UTAH ACCIDENT & HEALTH SURVEY
ASO SUPPLEMENT INSTRUCTIONS
For Reporting Year 2025

The ASO Supplement is in addition to the Utah Accident & Health Survey. All companies that filed a Utah Accident & Health Survey and had administrative services business during the reporting year must complete and submit the ASO Supplement. If you do not have any administrative services business you are exempt from filing the ASO Supplement.

This follow-up survey is designed to collect data on administrative services in greater detail. All data values reported on the survey form should represent the year-end totals of the reporting year (December 31st).

Submit the completed supplement to the Utah Insurance Department by April 1st of each year. All surveys should be submitted through the UID secure file upload website: https://forms.uid.utah.gov/fileUploads/ then select the **HEALTH RESEARCH*Notify All**. Any other forms of data submission are not acceptable. To submit your form, you will need to have a UtahID account. If you do not have one already, you can find instructions on setting up your UtahID here (https://insurance.utah.gov/wp-content/uploads/CreatingYourUtahID.pdf).

Failure to file by the deadline may subject your company to the enforcement penalties under Utah Code § 31A-2-308. Any questions on completing this survey form should be directed to the Research Analyst via email to healthresearch@utah.gov.

SIGNATURE FORM

The signature form submitted to the Utah Insurance Department by your company with the Accident and Health Survey also covers the follow-up supplements, such as the Administrative Services and Stop Loss Supplement.

Part 1-A
ADMINISTRATIVE SERVICES FOR UTAH SELF-FUNDED HEALTH BENEFIT PLANS

Self-Funded Health Benefit Plans
Include any administrative business such as third party administration, administrative services only or administrative services contract, provided to a self-funded or ERISA eligible employer-sponsored health benefit plan in the State of Utah. Only include plans that function as the primary health benefit plan of the covered member.

COLUMN DEFINITIONS

Number of Members
Enter the total number of members in self-funded health benefit plans administered by the insurer.

Admin. Income
Enter the total dollar amount of administrative income received by the insurer for administrating self-funded health benefit plans.

Total Claims Paid
Enter the total dollar amount of claims processed by the insurer while administrating self funded health benefit plans.

ROW DEFINITIONS

Indemnity / Fee for Service Plan (FFS)
Under a Traditional Indemnity or Fee For Service plan (FFS), members may receive care from any provider as long as the services are a covered benefit under the health benefit plan. There are no preferred provider networks and all services are reimbursed at the same cost sharing level, typically a fixed percentage of billed charges, regardless of which provider is selected. Members generally pay a fixed coinsurance amount after meeting the deductible.

If an FFS plan includes a PPO rider that allows individuals to pay a lower copayment or coinsurance rate when using preferred network providers, then the plan should be classified as a PPO for the purposes of this survey.

Preferred Provider Organization Plan (PPO)
Under a Preferred Provider Organization plan (PPO), members receive lower deductibles and coinsurance when they use physicians or hospitals within the preferred provider network. PPO's cannot restrict members to in-network providers only. Doing so would create an EPO arrangement which is not permitted under Utah law. Instead, PPOs provide a financial incentive for members to stay within the network, as in-network services cost less. Members may use providers outside the network, but those services are reimbursed at a lower rate which creates higher costs to the member. If a PPO plan required permission from a primary care physician, gatekeeper, or any other type of preauthorization before members could receive services from an out-of-network non-preferred provider, it is classified as a PPO for this survey. Do not place PPO with POS feature plans in the "Other" category; classify them as "PPO".

Exclusive Provider Organization Plan (EPO)
Under an Exclusive Provider Organization plan (EPO plan), the insured member must use the EPO network providers exclusively, except in the case of an emergency. Services received outside of the EPO network are not covered. EPO plans function similarly to HMO plans in that they limit services to a defined set of network providers. However, they differ from HMO plans because they are offered by a standard accident & health insurance carrier that may offer both PPO and EPO plans and does not qualify as a licensed HMO.

Health Maintenance Organization Plan (HMO)
Under an HMO plan, the member must use the HMO network providers exclusively, except in the case of an emergency. Services provided outside of the HMO network are not covered. Only licensed HMOs can offer HMO plans in Utah.

Health Maintenance Organization Plan with Point of Service
Use this category for HMO plans which include a point-of-service option, indemnity carve out, out-of-network rider, or similar feature allowing members to use providers outside of the HMO network for routine medical services (not emergencies), and reimbursed at a lower reimbursement rate.

Other Plans
The "other" category should be used only for plans that do not fit into any of the previously defined categories. If used, provide a description of the plan features and explain why none of the other categories apply.

Do not include PPO plans with POS features plans in this category, they should be classified as a PPO. In most cases this category should not be used, as Utah self-funded health benefit plans typically fit into one of the other categories.

Part 1-B
ADMINISTRATIVE SERVICES FOR FEHBP, MEDICARE, MEDICAID, DENTAL AND VISION

You should only complete this section if your company provides administrative services only (ASO), administrative services contracts (ASC) and other non-underwritten administrative business related to the Federal Employee Health Benefit Plan (FEHBP), Utah Medicaid, Federal Medicare programs, self-funded dental benefit plans, self-funded vision benefit plans, or other type of administrative services that the Utah Insurance Department needs additional information on. Exclude all business reported under self-funded health benefit plans. All data should be current as of December 31 of the reporting year. Most companies that need this category have already been instructed to use it. If you have questions on whether you should use this category, contact the Research Analyst at healthresearch@utah.gov.

Part 2
UTAH SELF-FUNDED HEALTH BENEFIT PLANS

COLUMN DEFINITIONS

Number of Members
Enter the total number of members, including all dependents, in self-funded health benefit plans administered by the insurer. For group policies, the total should equal the number of subscribers, plus their dependents.

Cumulative Member Months
Enter the cumulative year-end member months for each Utah self-funded health benefit plan category. If you report self-funded health benefit plan business, you are required to report member months, even if the year-end membership is zero. To calculate member months, determine the number of members for each month of the calendar year, resulting in 12 monthly member counts. Add these twelve counts together to obtain the cumulative member months for the year. For example, if your company had 10

members in each of the 12 months, the calculation would be: 10 members x 12 months = 120 member months.

Number of Subscribers
Subscriber (also called certificate holder) refers to the individual whose eligibility is the basis for the enrollment in the individual or group health plan and/or who is responsible for the payment of premiums.

Number of Dependents
A dependent is a covered member who relies on another member (typically the subscriber) for support, or who receives health coverage through a spouse or parent who is the primary covered member or subscriber under a health plan.

Number of Groups
Enter the total number of employer groups covered as of the last day of the reporting period. This figure represents the number of employer groups, not the number of subscribers. Provide the total number of employer groups for each row category. "Number of Groups" refers to the count of the number of employer groups that have a particular type of health benefit plan.

Because a single employer group may have multiple types of health benefit plans, the counts in this column may not add up to the subtotals and totals shown elsewhere in the table. For example, in Table 2, if one employer group had an FFS plan (line 3.1), a PPO plan (line 3.2), an EPO plan (line 3.3), a HMO plan (line 3.4), and a POS plan (line 3.5) the total number of groups (line 3.7) is still be one, not five because there is still only one employer being covered even though the employer offers multiple plans. The unit of analysis is the employer group, not the health benefit plan. Therefore, this column may not sum total due to such overlap. Report the actual number of employer groups applicable to each row category.

ROW DEFINITIONS

Group Categories

- **Small Group (1 to 50)**
  Insured policies issued to a group organization of 1 to 50 employees.
- **Large Group (51 to 100)**
  Insured policies issued to a group organization of 51 to 100 employees.
- **Large Group (101 or more)**
  Insured policies issued to a group organization of 101 or more employees.
- **Total**
  This represents the combined total of Small Group and Large Group categories. Note: Column 5 “Number of Groups” may not sum to the totals shown in the subtotals of lines 1.7, 2.7, 3.7, and 4.7.

PLAN CATEGORIES

Indemnity / Fee For Service Plan (FFS)
Under a Traditional Indemnity or FFS plan, members may receive care from any provider as long as the

service is covered under the health benefit plan. There are no preferred provider networks, and all services are reimbursed at the same cost sharing level, typically a fixed percentage of billed charges regardless of the provider they choose. Members generally pay a fixed coinsurance rate after meeting the deductible.

If the FFS plan includes a PPO rider that allows members to pay a lower copayment or coinsurance rate using a network of preferred providers, classify the plan as a PPO for this survey.

Preferred Provider Organization Plan (PPO)
Under a PPO, members pay lower deductibles and coinsurance when using physicians or hospitals in the preferred provider network. PPOs cannot restrict members to this network only, as doing so would create an EPO which is prohibited under Utah law.

Members have a financial incentive to use in-network providers, as costs are lower. Members may use any provider outside the network, but services are reimbursed at a lower rate and typically members must pay higher costs to do so.

Previously, if the PPO plan required primary physician referrals, gatekeeper approval, or pre-authorization for out of network services, it was classified as a PPO with POS features. For this survey all PPO plans including those with POS features should be classified as a PPO. Do not place PPO with POS feature plans in the “Other”category.

Exclusive Provider Organization Plan (EPO)
Members must use the EPO network providers exclusively, except in emergencies. Services outside the EPO network are not covered. EPOs are similar to HMOs in restricting care to a defined network, but differ in that they are offered by standard accident & health insurance carriers (which may also offer PPO plans) and are not licensed HMOs.

Health Maintenance Organization (HMO)
Members must use the HMO network providers exclusively, except in emergencies. Services provided outside the HMO network are not covered. Only licensed HMOs can offer HMO plans in Utah.

Exclusive Provider Organization Plan (EPO)
Members must use the EPO network providers exclusively, except in emergencies. Services outside the EPO network are not covered. EPOs are similar to HMOs in restricting care to a defined network, but differ in that they are offered by standard accident & health insurance carriers (which may also offer PPO plans) and are not licensed HMOs.

Health Maintenance Organization Plan (HMO)
Members must use the HMO network providers exclusively, except in emergencies. Services provided outside the HMO network are not covered. Only licensed HMOs can offer HMO plans in Utah.

Health Maintenance Organization Plan with Point of Service (POS)
Use this category for HMO plans that include a point-of-service option, indemnity carve out,

out-of-network rider, or similar feature allowing members to use providers outside of the network for routine non-emergency services at a lower reimbursement rate resulting in higher member costs.

Other Plans
Use this category only for plans that do not fit into any of the above categories. Include a description of the plan and explain why the other categories do not apply. Do not place PPO plans with POS features in "Other". They should be classified as PPO. This category is rarely used as most Utah self-funded health benefit plans fit into one of the defined categories.

Part 3
STANDARD VS HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLANS

COLUMN DEFINITIONS

Number of Members
Enter the total number of members in self-funded health benefit plans administered by the insurer including all dependents. For group policies, the total must equal the number of subscribers plus dependents.

Cumulative Member Months
Report the cumulative year-end member months for each Utah self-funded health benefit plan category. If you report self-funded plan business, you must report member months, even if the ending membership for the calendar year is zero. To calculate member months, count the number of members for each month of the year. Then add them together. This total is the cumulative member months for the year. For example: if your company had 10 members during each of the 12 months of the year, the cumulative member months would be calculated as follows: 10 members x 12 months = 120 member months.

Number of Subscribers
A subscriber (also called certificate holder) is the individual whose eligibility determines enrollment in the individual or group plan and/or who is responsible for the premium payments.

Number of Dependents
A dependent is a covered member who relies on another member (typically the subscriber) for support or who receives health coverage through a spouse or parent who is the primary covered member under the health plan.

Number of Groups
Enter the total number of employer groups covered as of the last day of the reporting period. This is not a count of the number of subscribers. Enter the total number of employer groups for each row category. "Number of groups" refers to the count of employer groups that have a particular type of health benefit plan. Unlike the other column categories, the total in this column may not sum to the total number of groups reported in the subtotals. For example, in Table 3, if one employer group offers both a Standard plan (line 1.1) and an HSA-qualified HDHP plan, the total number of groups (line 1.3) is still be one, not two, because there is only one employer, even though the employer sponsors two separate health benefit plans. The unit of analysis is the employer group, not the number of plans. Therefore, this column may

appear to "double count" and will not necessarily total across the categories. Report the actual number of employer groups that apply to each row.

Total Claims Paid (Dollars)
Enter the total dollar amount of claims processed by the insurer while administrating self-funded health benefit plans.

ROW DEFINITIONS
***Group Categories*:** See page 4

Product Categories

- **Standard**
  These are standard employee health benefit plans traditionally offered in Utah by self-funded groups. They are not subject to state mandates or plan requirements described under the Utah Insurance Code. Exclude HSA-qualified HDHP plans.

- **HSA-Qualified HDHP**
  Include any high-deductable health plan that qualifies for use with a Health Savings Account (HSA). Exclude all plans that are not an HSA-Qualified HDHP plan (e.g., All traditional health plans).

Part 4
STOP-LOSS INSURANCE COVERAGE

Stop-Loss Insurance Coverage
"Stop-loss insurance" is insurance purchased to protect a group health benefit plan from losses that exceed a specified amount, on either a per-claim or aggregate basis, subject to the policy limit. Stop-loss coverage may include specific stop-loss limits (*see "Specific Attachment Point"*) and/or aggregate stop-loss limits (*see "Aggregate Attachment Point"*). These products protect employer groups from catastrophic or unpredictable losses.

Stop-loss insurance is typically used by employers or administrators of unfunded or self-funded plans who do not wish to assume full liability for all claims. Under these arrangements, the employer pays health care costs up to predetermined limits, and the stop-loss insurer assumes the risk above those limits, whether for a single high-cost claim (specific stop-loss) or for a total combined claims (aggregate stop-loss). This coverage limits the employer's financial risk while allowing the employer to retain control over plan design, claims and benefits.

Specific Stop-loss
Specific stop-loss limits the employer group's cost for eligible medical expenses for each individual. This is known as the individual stop-loss, individual attachment point, or individual deductible. Minimum attachment points are generally based on the stop-loss carrier's review of the group's demographics, expected claims, claims history, and the employer group's risk tolerance. The optimal specific stop-loss limit is often set as a percentage of expected claims.

Specific Attachment Point
The specific attachment point is the dollar threshold at which a stop-loss insurance carrier begins paying for an individual's claims. Once an individual's medical claims exceed this set limit within the policy year, the stop-loss carrier covers the remaining costs. This amount is also known as a specific limit or individual stop-loss deductible.

Aggregate Stop-Loss
Insurance that protects against an unusually high frequency of medium and large claims over an entire group. It places a cap on the dollar amount of eligible expenses that an employer or group health plan must pay during a contract period.

Aggregate Attachment Point
The aggregate attachment point is the dollar threshold when a stop-loss insurance contract will pay for a group's excess claims. This limit is the threshold at which medical claims become payable from the assets for the stop-loss carrier for the remainder of the policy year when claims for the group as a whole exceed the limits based on the factors outlined in the policy. No payments are made until the sum of all paid claims for the contract period exceeds a predetermined limit or aggregate attachment point. This limit is based on the expected claim costs (often based on an evaluation of claims from previous years and a projection of expected claims from the coming year). The aggregate attachment point is often expressed as an aggregate factor or margin (e.g., 100 percent of expected claims plus a 25 percent margin). The stop-loss carrier begins paying out after the aggregate stop-loss funding level (e.g., 125 percent of expected claims) is reached.

Part 4-A
STOP-LOSS INSURANCE COVERAGE

This table shows the number of individual members and groups participating in a self-funded health benefit plan that is protected by some form of stop-loss insurance.

COLUMN DEFINITIONS

Number of Members Covered
Enter the total number of members enrolled in a self-funded health benefit plan administered by the insurer that is covered by any type of stop-loss insurance.

Number of Groups Covered
Enter the total number of groups in a self-funded health benefit plan administered by the insurer that are covered by any type of stop-loss insurance. Report the number of employer groups for each row category. The term "number of groups" refers to the count of distinct employer groups that have a particular type of health benefit plan.

Because a single employer may sponsor multiple plans, the total in this column may not always match the subtotals reported for the table. For example, in Table 4-A, if one employer offers both a plan with stop-loss coverage (line 1.1) and a plan without stop loss coverage (line 1.2), the total number of groups

(line 1.3) remains one, not two because there is only one employer group even though it sponsors two separate plans. The unit of analysis is the employer group, not the number of plans. Therefore unlike other columns, this column may not sum to the overall total due to potential double counting of groups.

ROW DEFINITIONS

With Stop-Loss Coverage

Enter the total number of members and groups enrolled in a self-funded health benefit plan administered by the insurer that are covered by any type of stop-loss insurance.

Without Stop-Loss Coverage

Enter the total number of members and employer groups in a self-funded health benefit plan administered by the insurer that does not have any type of stop-loss insurance coverage.

Total

Enter the total number of members and employer groups in self-funded health benefit plans administered by the insurer. Note: The values reported in Column 2 (number of groups covered) may not always equal the subtotal of groups shown on lines 1.3. Line 1.3 should align with the total number of members and groups reported in line 4.6, part 2.

Part 4-B
STOP-LOSS INSURANCE SPECIFIC ATTACHMENT POINTS

This table reports the number of individual members and employer groups enrolled in self-funded health benefit plans covered by stop-loss insurance, categorized by their specific attachment points. It does not include or measure aggregate attachment points.

COLUMN DEFINITIONS

Number of Members

Enter the total number of members enrolled in self-funded health benefit plans administered by the insurer that are covered by stop-loss insurance categorized by their specific attachment point (individual stop-loss deductible). The total number of members reported in part 4-B, line 1.22, columns 1, 3, and 5 must equal the total number of members covered in part 4A, line 1.1, column 1.

Number of Groups Covered

Enter the total number of employer groups in a self-funded health benefit plan administered by the insurer that are covered by stop-loss insurance, broken out by a specific attachment point (individual stop-loss deductible). The term "Number of Groups Covered" refers to a count of distinct employer groups that offer a particular type of health benefit plan. Because a single employer may sponsor multiple plans with different attachment points, the totals in this column may not add up to the subtotals for the table.

For example, in part 4-B, if a one employer offers a plan a $10,000 (line 1.2) and another plan with a $20,000 attachment point (line 1.3), the total number of groups (line 1.22) would still be one, not two, because only one employer group is being counted, even though it sponsors two separate plans. The unit

of analysis is the employer group, not the number of plans. Therefore this column may not sum to the total due to potential double counting across categories.

Report the actual number of employer groups that apply to each row category. The total number of groups reported in part 4-B, line 1.22, columns 2, 4, and 6 must balance to the total number of groups covered in part 4-A, line 1.1, column 2.

ROW DEFINITIONS

None
Total number of members and groups protected under a stop-loss insurance policy without a specific individual stop-loss attachment point (deductible).

$10,000 – $19,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $10,000 and $19,999.

$20,000 – $29,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point deductible) between $20,000 and $29,999.

$30,000 – $39,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $30,000 and $39,999.

$40,000 – $49,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $40,000 and $49,999.

$50,000 – $59,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $50,000 and $59,999.

$60,000 – $69,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point deductible) between $60,000 and $69,999.

$70,000 – $79,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $70,000 and $79,999.

$80,000 – $89,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $80,000 and $89,999.

$90,000 – $99,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point deductible) between $90,000 and $99,999.

$100,000 – $199,999
Total number of members and groups protected under a stop-loss insurance policy with a specific attachment point (individual stop-loss deductible) between $100,000 and $199,999.

$200,000 – $299,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $200,000 and $299,999.

$300,000 – $399,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $300,000 and $299,999.

$400,000 – $499,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $400,000 and $499,999.

$500,000 – $599,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $500,000 and $599,999.

$600,000 – $699,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $600,000 and $699,999.

$700,000 – $799,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $700,000 and $799,999.

$800,000 – $899,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $800,000 and $899,999.

$900,000 – $999,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $900,000 and $999,999.

$1,000,000 – $1,999,999
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) between $1,000,000 and $1,999,999.

$2,000,000 or More
Total number of members and groups protected under a stop-loss insurance policy with a specific individual stop-loss attachment point (deductible) of $2,000,000 or more.

Total
Enter the total number of members and groups protected under a stop-loss insurance policy. Note: The "Number of Groups Covered"(Columns 2, 4, 6) may not necessarily add up to the total number of groups reported in the totals of lines 1.22. Refer to the definition of "Number of Groups" for more information. Line 1.22 should balance to the number of members and groups reported in part 3.

Part 4-C
STOP-LOSS INSURANCE AGGREGATE ATTACHMENT POINTS

This table reports the number of individual members and employer groups enrolled in self-funded health benefit plans that are covered by stoploss insurance, categorized by their aggregate attachment points. It does not include or measure specific attachment points.

COLUMN DEFINITIONS
Number of Members Covered
Enter the total number of members in group health benefit plans covered by stoploss insurance categorized by their aggregate attachment point (aggregate stop-loss deductible). The total number of members reported in part 4-C, line 1.12, columns 1, 3, and 5 must match the total number of members covered in part 4-A, line 1.1, column 1.

Number of Groups Covered
Enter the total number of groups in a group health benefit plan covered by stop-loss insurance categorized by their aggregate attachment point (aggregate stop-loss deductible).

The term "Number of Groups Covered" refers to the count of distinct employer groups offering a particular type of health benefit plan. Because a single employer may sponsor multiple plans with different aggregate attachment points, the totals in this column may not necessarily add up to the subtotals for the table.

For example, in part 4-C, if one employer group offers a plan with an attachment point at 85% to 89% (line 1.2) and a plan with an attachment point at 90% to 94% (line 1.3), the total number of groups (line 1.12) would still be one, not two, because only one employer group exists even though it sponsors two separate plans. The unit of analysis is the employer group, not the number of plans. As a result, this column may not sum to the overall total due to potential double counting.
Report the actual number of employer groups applicable to each row category. The total number of groups reported in part 4-C, line 1.12, columns 2, 4, and 6 must match the total number of groups covered in part 4-A, line 1.1, column 2.

ROW DEFINITIONS

None

Total number of members and groups protected under a stop-loss insurance policy without an aggregate stop-loss attachment point (deductible).

85% - 89%

Total number of members and groups protected under a stop-loss insurance policy with an aggregate stop-loss attachment point (deductible) between 85% to 89% of expected paid claim costs.

90% - 94%

Total number of members and groups protected under a stop-loss insurance policy with an aggregate stop-loss attachment point (deductible) between 90% to 94% of expected paid claim costs.

95% - 99%

Total number of members and groups protected under a stop-loss insurance policy with an aggregate stop-loss attachment point (deductible) between 95% to 99% of expected paid claim costs.

100% - 104%

Total number of members and groups protected under a stop-loss insurance policy with an aggregate stop-loss attachment point (deductible) between 100% to 104% of expected paid claim costs.

105% - 109%

Total number of members and groups protected under a stop-loss insurance policy with an aggregate stop-loss attachment point (deductible) between 105% to 109% of expected paid claim costs.

110% - 114%

Total number of members and groups protected under a stop-loss insurance policy with an aggregate stop-loss attachment point (deductible) between 110% to 114% of expected paid claim costs.

115% - 119%

Total number of members and groups protected under a stop-loss insurance policy with an aggregate stop-loss attachment point (deductible) between 115% to 119% of expected paid claim costs.

120% - 124%

Total number of members and groups protected under a stop-loss insurance policy with an aggregate stop-loss attachment point (deductible) between 120% to 124% of expected paid claim costs.

125% - 129%

Total number of members and groups protected under a stop-loss insurance policy with an aggregate stop-loss attachment point (deductible) between 125% to 129% of expected paid claim costs.

130% or More

Total number of members and groups protected under a stop-loss insurance policy with an aggregate stop-loss attachment point (deductible) at least 130% or more of expected paid claim costs.

Total

Enter the total number of members and groups protected under a stop-loss insurance policy. Note: The "Number of Groups Covered" (Columns 2, 4 and 6) may not necessarily add up to the total number of groups reported in the totals of lines 1.12. Refer to the definition of "Number of Groups" for additional guidance. Line 1.12 must align with the number of members and groups reported in part 3.

Part 4-D
STOP-LOSS INSURANCE CARRIERS

List the names of all commercial health insurance carriers that provide stop-loss insurance coverage to the self-funded health benefit plans administered by your company as of the end of the reporting year. Include each carrier's NAIC company codes where applicable.

UTAH INSURANCE DEPARTMENT

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