Added explanation for No Stop Loss ReInsurance to General Interrogatories Part 2 5.2

1 5 2 8 4 2 0 2 0 2 0 1 0 0 1 0 5

# ANNUAL STATEMENT

**FOR THE YEAR ENDING DECEMBER 31, 2020**

OF THE CONDITION AND AFFAIRS OF THE

**HealthSpan Inc**

(Name)

NAIC Group Code 04831 (Current Period), 04831 (Prior Period) NAIC Company Code 15284 Employer's ID Number 31-1431434

Organized under the Laws of Ohio, State of Domicile or Port of Entry Ohio

Country of Domicile United States

Licensed as business type: Life, Accident & Health [ X ] Property/Casualty [ ] Hospital, Medical & Dental Service or Indemnity [ ]

Dental Service Corporation [ ] Vision Service Corporation [ ] Health Maintenance Organization [ ]

Other [ ] Is HMO, Federally Qualified? Yes [ ] No [ ]

Incorporated/Organized 07/30/2013 Commenced Business 07/30/2013

Statutory Home Office 1701 Mercy Health Place (Street and Number), Cincinnati, OH, US 45237 (City or Town, State, Country and Zip Code)

Main Administrative Office 1701 Mercy Health Place (Street and Number)

Cincinnati, OH, US 45237 (City or Town, State, Country and Zip Code) 310-561-7932 (Area Code) (Telephone Number)

Mail Address 1701 Mercy Health Place (Street and Number or P.O. Box), Cincinnati, OH, US 45237 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 1701 Mercy Health Place (Street and Number)

Cincinnati, OH, US 45237 (City or Town, State, Country and Zip Code), 310-561-7932 (Area Code) (Telephone Number) (Extension)

Internet Web Site Address N/A

Statutory Statement Contact Dorothy Williamson (Name), 310-561-7932 (Area Code) (Telephone Number) (Extension)

dorothywilliamson@mercy.com (E-Mail Address) 513-671-3721 (Fax Number)

## OFFICERS

| Name | Title | Name | Title |
|---|---|---|---|
| Jeffery Copeland | President & CEO | Ron Wehtje | Treasurer |
| | | | |

## OTHER OFFICERS

| | | | |
|---|---|---|---|
| | | | |

## DIRECTORS OR TRUSTEES

| | | | |
|---|---|---|---|
| Jeffery Copeland | Ronald Wehtje | Allan Calonge | |

State of .....Ohio.....

**ss**

County of .....

The officers of this reporting entity, being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC *Annual Statement Instructions* and *Accounting Practices* and *Procedures* manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

| | | |
|---|---|---|
| Jeffery Copeland<br>President & CEO | Ron Wehtje<br>Treasurer | |

Subscribed and sworn to before me this

_____ day of _____,

_____

a. Is this an original filing? Yes [ ] No [ X ]

b. If no:

1. State the amendment number 1
2. Date filed 05/03/2021
3. Number of pages attached

# GENERAL INTERROGATORIES

## PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [ ] No [ X ]

1.2 If yes, indicate premium earned on U.S. business only. $ 0

1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? $

1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above $

1.5 Indicate total incurred claims on all Medicare Supplement insurance. $ 0

1.6 Individual policies:

| | |
|---|---|
| Most current three years: | |
| 1.61 Total premium earned | $ 0 |
| 1.62 Total incurred claims | $ 0 |
| 1.63 Number of covered lives | 0 |
| All years prior to most current three years: | |
| 1.64 Total premium earned | $ 0 |
| 1.65 Total incurred claims | $ 0 |
| 1.66 Number of covered lives | 0 |

1.7 Group policies:

| | |
|---|---|
| Most current three years: | |
| 1.71 Total premium earned | $ 0 |
| 1.72 Total incurred claims | $ 0 |
| 1.73 Number of covered lives | 0 |
| All years prior to most current three years: | |
| 1.74 Total premium earned | $ 0 |
| 1.75 Total incurred claims | $ 0 |
| 1.76 Number of covered lives | 0 |

2. Health Test:

| | | 1<br>Current Year | 2<br>Prior Year |
|---|---|---|---|
| 2.1 | Premium Numerator | $ | $ 0 |
| 2.2 | Premium Denominator | $ 0 | $ 1,347 |
| 2.3 | Premium Ratio (2.1/2.2) | 0.000 | 0.000 |
| 2.4 | Reserve Numerator | $ | $ 0 |
| 2.5 | Reserve Denominator | $ 0 | $ 0 |
| 2.6 | Reserve Ratio (2.4/2.5) | 0.000 | 0.000 |

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [ ] No [ X ]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [ X ] No [ ]

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [ ] No [ X ]

5.1 Does the reporting entity have stop-loss reinsurance? Yes [ ] No [ X ]

5.2 If no, explain:

HealthSpan Inc had no members or incurred claims to insure for 2020.

5.3 Maximum retained risk (see instructions)

| | |
|---|---|
| 5.31 Comprehensive Medical | $ |
| 5.32 Medical Only | $ |
| 5.33 Medicare Supplement | $ |
| 5.34 Dental and Vision | $ |
| 5.35 Other Limited Benefit Plan | $ |
| 5.36 Other | $ |

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes [ X ] No [ ]

7.2 If no, give details

8. Provide the following information regarding participating providers:

| | |
|---|---|
| 8.1 Number of providers at start of reporting year | 0 |
| 8.2 Number of providers at end of reporting year | |

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes [ ] No [ X ]

9.2 If yes, direct premium earned:

| | |
|---|---|
| 9.21 Business with rate guarantees between 15-36 months | |
| 9.22 Business with rate guarantees over 36 months | |

# GENERAL INTERROGATORIES

## PART 2 - HEALTH INTERROGATORIES

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [ ] No [ X ]

10.2 If yes:

10.21 Maximum amount payable bonuses $.....

10.22 Amount actually paid for year bonuses $.....

10.23 Maximum amount payable withholds $.....

10.24 Amount actually paid for year withholds $.....

11.1 Is the reporting entity organized as:

11.12 A Medical Group/Staff Model, Yes [ ] No [ X ]

11.13 An Individual Practice Association (IPA), or, Yes [ ] No [ X ]

11.14 A Mixed Model (combination of above) ? Yes [ ] No [ X ]

11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes [ X ] No [ ]

11.3 If yes, show the name of the state requiring such minimum capital and surplus. Ohio.....

11.4 If yes, show the amount required. $.....

11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes [ ] No [ X ]

11.6 If the amount is calculated, show the calculation

12. List service areas in which reporting entity is licensed to operate:

| 1<br>Name of Service Area |
|---|
| Adams |
| Allen |
| Aulaize |
| Brown |
| Butler |
| Champaign |
| Clark |
| Clermont |
| Clinton |
| Cuyahoga |
| Fulton |
| Geauga |
| Hamilton |
| Henry |
| Highland |
| Lake |
| Lorain |
| Lucas |
| Mahoning |
| Medina |
| Mercer |
| Ottawa |
| Portage |
| Preble |
| Putnam |
| Shelby |
| Stark |
| Summit |
| Trumbull |
| Van Wert |
| Wayne |
| Wood |

13.1 Do you act as a custodian for health savings accounts? Yes [ ] No [ X ]

13.2 If yes, please provide the amount of custodial funds held as of the reporting date. $.....

13.3 Do you act as an administrator for health savings accounts? Yes [ ] No [ X ]

13.4 If yes, please provide the balance of the funds administered as of the reporting date. $.....

14.1 Are any of the captive affiliates reported on Schedule S, Part 3 as authorized reinsurers? Yes [ ] No [ X N/A [ ]

14.2 If the answer to 14.1 is yes, please provide the following:

| 1<br>Company Name | 2<br>NAIC Company Code | 3<br>Domiciliary Jurisdiction | 4<br>Reserve Credit | Assets Supporting Reserve Credit | | |
|---|---|---|---|---|---|---|
| | | | | 5<br>Letters of Credit | 6<br>Trust Agreements | 7<br>Other |
| | | | | | | |

# GENERAL INTERROGATORIES

## PART 2 - HEALTH INTERROGATORIES

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded).

| | |
|---|---|
| 15.1 Direct Premium Written | $..... |
| 15.2 Total Incurred Claims | $..... |
| 15.3 Number of Covered Lives | ..... |

| *Ordinary Life Insurance Includes |
|---|
| Term (whether full underwriting, limited underwriting, jet issue, “short form app”) |
| Whole Life (whether full underwriting, limited underwriting, jet issue, “short form app”) |
| Variable Life (with or without secondary guarantee) |
| Universal Life (with or without secondary guarantee) |
| Variable Universal Life (with or without secondary guarantee) |

16. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? ..... Yes [ ] No [ ]

16.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? ..... Yes [ ] No [ ]