PINNACOL ASSURANCE

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Denver, CO 80230-7006
303.361.4000 1.800.873.7242
www.pinnacol.com

October 6, 2014

Honorable Governor John Hickenlooper
201 E. Colfax Ave.
Denver, CO 80203

Dear Governor Hickenlooper:

Pursuant to C.R.S. §8-45-122, Section 2, Pinnacol Assurance is submitting the attached report with the information outlined in Subsection 2.

(a) Number of policies held by Pinnacol assurance
(b) Total assets of Pinnacol Assurance
(c) Amount of reserves
(d) Amount of surplus
(e) Number of claims filed
(f) Number of claims admitted or contested within the twenty-day period pursuant to section 8-43-203, specifying the number of contested claims that are medical only and those that are indemnity claims
(g) Number of medical procedures denied
(h) Amount of total compensation each executive officer or staff member receives, including bonuses or deferred compensation
(i) Amount spent on commissions
(j) Amount paid to trade associations for marketing fees
(k) All information relating to bonus programs
(l) Any other information the CEO deems relevant to the report

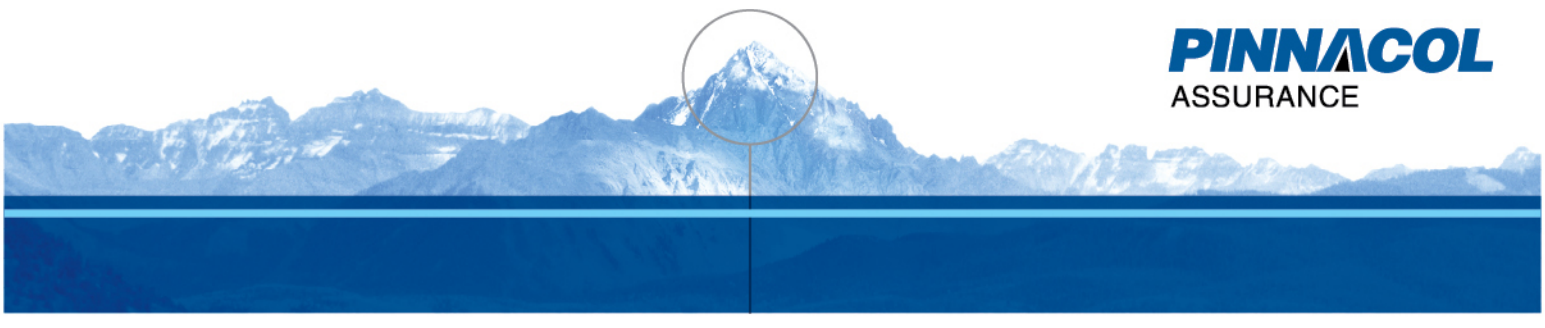
All data is as of year-end 2013. We have also included additional information regarding Pinnacol, per subsection (l) in the appendix of this document.

If you have any questions concerning the information included in this report, please contact me at 303.361.4891.

Sincerely,

Philip B. Kalin
President and CEO

cc:
Sen. Irene Aguilar, Chair, Senate Health and Human Services
Sen. Lois Tochtrop, Chair, Senate Business, Labor and Technology
Rep. Angela Williams, Chair, House Business, Labor, Economic and Workforce Development
Rep. Beth McCann, Chair, House Health and Environment
Sen. Morgan Carroll, Senate President
Sen. Bill Cadman, Senate Minority Leader
Rep. Mark Ferrandino, Speaker of the House
Rep. Brian DelGrosso, House Minority Leader



PINNACOL
ASSURANCE

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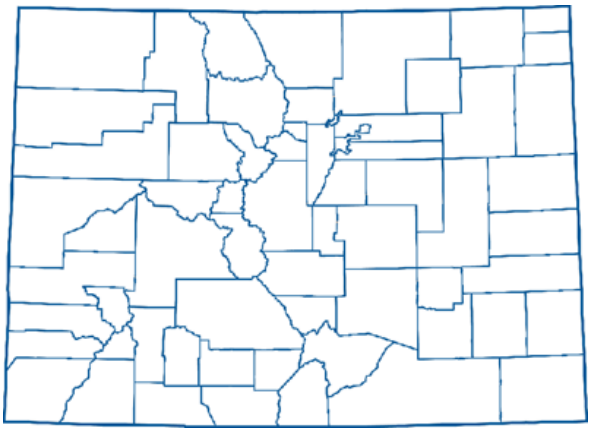
EXECUTIVE SUMMARY

This annual report to the Governor and members of the Colorado legislature provides data pursuant to the specifications outlined in Section 2, C.R.S. §8-45-122. All data is for the calendar year 2013.

As a Colorado-headquartered company, Pinnacol Assurance provides workers' compensation insurance to approximately 56,000 employers in the state, and protects the lives of more than 850,000 Colorado workers. From underwriting and safety services to claims management, return-to-work programs and online tools, our nearly 600 employees are dedicated to providing best-in-class workers' compensation services to make Colorado the best place for businesses to grow and thrive.

Pinnacol's Colorado Presence
Headquarters: Denver
Offices: Denver and Grand Junction
Annual Economic Impact: $364 Million

Pinnacol has policyholders in all 64 Colorado counties



Financial responsibility
In 2013, we improved our financial performance. A growing Colorado economy helped increase our earned premium by 13 percent, to $487 million. To maintain our financial stability and guarantee the payment of claims that may span years or even decades, we're continuing to manage expenses tightly, carefully steward our financial resources, apply disciplined underwriting practices, and focus on managing risks to our investment portfolio. We are committed to maintaining the financial stability required to fulfill our commitment to policyholders and injured workers.

Audit findings
Our 2013 annual financial statement audit, conducted by independent auditors (KPMG) contracted by the Colorado Office of the State Auditor, had extremely favorable results. The auditors reported no deficiencies in internal controls and made no recommendations for improvements. A copy of the full audit report is attached in Appendix B.

Policyholder services
Providing workers' compensation coverage for a majority of Colorado employers, we understand our responsibility to provide reliable, quality service to our policyholders. We partner with our policyholders, helping them manage the inevitable risks that come with operating a business.

Customer satisfaction: In 2013, Pinnacol's policyholder satisfaction score was 8.8 out of 10 points for overall service quality, and our policyholder retention rate, based on written premium, was 91.3% at year-end 2013. Our 2012 policyholder satisfaction score was 8.8, and our retention rate was 92.4%, which was Pinnacol's highest retention rate ever achieved.

2013 Policyholder Satisfaction Score
8.8 out of 10

Safety services: Every Colorado employee deserves a safe workplace, and Pinnacol is doing its part to make that a reality. We have the largest, most experienced team of safety experts in the state, and they spend more than 4,300 workdays every year helping employers across the state keep their worksites safe.

Cost Containment Certification: The State of Colorado's Cost Containment program encourages employers to implement and maintain a standardized safety and loss control program, helping prevent injuries and lower claims costs. As a partner in this effort, Pinnacol provides sample documents, instructional webinars and hands-on support to policyholders to help them meet the criteria of the program, making them eligible for a premium discount. More than five percent of our policyholders are now Cost Containment Certified.

Spanish-language services: Our designated Spanish Services Team provides customer support, training and materials to serve Colorado's Spanish-speaking policyholders and workers.

Injured worker services
Pinnacol covers workers across Colorado, and we provided compassionate care to more than 40,000 of them who were injured on the job in 2013. The first survey of injured workers on their experience with Pinnacol in 2010 resulted in a score of 3.6 out of 5. Our satisfaction score improved to 4.0 in 2013, an increase of 9% since the initial survey. Injured workers have access to their compensation benefit status and other information about their claims through a secure online portal designed specifically for them.

2013 Injured Worker Satisfaction Score
4.0 out of 5

Provider relationships
We proudly partner with a designated network of experienced medical providers, the largest network of its kind in the state. These SelectNet physicians and providers help ensure injured workers receive timely, appropriate and compassionate care. An injured worker can receive care from non-SelectNet providers if the workers' employer designates out-of-network providers. Our unique Physician Advisor Program is comprised of independent physicians who provide peer reviews on injured worker care when treatment is unclear.

Innovation
With our significant role in the state, we have a responsibility to innovate and explore better ways to serve Colorado. For example, as the workers' compensation leader in the state, we are utilizing our statewide access to help champion economic development opportunities. Pinnacol is proud to be a member of over 35 chambers of commerce, better business bureaus and industry trade associations across the state.

As part of our commitment to the health and safety of Colorado's workers we are exploring the link between workers' compensation and total worker safety and health to see how we can improve outcomes.

Reaching out
The Pinnacol Foundation provides college scholarships to the children of Colorado workers seriously injured or killed on the job, regardless of which insurer handled the parent's claim. In 2013, the foundation awarded $400,000 to 112 students, bringing its 13-year total to nearly $3 million.

Keeping Pinnacol strong and healthy for Colorado employers and workers means that we will continue to focus on workers' comp, innovate to be where our customers need us, and manage our finances responsibly. We are looking forward to another 100 years of doing just that.

All data as of Dec. 31, 2013

A. Policy Count: 55,988

Pinnacol's policies-in-force (active) as of Dec. 31, 2013 grew by roughly 1% over year-end 2012, partly due to an improving economy in Colorado.

B. Total (Admitted) Assets: $2,043,552,956

Pinnacol's total assets grew by 7.4% over year-end 2012. The change was driven primarily by strong performance in the investment market, and particularly common stock (equities). Pinnacol's investment portfolio emphasizes high quality, taxable bonds, supplemented by a smaller portfolio of equities and short-term investments.

C. Reserves: $876,954,000

Our reserves represent the financial obligations of Pinnacol to pay injured workers' expected future benefits and related claims expenses, as determined by a contracted third-party actuarial firm (Milliman).

Pinnacol's total reserves increased by 11.2% over year-end 2012. The change was driven in large part by the way Pinnacol accounts for permanent total disability and fatal claims. Prior to 2013 Pinnacol used an acceptable insurance accounting procedure called discounting which reduces the reserves on permanent total and fatal claims due to the time value of money. We removed the discounting on these reserves in 2013, to more conservatively reflect their long-term exposure and protect policyholder and injured worker interests.

D. Surplus: $625,559,887

Our surplus is the difference between our assets and liabilities, i.e. our net worth. Pinnacol's surplus protects the financial interests of policyholders and injured workers in the event of an unexpected loss of assets, ensuring the company's long-term financial strength and stability.

Pinnacol's surplus grew by 1.4% in 2013. This increase was driven by the change in assets and reserves noted above, Colorado's improving economy, and the performance of Pinnacol's investment portfolio.

E. Claims filed in 2013: 45,842

F. Claims required by statute to be approved or denied within 20 days and notice provided to the Colorado Division of Workers' Compensation (DOWC): 6,272
Contested claims that are medical-only: 1,459
Contested claims that are indemnity claims: 115

The number of claims Pinnacol admitted (approved) or contested (denied) within 20 days grew by nearly 1% in 2013 compared to 2012, which was similar to our overall change in claims filed. The percent of claims we provide notice of to the DOWC has held steady at 13-14% of total claims filed for a number of years.

The total number of claims Pinnacol contested (denied) and reported to the DOWC dropped in 2013 from 2012 by 5.9%. The number of contested indemnity claims was up 16 while the number of contested med-only claims was down 114. Pinnacol's most common basis for contesting (denial) claims in 2013 was due to an injury not being work related or the need for further investigation.

Here is a more complete picture of key data elements for 2013 with explanations to follow.

1.	Claims processed with no filing required with DOWC	= 39,570 (86.3%)
2.	Claims admitted (approved) within 20 days with DOWC	= 4,698 (10.3%)
3.	Claims contested (denied) within 20 days with DOWC	= 1,574 (3.4%)
	Subtotal of items 2 and 3	= 6,272
	Total claims in fiscal year 2013	= 45,842 (100%)

Item 1: No Filing Required: Claims that are minor in nature; the injured worker has not sustained a permanent disability, disfigurement, or lost time from work in excess of three calendar days/shifts – are processed by Pinnacol and do not require a filing of admission or contest with the DOWC. These claims represent 86.3% of all claims received by Pinnacol in 2013.

Items 2 and 3: Admitted or Contested within 20 days: Claims that are more complex in nature *require* a formal filing with the DOWC of "contested" or "admitted". It should be noted that not all contested claims are ultimately denied – as many may initially be contested based on the need for more information within the 20 day window, the time in which compensability must be determined.

Claims where the injured worker has sustained one of the following require a formal filing of "contested" or "admitted" with the DOWC:

- The injured employee contracted an occupational disease
- The injured employee permanently physically impaired
- The injury or occupational disease resulted in lost time from work for the injured employee in excess of three shifts or calendar days

As noted above, the number of claims that fall into these two categories has stayed between 13 – 14% of total claims filed for the last few years.

Item 3: Contested Claims:

The 1,574 (3.4% of total claims in 2013) contested claims were for one or more of the following reasons:

- Injury or illness was not work related – 820 (52%)
- Pending further investigation or information – 403 (26%)
- Other – 351 (22%) *This category includes such things as no insurance policy or the injured worker is covered by another carrier.*

Pinnacol's percentage of claims contested has remained relatively constant around 3.5% of total claims each year over the past few years.

G. Medical procedures denied: 2,021

Pinnacol's percentage of medical procedures denied compared to total claims received was 4% for 2013. This metric has remained relatively stable over the past few years. The most common reason for denying medical procedures that require prior approval from Pinnacol (see Rule 16 note below) is the procedure was found not to be medically necessary (885).

Medical procedures denied are in accordance with Rule 16 of the Colorado Division of Workers' Compensation's Rules of Procedure. Many medical procedures require prior approval from the insurance company. Once a request for prior authorization is received, Pinnacol has 7 business days to inform the medical provider and the injured worker that we will pay or deny payment for the procedure.

H. Amount of total compensation each executive officer or staff member receives, including bonuses or deferred compensation

Title	2013 Total Compensation
President and CEO	$34,285 * Started 11/27/2013
Chief Financial Officer	$348,786
Vice President of Strategic Development and CIO	$343,337
Vice President, General Counsel & Corporate Secretary	$317,973
Vice President of Corporate Resources	$305,018
Vice President, Chief Investment Officer	$267,775
Vice President, Claims	$240,411
Vice President, Underwriting	$232,802
Vice President of Communications and Public Affairs	$210,228
Average total compensation for 11 Associate Vice Presidents	$143,540
Former President and CEO	$292,348
Former Vice President of Communications and Chief Marketing Officer	$377,307
Former Vice President of Business Operations	$389,064

I. Amount spent on commissions: $62,597,827

J. Amount paid to trade associations for marketing fees: $708,367

K. Information related to bonus programs
See Appendix A

L. Other information the CEO deems relevant to the report
See Appendix B

Note: Sources for all items except H and the Appendices are the 2013 Pinnacol Annual Statement, the Pinnacol Assurance Key Factor Report, the General Ledger Account (60511-100 — Advertising Expenses — Association Marketing) and other internal reports.

Appendix A

Information related to bonus programs

PINNACOL ASSURANCE
AMENDED AND RESTATED EXECUTIVE PERFORMANCE PLAN

SUMMARY

This Executive Performance Plan ("Performance Plan") is amended and restated effective for Plan Years commencing on or after January 1, 2013, except as otherwise provided herein, and amends and restates the Executive Performance Plan previously adopted by the Board of Directors of Pinnacol Assurance ("Board") on August 4, 2010. The Performance Plan is intended to recognize the achievement of major company objectives and individual objectives, measured on an annual basis.

This program appropriately emphasizes individual and group accountability for making specific contributions to Pinnacol Assurance's overall business results. Based on Board approval, the Performance Plan will be finalized and communicated to Executive Staff. A relatively short decision-result cycle should be attainable (first quarter of the following year) to determine award payout following Board approval.

PLAN DESCRIPTION

Plan Year – The Plan Year shall be a calendar year.

Performance Measures – Awards are paid under this Performance Plan only for meeting or exceeding annual threshold performance objectives for certain company metrics for the Plan Year, as set forth by the Board.

No awards under this Performance Plan will be made or paid unless Pinnacol Assurance meets or exceeds the annual performance objectives for the Plan Year, as set forth by the Board.

Eligibility – This Performance Plan will only apply to the following positions, each of which will be considered an Eligible Employee: CEO, Vice Presidents, and Associate Vice Presidents. An Eligible Employee's participation will be based on a pro-rata calculation of the number of months of service worked in the Plan Year if that Eligible Employee has been employed at Pinnacol Assurance for less than the twelve calendar months of the Plan Year and was hired prior to October 1 of the Plan Year. An Eligible Employee who is hired on or after October 1 of a Plan Year is not eligible to participate in the Performance Plan for the year of hire.

Incentive Award Plans – Eligible Employees will have incentive award plans based on meeting major company objectives and individual objectives related to Pinnacol Assurance's annual business plan. For Vice Presidents and Associate Vice Presidents, the amount of an award under this Performance Plan, if any, is subject to the approval of the CEO and then ultimately the Board. For the CEO, the amount of an award under this Performance Plan, if any, is subject to the approval of the Board.

Determination of Payment

1. Eligible Employees Other Than the CEO

The CEO shall make a determination as soon as practicable after the end of the Plan Year as to whether each Eligible Employee (other than the CEO) has met his or her individual objectives and whether the company objectives have been met. The CEO shall make an initial determination as to the award that each such Eligible Employee is eligible for under this Performance Plan for the Plan Year. The Board shall then approve the amount of all awards (the date of such approval being the "Initial Determination Date" with respect to such Eligible Employee). The determination ("Determination") of an award by the Board, as well as the decision as to whether to make any such award, and the amount, if any, of such award, shall be in the sole discretion of the Board. Determination means the Board has passed a resolution approving or denying a bonus award as well as the amount of any such award.

2. CEO

The Compensation Committee of the Board (the "Committee") shall make a determination as soon as practicable after the end of the Plan Year as to whether the CEO has met his individual objectives and whether the company objectives have been met. The Committee shall make an initial determination as to the award that the CEO is eligible for under this Performance Plan for the Plan Year. The Board shall then approve the amount of the final award (the date of such approval being the "Initial Determination Date" with respect to the CEO). The determination ("Determination") of an award by the Board, as well as the decision as to whether to make any such award, and the amount, if any, of such award, shall be in the sole discretion of the Board. Determination means the Board has passed a resolution approving or denying a bonus award as well as the amount of any such award.

3. Subsequent Adjustment

The Board may increase or decrease the amount of an award subsequent to an Initial Determination Date (a "Subsequent Adjustment"), provided, however, that a Subsequent Adjustment shall only be made because of a mathematical error, an adjustment to results as described below under "Company Objectives," or upon the determination of the Board that a metric or criterion used to compute an award had been determined in error. The date on which the Board approves a Subsequent Adjustment shall be a Subsequent Determination Date with respect to such Subsequent Adjustment.

4. The Initial Determination Date with respect to a Plan Year shall be on or after January 1 of the calendar year immediately following the Plan Year but no later than the May 31 of the calendar year immediately following such Plan Year. Any Subsequent Determination Date with respect to a Plan Year shall be no later than the September 30 of the calendar year immediately following such Plan Year.

Payment – Payment of an award, or of a Subsequent Adjustment that increases an award, shall be made within 2-1/2 months of the Initial Determination Date (with respect to the award) or within 2-1/2 months of the Subsequent Determination Date (with respect to the Subsequent Adjustment).

In the event that a Subsequent Adjustment reduces an award that has already been paid, Pinnacol Assurance may recoup such Subsequent Adjustment from the recipient of an award by reducing the compensation otherwise payable to such recipient within sixty (60) days of the Subsequent Determination Date (including, but not limited to, regular compensation, bonuses, commissions, or severance pay and any amount of such Subsequent Adjustment that Pinnacol Assurance has not recouped from such compensation shall be paid by the recipient to Pinnacol Assurance on the sixtieth (60^{th}) day following the Subsequent Determination Date. This paragraph applies whether or not such recipient has remained an Eligible Employee.

Vesting – An Eligible Employee who is not employed by Pinnacol Assurance on a Determination Date (whether an Initial or Subsequent Determination Date) forfeits all rights to an award (or an increase in an award in the case of a Subsequent Adjustment) for the Plan Year to which such Determination Date relates. An Eligible Employee who is employed by Pinnacol Assurance on an Initial or Subsequent Determination Date is fully vested in the award (or an increase in an award, in the case of a Subsequent Adjustment) granted on such Initial or Subsequent Determination Date.

Allocation of Award Under Each Plan - Incentive awards will be earned as follows once the Board has determined that an Eligible Employee has met the criteria for an individual award, which for all Performance Plan participants shall be based 100% on achievement of company objectives.

Eligible Employee's Performance Plan Award Range (% of Base Salary)

	Threshold	Commendable	Maximum
Associate Vice Presidents	20.0%	32.5%	45.0%
Vice Presidents	22.5%	37.5%	52.5%
CEO	25.0%	42.5%	55.0% (effective 1/1/2011)

Award Payout Calculation

Individual worksheets will be prepared for each Eligible Employee. Pinnacol Assurance will use the following factors in determining the amount of the award once the threshold criteria are met:

1. Company Objectives

Annual targets forCombined Ratio Before General Dividends, Policyholder Customer Satisfaction, Injured Worker Satisfaction, and Leading The Organization (each as defined or described below) will be established by the Board. Projected as well as past performance will be factored into the formula for establishing company objectives.

C. "Combined Ratio Before General Dividends" is based on the combined ratio results for insurance operations, excluding structured settlements, as determined by the company's financial statements. The numerator in the ratio is total expenses (all losses incurred, loss adjustment expenses, underwriting expenses and association dividends) The denominator in the ratio is net underwriting premiums earned (underwriting premiums earned minus program dividends (but not minus association and general dividends).

D. "Customer Service Quality" will be based on the average score, adjusted for selection

bias, of the overall service quality question contained in the service quality surveys of customers (policyholders) sent during the Plan Year.

E. "Injured Worker Satisfaction" will be based on the average score of the overall satisfaction question contained in the statutory surveys of injured workers for surveys sent during the Plan Year.

F. "Leading The Organization" will be based on the total score of the leadership competencies established by the Board. The Board will evaluate the CEO's performance and the CEO will evaluate the Vice Presidents performance for this measure.

The weighting of the objectives shall be:

- Combined Ratio Before General Dividends: 60%
- Customer Service Quality: 10%
- Injured Worker Satisfaction: 10%
- Leading The Organization: 20%

The final results pertaining to any objective may be adjusted by the Board, based on the recommendation of the Committee, to account for unforeseen or uncontrollable events. Such adjustments will be made to assure that the results of this Performance Plan are a fair reflection of the business performance of Pinnacol Assurance. Unforeseen or uncontrollable events may include, without limitation, adverse court rulings, imposed regulatory costs and/or revenue reductions, and Board-approved budget adjustments.

3. Calculation of the award incentive amount

A. If the actual result is between two measurements (i.e., threshold and commendable or commendable and maximum) then the award will be linearly interpolated to match the actual result, but not to exceed the maximum award for that performance measure.

B. The CEO may review any additional issues or concerns regarding any award with the Committee prior to final award approval by the full Board.

Section 409A

All payments contemplated by this Plan are intended to qualify as "short-term deferrals" as such term is defined in Treasury Regulation Section 1.409A-1(b)(4) and this Performance Plan shall be administered and construed accordingly. To the extent that any such payment is not a short-term deferral, this Performance Plan is intended to otherwise comply with Section 409A of the Internal Revenue Code of 1986, as amended, the Treasury Regulations promulgated thereunder, and any administrative guidance or judicial decisions with respect thereto ("Section 409A") and shall be administered and construed accordingly. It is the intention of Pinnacol Assurance that payments under this Performance Plan not be subject to the additional tax or interest imposed pursuant to Section 409A. To the extent such potential payments or benefits are or could become subject to Section 409A, Pinnacol Assurance may amend this Performance Plan with the goal of giving Eligible Employees the economic benefits described herein in a manner that does not result in such additional tax or interest being imposed. It is the intention of Pinnacol Assurance that no person shall be considered to have a legally binding right to any award under this Performance Plan at any time prior to an Initial Determination Date that relates to an award, or,

in the case of a Subsequent Determination that provides for an increase to an award, prior to such Subsequent Determination Date. Each payment described in this Performance Plan shall be a separate payment and a separately identifiable payment to the maximum extent permitted by Section 409A.

Pinnacol Assurance reserves the right to add, change, end, or suspend this Performance Plan at any time, with or without notice. This document shall not be construed as a contract of employment, nor does it restrict the right of Pinnacol Assurance to discharge the employee or the right of the employee to terminate his or her employment at any time.

Pinnacol Assurance has evidenced its adoption of the Pinnacol Assurance Executive Performance Plan (As Amended and Restated January 1, 2013) effective January 1, 2013 by the signature of its duly authorized officer.

PINNACOL ASSURANCE

By: _____

John Plotkin
Interim CEO and
Title: Vice Chair of Board

Date: 5.1.2013

Appendix B

Other information the CEO deems relevant to the report:

Annual financial statement audit report

Rule 16 of the Colorado Division of Workers' Compensation
Rules of Procedure

PINNACOL ASSURANCE

Statutory-Basis Financial Statements and
Supplemental Schedules of Investment Information

December 31, 2013 and 2012

(With Independent Auditors' Report Thereon)

LIMITATIONS ON DISCLOSURE OF INFORMATION CONTAINED IN THIS DOCUMENT

The enclosed report is being distributed to you at this time for your information in accordance with Colorado Revised Statutes (CRS).

SECTION 2-3-103 (2) states in part:

> All reports shall be open to public inspection except for that portion of any report containing recommendations, comments, and any narrative statements, which is **released only upon the approval of a majority vote of the committee (emphasis supplied).**

SECTION 2-3-103.7 (1) states in part:

> Any state employee **or other individual acting in an oversight role as a member of a committee, board, or commission** who willfully and knowingly discloses the contents of any report prepared by, or at the direction of, the Office of the State Auditor prior to **the release of such report by a majority vote** of the committee as provided in Section 2-3-103 (2) is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than five hundred dollars (emphasis supplied).

COSA – 201 10/2006

LEGISLATIVE AUDIT COMMITTEE
2014 MEMBERS

Senator Steve King
Chair

Senator Lucia Guzman
Vice Chair

Senator Owen Hill
Representative Dan Nordberg
Representative Dianne Primavera
Representative Su Ryden
Representative Jerry Sonnenberg
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Deputy State Auditor

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Richard A. Rivera, M.D.

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PINNACOL ASSURANCE

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Authority and Purpose/Scope of the Audit

This audit is conducted under the authority of Section 8-45-121(2) of the Colorado Revised Statutes (C.R.S.), which authorizes the State Auditor to conduct an annual audit of Pinnacol Assurance (Pinnacol or the Company) and contract with an auditor or firm of auditors, having the specialized knowledge and experience. The primary purpose of our engagement is to audit the statutory-basis financial statements of Pinnacol as of December 31, 2013, and for the year then ended, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, and to express an opinion on those statutory-basis financial statements and the supplemental schedules of investment information. The objective of an audit conducted in accordance with such standards is to obtain reasonable, but not absolute, assurance about whether the statutory-basis financial statements are free of material misstatement.

The financial statements of Pinnacol are prepared in accordance with statutory accounting principles prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado (hereinafter referred to as statutory-basis financial statements, or financial statements in accordance with statutory accounting principles). Accordingly, they are not designed to present, and do not present, the financial position or results of operations in accordance with accounting principles generally accepted in the United States of America.

In the course of our audit, we examined, on a test basis, evidence supporting the amounts and disclosures in Pinnacol's statutory-basis financial statements as of and for the year ended December 31, 2013.

Required Communications to the Legislative Audit Committee

In accordance with auditing standards generally accepted in the United States of America (AU Section 260 – *The Auditor's Communication With Those Charged With Governance*), we must communicate to the Legislative Audit Committee certain matters noted during our audit. The following sets forth these required communications:

Auditor's Responsibility under Professional Standards – The objective of a financial statement audit conducted in accordance with generally accepted auditing standards (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (GAGAS) is to express an opinion on the fairness of the presentation of the Company's statutory-basis financial statements as of and for the year ended December 31, 2013, in conformity with accounting principles prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado. The audit of the statutory-basis financial statements does not relieve management of its responsibilities.

The audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether caused by fraud or error. In making those risk assessments, we considered internal control over financial reporting relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that were appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control over financial reporting. Our consideration of internal control over financial reporting was not designed to identify all deficiencies in internal control over financial reporting that might be significant deficiencies or material weaknesses.

1. **Accounting Estimates** – Accounting estimates are an integral part of the statutory-basis financial statements prepared by management and are based on management's current judgments. Those judgments are ordinarily based on knowledge and experience about past and current events and on assumptions about future events. Significant accounting estimates reflected in the Company's 2013 statutory-basis financial statements include the following:

   Bonds and Common Stocks – Pinnacol must consider the statutory requirements related to other-than-temporary impairments when determining whether any declines in value are recognized through realized losses in the statutory statement of operations or through change in unrealized losses, which is a direct charge to policyholders' surplus. These statutory requirements for other-than-temporary impairments (OTTI) require management's judgment and consideration of various characteristics of the investments, the underlying causes of the decline in value, as well as management's intent related to future sales of the securities. The Company recorded $613,000 in other-than-temporary impairments on common stocks, mutual funds, and bonds for the year ended December 31, 2013.

   Reserve for Unpaid Losses and Loss Adjustment Expenses – Estimating the reserve for unpaid losses and loss adjustment expenses (reserves) of an insurance company is a subjective and judgmental process, particularly for workers' compensation insurance, where the ultimate liability to a claimant may not be known with certainty for a number of years. To assist management in estimating the liability for unpaid losses and loss adjustment expenses, Pinnacol retains the assistance of an actuarial consulting firm. At December 31, 2013, Pinnacol has recorded $1,243,038,000 as reserves for unpaid losses and loss adjustment expenses as management's best estimate, which management believes to be a reasonable estimate of future amounts to be paid for claims incurred in 2013 and in prior years. Pinnacol discounts internal structured settlement liabilities on a tabular basis using a discount rate of 2.5% for 2013. The discount rate is based on an estimate of expected investment yield and considers the risk of adverse deviation in the future from such yield.

   Premium Deficiency Reserve – A premium deficiency reserve is recognized by recording an additional liability for the deficiency, which results when anticipated losses, loss adjustment expenses, commissions and other acquisition costs, and maintenance costs exceed the recorded unearned premium reserve and any future installment premiums on existing policies, and anticipated investment income. The change in this reserve is recorded as a component of other underwriting expenses incurred.

   Pinnacol recorded a premium deficiency reserve of $7,600,000, which decreased as a result of rate increases in 2012 and 2013. Although the reserve decreased, it still remains as a result of the consecutive years of rate decreases driven by a competitive market and the downturn in the economy in previous years. The premium deficiency reserve evaluation was completed on January 27, 2014 by an independent actuary.

(Continued)

Pinnacol considered anticipated investment income at 3.5% when evaluating the premium deficiency reserve for 2013.

Other accounting estimates are as follows:

Uncollected Premiums – The amount of uncollected premiums, which affects the amount of premium revenue recognized, is estimated using statutory requirements, as well as certain management judgments. Management must determine whether an allowance should be established to provide for all reasonably anticipated uncollectible amounts inherent in the uncollected premiums balance. Factors that are considered in establishing reserves for anticipated uncollectible amounts are collection experience and trends, current overall aging of balances, economic conditions and trends, and evaluations of individual accounts. At December 31, 2013, the admitted value of uncollected premiums as reflected in Pinnacol's statutory-basis financial statements is $40,527,000.

Earned but Unbilled Premiums – Earned but unbilled premiums represent a receivable or liability for audit premiums, which are amounts due from or to policyholders after the respective policy period has expired based on audits performed by Pinnacol. A receivable is included as a component of uncollected premiums. A liability is included as a component of credit balances due policyholders. Such amounts are estimated by Pinnacol based upon internal calculations using historical premium data. Based on this analysis, Pinnacol recorded an estimated earned but unbilled receivable of approximately $18,690,000 in 2013.

Safety Group Dividends Payable to Policyholders – Pinnacol has a safety group dividend program whereby policyholders who are members of the program are entitled to a dividend based on established criteria. Based on the payment pattern for these dividends, management must estimate the future loss ratio for the eligible policyholders in order to determine the accrual recorded at December 31, 2013. For 2013, safety group dividends payable of $2,170,000 are included in dividends payable to policyholders.

2. **Uncorrected Misstatements** – Our audit of the financial statements was designed to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement, whether caused by error or fraud. We have discussed with management certain financial statement misstatements that have not been corrected in the Company's books and records as of and for the year ended December 31, 2013, which would increase the Company's admitted assets by $8,054,000, total liabilities by $4,127,000, surplus by $3,927,000, and net income by $1,100,000. We have reported such misstatements to management on a Summary of Uncorrected Financial Statement Misstatements and have received representations from management that management believes, and concur, that the effects of the uncorrected financial statement misstatements are immaterial, both individually and in the aggregate, to the statutory financial statements taken as a whole.

3. **Material Corrected Misstatements** – Our audit of the statutory-basis financial statements was designed to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement, whether caused by error or fraud. There were no material misstatements that were brought to the attention of management as a result of our audit procedures.

4. **Significant Accounting Policies** – The Company's significant accounting policies are set forth in note 1 to the Company's 2013 statutory-basis financial statements. As discussed in note 2 to the financial statements, in 2013 the Company elected to change its method of accounting to no longer discount its case reserves on a tabular basis.

(Continued)

5. **Other Information in the Annual Report to Policyholders** – When audited financial statements are included in documents containing other information such as the Company's Annual Report to Policyholders, we read such other information and consider whether it, or the manner of its presentation, is materially inconsistent with the information, or the manner of its presentation, in the statutory-basis financial statements audited by us.

6. **Disagreements with Management** – We have not had any disagreements with management related to matters that are material to the Company's 2013 statutory-basis financial statements.

7. **Our Views about Significant Matters that were the Subject of Consultation with Other Accountants** – We are not aware of any consultations that management may have had with other accountants about auditing and accounting matters during 2013.

8. **Significant Issues Discussed, or Subject of Correspondence, with Management prior to our Retention** – Throughout the year, routine discussions were held, or were the subject of correspondence, with management regarding the application of accounting principles or auditing standards in connection with transactions that have occurred, transactions that are contemplated, or reassessment of current circumstances. In our judgment, such discussions or correspondence were not held in connection with our retention as auditors.

9. **Other Significant Findings or Issues Arising from the Audit Discussed, or Subject to Correspondence, with Management** – Throughout the year, routine discussions were held, or were the subject of correspondence, with management. In our judgment, such discussions or correspondence did not involve significant findings or issues requiring communication to the Legislative Audit Committee.

10. **Significant Difficulties Encountered in Performing the Audit** – In our judgment, we received the full cooperation of the Company's management and staff and had unrestricted access to the Company's senior management in the performance of our audit.

11. **Management Representations** – We have made specific inquiries of the Company's management about the representations embodied in the statutory-basis financial statements. Additionally, we have requested that management provide to us the written representations the Company is required to provide to its independent auditors under GAAS.

12. **Other Findings or Issues** – KPMG LLP performed this audit under contract with the Office of the State Auditor and did not discuss accounting or auditing issues with Pinnacol in connection with our retention as auditor.

13. **Modifications to the Opinion in the Independent Auditor's Report** – As we are issuing an opinion on the statutory-basis financial statements in conformity with accounting principles prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado, we have modified our financial statement opinion to include an adverse opinion on accounting principles generally accepted in the United States of America (GAAP).

(Continued)

14. **Independence** – Our professional standards and other regulatory requirements specify that we communicate to you in writing, at least annually, all independence-related relationships between our firm and Pinnacol and provide confirmation that we are independent accountants with respect to Pinnacol.

We hereby confirm that as of May 14, 2014 we are independent accountants with respect to Pinnacol under all relevant professional and regulatory standards.

Summary of Audit Findings

No material weaknesses in internal control were discovered during the 2013 audit of the statutory-basis financial statements.

PINNACOL ASSURANCE

Description of Pinnacol Assurance

December 31, 2013

Pinnacol Assurance (Pinnacol or the Company) was established as a political subdivision of the State of Colorado under provisions of the Workers' Compensation Act of Colorado (Title 8, Article 45 of the Colorado Revised Statutes, as amended) to operate as a domestic mutual insurance company for the benefit of injured employees and dependents of deceased employees in Colorado. As required under state law, Pinnacol provides an assured source of workers' compensation insurance to Colorado employers. Pinnacol shall not refuse to insure any Colorado employer or cancel any insurance policy due to the risk of loss or amount of premium, except as otherwise provided in Title 8, Article 45, C.R.S., as amended.

Pinnacol is controlled by a nine-member board of directors, which is appointed by the Governor with the consent of the Colorado Senate. The board of directors has control over all monies of Pinnacol and is restricted to use such monies only for the purposes provided in Title 8, Article 45, C.R.S., as amended. The board of directors appoints a chief executive officer who is vested with full power and jurisdiction over the administration of Pinnacol. Pinnacol is not an agency of state government. The state retains no liability on the part of Pinnacol and no state monies are used for Pinnacol operations. All revenues, monies, and assets of Pinnacol belong solely to Pinnacol. The State of Colorado has no claim to, nor any interest in, such revenues, monies, and assets and shall not borrow, appropriate, or direct payments from such revenues, monies, and assets for any purpose.

Policyholders' Surplus

Pinnacol had policyholders' surplus of $625,560,000 and $616,102,000 as of December 31, 2013 and 2012, respectively. The increase in surplus is primarily related to current year net income, and unrealized gains on common stock.

In 2013, the Board did not issue a general policyholder dividend to its policyholders in good standing. See further information at note 1(m), General Policyholder Dividends.

KPMG LLP
Suite 800
1225 17th Street
Denver, CO 80202-5598

Independent Auditors' Report

The Members of the Legislative Audit Committee
Pinnacol Assurance Board of Directors:

Report on the Financial Statements

We have audited the accompanying financial statements of Pinnacol Assurance, which comprise the statutory statements of admitted assets, liabilities, and policyholders' surplus as of December 31, 2013, and the related statutory statements of operations, changes in policyholders' surplus, and cash flows for the year then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in note 1 to the financial statements, the 2013 financial statements are prepared by Pinnacol Assurance using statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado, which is a basis of accounting other than

U.S. generally accepted accounting principles. Accordingly, the 2013 financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

The effects on the 2013 financial statements of the variances between the statutory accounting practices described in note 1 and U.S. generally accepted accounting principles, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the variances between statutory accounting principles and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of Pinnacol Assurance as of December 31, 2013, or the results of its operations or its cash flows for the year then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and policyholders' surplus of Pinnacol Assurance as of December 31, 2013, and the results of its operations and its cash flow for the year then ended, in accordance with statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado described in note 1.

Emphasis of Matter

As discussed in note 2 to the financial statements, in 2013 the Company elected to change its method of accounting to no longer discount its case reserves on a tabular basis. Our opinion is not modified with respect to this matter.

Other Matters

Supplemental Schedule

Our audit was conducted for the purpose of forming an opinion on the 2013 financial statements as a whole. The supplementary information included in the supplemental schedule of investment risks interrogatories and supplemental summary investment schedule are presented for purposes of additional analysis and are not a required part of the 2013 financial statements but are supplementary information required by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the 2013 financial statements. The information has been subjected to the auditing procedures applied in the audit of the 2013 financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the 2013 financial statements or to the 2013 financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the 2013 financial statements as a whole.

2012 Financial Statements

The accompanying financial statements of Pinnacol Assurance as of December 31, 2012 and for the year then ended were audited by other auditors whose report thereon, dated May 17, 2013, expressed an adverse opinion on those financial statements with respect to U.S. generally accepted accounting principles and an unmodified opinion with respect to statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated May 14, 2014 on our consideration of Pinnacol Assurance's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Pinnacol Assurance's internal control over financial reporting and compliance.

KPMG LLP

Denver, Colorado
May 14, 2014

PINNACOL ASSURANCE

Statutory-Basis Statements of Admitted Assets, Liabilities and Policyholders' Surplus

December 31, 2013 and 2012

(In thousands)

Admitted Assets		2013	2012
Cash and invested assets:			
Bonds at adjusted carrying value, fair value of $1,536,939 in 2013 and $1,582,254 in 2012 (note 3)	$	1,454,706	1,397,763
Preferred stock at adjusted carrying value, fair value of $0 in 2013 and $9 in 2012 (note 3)		—	9
Common stock at fair value, adjusted cost of $308,824 in 2013 and $247,185 in 2012 (note 3)		428,430	309,691
Real estate at cost – net of accumulated depreciation of $10,824 in 2013 and $9,693 in 2012		18,138	19,209
Cash, cash equivalents, and short-term investments		86,416	129,571
Receivables for securities sold		699	—
Total cash and invested assets		1,988,389	1,856,243
Uncollected premiums – net of allowance		40,527	30,480
Electronic data processing equipment – at cost – net of accumulated depreciation of $4,161 in 2013 and $3,625 in 2012		514	864
Accrued investment income		14,123	14,901
Total admitted assets	$	2,043,553	1,902,488
Liabilities and Policyholders' Surplus			
Reserve for unpaid losses and loss adjustment expenses:			
Reserve for unpaid losses (note 2)	$	1,124,100	1,016,988
Reserve for unpaid loss adjustment expenses (note 2)		118,938	122,431
Total reserve for unpaid losses and loss adjustment expenses		1,243,038	1,139,419
Unearned premiums		70,861	62,150
Advance premiums		10,433	8,931
Dividends payable to policyholders		13,265	12,748
Premium deficiency reserve		7,600	20,207
Credit balances due policyholders		6,686	4,781
Payable for securities purchased		26,529	—
Other liabilities		39,581	38,150
Total liabilities		1,417,993	1,286,386
Commitments and contingencies (note 8)			
Policyholders' surplus (note 7)		625,560	616,102
Total liabilities and policyholders' surplus	$	2,043,553	1,902,488

See accompanying notes to statutory-basis financial statements.

PINNACOL ASSURANCE

Statutory-Basis Statements of Operations and Changes in Policyholders' Surplus

Years ended December 31, 2013 and 2012

(In thousands)

	2013	2012
Underwriting income:		
Premiums earned (note 5)	$ 479,719	425,882
Deductions:		
Losses incurred (notes 2 and 5)	371,257	326,674
Loss adjustment expenses incurred (notes 2 and 5)	62,695	43,592
Other underwriting expenses incurred	110,022	116,312
Total underwriting deductions	543,974	486,578
Net underwriting loss	(64,255)	(60,696)
Investment income:		
Net investment income earned (note 3)	71,848	79,841
Net realized capital gain (note 3)	22,356	47,006
Total investment income	94,204	126,847
Other income (loss):		
Provision for uncollectible premiums	(2,480)	(385)
Other income	346	407
Dividends to policyholders	(1,720)	(38,922)
Net income	26,095	27,251
Change in nonadmitted assets	(2,055)	909
Change in net unrealized gains on investments	57,011	6,139
Other changes in policyholders' surplus (note 1)	—	(23)
Change in method of accounting (note 2)	(71,593)	—
Policyholders' surplus – beginning of year	616,102	581,826
Policyholders' surplus – end of year	$ 625,560	616,102

See accompanying notes to statutory-basis financial statements.

PINNACOL ASSURANCE

Statutory-Basis Statements of Cash Flows

Years ended December 31, 2013 and 2012

(In thousands)

	2013	2012
Cash flows from operations:		
Premiums collected – net of reinsurance	$ 477,934	421,118
Losses and loss adjustment expenses paid – net of reinsurance and deductibles	(401,926)	(401,658)
Underwriting expenses paid	(107,474)	(107,126)
Dividends paid to policyholders	(1,202)	(37,871)
Investment income received, net of investment expenses paid	73,924	81,171
Net amount withheld or retained for account of others	(2,133)	22
Net cash provided by (used in) operations	39,123	(44,344)
Cash flows from investments:		
Proceeds from sale, maturity, or redemption of investments:		
Bonds	404,872	275,974
Stocks	58,366	123,918
Total proceeds from sale or redemption of investments	463,238	399,892
Cost of investments acquired:		
Bonds	(459,608)	(182,777)
Stocks	(100,104)	(115,145)
Miscellaneous proceeds	25,771	(285)
Total investments acquired	(533,941)	(298,207)
Net cash provided by (used in) investments	(70,703)	101,685
Cash flows from financing and miscellaneous sources – cash used in other miscellaneous sources	(11,575)	(7,823)
Net increase (decrease) in cash, cash equivalents, and short-term investments	(43,155)	49,518
Cash, cash equivalents, and short-term investments – beginning of year	129,571	80,053
Cash, cash equivalents, and short-term investments – end of year	$ 86,416	129,571

See accompanying notes to statutory-basis financial statements.

(1) Nature of Operations and Significant Accounting Policies

(a) Organization

Pinnacol Assurance (Pinnacol or the Company) was established under provisions of the Workers' Compensation Act of Colorado (Title 8, Article 45 of the Colorado Revised Statutes (C.R.S.), as amended), as a political subdivision of the State of Colorado, to operate as a domestic mutual insurance company for the benefit of injured employees and dependents of deceased employees. Pinnacol provides insurance to employers operating within the State of Colorado (the State) not otherwise insured through private carriers or self-insurance.

Pinnacol is controlled by a nine-member board of directors, which is appointed by the Governor with the consent of the Senate. In accordance with the applicable statutes of the State, the administration of Pinnacol is under the direction of a chief executive officer, appointed by the board of directors. Pinnacol is not an agency of the State and the State retains no liability on behalf of Pinnacol and no State monies are used for Pinnacol operations.

(b) Basis of Presentation

The accompanying statutory-basis financial statements of Pinnacol have been prepared in accordance with accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado (the Division). Prescribed statutory accounting practices (SAP) are those practices that are incorporated directly or by reference to state laws, regulations, and general administrative rules applicable to all insurance enterprises domiciled in a particular state. Colorado has adopted the National Association of Insurance Commissioners' (NAIC) statutory accounting practices, which are codified in the NAIC's *Accounting Practices and Procedures Manual* (the Manual). Therefore, compliance with the Manual is a prescribed accounting practice. In the preparation of the accompanying statutory-basis financial statements, the Company has followed NAIC guidelines and has not utilized any practices which are considered to be permitted practices.

Statutory accounting practices contained in the Manual vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The more significant differences between SAP and GAAP are as follows:

- Policy acquisition costs, such as commissions, premium taxes, and other expenses directly related to the cost of acquiring new business are expensed as incurred, while under GAAP, they are deferred and amortized over the policy term to provide for proper matching of revenue and expense;
- Investments in debt securities are generally carried at amortized cost, while under GAAP, they would be carried at fair value. For GAAP, changes in fair value in bonds go through net investment income;
- Short-term investments, which include investments with maturities at the time of acquisition of one year or less, are included with cash and cash equivalents in the accompanying statutory-basis financial statements, while under GAAP, only investments with maturities at the time of acquisition of three months or less are included with cash and cash equivalents.

- Assets are reported under NAIC SAP at "admitted-asset" value and "nonadmitted" assets are excluded through a charge against policyholders' surplus, while under GAAP, all assets are reported on the balance sheet, net of any required valuation allowance. Nonadmitted assets at December 31, 2013 and 2012 comprised the following (in thousands):

		2013	2012
Receivables	$	9,488	6,760
Prepaids		3,496	4,169
Total nonadmitted assets	$	12,984	10,929

- The reserve for losses and loss adjustment expenses (LAE) is reported net of reinsurance, while under GAAP, the balance sheet reports reinsurance recoverable, including amounts related to losses incurred but not reported, as assets.

The effect of the differences between statutory-basis of accounting and generally accepted accounting principles, although not reasonably determinable, is presumed to be material. Pinnacol is a political subdivision of the state and as such would follow all applicable Governmental Accounting Standards Board (GASB) pronouncements.

(c) Use of Estimates

The preparation of statutory-basis financial statements in accordance with accounting practices prescribed by the Division requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the statutory-basis financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include the premium deficiency reserve, internal structured settlement liability, the reserves for unpaid losses and loss adjustment expenses, the earned but unbilled premiums asset, as well as the allowance for uncollectible premiums, among others. Reserve for unpaid losses and loss adjustment expenses represent estimates of the ultimate unpaid cost, net of reinsurance, of all losses incurred including losses incurred but not reported. This liability is an estimate and, as such, the ultimate actual liability may vary from the recorded amounts. These liabilities are reviewed periodically and adjustments to the reserve are included in operations in the period such determination is made. Actual results could differ from those estimates and such differences could be significant.

(d) Investments

Investments are recorded on the trade date. Bonds and preferred stocks are stated at amortized cost or fair value, based on their NAIC designation, and are adjusted for other-than-temporary declines in fair value. Common stocks, mutual funds, and common trust funds are carried at fair value. Unrealized capital gains on common stocks, mutual funds, and common trust funds are reported as a direct adjustment to policyholders' surplus. Common stocks, preferred stocks, mutual funds, and common trust funds in an unrealized loss position for the years ended December 31, 2013 and 2012 are recorded as other-than-temporarily impaired and are recorded as a realized loss in the statutory-basis statement of operations in the period in which they occur.

Amortization of bond premium or discount is calculated using the effective interest method taking into consideration specified interest and principal provisions over the life of the bond. Bonds containing call provisions are amortized to the call or maturity value or date that produces the lowest asset value.

Gains and losses on investments sold are realized in operations and are computed using the specific-identification method.

Prepayment assumptions for purposes of recognition of income and valuing of loan-backed bonds and structured securities were obtained from widely accepted models with inputs from major third party data providers. Model assumptions are specific to asset class and collateral type and are regularly evaluated and adjusted where appropriate. The prospective adjustment method is used to value all loan-backed securities.

Real estate includes land, the building on the land, and capitalized building improvements used in conducting the Company's business. Land is carried at cost. Building and capitalized building improvements are carried at cost less accumulated depreciation. The cost of the building and capitalized improvements is depreciated over an estimated useful life of 30 years using the straight-line method. Depreciation expense was approximately $1,131,000 and $1,137,000 for the years ended December 31, 2013 and 2012, respectively, and is included in other underwriting expenses incurred in the statutory-basis statements of operations and changes in policyholders' surplus.

(e) Cash, Cash Equivalents, and Short-Term Investments and Other Invested Assets

For purposes of the statement of cash flows, cash, cash equivalents, and short-term investments include cash on deposit, money market funds, and other investments with maturities of one year or less at the date of acquisition.

As of December 31, 2013, cash, cash equivalents, and short-term investments of approximately $86,416,000 include $(11,502,000) of book overdrafts, $0 of cash equivalents, and $97,918,000 of short-term investments. As of December 31, 2012, cash, cash equivalents, and short-term investments of approximately $129,571,000 include $(11,723,000) of book overdrafts, $6,000,000 of cash equivalents, and $135,294,000 of short-term investments. In the accompanying statutory-basis statements of admitted assets, liabilities and policyholders' surplus, Pinnacol has recorded checks that have been issued, but not presented for payment, as a reduction of cash and cash equivalents.

(f) Receivables for Securities Sold

As of December 31, 2013, receivables for securities sold were approximately $699,000. As of December 31, 2012, receivables for securities sold were $0. Receivables for securities arise when sales of securities are recorded as of the trade date. A receivable due from the broker is established when a security has been sold, but the proceeds from the sale have not yet been received. Receivables for securities not received within 15 days from the settlement date are nonadmitted.

(g) Uncollected Premiums

Uncollected premiums are reported net of allowances for uncollectible and nonadmitted balances. Certain receivables are not admissible for statutory accounting purposes.

Receivables for canceled policies and billed receivables that have been outstanding for a period exceeding 90 days are not admissible according to the Manual. Pinnacol independently estimates the realizable amounts of premiums receivable and nonadmits uncollectible premiums for the difference between the gross receivable amount and the estimate of the amount to be ultimately realized. Pinnacol also nonadmits receivables for the amount by which nonadmissible receivables, as defined above, exceed the estimate of uncollectible receivables.

During 2013 and 2012, Pinnacol recorded a provision of approximately $2,480,000 and $385,000, respectively, for premiums receivable due to the unlikelihood of ultimate collection thereof. These amounts are reflected as provision for uncollectible premiums in the accompanying statutory-basis statements of operations and changes in policyholders' surplus.

A significant portion of Pinnacol's premium receivable balances at December 31, 2013 and 2012 were from companies operating in the construction and services industries in Colorado. The construction industry represents approximately 31% of premiums earned as of December 31, 2013 and 2012. The services industry represents approximately 44% of premiums earned as of December 31, 2013 and 45% of premiums earned as of December 31, 2012, with all other individual industries constituting the remainder of premiums receivable balances.

(h) Earned but Unbilled Premiums

Earned but unbilled premiums represent a receivable or liability for audit premiums, which are amounts due from or to policyholders after the respective policy period has expired based on payroll audits performed by Pinnacol. A receivable is included as a component of uncollected premiums. A liability is included as a component of credit balances due policyholders. Such amounts are estimated by Pinnacol based upon internal calculations using historical premium data. Based on this analysis, Pinnacol recorded an estimated audit premiums receivable in 2013 and 2012 of approximately $18,690,000 and $9,790,000, respectively. The receivable is due to rate increases and increased covered payroll.

(i) Credit Balances Due Policyholders

Credit balances due policyholders represent excess premiums or are amounts due to policyholders. Generally, credit balances due policyholders are applied to future premium obligations of policyholders. For 2013 and 2012, such amounts are approximately $6,686,000 and $4,781,000, respectively.

(j) Electronic Data Processing Equipment

Electronic data processing equipment is recorded at cost, less accumulated depreciation, and depreciated on a straight-line basis over an estimated useful life of three years. Net book value of these assets at December 31, 2013 and 2012 was approximately $514,000 and $864,000, respectively. Related depreciation expense of approximately $536,000 and $370,000 was incurred

during 2013 and 2012, respectively, and is included in other underwriting expenses incurred in the statutory-basis statements of operations and changes in policyholders' surplus.

(k) Office Furniture and Equipment and Software

Office furniture and equipment and software are recorded at cost and depreciated on a straight-line basis. Office furniture and equipment are depreciated over an estimated useful life of five years. Software is depreciated over an estimated useful life of three years. In accordance with the Manual, these are nonadmitted assets. The net book value of these assets at December 31, 2013 and 2012 was approximately $1,111,000 and $1,056,000, respectively. Related depreciation expense of approximately $680,000 and $965,000 was incurred in 2013 and 2012, respectively, and is included in other underwriting expenses incurred in the statutory-basis statements of operations and changes in policyholders' surplus.

(l) Other Assets

At December 31, 2013 and 2012, Pinnacol had prepaid assets and deposits totaling approximately $6,323,000 and $6,271,000, respectively. In accordance with the Manual, these are nonadmitted assets.

(m) General Policyholder Dividends

The board of directors, at its discretion, determines the amount of general policyholder dividends to be declared based on Pinnacol's overall experience and financial condition. Pinnacol paid general policyholder dividends to its policyholders in good standing of approximately $37,453,000 in May 2012. The board did not issue a general dividend in 2013.

(n) Safety Group Dividend Program

Pinnacol has a safety group program (formerly the association dividend program) whereby policyholders who are members of the program are entitled to a dividend based on established criteria. Pinnacol paid out safety group dividends of $1,650,000 in 2013 and association dividends of $1,069,000 in 2012. As of December 31, 2013 and 2012, safety group and association dividends payable of $2,170,000 and $2,100,000, respectively, are included in dividends payable to policyholders. These dividends are not declared from surplus nor are they recorded as a direct reduction to policyholders' surplus. The dividends are settled via premium credits and are recorded as dividends to policyholders in the statutory-basis statements of operations and changes in policyholders' surplus.

(o) Revenue Recognition

For certain policies, earned premium is recorded on an installment basis to match the billing frequency stated in the policyholder contract with a provision for amounts earned but unbilled. Earned premium for all other contracts is recognized using the daily pro rata method over the period the policy is effective.

(p) Reserve for Unpaid Losses and Loss Adjustment Expenses

The reserve for unpaid losses and loss adjustment expenses represents management's best estimate of ultimate net cost of all reported and unreported losses incurred through December 31, 2013 and 2012. The reserve for unpaid losses and loss adjustment expenses is estimated by management, which uses an independent third-party actuary to provide estimates based on individual case basis valuations and statistical analyses. Those estimates are subject to the effects of trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management believes the reserve for unpaid losses and loss adjustment expenses is adequate. These estimates are continually reviewed and adjusted, as necessary, as experience develops or new information becomes known. Such adjustments are included in losses incurred or loss adjustment expenses incurred within the statutory-basis statements of operations and changes in policyholders' surplus in the period such information becomes known.

Effective January 1, 2013, Pinnacol no longer discounts its case unpaid losses on a tabular basis. Workers' compensation case unpaid losses had been discounted on a tabular basis using a discount rate of 2.5% since 2010 (note 2).

Internal structured settlement liabilities represent obligations to claimants and dependents on cases that have been closed by contract. These obligations are discounted at 2.5% in 2013 and 2012.

(q) Unearned Premiums

Unearned premiums represent amounts either collected or billed and due from policyholders at December 31, 2013 and 2012 but unearned at that date as they pertain to subsequent policy periods. Unearned premiums billed, which relate to policy effective dates subsequent to December 31, 2013 are not included in the unearned premiums balance, but are included as advance premium if the related cash is collected. Unearned premiums are computed on a daily pro rata basis over the 12-month term of the policies.

(r) Premium Deficiency Reserve

A premium deficiency reserve is recognized by recording an additional liability for the deficiency, which results when anticipated future loss, loss adjustment expense, commissions, other acquisition costs and maintenance costs exceed the recorded unearned premium reserve, any future installment premiums on existing policies, and anticipated investment income. The change in this reserve is recorded as a component of other underwriting deductions.

Pinnacol recorded a premium deficiency reserve of $7,600,000 and $20,207,000 at December 31, 2013 and 2012, respectively. The decrease is the result of rate increases in 2012 and 2013. Although the reserve decreased, it still remains a liability as a result of the consecutive years of rate decreases driven by a competitive market and the downturn in the economy in previous years. The premium deficiency reserve evaluation was completed on January 27, 2014 by an independent actuary. Pinnacol considered anticipated investment income at 3.5% when evaluating the premium deficiency reserve for 2013.

(s) Multiemployer Pension Plans and Other Postretirement Benefits

Pinnacol participates in a cost sharing multiemployer defined benefit pension plan and health care trust fund administered by the Public Employees' Retirement Association (PERA). All employees of Pinnacol are members of the plan and trust fund, and the plan and trust fund provide retirement, disability, health premium subsidies, and death benefits for members or their beneficiaries.

As a participant in a multiemployer pension plan and health care trust fund, Pinnacol recognizes as net pension cost and net postretirement benefit cost the required contribution for the period and as a liability any contributions due and unpaid.

Effective January 1, 2013, SSAP No. 92, *Accounting for Postretirement Benefits Other Than Pensions,* replaced SSAP No. 14 and SSAP No. 102, *Accounting for Pensions,* replaced SSAP No. 89. There was no material impact to Pinnacol as a result of adopting SSAP No. 92 and 102.

(t) Division of Insurance Stipulation Order

In 2010, the Colorado Division of Insurance and Pinnacol entered into a stipulation order where, among other things, Pinnacol agreed to pay $15,000,000 from surplus to policyholders as a premium credit during 2011 and 2012. This amount was established as a liability in 2010 and is a direct reduction of policyholders' surplus. The liability was paid in full, including an additional $500,000 for total payments to policyholders of $15,500,000.

(u) Subrogation

Subrogation claims (claims against third parties) are recognized as a reduction of losses incurred when collections are received. The Company received $5,338,000 and $6,349,000 in subrogation as of December 31, 2013 and 2012, respectively.

(v) Reinsurance

Ceded reinsurance transactions are accounted for based on estimates of their ultimate cost. Losses incurred, loss adjustment expenses incurred, and the reserve for loss adjustment expenses are reported net of reinsured amounts in accordance with the Manual. Reinsurance premiums are reflected as a reduction of premiums earned (note 5).

(w) Taxes

As a political subdivision of the State of Colorado, Pinnacol is not subject to federal or state income taxes under a specific exemption granted under Section 501(c) of the Internal Revenue Code; nor is Pinnacol subject to property tax or sales and use taxes. Additionally, Pinnacol is not subject to a premium tax pursuant to Section 8-45-117(3), C.R.S. However, Pinnacol is subject to a surcharge on premiums pursuant to Section 8-44-112(1)(s), C.R.S. The surcharge is based on a rate established annually, approximately 1.27% for 2013 and 1.73% for 2012. Such amounts are included in other underwriting expenses incurred.

(x) Application of Recent Statutory Accounting Pronouncements

During 2013, there were no substantive revisions to statutory accounting that were applicable to Pinnacol and, therefore, there were no substantive revisions adopted by the Company.

(2) Unpaid Losses and Loss Adjustment Expenses and Internal Structured Settlement Reserves

Unpaid losses and loss adjustment expenses (both allocated and unallocated) represent management's best estimate of the ultimate medical and indemnity net cost of all losses and loss adjustment expenses that are incurred but unpaid at year-end. Such estimates are based on individual case estimates for reported claims and actuarial estimates for losses that have been incurred but not reported. Any change in probable ultimate liabilities is reflected in losses incurred or loss adjustment expenses incurred within the statutory-basis statements of operations and changes in policyholders' surplus in the period such determination is made.

The estimated ultimate cost of losses is based on historical patterns and the expected impact of current socioeconomic trends. The ultimate settlement of claims will not be known in many cases for years after the time a policy expires. Court decisions and federal and state legislation between the time a policy is written and the time associated claims are ultimately settled, among other factors, may dramatically impact the ultimate cost. Due to these factors, among others, the process to estimate loss and loss adjustment reserves at a point in time cannot provide an exact forecast of future payments. Rather, it produces a best estimate of liability as of a certain date. Management believes the reserves currently estimated to be adequate. While the ultimate liability may differ from the current estimate, management does not believe the difference will have a material effect, either adverse or favorable, on Pinnacol's financial position or results of operations.

Pinnacol also has an internal structured settlement program in which it retains the liability for settlements to claimants rather than purchasing annuities from third parties. This liability has mortality risk and is discounted using a market rate. The discount applied to this liability was 2.5% at December 31, 2013 and 2012. The internal structured settlement liability is actuarially valued. The internal structured settlement liability is included in unpaid losses and loss adjustment expenses on the statutory-basis statements of admitted assets, liabilities and policyholders' surplus.

(a) Discount of Liabilities for Unpaid Losses

Effective January 1, 2013, Pinnacol no longer discounts its case reserves on a tabular basis for certain workers' compensation long-term indemnity payments. The change in accounting principle was adopted in accordance with Statements of Statutory Accounting Principles (SSAP) 65 *Property and Casualty Contracts*, which permits insurers to discount their tabular reserves; however, it is not required. The accounting change represents a change in the method of applying this principle, which differs from the previous method. A majority of Pinnacol's peer mono-line, mono-state companies in other states do not discount their case reserves on a tabular basis. Estimating case reserves on known claims involves a high degree of subjectivity. Removing the discount assumption, which is a projection of future interest rates, eliminates one additional assumption from this significant estimation process. The cumulative effect of the removal of the discount increased loss reserves by $71,593,000 in the current year.

(b) Unpaid Losses and Loss Adjustment Expenses

Activity in the liability for unpaid losses and loss adjustment expenses in 2013 and 2012 is summarized as follows (in thousands):

	Unpaid losses and loss adjustment expenses	
	2013	2012
Balance at January 1	$ 788,778	840,158
Removal of tabular reserve discount	71,593	—
Additional amounts incurred related to:		
Current year	458,584	445,900
Prior years	(34,180)	(83,943)
Total incurred	424,404	361,957
Reductions relating to payments for:		
Current year	141,377	135,439
Prior years	266,444	277,898
Total paid	407,821	413,337
Balance at December 31	$ 876,954	788,778

As a result of changes in estimates of insured events in prior years, the provision for unpaid losses and loss adjustment expenses decreased by approximately $34,180,000 and $83,943,000 in 2013 and 2012, respectively. During the year ended December 31, 2013, approximately $266,444,000 was paid for unpaid losses and loss adjustment expense attributable to insured events of prior years. Reserves for unpaid losses and loss adjustment expense remaining for prior years are now $488,154,000 as a result of re-estimation of unpaid losses and loss adjustment expenses. This decrease is generally the result of ongoing analysis of recent loss development trends and better than expected development. Pinnacol's claims continue the trend of favorable development that has been evident for a number of calendar years. When the actual selected ultimate cost of an accident year's claims is less than the original estimate, favorable development is recorded. This favorable development resulted from aggressive claim closure, a reduction of ultimate claim frequency in Colorado, and consistently favorable emergence of medical losses and Defense and Cost Containment (DCC) expenses throughout the year. Pinnacol management continually evaluates the estimated ultimate cost of all accident years and on a calendar year basis adjusts to the best estimate available, favorable or unfavorable, in the current period. At the end of the current year, the amount of reserve credit recorded for high deductibles on unpaid losses was $5,270,000. Such reduction is collateralized generally with letters of credit for the benefit of Pinnacol.

(c) Internal Structured Settlements

Activity in the liability for internal structured settlements in 2013 and 2012 is summarized as follows (in thousands):

		2013	2012
Beginning balance	$	350,641	330,649
Amounts incurred:			
Change in valuation		9,546	8,312
Amounts paid		(20,939)	(19,603)
New internal structured settlements		26,836	31,283
Ending balance	$	366,084	350,641

Pinnacol uses an annuity quote that is based upon an estimated discount rate as a basis for the paid claim amount. As such, the liability should be discounted at a market rate. The discount rate applied to internal structured settlement liabilities is 2.5% at December 31, 2013 and 2012.

The amount of the discount for unpaid internal structured settlements as of December 31, 2013 and 2012 is approximately $160,753,000 and $159,341,000, respectively. The discount amounts for internal structured settlement reserves at December 31, 2013 and 2012 are distributed over the years in which the losses were incurred as follows (in thousands):

2013			2012		
Loss year		Discount	Loss year		Discount
Prior	$	78,346	Prior	$	82,008
2004		7,504	2004		7,868
2005		13,064	2005		13,577
2006		15,895	2006		16,685
2007		10,382	2007		10,427
2008		13,417	2008		12,260
2009		11,787	2009		10,289
2010		4,654	2010		3,106
2011		4,748	2011		2,990
2012		942	2012		131
2013		14	2013		—
Total	$	160,753	Total	$	159,341

(3) Investments

Estimated fair value of investments in bonds is based on quotations provided by widely accepted third party data providers. In 2012, Interactive Data Corporation (IDC) and Standard and Poor's Security Evaluations (SPSE) were used to obtain fair market values. In 2013, Interactive Data Corporation (IDC), Reuters and Markit Partners were also used to obtain fair market values. Additionally, in 2013, the fair value of certain common trust funds was primarily determined by a widely accepted third-party vendor,

followed by a hierarchy using broker/dealer quotes, Bloomberg, Yield Book analytic model and a benchmark to index model. Prior month price is used only when information is limited or unavailable.

The Securities Valuation Office (SVO) of the NAIC assigns designations of bonds from 1 to 6. Bonds with designations of 1–2 are stated at amortized cost using the interest method. Bonds with designations of 3–6 require the bond to be carried at the lower of amortized cost or fair value, with any related unrealized loss reported in policyholders' surplus.

During 2013 and 2012, Pinnacol had investments in long-term bonds which the SVO assigned a 3 or higher designation. At December 31, 2013, the fair value on these long-term bonds was less than amortized cost, which resulted in a cumulative unrealized loss of $89,000. At December 31, 2012, the fair value was greater than amortized cost, which resulted in a cumulative unrealized loss of $0. Carrying values are equal to the lower of amortized cost or fair value for these bonds.

The book/adjusted carrying value and the fair value of investments in long-term bonds in 2013 and 2012 are summarized as follows (in thousands):

	2013			
	Book/adjusted carrying value	**Gross unrealized gains**	**Gross unrealized losses**	**Fair value**
Government obligations:				
Non loan-backed bonds	$ 247,098	21,643	(2,181)	266,560
Loan-backed bonds	76,383	5,074	—	81,457
Special revenue:				
Non loan-backed bonds	9,962	853	(220)	10,595
Loan-backed bonds	74,033	2,230	(1,093)	75,170
Industrial and miscellaneous:				
Non loan-backed bonds	977,953	69,680	(13,802)	1,033,831
Loan-backed bonds	69,277	273	(224)	69,326
	$ 1,454,706	99,753	(17,520)	1,536,939

	2012			
	Book/adjusted carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
Government obligations:				
Non loan-backed bonds	$ 266,861	48,754	—	315,615
Loan-backed bonds	134,284	9,662	—	143,946
Special revenue:				
Non loan-backed bonds	26,452	2,156	—	28,608
Loan-backed bonds	62,934	4,080	—	67,014
Industrial and miscellaneous:				
Non loan-backed bonds	907,232	120,471	(632)	1,027,071
	$ 1,397,763	185,123	(632)	1,582,254

The book/adjusted carrying value and estimated fair value of investments in long-term bonds at December 31, 2013, by contractual maturity, are shown in the following table (in thousands). Investments such as mortgage-backed securities have been allocated based on the original maturity date at issuance. Contractual maturities may differ from actual maturities because the borrower may have the right to call or prepay obligations with or without call or prepayment penalties.

	2013	
	Book/adjusted carrying value	Fair value
Due in one year or less	$ 117,169	120,766
Due after one year through five years	576,764	629,324
Due after five years through ten years	459,835	465,625
Due after ten years	300,938	321,224
	$ 1,454,706	1,536,939

Proceeds from sales, redemptions, or maturities of investments in long-term bonds during 2013 and 2012 were approximately $404,872,000 and $275,974,000, respectively. Realized gains on long-term bonds of approximately $5,195,000 and $13,508,000 and realized losses of approximately $(2,208,000) and $0 were recognized during 2013 and 2012, respectively.

(Continued)

Unrealized gains on investments in common stocks, mutual funds, and common trust funds are reported as a component of policyholders' surplus. Equities in an unrealized loss position are deemed to be other-than-temporarily impaired, with the resulting loss recognized in the statement of operations. Other-than-temporary impairments of common stocks, mutual funds, and common trust funds result in the establishment of a new, adjusted cost basis for such investments. The original cost, adjusted cost, gross unrealized gains (measured against adjusted cost), and fair value of common stocks, mutual funds, and common trust funds are summarized as follows (in thousands):

	Original cost	Adjusted cost	Gross unrealized gains	Fair value
December 31, 2013	$ 330,924	308,824	119,606	428,430
December 31, 2012	277,471	247,185	62,506	309,691

The following table provides the length of impairment for those investments in long-term bonds with an unrealized loss as of December 31, 2013 (in thousands):

	Less than 12 months		12 months or greater		Total	
Description of securities	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
U.S. government	$ 27,907	(2,181)	—	—	27,907	(2,181)
U.S. special revenue and special assessment	32,463	(1,313)	—	—	32,463	(1,313)
Industrial and miscellaneous	284,026	(10,932)	19,611	(3,184)	303,637	(14,116)
Total	$ 344,396	(14,426)	19,611	(3,184)	364,007	(17,610)

The following table provides the length of impairment for those investments in long-term bonds with an unrealized loss as of December 31, 2012 (in thousands):

	Less than 12 months		12 months or greater		Total	
Description of securities	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
Industrial and miscellaneous	$ 27,220	(632)	—	—	27,220	(632)
Total	$ 27,220	(632)	—	—	27,220	(632)

There were 101 and 7 long-term bonds in an unrealized loss position as of December 31, 2013 and 2012, respectively.

Impairment of Bonds – The Company writes securities down to fair value that it deems to be other-than-temporarily impaired in the period the securities are deemed to be so impaired. The Company records write-downs as realized capital losses and adjusts the cost basis of the securities accordingly. The Company does not adjust the revised cost basis for subsequent recoveries in value.

(Continued)

The assessment of whether an other-than-temporary impairment has occurred is based upon management's case-by-case evaluation of the underlying reasons for the decline in fair value. Management considers a wide range of factors, as described below, regarding the security issuer and uses its best judgment in evaluating the cause of the decline in its estimated fair value and in assessing the prospects for near-term recovery. Inherent in management's evaluation of the security are assumptions and estimates about the operations and future earnings potential of the issuer.

Considerations used by the Company in the impairment evaluation process include, but are not limited to, the following:

- Fair value is significantly below cost.
- The decline in fair value is attributable to specific adverse conditions affecting a particular instrument, its issuer, an industry, or geographic area.
- The decline in fair value has existed for an extended period of time.
- A debt security has been downgraded by a credit rating agency.
- The financial condition of the issuer has deteriorated.
- A change in future expected cash flows has occurred.
- Dividends have been reduced or eliminated or scheduled interest payments have not been made.
- The ability and intent to hold investments until recovery, including consideration of the investment manager's discretion to sell securities.

While all available information is taken into account, it is difficult to predict the ultimate recoverable amount from a distressed or impaired security.

Bonds – At December 31, 2013 and 2012, 6.2% and less than 1.0% of long-term bonds held by the Company were rated noninvestment grade, respectively. At December 31, 2013 and 2012, the Company had approximately $17,610,000 and $632,000, respectively, of unrealized losses related to its long-term bonds. The Company does not have any significant concentrations by issuer or by sector. The unrealized losses on securities are primarily attributable to fluctuations in market interest rates and changes in credit spreads since the securities were acquired.

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Loan-Backed and Structured Securities – Loan-backed securities are stated at amortized cost or fair value based on their NAIC designation. The prospective method is used to value mortgage-backed securities. Prepayment assumptions for single class and multi-class mortgage-backed/asset-backed securities were obtained from widely accepted models with inputs from major third party data providers. Any loan-backed and structured securities in an unrealized loss position were reviewed to determine whether an other-than-temporary impairment should be recognized at year-end. Pinnacol did not recognize any other-than-temporary impairments on loan-backed securities during the years ended December 31, 2013 and 2012. Loan-backed and structured securities in an unrealized loss position as of year-end, stratified based on length of time continuously in these unrealized loss positions, are as follows (in thousands):

	2013	
	Aggregate amount of unrealized loss	**Aggregate fair value of securities with unrealized loss**
Less than twelve months	$ 1,318	58,611
Twelve months or longer	—	—
	$ 1,318	58,611

Other-Than-Temporary Impairment – During 2013 and 2012, the Company recognized $524,000 and $0, respectively, in other-than-temporary impairments on long-term bonds. During 2012, a preferred stock was purchased, and there was no other-than-temporary impairment recorded. This security was sold in 2013. During the years ended December 31, 2013 and 2012, the Company recorded other-than-temporary impairments on common stocks, mutual funds, and common trust funds in the amounts of approximately $89,000 and $1,274,000, respectively. These impairments relate to market declines in value as of the last day of the year.

Fair Value Measurements – The Company has categorized its assets and liabilities that are reported on the statutory-basis statements of admitted assets, liabilities and policyholder's surplus at fair value into the three-level fair value hierarchy. The three-level fair value hierarchy is based on the degree of subjectivity inherent in the valuation method by which fair value was determined. The three levels are defined as follows.

- Level 1 – Quoted Prices in Active Markets for Identical Assets and Liabilities: This category, for items measured at fair value on a recurring basis, includes exchange-traded preferred and common stocks. The estimated fair value of the equity securities within this category are based on quoted prices in active markets and are thus classified as Level 1.
- Level 2 – Significant Other Observable Inputs: This category for items measured at fair value on a recurring basis includes bonds and common stocks, which are not exchange-traded. The estimated fair values of some of these items were determined by independent pricing services using observable inputs. Others were based on quotes from markets, which were not considered actively traded.

- Level 3 – Significant Unobservable Inputs: This category includes inputs that are unobservable and include situations where there is little, if any, market activity for the asset. The Company has no assets or liabilities measured at fair value in this category.

At the end of each reporting period, the Company evaluates whether or not any event has occurred or circumstances have changed that would cause an instrument to be transferred between Levels 1 and 2. This policy also applies to transfers into or out of Level 3 as stated below. During the current year, no transfers between Level 1, 2 or 3 were required.

The following table presents (in thousands) information about the Company's financial assets measured at fair value on a recurring basis for accounting purposes as of December 31, 2013 and 2012, respectively, and indicates the fair value hierarchy of the valuation techniques utilized by the Company to determine such fair value:

	Fair value measurements – recurring basis December 31, 2013			
Assets	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**	**Total**
Common stocks, mutual funds, and common trust funds	$ 356,707	71,723	—	428,430
Total assets	$ 356,707	71,723	—	428,430

	Fair value measurements – recurring basis December 31, 2012			
Assets	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**	**Total**
Common stocks, mutual funds, and common trust funds	$ 279,836	29,855	—	309,691
Total assets	$ 279,836	29,855	—	309,691

Certain assets are measured at fair value on a nonrecurring basis quarterly or more frequently if events dictate that the carrying value of the asset may not be recovered. These assets include bonds held at fair value with an NAIC designation of 3–6 and redeemable preferred stocks held at fair value with an NAIC

designation of RP3-RP6. There were bonds with these designations where the fair value was less than carrying value, which resulted in an unrealized loss of $89,000 at December 31, 2013 and $0 at December 31, 2012.

The Company did not have any significant concentrations by industry or by issuer as of December 31, 2013 or 2012.

The following table reflects (in thousands) the fair values and admitted values of all admitted assets and liabilities that are financial instruments excluding those accounted for under the equity method as of December 31, 2013 and 2012, respectively. The fair values are also categorized into the three-level fair value hierarchy as described above.

	December 31, 2013				
Type of financial instrument	Fair value	Admitted value	Level 1	Level 2	Level 3
Financial instruments-assets:					
Long-term bonds	$ 1,536,939	1,454,706	—	1,536,939	—
Common stocks, mutual funds, and common trust funds	428,430	428,430	356,707	71,723	—
Cash equivalents and short-term investments	86,416	86,416	86,416	—	—
Total assets	$ 2,051,785	1,969,552	443,123	1,608,662	—

	December 31, 2012				
Type of financial instrument	Fair value	Admitted value	Level 1	Level 2	Level 3
Financial instruments-assets:					
Long-term bonds	$ 1,582,255	1,397,763	—	1,582,255	—
Preferred stocks	9	9	9	—	—
Common stocks, mutual funds, and common trust funds	309,691	309,691	279,836	29,855	—
Cash equivalents and short-term investments	141,304	141,293	85,308	55,996	—
Total assets	$ 2,033,259	1,848,756	365,153	1,668,106	—

(Continued)

Investment Income – Major categories of net investment income for the years ended December 31, 2013 and 2012 are summarized as follows (in thousands):

		2013	2012
Investment income:			
Corporate and miscellaneous bonds	$	49,269	54,917
U.S. government bonds		15,256	18,050
Cash and other investments		55	38
Real estate		4,431	3,857
Equity securities		8,408	7,855
Investment expenses		(5,571)	(4,876)
Net investment income earned		71,848	79,841
Net realized capital gain (loss):			
Corporate and miscellaneous bonds		3,210	3,565
U.S. government bonds		(747)	9,943
Cash and other investments		1	—
Equity securities		19,892	33,498
Net realized capital gains		22,356	47,006
Net investment income	$	94,204	126,847

(4) Reinsurance

Ceded Reinsurance – Pinnacol purchases excess of loss reinsurance with two layers. The reinsurance coverage for individual workers' compensation accidents was as follows:

- Layer 1 – Limit of $20,000,000 in excess of retention of $20,000,000 per occurrence
- Layer 2 – Limit of $40,000,000 in excess of retention of $40,000,000 per occurrence

This coverage was in effect during 2013 and 2012. Management is not aware of any loss nor did the Company record any loss great enough to attach to these layers during any of the aforementioned policy periods.

Reinsurance contracts do not relieve Pinnacol of its obligations, and a failure of the reinsurer to honor its obligations could result in losses unreimbursed to Pinnacol. Pinnacol evaluates and monitors the financial condition of its reinsurers to minimize its exposure to loss from reinsurer insolvency. Management of Pinnacol believes its reinsurers are financially sound and will continue to meet their contractual obligations.

(Continued)

Pinnacol uses Lloyd's Syndicates as part of its ceded reinsurer program. The Syndicates are generally not rated by AM Best. The remaining reinsurers had the following AM Best ratings at December 31, 2013:

Reinsurer	Best Rating
AXIS Specialty Limited	A+
AXIS Reinsurance Company (US)	A
Endurance Specialty Insurance Limited	A
Validus Reinsurance Limited	A
Aspen Insurance UK Limited	A

Assumed Reinsurance – Pinnacol has entered into assumed reinsurance contracts that allow the Company to provide insurance coverage under the workers' compensation provisions of other states for the employees of Colorado companies who work outside of Colorado (Other States Coverage). Effective March 1, 2004, Pinnacol executed a reinsurance contract with Argonaut Insurance Company (a California corporation) for Other States Coverage. The contract was canceled in 2010; however, Pinnacol will continue to pay existing claims in accordance with this reinsurance agreement until these claims are closed or these risks are transferred. As the Company entered into a reinsurance agreement in 2010 with Zurich American Insurance Company, there were no gaps in coverage. This agreement was still in effect as of December 31, 2013. The Other States Coverage contracts are designed as 100% quota share arrangements with Pinnacol acting as the assuming company. Premium revenue is recognized pro rata over the period the policy is effective.

Pinnacol held unearned premium reserves related to assumed business of $1,564,000 and $1,880,000 for the years ended December 31, 2013 and 2012, respectively. Pinnacol had loss and loss adjustment expense reserves related to assumed business of $26,186,000 and $28,123,000 for the years ended December 31, 2013 and 2012, respectively.

(Continued)

The following reinsurance activity has been recorded in the accompanying statutory-basis financial statements (in thousands):

		2013	2012
Direct premiums written	$	478,230	414,982
Premiums ceded		(1,014)	(1,106)
Premiums assumed		11,213	17,573
Net premiums written	$	488,429	431,449
Direct premiums earned	$	469,204	409,326
Premiums ceded		(1,014)	(1,106)
Premiums assumed		11,529	17,662
Net premiums earned	$	479,719	425,882
Direct losses incurred	$	355,496	309,286
Losses ceded		—	—
Losses assumed		6,214	9,077
Net losses incurred *	$	361,710	318,363
Direct loss adjustment expenses incurred	$	61,297	41,271
Loss adjustment expenses ceded		—	—
Loss adjustment expenses assumed		1,398	2,321
Net loss adjustment expenses incurred	$	62,695	43,592

* Net losses incurred excludes activity related to the internal structured settlement liability.

(5) Employee Benefits

(a) Defined Benefit Pension Plan through the State of Colorado

Plan Description – All of Pinnacol's employees participate in a defined benefit pension plan. The plan's purpose is to provide income to members and their families at retirement or in case of death or disability. The plan is a cost sharing multiple employer plan administered by the Public Employees' Retirement Association (PERA). PERA was established by state statute in 1931. Responsibility for the organization and administration of the plan is placed with the PERA Board of Trustees. Changes to the plan require an actuarial assessment and legislation by the General Assembly. The state plan and other divisions' plans are included in PERA's financial statements, which may be obtained by writing PERA at PO Box 5800, Denver, Colorado 80217, by calling PERA at 1-800-759-PERA (7372), or by visiting http://www.copera.org.

PERA members electing the defined contribution plan are allowed an irrevocable election between the second and fifth year to use their defined contribution account to purchase service credit and be covered under the defined benefit retirement plan. However, making this election subjects the member to the rules in effect for those hired on or after January 1, 2007, as discussed below. Employer contributions to both defined contribution plans are the same as the contributions to the PERA defined benefit plan.

(Continued)

Defined benefit plan members vest after five years of service and are eligible for full retirement based on their original hire date as follows:

- Hired before July 1, 2005 – age 50 with 30 years of service, age 60 with 20 years of service, or age 65 with 5 years of service.
- Hired between July 1, 2005 and December 31, 2006 – any age with 35 years of service, age 55 with 30 years of service, age 60 with 20 years of service, or age 65 with any years of service.
- Hired between January 1, 2007 and December 31, 2010 – any age with 35 years of service, age 55 with 30 years of service, age 60 with 25 years of service, or age 65 with 5 years of service. For members with less than five years of service credit as of January 1, 2011 age and service requirements increase to those required for members hired between January 1, 2007 and December 31, 2010.
- Hired between January 1, 2011 and December 31, 2016 – any age with 35 years of service, age 58 with 30 years of service, or age 65 with 5 years of service.
- Hired on or after January 1, 2017 – any age with 35 years of service, age 60 with 30 years of service, or age 65 with 5 years of service.

Members are also eligible for retirement benefits without a reduction for early retirement based on their original hire date as follows:

- Hired before January 1, 2007 – age 55 with a minimum of 5 years of service credit and age plus years of service equals 80 or more.
- Hired between January 1, 2007 and December 31, 2010 – age 55 and age plus years of service equals 85 or more. For members hired before January 1, 2007, age plus years of service increase to 85 for members with less than five years of service credit as of January 1, 2011.
- Hired on or after January 1, 2011 but before January 1, 2017 – age 58 and age plus years of service equals 88 or more.
- Hired on or after January 1, 2017 – age 60 plus years of service equals 90.

Members automatically receive the higher of the defined retirement benefit or money purchase benefit at retirement. Defined benefits are calculated as 2.5% times the number of years of service times the highest average salary (HAS). For retirements before January 1, 2009 HAS is calculated as one-twelfth of the average of the highest salaries on which contributions were paid, associated with three periods of 12 consecutive months of service credit and limited to a 15% increase between periods. For retirements after January 1, 2009, or persons hired on or after January 1, 2007, more restrictive limits are placed on salary increases between periods used in calculating HAS.

Retiree benefits are increased annually in July after one year of retirement based on the member's original hire date as follows:

- Hired before July 1, 2007 – the lesser of 2% or the average of the monthly national Consumer Price Index (CPI) increases.

- Hired on or after January 1, 2007 – the lesser of 2% or the actual increase in the CPI, limited to a 10% reduction in a reserve established for cost of living increases related strictly to those hired on or after January 1, 2007 (the reserve is funded by 1% point of salaries contributed by employers for employees hired on or after January 1, 2007).
- The upper limits on benefits increase by one-quarter percentage point each year when the funded ratio of PERA equals or exceeds 103% and declines by one-quarter percentage point when the funded ratio drops below 90% after having exceeded 103%. The funded ratio increase does not apply for three years when a negative return on investment occurs.

Members who are disabled, who have five or more years of service credit, six months of which has been earned since the most recent period of membership, may receive retirement benefits if determined to be permanently disabled. If a member dies before retirement, their eligible children under the age of 18 (23 if a full time student) or their spouse may be entitled to a single payment or monthly benefit payments. If there is no eligible child or spouse, then financially dependent parents, beneficiaries, or the member's estate, may be entitled to a survivor's benefit.

Funding Policy – The contribution requirements of plan members and their employers are established, and may be amended, by the General Assembly. Salary subject to PERA contribution is gross earnings less any reduction in pay to offset employer contributions to the state sponsored IRC 125 plan established under Section 125 of the Internal Revenue Code.

Most employees contribute 8.0% of their salary, as defined in CRS 24-51-101(42), to an individual account in the plan. Effective July 1, 2012 the temporary contribution rate increase of 2.5% to replace the 2.5% reduction in employer contributions effective in 2010 and 2011.

From January 1, 2012, to June 30, 2012 Pinnacol contributed 13.15% and from July 1, 2012 to December 31, 2012 Pinnacol contributed 15.65% of the employee's salary. From January 1, 2013 to December 31, 2013 Pinnacol contributed 16.55% of the employee's salary. During all of 2013, 1.02% of the employees' total salary was allocated to the Health Care Trust Fund.

Per Colorado Revised Statutes, an amortization period of 30 years is deemed actuarially sound. At December 31, 2012, the division of PERA in which Pinnacol participates has a funded ratio of 59.2% and a 53 year amortization period based on current contribution rates. The funded ratio on the market value of assets is higher at 60.2%.

In the 2004 and 2010 legislative sessions, the General Assembly authorized an Amortization Equalization Disbursement (AED) to address a pension-funding shortfall. The AED requires PERA employers to pay an additional 0.5% of salary beginning January 1, 2006, another 0.5% of salary in 2007, with subsequent year increases of 0.4% of salary through 2017, to a maximum of 5%.

In the 2006 and 2010 legislative sessions, the General Assembly authorized a Supplemental Amortization Equalization Disbursement (SAED) that requires PERA employers to pay an additional one half percentage point of total salaries paid beginning January 1, 2008 through 2017, to a maximum 5%. Both the AED and SAED will terminate when funding levels reach 100%.

At 103% funding ratio, both the AED and the SAED will be reduced by one-half percentage point, and for subsequent declines to below 90% funded both the AED and SAED will be increased by one-half percentage point.

Historically members had been allowed to purchase service credit at reduced rates. However, legislation passed in the 2006 session required that future agreements to purchase service credit be sufficient to fund the related actuarial liability.

Pinnacol expects the annual contribution rate, including AED and SAED, to increase as follows from 2014 to 2017:

Year	Employer contribution	AED	SAED	Total Pinnacol contribution
2014	10.15%	3.80%	3.50%	17.45%
2015	10.15	4.20	4.00	18.35
2016	10.15	4.60	4.50	19.25
2017	10.15	5.00	5.00	20.15

Pinnacol's contributions to PERA for the years ending December 31, 2013 and 2012 were $7,146,000 and $6,035,000 respectively. These contributions met the contribution requirement for each year.

(b) Voluntary Tax-Deferred Retirement Plans

PERA offers a voluntary 401(k) plan entirely separate from the defined benefit pension plan. Pinnacol matches employee's elective contributions into the PERA 401(k) plan at 50% up to the first 6% of employees' elected deferrals. The matching contribution is immediately vested and available to the employees. During the years ended December 31, 2013 and 2012, Pinnacol contributed approximately $1,022,000 and $1,029,000, respectively, in matching contributions to the 401(k) plan. Pinnacol also offers a 457 deferred compensation plan.

(c) Postretirement Health Care and Life Insurance Benefits through the State of Colorado

Health Care Program – The PERA Health Care Program began covering benefit recipients and qualified dependents on July 1, 1986. This benefit was developed after legislation in 1985 established the Program and the Health Care Fund; the program was converted to a trust fund in 1999. The plan is a cost-sharing multiple-employer plan under which PERA subsidizes a portion of the monthly premium for health care coverage. The benefits and employer contributions are established in statute and may be amended by the General Assembly. PERA includes the Health Care Trust Fund in its Comprehensive Annual Financial Report, which may be obtained in writing PERA at PO Box 5800, Denver, Colorado 80217, by calling PERA at 1-800-759-PERA (7372), or by visiting http://www.copera.org.

After the PERA subsidy, the benefit recipient pays the balance of the premium through an automatic deduction from the monthly retirement benefit. Monthly premium costs for participants depend on

the health care plan selected, the PERA subsidy amount, Medicare eligibility, and the number of persons covered. Effective July 1, 2000, the maximum monthly subsidy is $230 per month for benefit recipients who are under 65 years of age and who are not entitled to Medicare and $115 per month for benefit recipients who are 65 years of age or older or who are under 65 years of age and entitled to Medicare. The maximum subsidy is based on the recipient having 20 years of service credit, and is subject to reduction of 5% for each year less than 20 years.

Employees are not required to contribute to the Health Care Trust Fund, which is maintained by employer's contributions as discussed above. Beginning July 1, 2004, employers are required to contribute 1.02% of gross covered wages to the Health Care Trust Fund. Pinnacol contributed approximately $442,000 and $430,000 as required by statute in the years ended December 31, 2013 and 2012, respectively. In each year the amount contributed was 100% of the required contribution.

The Health Care Trust Fund offers two general types of plans: fully insured plans offered through health care organizations and self-insured plans administered for PERA by third-party vendors. As of December 31, 2012, there were 51,666 enrolled participants, including spouses and dependents, from all contributors to the plan. At December 31, 2012, the Health Care Trust Fund had an unfunded actuarial accrued liability of $1.43 billion, a funded ratio of 16.5%, and a 66-year amortization period.

(d) Other

Health and Welfare Trust – Effective January 1, 2010, Pinnacol entered into certain self-funded benefit programs with its vendors for healthcare, dental care, and vision care and established a separate legal trust for administrative purposes. Pinnacol withholds monthly premium from its employee participants' payroll checks and uses these premiums and the employer contribution amounts to fund the trust account. Medical claims are processed and paid by the third party vendors and subsequently reimbursed by the funds held in the trust.

Accrued Paid Leave – Pinnacol employees may accrue paid time off based on their length of service subject to certain limitations on the amount that will be paid upon termination or taken in future periods. Paid time off is recorded as an expense and a liability at the time the paid time off is earned. The estimated liability for cumulative accrued paid time off of approximately $1,677,000 and $1,813,000 at December 31, 2013 and 2012, respectively, is included in other liabilities in the statutory-basis statements of admitted assets, liabilities and policyholders' surplus.

(6) Policyholders' Surplus

Pinnacol paid approximately $37,453,000 in general policyholder dividends to its policyholders in good standing in 2012. This is included in dividends to policyholders on the statutory-basis statements of operations and changes in policyholders' surplus and reduces net income for the year ended December 31, 2012. There were no general policyholder dividends paid in 2013.

The Division monitors a company's "risk based capital" in assessing the financial strength of an insurance company. Pinnacol's level of surplus exceeds the "company action level" of risk-based capital, which is approximately $141,988,000 for 2013.

(7) Commitments and Contingencies

Lawsuits arise against the Company in the normal course of business. Contingent liabilities arising from litigation and other matters are not considered material in relation to the financial position of the Company.

At December 31, 2013 and 2012, Pinnacol had a letter of credit for the benefit of Argonaut Insurance Company under an assumed reinsurance agreement for approximately $17,386,000 and $19,248,000, respectively. In addition, Pinnacol had a letter of credit for the benefit of Zurich American Insurance Company under an assumed reinsurance agreement for approximately $37,000,000 and $22,000,000 as of December 31, 2013 and 2012, respectively. These reinsurance agreements allow each reinsurer to draw upon the letter of credit, which is 100% collateralized, at any time to secure any of Pinnacol's obligations under the agreement. Included in long-term bonds and money market securities are amounts held as collateral for the letter of credit of approximately $94,472,000 and $88,845,000, compared to a requirement of $54,386,000 and $41,248,000, as of December 31, 2013 and 2012, respectively.

Pinnacol is contingently liable for approximately $48,973,000 of claims closed by the purchase of annuities from life insurers for structured settlements. Pinnacol has not purchased annuities from life insurers under which the Company is payee and, therefore, no balances are due from such annuity insurers.

Pinnacol is aware of an unfunded liability related to PERA. The variables that impact the determination of the liability are the number of active and inactive members, annual payroll, required contribution rates and the investment returns of PERA. GASB Statement No. 68, *Accounting and Financial Reporting for Pensions,* is effective for fiscal years beginning after June 15, 2014. The statement will require cost-sharing employers participating in defined benefit plans to record their proportionate share of the unfunded pension liability. At this time, management is unable to estimate the magnitude of Pinnacol's share of the unfunded pension liability, but it is expected to be material. The unfunded liability for vested service of Pinnacol employees and retirees has not been recorded in Pinnacol's statutory-basis financial statements as of December 31, 2013.

(8) Subsequent Events

New Board Members – One new member was appointed to the Company's Board of Directors on December 20, 2013 with an effective date of January 1, 2014.

Surplus Note - On May 7, 2014, Pinnacol's Board of Directors approved a surplus note of $100,000,000 to an unaffiliated third-party in exchange for cash, subject to regulatory approval. The interest on the unpaid principal amount of this note will be paid in semi-annual installments at the rate of 8.625% per annum. The note will be due and payable twenty years from the issuance date, with a call date in whole or part in fifteen years with no penalty. Each payment of interest or principal may be made only to the extent that the Company has sufficient policyholders' surplus and has received the prior approval of the Commissioner of the Colorado Division of Insurance. The note has not yet been issued as of May 14, 2014, since it has not yet been approved by the Colorado Division of Insurance.

Subsequent events have been evaluated through May 14, 2014, the date these statutory-basis financial statements were available to be issued.

SUPPLEMENTAL SCHEDULES OF INVESTMENT INFORMATION
(See Independent Auditors' Report)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Investment Risks Interrogatories

Year ended December 31, 2013

(In thousands)

1. Pinnacol's total admitted assets as reported on page 2 of its annual statement are: $ 2,043,553

2. The following are the ten largest exposures to a single issuer/borrower/investment by investment category, excluding: (i) U.S. government securities, U.S. government agency securities, and those U.S. government money market funds listed in the Appendix to the *Purposes and Procedures Manual of the NAIC Securities Valuation Office (SVO)* as exempt, (ii) property occupied by Pinnacol, (iii) policy loans, and (iv) asset types that are investment companies (mutual funds) and common trust funds that are diversified within the meaning of the Investment Company Act of 1940 [Section 5(b) (1)].

Issuer	Description of Exposure	Amount	Percentage of total admitted assets
a. FNMA	LONG TERM BOND	$ 34,394	1.683%
b. GENERAL ELECTRIC CO	LONG TERM BOND AND COMMON STOCK	32,171	1.574
c. PROCTER & GAMBLE CO	LONG TERM BOND AND COMMON STOCK	29,649	1.451
d. BURLINGTON NORTHERN SANTA FE	LONG TERM BOND	28,544	1.397
e. ANHEUSER-BUSCH COS	LONG TERM BOND	25,568	1.251
f. FGLMC	LONG TERM BOND	24,364	1.192
g. NORTHERN STATES POWER	LONG TERM BOND	22,864	1.119
h. AT&T INC	LONG TERM BOND	22,383	1.095
i. DIAGEO CAPITAL PLC	LONG TERM BOND	20,684	1.012
j. HERSHEY COMPANY	LONG TERM BOND	19,977	0.978

3. Pinnacol's total admitted assets held in bonds and preferred stocks by NAIC designation are:

NAIC Designation	Amount	Percentage of total admitted assets
Bonds:		
NAIC-1	$ 1,232,828	60.328%
NAIC-2	224,611	10.991
NAIC-3	21,431	1.049
NAIC-4	73,753	3.609
NAIC-5	—	—
NAIC-6	—	—
Preferred stocks:		—
P/RP-1	—	—
P/RP-2	—	—
P/RP-3	—	—
P/RP-4	—	—
P/RP-5	—	—
P/RP-6	—	—
	$ 1,552,623	

4. Assets held in foreign investments are $91,021 and assets held in foreign-currency-denominated investments are $0 which is approximately 4.454% and 0% of Pinnacol's total admitted assets, respectively.

5. The following represents aggregate foreign investment exposure categorized by NAIC sovereign designation:

Foreign investment assets

NAIC Designation	Amount	Percentage of total admitted assets
Countries designated NAIC-1	$ 91,021	4.454%
Countries designated NAIC-2	—	—
Countries designated NAIC-3 or below	—	—
	$ 91,021	

(Continued)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Investment Risks Interrogatories

Year ended December 31, 2013

(In thousands)

6. The following represents the largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

Foreign investment assets

NAIC Designation	Country	Amount	Percentage of total admitted assets
Countries designated NAIC-1:			
Country 1:	United Kingdom	$ 21,023	1.029%
Country 2:	Norway	19,574	0.958
Countries designated NAIC-2:			
Country 1:		—	—
Country 2:		—	—
Countries designated NAIC-3 or below:			
Country 1:		—	—
Country 2:		—	—
		$ 40,597	

7. Aggregate unhedged foreign currency exposure is $0 which is approximately 0% of Pinnacol's total admitted assets.

8. The following represents aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

Foreign-Currency-Denominated investment assets

NAIC Designation	Amount	Percentage of total admitted assets
Countries designated NAIC-1	$ —	—%
Countries designated NAIC-2	—	—
Countries designated NAIC-3 or below	—	—
	$ —	

9. The following represents the largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

Foreign-Currency-Denominated investment assets

NAIC Designation	Country	Amount	Percentage of total admitted assets
Countries designated NAIC-1:			
Country 1:		$ —	—%
Country 2:		—	—
Countries designated NAIC-2:			
Country 1:		—	—
Country 2:		—	—
Countries designated NAIC-3 or below:			
Country 1:		—	—
Country 2:		—	—
		$ —	

10. The following represents the ten largest nonsovereign (i.e. nongovernmental) foreign issues:

Issuer	NAIC Designation	Amount	Percentage of total admitted assets
a. STATOIL ASA	1FE	$ 14,578	0.713%
b. WEATHERFORD BERMUDA	2FE	13,258	0.649
c. DIAGEO CAPITAL PLC	1FE	12,688	0.621
d. TEVA PHARMACEUTICAL FIN BV	1FE	9,982	0.488
e. TOTAL CAPITAL	1FE	8,807	0.431
f. TYCO ELECTRONICS GROUP	2FE	6,506	0.318
g. LLOYDS BANK PLC	1FE	4,999	0.245
h. SCHLUMBERGER NORGE AS	1FE	4,996	0.244
i. PENTAIR LTD	COMMON STOCK	3,728	0.182
j. VODAFONE GROUP PLC	1FE	3,336	0.163

(Continued)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Investment Risks Interrogatories

Year ended December 31, 2013

(In thousands)

11. Assets held in Canadian investments are less than 2.5% of Pinnacol's total admitted assets.

12. Pinnacol does not hold any investments with contractual sales restrictions.

13. The following are the ten largest equity interests (including investments in the shares of mutual funds, preferred stocks, publicly traded equity securities, and other securities and excluding money market and bond mutual funds listed in the Appendix to the Purposes and Procedures Manual of the NAIC Securities Valuation Office (SVO) as exempt or Class 1):

Issuer	Amount	Percentage of total admitted assets
a. VANGUARD TOT STK MKT INDEX FUND	$ 69,055	3.379%
b. VANGUARD INST INDEX FUND	35,458	1.735
c. BLACKROCK MSCI ACWI IMI INDEX FUND	34,750	1.700
d. T. ROWE PRICE INST FUND	32,139	1.573
e. WESTWOOD INCOME OPPORTUNITY FUND	31,415	1.537
f. FIRST EAGLE OVERSEAS FUND	24,514	1.200
g. SCOUT INTERNATIONAL FUND	24,426	1.195
h. MATTHEWS ASIAN GROWTH FUND	24,242	1.186
i. MSCI ACWI EX USA NL QP CTF	16,461	0.806
j. MSCI US INDX NL QP CTF	15,581	0.762

14. Assets held in nonaffiliated, privately placed equities is $71,723, which represents 3.510% of Pinnacol's total admitted assets. The following represents the three largest investments held in nonaffiliated, privately placed equities:

Issuer	Amount	Percentage of total admitted assets
a. BLACKROCK MSCI ACWI IMI INDEX FUND	$ 34,750	1.700%
b. MSCI ACWI EX USA NL QP CTF	16,461	0.806
c. MSCI US INDX NL QP CTF	15,581	0.762

Items 15 through 23 are not applicable.

See accompanying independent auditors' report.

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Summary Investment Schedule

December 31, 2013

Investment Categories	Gross Investment Holdings*		Admitted assets as reported in the annual statement	
	Amount	Percentage of Gross Investment Holdings	Amount	Percentage of total admitted assets
Bonds:				
U.S. Treasury securities	$ 247,098,079	12.4%	$ 247,098,079	12.4%
U.S. government agency obligations (excluding mortgage-backed securities):				
- Issued by U.S. government agencies				
- Issued by U.S. government sponsored agencies	5,011,647	0.3	5,011,647	0.3
Non-U.S. government (including Canada, excluding mortgage-backed securities)				
Securities issued by states, territories, and possessions and political subdivisions in the U.S.:				
- States, territories, and possessions general obligations	600,000	—	600,000	—
- Political subdivisions of states, territories, and possessions and political general obligations				
- Revenue and assessment obligations	4,350,000	0.2	4,350,000	0.2
- Industrial development and similar obligations				
Mortgage-backed securities (includes residential and commercial MBS):				
Pass-through securities:				
- Issued or guaranteed by GNMA	8,405,848	0.4	8,405,848	0.4
- Issued or guaranteed by FNMA and FHLMC	58,757,287	3.0	58,757,287	3.0
- All other				
CMOs and REMICs:				
- Issued or guaranteed by GNMA, FNMA, FHLMC or VA	83,253,187	4.2	83,253,187	4.2
- Issued by non-U.S. government issuers and collateralized by mortgage-based securities issued by above				
- All other	59,445,209	3.0	59,445,209	3.0
Other debt and other fixed income securities (excluding short term):				
- Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	900,991,386	45.3	900,991,386	45.3
- Unaffiliated non-U.S. securities (including Canada)	86,793,415	4.4	86,793,415	4.4
- Affiliated securities				
Equity interests:				
- Investments in mutual funds				
Preferred stocks:				
- Affiliated				
- Unaffiliated				
Publicly traded equity securities (excluding preferred stocks):				
- Affiliated				
- Unaffiliated	356,707,085	17.9	356,707,085	17.9
Other equity securities:				
- Affiliated				
- Unaffiliated	71,722,507	3.6	71,722,507	3.6
Other equity interests including tangible personal property under lease:				
- Affiliated				
- Unaffiliated				

(Continued)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Summary Investment Schedule

December 31, 2013

Investment Categories	Gross Investment Holdings*		Admitted assets as reported in the annual statement	
	Amount	Percentage of Gross Investment Holdings	Amount	Percentage of total admitted assets
Mortgage loans:				
- Construction and land development	$		$	
- Agricultural				
- Single-family residential properties				
- Multifamily residential properties				
- Commercial loans				
- Mezzanine real estate loans				
Real estate investments:				
- Property occupied by Company	18,138,569	0.9%	18,138,569	0.9%
- Property held for production of income				
- Property held for sale				
Contract loans				
Derivatives				
Receivables for securities	699,331	0.1	699,331	0.1
Securities lending				
Cash, cash equivalents, and short-term investments	86,415,728	4.3	86,415,728	4.3
Write-ins for invested assets				
Total invested assets	$ 1,988,389,278	100.0%	$ 1,988,389,278	100.0%

* Gross investment holdings as valued in compliance with NAIC *Accounting Practices and Procedures Manual*

Note: Reinsurance Interrogatories are excluded as they are not applicable.

See accompanying independent auditors' report.

KPMG LLP
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1225 17th Street
Denver, CO 80202-5598

Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Members of the Legislative Audit Committee
Pinnacol Assurance Board of Directors:

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the financial statements of Pinnacol Assurance, which comprise the statutory statements of admitted assets, liabilities, and policyholders' surplus as of December 31, 2013, and the related statutory statements of operations and changes in policyholders' surplus, and cash flows for the year then ended, and the related notes to the statutory financial statements, and have issued our report thereon dated May 14, 2014. Our report on the financial statements includes an adverse opinion on U.S. generally accepted accounting principles because the financial statements are prepared using statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado, which is a basis of accounting other than U.S. generally accepted accounting principles. Our report on the financial statements also includes an unmodified opinion on the financial statements in accordance with statutory accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado, which is a basis of accounting other than U.S. generally accepted accounting principles.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered Pinnacol Assurance's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Pinnacol Assurance's internal control. Accordingly, we do not express an opinion on the effectiveness of Pinnacol Assurance's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

KPMG

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Pinnacol Assurance's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Pinnacol Assurance's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Pinnacol Assurance's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

KPMG LLP

Denver, Colorado
May 14, 2014

PINNACOL ASSURANCE

Distribution

December 31, 2013

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Report Control Number 1410F

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 16 UTILIZATION STANDARDS

16-1 STATEMENT OF PURPOSE

In an effort to comply with its legislative charge to assure appropriate and timely medical care at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 2014. This Rule defines the standard terminology, administrative procedures and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule. With respect to any matter arising under the Colorado Workers' Compensation Act and/or the Workers' Compensation Rules of Procedure and to the extent not otherwise precluded by the laws of this state, all providers and payers shall use and comply with the provisions of the "Medical Treatment Guidelines," Rule 17, and the "Medical Fee Schedule," Rule 18, as incorporated and defined in the Workers' Compensation Rules of Procedure, 7 CCR 1101-3.

16-2 STANDARD TERMINOLOGY FOR RULES 16 AND 18

(A) Ambulatory Surgical Center (ASC) – licensed as an ambulatory surgery center by the Colorado Department of Public Health and Environment.

(B) Authorized Treating Provider (ATP) – may be any of the following:

(1) The treating physician designated by the employer and selected by the injured worker;

(2) A health care provider to whom an authorized treating physician refers the injured worker for treatment, consultation, or impairment rating;

(3) A physician selected by the injured worker when the injured worker has the right to select a provider;

(4) A physician authorized by the employer when the employer has the right or obligation to make such an authorization;

(5) A health care provider determined by the Director or an administrative law judge to be an ATP;

(6) A provider who is designated by the agreement of the injured worker and the payer.

(C) Billed Service(s) – any billed service, procedure, equipment or supply provided to an injured worker by a provider.

(D) Billing Party – a service provider or an injured worker who has incurred authorized medical costs.

(E) Certificate of Mailing – a signed and dated statement containing the names and mailing addresses of all persons receiving copies of attached or referenced document(s), certifying the documents were placed in the U.S. Mail, postage pre-paid, to those persons.

(F) Children's Hospital – as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(G) Convalescent Center – as licensed by the Colorado Department of Public Health and Environment.

(H) Critical Access Hospital (CAH) – as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(I) Dispute Resolution: Division review of materials for compliance with the Rules prior to any pre-hearing/hearing before an Administrative Law Judge (ALJ) in the Office of Administrative Courts.

(J) Day – defined as a calendar day unless otherwise noted.

(K) Hospital – as identified and licensed by the Colorado Department of Public Health and Environment.

(L) Long-Term Care Facility – as identified and Medicare certified by the Colorado Department of Public Health and Environment

(M) Medical Fee Schedule – Division's Rule 18, its Exhibits, and the documents incorporated by reference in that Rule.

(N) Medical Treatment Guidelines – the medical treatment guidelines as incorporated into Rule 17, "Medical Treatment Guidelines."

(O) Over-the-Counter Drugs – drugs that are safe and effective for use by the general public without a prescription.

(P) Payer – an insurer, employer, or their designated agent(s) who is responsible for payment of medical expenses.

(Q) Prior Authorization – assurance that appropriate reimbursement for a specific treatment will be paid in accordance with Rule 18, its' Exhibits, and the documents incorporated by reference in that Rule.

(R) Private Psychiatric Facilities – licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

(S) Provider – a person or entity providing authorized health care service, whether involving treatment or not, to a worker in connection with work-related injury or occupational disease.

(T) Rehabilitation Facilities – licensed as a rehabilitation hospital by the Colorado Department of Public Health and Environment.

(U) Rural Health Facility – as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(V) Skilled Nursing Facility (SNF) – licensed as a skilled nursing facility by the Colorado Department of Public Health and Environment

(W) State Psychiatric Hospitals and State Mental Health Institutions – licensed as a psychiatric facility and operated by the state.

(X) "Supply et al." – any single supply, durable medical equipment (DME), orthotic, prosthesis, biologic item, or single drug dose, for which the billed amount exceeds $500.00 and all implants.

(Y) Veterans' Administration Medical Facilities – all medical facilities overseen by the Federal Veterans' Administration.

16-3 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES AND PAYMENT FOR SERVICE

When an injury or occupational disease falls within the purview of Rule 17, Medical Treatment Guidelines and the date of injury occurs on or after July 1, 1991, providers and payers shall use the medical treatment guidelines, in effect at the time of service, to prepare or review their treatment plan(s) for the injured worker. A payer may not dictate the type or duration of medical treatment. Nor may a payer rely solely on its' own internal guidelines or other standards for medical determination. When treatment exceeds or is outside of the Medical Treatment Guidelines, prior authorization is required. In all instances of contest appropriate processes to deny are required. Refer to applicable sections of 16-9, 16-10 and/or 16-11.

16-4 REQUIRED USE OF THE MEDICAL FEE SCHEDULE

(A) When services provided to an injured worker fall within the purview of the Medical Fee Schedule, all payers shall use the fee schedule to determine maximum allowable fees.

(B) All providers are required to report services in accordance with codes, modifiers (both CPT and Level II HCPCS/National Modifiers as listed in RVP Introduction and or in Appendix A of CPT) and standards in Rule 18, Medical Fee Schedule that accurately represent the services provided. The Medical Fee Schedule sets the maximum allowable payment but the fee schedule does not limit the billing charges.

(C) The provider may be subject to penalties under the Workers' Compensation Act for inaccurate billing when the provider knew or should have known that the services billed were inaccurate, as determined by the Director or an administrative law judge.

16-5 RECOGNIZED HEALTH CARE PROVIDERS

(A) Physician and Non-Physician Providers

(1) For the purpose of this Rule, recognized health care providers are divided into the major categories of "physician" and "non-physician". Recognized providers are defined as follows:

(a) "Physician providers" are those individuals who are licensed by the State of Colorado through one of the following state boards:

(1) Colorado State Board of Medical Examiners;

(2) Colorado State Board of Chiropractic Examiners;

(3) Colorado Podiatry Board; or

(4) Colorado State Board of Dental Examiners.

(b) "Non-physician providers" are those individuals who are registered or licensed by the State of Colorado Department of Regulatory Agencies (DORA), or certified by a national entity recognized by the State of Colorado as follows:

(1) Acupuncturist (LAc) – licensed by the Office of Acupuncturist Registration, Colorado Department of Regulatory Agencies;

(2) Advanced Practice Nurse – licensed by the Colorado State Board of Nursing; Advanced Practice Nurse Registry;

(3) Athletic Trainers (ATC) – certified by the Board of Certification, Inc.;

(4) Audiologist (AU.D. CCC-A) – certified by the American Speech Language-Hearing Association or board certified in audiology from the American Board of Audiology;

(5) Clinical Social Worker (LCSW) – licensed by the Colorado State Board of Social Work Examiners;

(6) Marriage and Family Therapist (LMFT) – licensed by the Colorado State Board of Marriage and Family Therapist Examiners;

(7) Massage Therapist (RMT) – registered as a massage therapist by the Colorado Department of Regulatory Agencies;

(8) Occupational Therapist (OTR) – registered by the Colorado Department of Regulatory Agencies as an occupational therapist certified by the National Board for Certification of Occupational Therapy;

(9) Optometrist (OD) – licensed by the Colorado State Board of Optometric Examiners;

(10) Orthopedic Technologist (OTC) – certified by the Board for Certification of Orthopedic Technologists, National Association of Orthopedic Technologists;

(11) Pharmacist – licensed by the Colorado State Board of Pharmacy;

(12) Physical Therapist (PT) – licensed by the Colorado State Board of Physical Therapy;

(13) Physical Therapist Assistant (PTA) – certified by the Colorado Board of Physical Therapy.

(14) Physician Assistant (PA) – licensed by the Colorado State Board of Medical Examiners;

(15) Practical Nurse (LPN) – licensed by the Colorado State Board of Nursing;

(16) Professional Counselor (LPC) – licensed by the Colorado State Board of Professional Counselor Examiners;

(17) Psychologist (PsyD, PhD, EdD) – licensed by the Colorado State Board of Psychologist Examiners;

(18) Registered Nurse (RN) – licensed by the Colorado State Board of Nursing;

(19) Respiratory Therapist (RTL) – certified by the National Board of Respiratory Care and licensed by the Colorado Department of Regulatory Agencies;

(20) Speech Language Pathologist (CCC-SLP) – certified by DORA; and

(21) Surgical Technologist (CST) – certified under direction of the Association of Surgical Technologists.

(2) Upon request, health care providers must provide copies of license, registration, certification or evidence of health care training for billed services.

(3) Any provider not listed in 16-5(A)(1)(a) or (b) must comply with 16-9, Prior Authorization when providing all services.

(4) Referrals:

(a) A payer or employer shall not redirect or alter the scope of an authorized treating provider's referral to another provider for treatment or evaluation of a compensable injury. Any party who has concerns regarding a referral or its scope shall advise the other parties and providers involved.

(b) All non-physician providers must have a referral from an authorized treating physician. An authorized treating physician making the referral to any listed or unlisted non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care.

(c) Any listed or non-listed non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care with the referring authorized treating physician.

(5) Rule 18, Medical Fee Schedule applies to authorized services provided in relation to a specific workers' compensation case.

(B) Out-of-State Provider

(1) Injured Worker Relocated

(a) Upon receipt of the "Employer's First Report of Injury" or the "Worker's Claim for Compensation" form, the payer shall notify the injured worker

that the procedures for change-of-provider, should s/he relocate out-of-state, can be obtained from the payer.

(b) A change of provider must be made:

(1) Through referral by the injured worker's authorized treating physician; or

(2) In accordance with § 8-43-404 (5)(a), C.R.S.

(2) Injured Worker Referred

In the event an injured worker has not relocated out-of-state but is referred to an out-of-state provider for treatment or services not available within Colorado, the referring provider shall obtain prior authorization from the payer as set forth in 16-9, Prior Authorization, and 16-10, Contest of a Request for Prior Authorization. The referring provider's written request for out-of-state treatment shall include the following information:

(a) Medical justification prepared by the referring provider;

(b) Written explanation as to why the requested treatment/services cannot be obtained within Colorado;

(c) Name, complete mailing address and telephone number of the out-of-state provider;

(d) Description of the treatment/services requested, including the estimated length of time and frequency of the treatment/service, and all associated medical expenses; and

(e) Out-of-state provider’s qualifications to provide the requested treatment or services.

(3) The Colorado fee schedule should govern reimbursement for out-of-state providers.

16-6 HANDLING, PROCESSING AND PAYMENT OF MEDICAL BILLS

(A) Use of agents, including but not limited to Preferred Provider Organizations (PPO) networks, bill review companies, third party administrators (TPAs) and case management companies, shall not relieve the employer or insurer from their legal responsibilities for compliance with these Rules.

(B) Payment for billed services identified in the Medical Fee Schedule shall not exceed those scheduled rates and fees, or the provider's actual billed charges, whichever is less.

(C) Payment for billed services not identified or identified but without established value, by report (BR) and relativity not established (RNE), in the Medical Fee Schedule shall require prior authorization from the payer as set forth in 16-9 Prior Authorization, except when the billed non-established valued service or procedure is an emergency or a payment mechanism under Rule 18 is identifiable, but not explicit. Examples of the prior authorization request exception(s) include ambulance bills or supply bills that are covered under Rule18-6(H) with an identified payment mechanism of either CO Medicare HCPCS Level II values or cost of the supply plus 20%.

Similar established code values from the Medical Fee Schedule, recommended by the requesting physician, shall govern the maximum fee value payment.

(D) Any payer contesting a provider's treatment shall follow the procedures as outlined under 16-10, Contest of a Request for Prior Authorization, or 16-11, Payment of Medical Benefits.

(E) The payer should note that ICD-9 Supplementary Classification of External Causes of Injury and Poisoning codes (E-codes), when submitted, shall not be used to establish the work relatedness of an injury or treatment.

16-7 REQUIRED BILLING FORMS AND ACCOMPANYING DOCUMENTATION

(A) Providers may use electronic reproductions of any required form(s) referenced in this section; however, any such reproduction shall be an exact duplication of such form(s) in content and appearance. With the agreement of the payer, identifying information may be placed in the margin of the form.

(B) Required Billing Forms

All health care providers shall use only the following billing forms or electronically produced formats when billing for services:

(1) CMS (Centers for Medicare & Medicaid Services) -1500 shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance services with the exception of those providers billing for dental services or procedures; hospitals are required to use the CMS-1500 when billing for professional services. Health care providers shall provide their name and credentials in an appropriate box of the CMS-1500.

(2) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, Children's Hospitals, CAHs, Veterans' Administration Medical Facilities, home health and facilities meeting the definitions found in 16-2 when billing for hospital services or any facility fees billed by any other provider, such as ASCs, except for urgent care which may use the CMS-1500.

(3) American Dental Association's Dental Claim Form, Version 2006 shall be used by all providers billing for dental services or procedures.

(4) With the agreement of the payer, the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP (National Council For Prescription Drug Programs) electronic billing transaction containing the same information as in (1), (2) or (3) in this subsection may be used.

NCPDP Workers' Compensation/Property and Casualty (P&C) Universal Claim Form, version 1.1, for prescription drug billed on paper shall be used by dispensing pharmacies and pharmacy benefits management (PBM). Physicians may use the CMS-1500 billing form as described in Rule 16-7(B)(1).

(C) Required Billing Codes

All billed services shall be itemized on the appropriate billing form as set forth in 16-7(A) and (B), and shall include applicable billing codes and modifiers from the Medical Fee Schedule. National provider identification (NPI) numbers are required for workers' compensation bills; providers who cannot obtain NPI numbers are exempt from this

requirement. When billing on a CMS-1500, the NPI should be that of the rendering provider and should include the correct place of service codes at the line level whenever possible.

(D) Inaccurate Billing Forms or Codes

Payment for any services not billed on the forms identified and/or not itemized as instructed in 16-7(B) and (C), may be contested until the provider complies. However, when payment is contested, the payer shall comply with the applicable provisions set forth in 16-11, Payment of Medical Benefits.

(E) Accompanying Documentation

(1) Authorized treating physicians sign (or countersign) and submit to the payer, with their initial and final visit billings, a completed "Physician's Report of Workers' Compensation Injury" (Form WC 164) specifying:

(a) The report type as "initial" when the injured worker has their initial visit with the authorized treating physician managing the total workers' compensation claim of the patient. Generally, this will be the designated or selected authorized treating physician. When applicable, the emergency room or urgent care authorized treating physician for this workers' compensation injury may also create a WC 164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC 164 form. This form shall include completion of items 1-7 and 10. Note that certain information in item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) The report type as "closing" when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient determines the injured worker has reached maximum medical improvement (MMI) for all injuries or diseases covered under this workers' compensation claim, with or without a permanent impairment. The form requires the completion of items 1-5, 6.B, C, 7, 8 and 10. If the injured worker has sustained a permanent impairment, then item 9 must also be completed and the following additional information shall be attached to the bill at the time MMI is determined:

(1) All necessary permanent impairment rating reports when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient is Level II Accredited; or

(2) Referral to a Level II Accredited physician requested to perform the permanent impairment rating when a rating is necessary and the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

(c) At no charge, the physician shall supply the injured worker with one legible copy of all completed "Physician's Report of Workers' Compensation Injury" (WC 164) forms at the time the form is completed.

(d) The provider shall submit to the payer the completed WC 164 form as specified in 16-7(E), no later than 14 days from the date of service.

(2) Providers, other than hospitals, shall provide the payer with all supporting documentation at the time of submission of the bill unless other agreements have been made between the payer and provider. This shall include copies of the examination, surgical, and/or treatment records.

(3) Hospital documentation shall be available to the payer upon request. Payers shall specify what portion of a hospital record is being requested. (For example, only the emergency room (ER) chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.)

(4) In accordance with 16-11, the payer may contest payment for billed services until the provider completes and submits the relevant required accompanying documentation as specified by 16-7(E).

(F) Providers shall submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. Extenuating circumstances may include but are not limited to delays in compensability being decided or the provider has not been informed where to send the bill.

16-8 REQUIRED MEDICAL RECORD DOCUMENTATION

(A) A treating provider shall maintain medical records for each injured worker when the provider intends to bill for the provided services.

(B) All medical records shall contain legible documentation substantiating the services billed. The documentation shall itemize each contact with the injured worker and shall detail at least the following information per contact or, at a minimum for cases where contact occurs more than once a week, be summarized once per week:

(1) Patient's name;

(2) Date of contact, office visit or treatment;

(3) Name and professional designation of person providing the billed service;

(4) Assessment or diagnosis of current condition with appropriate objective findings;

(5) Treatment status or patient’s functional response to current treatment;

(6) Treatment plan including specific therapy with time limits and measurable goals and detail of referrals;

(7) Pain diagrams, where applicable;

(8) If being completed by an authorized treating physician, all pertinent changes to work and/or activity restrictions which reflect lifting, standing, stooping, kneeling, hot or cold environment, repetitive motion or other appropriate physical considerations; and

(9) All prior authorization(s) for payment received from the payer (i.e., who approved the prior authorization for payment, services authorized, dollar amount, length of time, etc.).

16-9 PRIOR AUTHORIZATION

(A) Granting of prior authorization is a guarantee of payment in accordance with Rule 18, RVP© and CPT© for those services/procedures requested by the provider per 16-9(F).

(B) Prior authorization for payment shall be requested by the provider when:

(1) A prescribed service exceeds the recommended limitations set forth in the Medical Treatment Guidelines;

(2) The Medical Treatment Guidelines otherwise require prior authorization for that specific service;

(3) A prescribed service is identified within the Medical Fee Schedule as requiring prior authorization for payment; or

(4) A prescribed service is not identified in the Medical Fee Schedule as referenced in 16-6(C).

(C) Prior authorization for a prescribed service or procedure may be granted immediately and without medical review. However, the payer shall respond to all providers requesting prior authorization within seven (7) business days from receipt of the provider's completed request as defined in 16-9(F). The duty to respond to a provider's written request applies without regard for who transmitted the request.

(D) The payer, upon receipt of the "Employer's First Report of Injury" or a "Worker's Claim for Compensation," shall give written notice to the injured worker stating that the requirements for obtaining prior authorization for payment are available from the payer.

(E) The payer, unless they have previously notified said provider, shall give notice to the provider of these procedures for obtaining prior authorization for payment upon receipt of the initial bill from that provider.

(F) To complete a prior authorization request, the provider shall concurrently explain the reasonableness and the medical necessity of the services requested, and shall provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure.

(1) When the indicatons of the Medical Treatment Guidelines are met, no prior authorization is required. If the provider requests prior authorization for payment the following documentation is recommended:

(a) An adequate definition or description of the nature, extent, and necessity for the procedure;

(b) Identify the appropriate Medical Treatment Guideline application to the requested service;

(c) Document that the indicators in the guidelines have been met; and

(d) Final diagnosis.

(2) When the service/procedure does not fall within the Medical Treatment Guidelines and/or past treatment failed functional goals or if the requested procedure is not

identified in the Medical Fee Schedule or does not have an established value under the Medical Fee Schedule, such as any unlisted procedure/service with a BR value or an RNE value listed in the RVP© authorization requests may be made using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188).

(G) To contest a request for prior authorization, the payer is required to comply with the provisions outlined in 16-10.

(H) The Division recommends payers confirm in writing, to providers and all parties, when a request for prior authorization is approved.

(I) If, after the service was provided, the payer agrees the service provided was reasonable and necessary, lack of prior authorization for payment does not warrant denial of payment. However, the provider is still required to provide with the bill the documentation as required by 16-9(F) for any unlisted valued service or procedure for payment.

16-10 CONTEST OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If the payer contests a request for prior authorization for non-medical reasons as defined under 16-11(B)(1), the payer shall notify the provider and parties, in writing, of the basis for the contest within seven (7) business days from receipt of the provider's completed request as defined in 16-9(F). A certificate of mailing of the written contest must be sent to the provider and parties.

If an ATP requests prior authorization and indicates in writing, including their reasoning and relevant documentation, that they believe the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny based solely on relatedness without a medical review as required by 16-10(B).

(B) If the payer is contesting a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:

(1) Have all the submitted documentation under 16-9(F) reviewed by a physician or other health care professional, as defined in 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review; and

(2) After reviewing all the submitted documentation, the reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written contest or approval still needs to be completed within the specified seven (7) business days under 16-10(B).

(3) Furnish the provider and the parties with a written contest that sets forth the following information:

(a) An explanation of the specific medical reasons for the contest, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(b) The specific cite from the Medical Treatment Guidelines exhibits to Rule 17, when applicable;

(c) Identification of the information deemed most likely to influence the reconsideration of the contest when applicable; and

(d) A certificate of mailing to the provider and parties.

(C) Prior Authorization Disputes

(1) The requesting party or provider shall have seven (7) business days from the date of the certificate of mailing on the written contest to provide a written response to the payer, including a certificate of mailing. The response is not considered a "special report" when prepared by the provider of the requested service.

(2) The payer shall have seven (7) business days from the date of the certificate of mailing of the response to issue a final decision, including a certificate of mailing to the provider and parties.

(3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(D) An urgent need for prior authorization of health care services, as recommended in writing by an authorized treating provider, shall be deemed good cause for an expedited hearing.

(E) Failure of the payer to timely comply in full with the requirements of 16-10(A) or (B), shall be deemed authorization for payment of the requested treatment unless:

(1) A hearing is requested within the time prescribed for responding as set forth in 16-10(A) or (B); and

(2) The requesting provider is notified that the request is being contested and the matter is going to hearing.

(F) Unreasonable delay or denial of prior authorization, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

16-11 PAYMENT OF MEDICAL BENEFITS

(A) Payer Requirements for Processing Medical Service Bills

(1) For every medical service bill submitted by a provider, the payer shall reply with a written notice or explanation of benefits. In those instances where the payer reimburses the exact billed amount, identification of the patient's name, the payer, the paid bill, the amount paid and the dates of service are required. If any adjustments are made then the payer's written notice shall include:

(a) Name of the injured worker or patient;

(b) Specific identifying information coordinating the notice with any payment instrument associated with the bill;

(c) Date(s) of service(s), if date(s) was (were) submitted on the bill;

(d) Payer's claim number and/or Division's workers' compensation claim number, if one has been created;

(e) Reference to the bill and each item of the bill;

(f) Notice that the billing party may resubmit the bill or corrected bill within 60 days;

(g) For compensable services for a work-related injury or occupational disease the payer shall notify the billing provider that the injured worker shall not be balance-billed for services related to the work-related injury or occupational disease;

(h) Name of insurer with admitted, ordered or contested liability for the workers' compensation claim, when known;

(i) Name, address, e-mail (if any), phone number and fax of a person who has responsibility and authority to discuss and resolve disputes on the bill;

(j) Name and address of the employer, when known; and

(k) Name and address of the Third Party Administrator (TPA) and name and address of the bill reviewer if separate company when known; and

(l) If applicable, a statement that the payment is being held in abeyance because a relevant issue is being brought to hearing.

(2) The payer shall send the billing party written notice that complies with 16-11(A)(1) and (B) or (C) if contesting payment for non-medical or medical reasons within 30 days of receipt of the bill. Any notice that fails to include the required information set forth in 16-11(A)(1) and (B) or (C) if contesting payment for non-medical or medical reasons is defective and does not satisfy the payer's 30-day notice requirements set forth in this section.

(3) Unless the payer provides timely and proper reasons as set forth by the provisions outlined in 16-11(B) - (D), all bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within 30 days after receipt of the bill by the payer.

(4) If the payer discounts a bill and the provider requests clarification in writing, the payer shall furnish to the requester the specifics of the discount within 30 days including a copy of any contract relied on for the discount. If no response is forthcoming within 30 days, the payer must pay the maximum Medical Fee Schedule allowance or the billed charges, whichever is less.

(5) Date of receipt of the bill may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the bill was mailed to the payer's correct address.

(6) Unreasonable delay in processing payment or denial of payment of medical service bills, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

(7) If the payer fails to make timely payment of uncontested billed services, the billing party may report the incident to the Division's Carrier Practices Unit who may use it during an audit.

(B) Process for Contesting Payment of Billed Services Based on Non-Medical Reasons

(1) Non-medical reasons are administrative issues. Examples of non-medical reasons for contesting payment include the following: no claim has been filed with the payer; compensability has not been established; the billed services are not related to the admitted injury; the provider is not authorized to treat; the insurance coverage is at issue; typographic, gender or date errors are in the bill; failure to submit any medical documentation at all; unrecognized CPT® code.

(2) If an ATP bills for medical services and indicates in writing, including their reasoning and relevant documentation that they believe the medical services are related to the admitted WC claim, the payer cannot deny based solely on relatedness without a medical review as required by 16-11(C).

(3) In all cases where a billed service is contested for non-medical reasons, the payer shall send the billing party written notice of the contest within 30 days of receipt of the bill. The written notice shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted on the bill;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested; and

(d) Clear and persuasive reasons for contesting the payment of any item specific to that bill including the citing of appropriate statutes, rules and/or documents supporting the payer's reasons for contesting payment.

Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30 day notice requirement set forth in this section.

(4) Prior to modifying a billed code, the payer must contact the billing provider and determine if the modified code is accurate.

(a) If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on their explanation of benefits (EOB) the agreement with the provider. The EOB shall include the name of the person at the provider's office who made the agreement.

(b) If the provider is in disagreement, then the payer shall proceed according to 16-11(B) or 16-11(C), as appropriate.

(5) Lack of prior authorization for payment does not warrant denial of liability for payment.

(6) When no established fee is given in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on their written notice of contest (see 16-11(A)(1)) one of the following payment options:

(a) A reasonable value based upon the similar established code value recommended by the requesting provider;

(b) The provider's requested payment based on an established similar code value as required by 16-9(F); or

(c) The billed charges.

If the payer disagrees with the provider's recommended code value, the payer's notice of contest shall include an explanation of why the requested fee is not reasonable and what their recommendation is, based on the payment options.

If the payer is contesting the medical necessity of any non-valued procedure after a prior authorization was requested, the payer shall follow 16-11(C).

(C) Process for Contesting Payment of Billed Services Based on Medical Reasons

When contesting payment of billed services based on medical reasons, the payer shall:

(1) Have the bill and all supporting medical documentation under 16-7(E) reviewed by a physician or other health care professional as defined in 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(2) In all cases where a billed service is contested for medical reasons, the payer shall send the provider and the parties written notice of the contest within 30 days of receipt of the bill. The written notice shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was (were) submitted on the bill;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested;

(d) An explanation of the clear and persuasive medical reasons for the decision, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(e) The specific cite from the Medical Treatment Guidelines exhibits to Rule 17, when applicable; and

(f) Identification of the information deemed most likely to influence the reconsideration of the contest, when applicable.

(3) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(4) If the payer is contesting the medical necessity of any non-valued procedure provided without prior authorization, the payer shall follow the procedures given in 16-11(C)(1)and (2).

(D) Process for Ongoing Contest of Billed Services

(1) The billing party shall have 60 days to respond to the payer's written notice under 16-11(A) – (C). The billing party's timely response must include:

(a) A copy of the original or corrected bill;

(b) A copy of the written notice or EOB received;

(c) A statement of the specific item(s) contested;

(d) Clear and persuasive supporting documentation or clear and persuasive reasons for the appeal; and

(e) Any available additional information requested in the payer's written notice.

(2) If the billing party responds timely and in compliance with 16-11(D)(1), the payer shall:

(a) When contesting for medical reasons, have the bill and all supporting medical documentation and reasoning under 16-7(E) and, if applicable, 16-11(D)(1) reviewed by a physician or other health care professional as defined in 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. After reviewing the provider's documentation and response, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(b) When contesting for non-medical reasons, have the bill and all supporting medical documentation and reasoning under 16-7(E) and, if applicable, 16-11(D)(1) reviewed by a person who has knowledge of the bill. After reviewing the provider's documentation and response, the reviewing person may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(3) If before or after conducting a review pursuant to 16-11(D)(2), the payer agrees with the billing party's response, the billed service is due and payable in accordance with the Medical Fee Schedule within 30 days after receipt of the billing party's response. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the response was mailed to the payer's correct address.

(4) After conducting a review pursuant to 16-11(D)(2), if there is still a dispute regarding the billed services, the payer shall send the billing party written notice of contest within 30 days of receipt of the response. The written notice shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted by the provider;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested;

(d) An explanation of the clear and persuasive medical or non-medical reasons for the decision, including the name and professional credentials of the person performing the medical or non-medical review and a copy of the medical reviewer's opinion when the contest is over a medical reason; and

(e) The explanation shall include the citing of appropriate statutes, rules and/or documents supporting the payer's reasons for contesting payment.

(5) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(6) In the event of continued disagreement, and within 12 months of the bill being processed in compliance with Rule 16-11, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(E) When seeking dispute resolution from the Division's Medical Policy Unit (MPU), the requesting party must complete the Division's "Medical Billing Dispute Resolution Intake Form" (Form WC 181) found on the Division's web page. The items listed on the bottom of the form must be provided at the time of submission. If necessary items are missing or if more information is required, the Division will forward a request for additional information and initiation of the process may be delayed.

When the request is properly made and the supporting documentation submitted, the Division will issue a confirmation of receipt. If after reviewing the materials the Division believes the dispute criteria have not been met, the Division will issue an explanation of those reasons. If the Division determines there is cause for facilitating the disputed items, the other party will be sent a request for a written response, allowing the other party ten (10) business days to respond.

The MPU will facilitate the dispute by reviewing the parties' compliance with Rules 16 and 18 within 30 days of receipt of the complete supporting documentation; or as soon thereafter as possible.

Upon review of all submitted documentation, disputes resulting from violation of Rules 16 and/or 18, as determined by the Director, may result in a Director's Order that cites the specific violation.

Evidence of compliance with the order shall be provided to the Director. If the party does not agree with the findings, it shall state with particularity and in writing its reasons for all disagreements by providing a response with all relevant legal authority, and/or other relevant proof upon which it relies in support of its position(s) concerning disagreements with the order.

Failure to respond or cure violations may result in penalties in accordance with § 8-43-304. Daily fines up to $1000/day for each such offence will be assessed until the party complies with the Director's Order.

Resolution of disputes not pertaining to Rule violations will be facilitated by the MPU to the extent possible. In the event both parties cannot reach an agreement, the parties will be provided additional information on pursuing resolution and adjudication procedures available through the Office of Administrative Courts. Use of the dispute resolution process does not extend the 12 month application period for hearing.

(F) Retroactive review of Medical Bills

(1) All medical bills paid by a payer shall be considered final at 12 months after the date of the original explanation of benefits unless the provider is notified that:

(a) A hearing is requested within the 12 month period, or

(b) A request for utilization review has been filed pursuant to § 8-43-501.

(2) If the payer conducts a retroactive review to recover overpayments from a provider based on medical reasons, the payer shall have the bill and all supporting documentation reviewed by a physician or other health care professional as defined in 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The payer shall send the billing party written notice that shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments;

(b) Clear and persuasive medical reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(3) If the payer conducts a retroactive review to recover overpayments from a provider based on non-medical reasons, the payer shall send the billing party written notice that shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments;

(b) Clear and persuasive reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(4) In the event of continued disagreement, the parties may follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(G) An injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act. In the event the injured worker has directly paid for medical services that are then admitted or ordered as covered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized services within 30 days after receipt of the bill. If the actual costs exceed the maximum fee allowed by the Medical Fee Schedule, the payer may seek a refund from the medical provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the service provided and the date of service(s) involved.

(H) To the extent not otherwise precluded by the laws of this state, contracts between providers, payers and any agents acting on behalf of providers or payers shall comply with 16-11.

16-12 ONSITE REVIEW OF HOSPITAL OR OTHER MEDICAL CHARGES

(A) The payer may conduct a review of billed and non-billed hospital or medical facility charges related to a specific workers' compensation claim.

(B) The payer shall comply with the following procedures:

Within 30 days of receipt of the bill, notify the hospital or other medical facility of its intent to conduct a review. Notification shall be in writing and shall set forth the following information:

(1) Name of the injured worker;

(2) Claim and/or hospital or other medical facility I.D. number associated with the injured worker's bill;

(3) An outline of the items to be reviewed; and

(4) If applicable, the name, address and telephone number of any person who has been designated by the payer to conduct the review (reviewer).

(C) The hospital or other medical facility shall comply with the following procedures:

(1) Allow the review to begin within 30 days of the payer's notification;

(2) Upon receipt of the patient's signed release of information form, allow the reviewer access to all items identified on the injured worker's signed release of information form;

(3) Designate an individual(s) to serve as the primary liaison(s) between the hospital or other medical facility and the reviewer who will acquaint the reviewer with the documentation and charging practices of the hospital or other medical facility;

(4) Provide a written response to each of the preliminary review findings within ten (10) business days of receipt of those findings; and

(5) Participate in the exit conference in an effort to resolve discrepancies.

(D) The reviewer shall comply with the following procedures:

(1) Obtain from the injured worker a signed information release form;

(2) Negotiate the starting date for the review;

(3) Assign staff members who are familiar with medical terminology, general hospital or other medical facility charging and medical records documentation procedures or have a level of knowledge equivalent at least to that of an LPN;

(4) Establish the schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or other medical facility, a ten (10) business day response period for the hospital or other medical facility, and the delivery of an itemized listing of discrepancies at an exit conference upon the completion of the review; and

(5) Provide the payer and hospital or other medical facility with a written summary of the review within 20 business days of the exit conference.