+L17)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Pro-Forma Statutory Balance Sheet (Florida Experience)

	Year 1 (YTD)											
	M1Y1	M2Y1	M3Y1	M4Y1	M5Y1	M6Y1	M7Y1	M8Y1	M9Y1	M10Y1	M11Y1	M12Y1
Admitted Assets												
1. Bonds	0	0	0	0	0	0	0	0	0	0	0	0
2. Stock	0	0	0	0	0	0	0	0	0	0	0	0
3. Real Estate/Mortgage Investments	0	0	0	0	0	0	0	0	0	0	0	0
4. Cash/Cash Equivalents	0	0	0	0	0	0	0	0	0	0	0	0
5. Health Insurers Provider Fee (from AHCA)	0	0	0	0	0	0	0	0	0	0	0	0
6. Affiliated Receivables	0	0	0	0	0	0	0	0	0	0	0	0
7. Affiliated Investments	0	0	0	0	0	0	0	0	0	0	0	0
8. Aggregate Write-Ins for Invested Assets	0	0	0	0	0	0	0	0	0	0	0	0
9. Aggregate Write-Ins for Other Than Invested Assets - ACA Risk Adjustment Receivable	0	0	0	0	0	0	0	0	0	0	0	0
10. Amounts Recoverable from Reinsurers	0	0	0	0	0	0	0	0	0	0	0	0
11. Other Assets	0	0	0	0	0	0	0	0	0	0	0	0
12. Total Assets(L1+L2+L3+L4+L5+L6+L7+L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities												
13. Net Claims Unpaid (Accident and Health Policies)	0	0	0	0	0	0	0	0	0	0	0	0
14. Unpaid Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0
15a. Aggregate Health Policy Reserves (Excluding ACA Risk Adjustment Payable and MLR Rebate)	0	0	0	0	0	0	0	0	0	0	0	0
15b. Aggregate Health Policy Reserves - ACA Risk Adjustment Payable	0	0	0	0	0	0	0	0	0	0	0	0
15c. Aggregate Health Policy Reserves - MLR Rebate	0	0	0	0	0	0	0	0	0	0	0	0
16. Aggregate Life Policy Reserves	0	0	0	0	0	0	0	0	0	0	0	0
17. Premiums Received in Advanced	0	0	0	0	0	0	0	0	0	0	0	0
18. General Expenses Due or Accrued	0	0	0	0	0	0	0	0	0	0	0	0
19. Ceded Reinsurance Payable	0	0	0	0	0	0	0	0	0	0	0	0
20. Payable to Parents, Subsidiaries & Affiliates	0	0	0	0	0	0	0	0	0	0	0	0
21. Aggregate Write-Ins for Other Liabilities - Health Insurer Fee (Payable This Year)	0	0	0	0	0	0	0	0	0	0	0	0
22. Other Liabilities	0	0	0	0	0	0	0	0	0	0	0	0
23. Total Liabilities (L13+L14+L15a,b,c+L16+L17+L18+L19+L20+L21+L22)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capital and Surplus												
24. Aggregate Write-Ins for Special Surplus Funds - Health Insurer Fee (Payable Next Year)	0	0	0	0	0	0	0	0	0	0	0	0
25. Capital Stock	0	0	0	0	0	0	0	0	0	0	0	0
26. Gross Paid In and Contributed Surplus	0	0	0	0	0	0	0	0	0	0	0	0
27. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0
28. Unassigned Surplus	0	0	0	0	0	0	0	0	0	0	0	0
29. Other Items(elaborate)	0	0	0	0	0	0	0	0	0	0	0	0
30. Total Capital and Surplus(L23+L24+L25+L26+L27+L28)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Pro-Forma Statutory Balance Sheet (Florida Experience)

	Year 2 (YTD)											
	M1Y2	M2Y2	M3Y2	M4Y2	M5Y2	M6Y2	M7Y2	M8Y2	M9Y2	M10Y2	M11Y2	M12Y2
Admitted Assets												
1. Bonds	0	0	0	0	0	0	0	0	0	0	0	0
2. Stock	0	0	0	0	0	0	0	0	0	0	0	0
3. Real Estate/Mortgage Investments	0	0	0	0	0	0	0	0	0	0	0	0
4. Cash/Cash Equivalents	0	0	0	0	0	0	0	0	0	0	0	0
5. Health Insurers Provider Fee (from AHCA)	0	0	0	0	0	0	0	0	0	0	0	0
6. Affiliated Receivables	0	0	0	0	0	0	0	0	0	0	0	0
7. Affiliated Investments	0	0	0	0	0	0	0	0	0	0	0	0
8. Aggregate Write-Ins for Invested Assets	0	0	0	0	0	0	0	0	0	0	0	0
9. Aggregate Write-Ins for Other Than Invested Assets - ACA Risk Adjustment Receivable	0	0	0	0	0	0	0	0	0	0	0	0
10. Amounts Recoverable from Reinsurers	0	0	0	0	0	0	0	0	0	0	0	0
11. Other Assets	0	0	0	0	0	0	0	0	0	0	0	0
12. Total Assets(L1+L2+L3+L4+L5+L6+L7+L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities												
13. Net Claims Unpaid (Accident and Health Policies)	0	0	0	0	0	0	0	0	0	0	0	0
14. Unpaid Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0
15a. Aggregate Health Policy Reserves (Excluding ACA Risk Adjustment Payable and MLR Rebate)	0	0	0	0	0	0	0	0	0	0	0	0
15b. Aggregate Health Policy Reserves - ACA Risk Adjustment Payable	0	0	0	0	0	0	0	0	0	0	0	0
15c. Aggregate Health Policy Reserves - MLR Rebate	0	0	0	0	0	0	0	0	0	0	0	0
16. Aggregate Life Policy Reserves												
17. Premiums Received in Advanced	0	0	0	0	0	0	0	0	0	0	0	0
18. General Expenses Due or Accrued	0	0	0	0	0	0	0	0	0	0	0	0
19. Ceded Reinsurance Payable	0	0	0	0	0	0	0	0	0	0	0	0
20. Payable to Parents, Subsidiaries & Affiliates	0	0	0	0	0	0	0	0	0	0	0	0
21. Aggregate Write-Ins for Other Liabilities - Health Insurer Fee (Payable This Year)	0	0	0	0	0	0	0	0	0	0	0	0
22. Other Liabilities	0	0	0	0	0	0	0	0	0	0	0	0
23. Total Liabilities (L13+L14+L15a,b,c+L16+L17+L18+L19+L20+L21+L22)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capital and Surplus												
24. Aggregate Write-Ins for Special Surplus Funds - Health Insurer Fee (Payable Next Year)	0	0	0	0	0	0	0	0	0	0	0	0
25. Capital Stock	0	0	0	0	0	0	0	0	0	0	0	0
26. Gross Paid In and Contributed Surplus	0	0	0	0	0	0	0	0	0	0	0	0
27. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0
28. Unassigned Surplus	0	0	0	0	0	0	0	0	0	0	0	0
29. Other Items(elaborate)	0	0	0	0	0	0	0	0	0	0	0	0
30. Total Capital and Surplus(L23+L24+L25+L26+L27+L28)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Pro-Forma Statutory Balance Sheet (Florida Experience)

	Year 3 (YTD)											
	M1Y3	M2Y3	M3Y3	M4Y3	M5Y3	M6Y3	M7Y3	M8Y3	M9Y3	M10Y3	M11Y3	M12Y3
Admitted Assets												
1. Bonds	0	0	0	0	0	0	0	0	0	0	0	0
2. Stock	0	0	0	0	0	0	0	0	0	0	0	0
3. Real Estate/Mortgage Investments	0	0	0	0	0	0	0	0	0	0	0	0
4. Cash/Cash Equivalents	0	0	0	0	0	0	0	0	0	0	0	0
5. Health Insurers Provider Fee (from AHCA)	0	0	0	0	0	0	0	0	0	0	0	0
6. Affiliated Receivables	0	0	0	0	0	0	0	0	0	0	0	0
7. Affiliated Investments	0	0	0	0	0	0	0	0	0	0	0	0
8. Aggregate Write-Ins for Invested Assets	0	0	0	0	0	0	0	0	0	0	0	0
9. Aggregate Write-Ins for Other Than Invested Assets - ACA Risk Adjustment Receivable	0	0	0	0	0	0	0	0	0	0	0	0
10. Amounts Recoverable from Reinsurers	0	0	0	0	0	0	0	0	0	0	0	0
11. Other Assets	0	0	0	0	0	0	0	0	0	0	0	0
12. Total Assets(L1+L2+L3+L4+L5+L6+L7+L8+L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities												
13. Net Claims Unpaid (Accident and Health Policies)	0	0	0	0	0	0	0	0	0	0	0	0
14. Unpaid Claims Adjustment Expenses	0	0	0	0	0	0	0	0	0	0	0	0
15a. Aggregate Health Policy Reserves (Excluding ACA Risk Adjustment Payable and MLR Rebate)	0	0	0	0	0	0	0	0	0	0	0	0
15b. Aggregate Health Policy Reserves - ACA Risk Adjustment Payable	0	0	0	0	0	0	0	0	0	0	0	0
15c. Aggregate Health Policy Reserves - MLR Rebate	0	0	0	0	0	0	0	0	0	0	0	0
16. Aggregate Life Policy Reserves												
17. Premiums Received in Advanced	0	0	0	0	0	0	0	0	0	0	0	0
18. General Expenses Due or Accrued	0	0	0	0	0	0	0	0	0	0	0	0
19. Ceded Reinsurance Payable	0	0	0	0	0	0	0	0	0	0	0	0
20. Payable to Parents, Subsidiaries & Affiliates	0	0	0	0	0	0	0	0	0	0	0	0
21. Aggregate Write-Ins for Other Liabilities - Health Insurer Fee (Payable This Year)	0	0	0	0	0	0	0	0	0	0	0	0
22. Other Liabilities	0	0	0	0	0	0	0	0	0	0	0	0
23. Total Liabilities (L13+L14+L15a,b,c+L16+L17+L18+L19+L20+L21+L22)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capital and Surplus												
24. Aggregate Write-Ins for Special Surplus Funds - Health Insurer Fee (Payable Next Year)	0	0	0	0	0	0	0	0	0	0	0	0
25. Capital Stock	0	0	0	0	0	0	0	0	0	0	0	0
26. Gross Paid In and Contributed Surplus	0	0	0	0	0	0	0	0	0	0	0	0
27. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0
28. Unassigned Surplus	0	0	0	0	0	0	0	0	0	0	0	0
29. Other Items(elaborate)	0	0	0	0	0	0	0	0	0	0	0	0
30. Total Capital and Surplus(L23+L24+L25+L26+L27+L28)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Company ABC
Analysis of Operations by Line Of Business (Florida Experience)

End of Year 1	Total	Comprehensive	Dental	Vision	Medicare	Medicaid
1a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	0	0	0	0	0	0
1b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	0	0	0	0	0	0
2. Fee for Service	0	0	0	0	0	0
3. Risk Revenue	0	0	0	0	0	0
4. Change in unearned premium reserves	0	0	0	0	0	0
5. Aggregate write in for other health related revenue	0	0	0	0	0	0
6. Total (L1a,b+L2+L3+L4+L5)	**0**	**0**	**0**	**0**	**0**	**0**
Hospital and Medical:						
7. Hospital/Medical Benefits	0	0	0	0	0	0
8. Other professional Services	0	0	0	0	0	0
9. Prescription Drugs	0	0	0	0	0	0
10. Aggregate write ins for other hospital/medical	0	0	0	0	0	0
11. Subtotal (L7+L8+L9+L10)	**0**	**0**	**0**	**0**	**0**	**0**
Less:						
12. Reinsurance recoveries	0	0	0	0	0	0
13. Total hospital and Medical (L11 -L12)	0	0	0	0	0	0
14. Claims adjustment expenses	0	0	0	0	0	0
15a. General admin expenses (excluding HIP Fee & User Fee paid)	0	0	0	0	0	0
15b. Health Insurance Fee Paid	0	0	0	0	0	0
15c. ACA Risk Adjustment User Fee Paid	0	0	0	0	0	0
16. Increase in reserves for accident and health contacts	0	0	0	0	0	0
17. Aggregate write in for other income or expenses	0	0	0	0	0	0
18. Total underwriting deductions (L13+L14+L15a,b,c+L16+L17)	**0**	**0**	**0**	**0**	**0**	**0**
19. Net underwriting gain or loss (L6 -L18)	**0**	**0**	**0**	**0**	**0**	**0**
Administrative Ratio (L15a/L6)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Other
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Company ABC
Preliminary MLR (Florida Experience)

End of Year 1	Total	Individual Comprehensive	Small Group Comprehensive	Large Group Comprehensive	Medicare (MA/Pt D)	Individual Mini-Meds	Small Group Mini-Meds	Large Group Mini-Meds	Expatriate Plans
1. Premiums Earned	0	0	0	0	0	0	0	0	0
2. Federal Taxes/Federal Assessments	0	0	0	0	0	0	0	0	0
3. State Insurance, Premium, and Other Taxes	0	0	0	0	0	0	0	0	0
4a. Regulatory Authority License and Fees	0	0	0	0	0	0	0	0	0
4b. Health Insurers Provider Fee	0	0	0	0	0	0	0	0	0
5. Adjusted Premium Earned (L1-L2-L3-L4a,b)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
6. Incurred Claims Excluding Prescription Drugs	0	0	0	0	0	0	0	0	0
7. Prescription Drugs	0	0	0	0	0	0	0	0	0
8. Pharmaceutical Rebates	0	0	0	0	0	0	0	0	0
9. State Stop Loss, Market Stabilization and Claim/Census Based Assessments	0	0	0	0	0	0	0	0	0
10. Net Risk Adjustment (+Payments - Recoverables)	0	0	0	0	0	0	0	0	0
11. Incurred Medical Incentive Pools and Bonuses	0	0	0	0	0	0	0	0	0
12. Total Incurred Claims (L6+L7-L8-L9+L10+L11)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
13. Deductible Abuse Detection/Recovery Expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
14. Improved Health Outcomes	0	0	0	0	0	0	0	0	0
15. Activities to Prevent Hospital Readmissions	0	0	0	0	0	0	0	0	0
16. Improve Patient Safety and Reduce Medical Errors	0	0	0	0	0	0	0	0	0
17. Wellness and Health Promotion Activities	0	0	0	0	0	0	0	0	0
18. QI Health Information Technology Expenses	0	0	0	0	0	0	0	0	0
19. Total Expenses Incurred for Improving Health Quality (L14+L15+L16+L17+L18)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
20. Preliminary MLR ((L12+L13+L19)/L5)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Company ABC
Summary of Results

	End of Year 1						End of Year 2						End of Year 3					
Scenario Description	Members	Net Cash	Net Income	Surplus	Required Surplus	Excess (Deficit)	Members	Net Cash	Net Income	Surplus	Required Surplus	Excess (Deficit)	Members	Net Cash	Net Income	Surplus	Required Surplus	Excess (Deficit)
Base																		
Increase Admin Expenses x%																		
Decrease Admin Expenses x%																		
Increase New Sales x%																		
Decrease New Sales x%																		
Increase Loss Ratio x%																		
Decrease Loss Ratio x%																		