COLUMN HEADINGS	
CLAIMS:	Total direct claims incurred during calendar year 2017 for Vermont residents covered under an individual policies, group certificates , or self-insured health plans.
LIVES:	The total number of Vermont lives covered, including dependents, under individual policies, group certificates or self-insured health plans as of December 31, 2017
MONTHS:	Cumulative total of member months for calendar year 2017
POLICIES:	The number of policies or certificates in force as of December 31, 2017 for ALL Vermont residents (and not the number of persons covered under individual policies , group certificates, or health insured health plans).
PREMIUM:	Total direct premium or premium equivalent collected in 2017 for Vermont residents that are covered under an individual policy, group certificate, or self-insured health plan. Please include premiums/premium equivalents paid in 2016 for 2017, but not premiums/premium equivalents paid in 2017 for the year 2018.
TYPES OF INSURANCE / PLANS	
COMPREHENSIVE MAJOR:	These policies include, but are not limited to, policies that provide indemnity, HMO, PPO, POS or expense based coverage for hospital, medical and surgical expenses. This category excludes limited benefit plans such as short term medical insurance, hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage as well as coverage described in the other categories of this exhibit. **Note: HDHP and Non-HDHP plans are now reported within this category.**
DENTAL:	Policies providing only dental treatment benefits such as routine dental examinations, preventative dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw. If dental benefits are part of a comprehensive medical plan, this data should be included under comprehensive/major medical category.
DISCRETIONARY GROUPS:	This line pertains to groups that do not meet the statutory requirements of employer groups, associations or trusts, and have received discretionary approval by the Department of Financial Regulation. Column totals should be calculated so as to include the total number covered lives in each discretionary group.
FEDERAL EMPLOYEES:	Coverage administered by the Office of Personnel Management under the FEHBP (Federal Employees Health Benefit Program) for federal employees, retirees and their survivors.
LIMITED BENEFIT:	Policies that provide coverage that is designed to provide specified health benefits in certain limited and clearly specified circumstances. Only include policies that are not requested elsewhere in the submission. For example include hospital confinement only, vision care only and short term major medical, but not dental only , specified disease and accident only & accidental death and dismemberment.
LONG TERM CARE:	Policies that provide coverage for not less than one year for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital including policies that provide benefits for cognitive impairment, or loss of functional capacity. This includes policies providing nursing home care plus home health care and/or community based care.
ASSOCIATIONS:	Policies issued to an association as defined in 8 V.S.A. 4079, including multiple employer welfare arrangements as defined by federal law. Municipal trusts should be reported as a trust.
MEDICARE PART C:	Refers to private managed care plans that offer Parts A and B services together. Also known as Medicare Advantage program, which offers the option of enrolling in a managed care plan to receive Medicare benefits. Types of plans authorized under The Federal Balanced Budget Act of 1997 include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans and high deductible plans linked to Medical Savings Accounts (MSAs), and as of 2003, Special Needs Plans (SNPs) for dual eligibles and other vulnerable populations.
MEDICARE PART D:	Created under the Medicare Modernization Act of 2003 (MMA), it is a voluntary outpatient prescription drug benefit for Medicare beneficiaries that began in 2006. Medicare Part D does not need to be licensed by the state of Vermont as it is licensed by Centers for Medicare and Medicaid Services (CMS).
MEDICARE SUPPLEMENT (MEDIGAP): (STANDARIZED & PRE-STANDARIZED PLANS)	Plans are policies sold by insurance companies to fill “gaps” in a policyholder’s Medicare coverage.

OTHER MEDICAL: (NON-COMPREHENSIVE)	This includes policies such as hospital only, hospital confinement, surgical, outpatient indemnity, intensive care, mental health/substance abuse, and organ and tissue transplant (including scheduled type policies). Expense reimbursement and indemnity plans should be included. This category does not include TRICARE/CHAMPUS supplement, Medicare supplement, or Federal Employee Health Benefit Program coverage, comprehensive major medical or limited benefit coverage.
SPECIFIED OR NAMED DISEASE:	This includes policies that provide benefits only for the diagnosis and/or treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or as a principle sum.
STOP LOSS / EXCESS LOSS:	This insurance or other risk-transfer arrangement that is purchased by a group health plan or by the sponsor or trustee of such plan to limit the exposure of such group health plan or plan sponor against losses sustained by such plan.
STUDENT POLICIES	This includes policies that cover students for both accident and health benefits while they are enrolled and attending school or college. These can be either individual policies or group policies sponsored by the school or college.
THIRD PARTY ADMINISTRATOR (TPA) and ADMINISTRATIVE SERVICES ONLY (ASO):	An entity or person contracting to provide any combination of services in administering health benefits for a health insurer or other entity such as self-insured employer plans, to include claims processing, underwriting, billing, case management, authorizations or customer service. **Note: Please estimate your comprehensive major medical business separately.**
TRUSTS:	The total number of policies issued to a trust, or to one or more trustees of a fund established or adopted by two or more employers or one or more labor unions or similar employee organizations. The total number of policies includes the number of trusts not the number of groups within the trust. The total number of lives includes all the members/employees and all dependents of all the groups that belong to every trust. Policies issued to a municipal trust (VEHI) should be included here.