PINNACOL ASSURANCE

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pinnacol.com

December 21, 2018

Honorable Governor John Hickenlooper
Governor-Elect Jared Polis
Members of the General Assembly
200 E. Colfax Ave.
Denver, CO 80203

Dear Governor Hickenlooper, Governor-Elect Polis and Members of the General Assembly:

Pursuant to C.R.S. §8-45-122, attached please find Pinnacol Assurance's 2017 Report to Colorado Policymakers. Per the statute, the report contains the following information:

(a) Number of policies held by Pinnacol
(b) Total assets of Pinnacol
(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 2017.*

The introduction to the report also highlights Pinnacol's focus and commitment to policyholders, injured workers and the Colorado community. Additional financial information may be found in the appendices to this document.

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

Sincerely,

Philip B. Kalin
President and CEO

cc:
Sen. Leroy Garcia, Senate President-Designate
Sen. Chris Holbert, Senate Minority Leader-Designate
Rep. KC Becker, Speaker-Designate
Rep. Patrick Neville, House Minority Leader
Sen. Angela Williams, Chair-Designate, Senate Business, Labor and Technology Committee
Sen. Rhonda Fields, Chair-Designate, Senate Health and Human Services Committee
Rep. Tracy Kraft-Tharp, Chair, House Business Affairs and Labor Committee
Rep. Susan Lontine, Chair-Designate, House Health and Insurance Committee

Colorado Legislative Council Library

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Introduction

Pinnacol has provided workers' compensation insurance to Colorado employers, regardless of risk, since 1915. We ensure workers receive wage replacement and the medical care they deserve when they're injured on the job, and we protect their employers from potentially catastrophic losses. Today, we cover more than 56,000 businesses across the state, including more than 900,000 Colorado employees.

Our priority has always been and remains on our customers: Colorado businesses and their employees. In 2017, we asked our employees to look at everything they do through two lenses: increase customer experience and decrease customer costs. In measuring Pinnacol's performance, these have become our North Star. Our strong financial results and our impressive customer satisfaction numbers are testaments to this approach.

Improving Customer Service

The world is changing at a rapid pace, and the insurance industry is too. Our customers tell us they expect the process of buying a policy and filing a claim to be easy, intuitive and seamless. In response, using Toyota Lean approaches, advanced analytics and digital tools, all of us at Pinnacol are working to simplify our customers' experiences and minimize wasted efforts. For example:

- We've changed the way we gather customer feedback to make it more meaningful. We began mapping out all the ways businesses interact with us, from the moment they purchase a policy through the closure of a claim. Then we interview them at six different points along their journey – after a safety visit, after an audit, after a claim has closed, etc. – to hear how it went and to learn from their responses.

- After better tracking the reasons customers call us – and the times when they call – we've added new functionality to our online portals, so customers can get the information they need without having to call us.

- We've implemented direct deposit for our injured workers. Now, rather than having to wait for a check, 72 percent of our injured workers have the confidence of knowing it's going straight to their bank account.

Innovating to Better Serve Small Businesses

Small businesses are Pinnacol's bread and butter. They include employers with annual premiums of $10,000 and less, who buy from us directly, rather than through an agent. We asked these businesses what they wanted, and they said simple, fast, online transactions and support. As a result, we launched Cake: an online platform, the first of its kind in the workers' compensation industry. We reduced the time to get a quote and purchase a policy from three to five days, to three to five minutes; set up live chat and text support; and enabled customers to obtain their required certificates of insurance online.

The response has been remarkable. Since Cake was launched in October 2017, nearly 2,000 customers have used it to buy a policy, generating over $3 million in premiums. It's also been recognized nationally with awards like IDG's "Digital Edge," Celent's "Model Insurer," and SMA's "Strategy Meets Action." Cake was a finalist for the Colorado Technology Association's APEX Project of the Year, and it was the subject of a case study by international consulting firm Forrester Research and Celent. Feedback from customers include: "Insurance right away!" and "This was the easiest insurance I have ever obtained."

Improving Policyholder and Injured Worker Satisfaction

We believe when you listen and respond to the voices of your customers, you're going to provide them a product or service that delights them.

We also believe transformative leaps in customer satisfaction, such as those with Cake, don't just happen. They're the result of looking simultaneously at the big picture – How is business changing? – and the small – How do you as an individual behave? – and synthesizing that information into new ways of serving customers. Our customers have responded to our efforts.

Pinnacol's Net Promoter Score (a standard way of measuring satisfaction) among policyholders stood at 52 in June, higher than the industry benchmark of 33. Cake's NPS score was even higher, consistently around 74. Recently, Pinnacol's satisfaction score among injured workers was the best we've ever received at 4.1 out of 5.

Keeping Colorado Workers Safe

Pinnacol has the largest, most experienced team of safety consultants in Colorado, including experts in industrial hygiene and ergonomics. Our team also features specialists in industries like construction, oil and gas and health care. Our consultants spend more than 35,000 hours every year helping employers across the state keep their workplaces safe. We also have hundreds of safety resources available to our policyholders at no cost, including webinars, posters and sample documents. Many of these materials are available for download whenever an employer needs them.

Caring for Injured Workers

In 2017, Pinnacol paid for wage replacement and medical care benefits to **nearly 32,000 injured workers**. Only three percent of claims were contested (denied) in 2017, most often because the injury was determined to be not work-related.

Developing the Workforce of Tomorrow

Pinnacol is an enthusiastic leader of Colorado's nationally-recognized apprenticeship program, CareerWise. Endorsed by Governor Hickenlooper, it's based on the Swiss model, where 70 percent of professionals complete an apprenticeship before moving on to post-secondary education and careers.

Like every other business, Pinnacol faces challenges in recruiting and retaining high-caliber staff. So growing our own team members is appealing. We believe in this model so much that we currently have 27 apprentices – more than any other employer in Colorado. Our apprentices (who went through a competitive interview process like any job applicant) will be with us for three years. During their junior and senior years of high school they spend two to three days a week at our office getting paid, hands-on work experience; they'll transition to working for us full time after they graduate. When they complete their apprenticeships in 2020, each will have earned up to 40 hours of debt-free college credit and a nationally-recognized industry certification – and we anticipate that many of them will choose to continue working for us. In fact, we already have one full-time employee who started as an apprentice.

Investing in Colorado

As the leading provider of worker's compensation insurance in Colorado, we recognize our impact on the state and its economy. Our commitment extends beyond our customers and their employees. With customers in all 64 Colorado counties, we spread our efforts across the state to help nonprofits large and small.

Pinnacol awarded grants totaling nearly $550,000 to 32 Colorado nonprofits to help keep its policyholders' employees safe and healthy, provide rehabilitative care to those who are injured, and ensure Colorado has a robust business climate and the workforce it needs. The grants were awarded to organizations statewide, including The Colorado School of Public Health, the Spinal Cord Injury Recovery Project and Sedgwick County Economic Development.

In 2017, Pinnacol also launched a pilot program to provide financial assistance to nonprofit policyholders that wish to improve workplace safety by purchasing equipment or implementing processes to reduce employee exposure to health and safety hazards. In the initial round of grants, Pinnacol awarded more than $71,000 to organizations around the state such as Laradon Hall Society in metro Denver and Family Health West in Fruita.

Through the employee-led Pinnacol in Action program, 80 percent of Pinnacol's 600+ employees volunteered with a nonprofit in 2017, spending a record-breaking 6,602 hours serving the community. Participation in the program is voluntary, and employees are free to lend a hand to organizations that are meaningful to them. They shared their time and talents with groups like Denver Health Foundation, Food Bank of the Rockies and National Sports Center for the Disabled.

One of the initiatives of which we are most proud is the Pinnacol Foundation, which awarded more than $400,000 in scholarships last year to children whose parents were seriously injured or killed in a work-related accident in Colorado, whether or not Pinnacol was the insurer on the claim. The students, 112 in total, applied their scholarships to traditional two- and four-year college programs as well as accredited vocational institutions. Since the Foundation was created in 2000, it has awarded $4.5 million to nearly 500 students in every corner of the state.

Maintaining Financial Stability to Benefit Colorado Businesses

For the third year in a row, Pinnacol decreased rates and issued a general dividend in 2017. Managing expenses, carefully stewarding our financial resources, applying disciplined underwriting practices, and focusing on managing risks to our investment portfolio, allow us to maintain our financial stability and guarantee the payment of benefits to injured workers and their dependents that may span years or even decades. This commitment has resulted in an A- (Excellent) rating from insurance rating agency A.M. Best and a BBB+ rating from Standard & Poor's.

In another recognition of Pinnacol's financial stability, Aon recognized Pinnacol in the "Ward Top 50" of best-performing property and casualty insurance carriers in the U.S., placing us in the top two percent of the nearly 3,000 property and casualty carriers evaluated by the company.

In 2017, Pinnacol received a clean audit of its financial statements, as conducted by independent auditors (KPMG) contracted by the Colorado Office of the State Auditor. The full audit report is attached in Appendix B.

Required reporting per C.R.S. §8-45-122 - All data as of Dec. 31, 2017

A. Policy Count: 55,837

Pinnacol's policies-in-force (active) as of Dec. 31, 2017 were virtually unchanged from 2016 (decrease of 132 policies) while premium grew by 2.6 percent despite a 3.2 percent rate decrease.

B. Total (Admitted) Assets: $2,833,711,330

Pinnacol's total assets grew by 7.63 percent over year-end 2016. The change was driven primarily by positive net income and operating cash flow as well as an increase in the value of invested assets. Pinnacol's investment portfolio emphasizes high quality, taxable bonds, supplemented by a smaller portfolio of equities, high-yield debt and alternative investments. It is overseen by an investment committee including outside professionals as well as members of Pinnacol's board.

C. Reserves: $923,095,000

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 decreased by a little more than 1 percent over year-end 2016, primarily due to fewer claims per premium dollar.

D. Surplus: $1,276,308,032

Our surplus is equity to cover unexpected claims/losses and economic fluctuations, as well as other risks. It is, essentially, our rainy day fund. It is important to recognize that, because Pinnacol is not allowed to participate in the state's insurance guaranty fund, our surplus serves as our own guaranty fund. Every year the board sets a surplus target range based on A.M. Best Capital Adequacy Ratio.

Colorado's strong economy and Pinnacol's attention to its operating performance helped drive positive net income, which is consistently the biggest driver of surplus growth for Pinnacol. Our surplus also reflects our share of PERA's unfunded liability, which has grown as PERA has changed its actuarial and investment assumptions.

E. Claims filed in 2017: 42,777

F. Claims required by statute to be admitted or denied within 20 days and notice provided to the Colorado Division of Workers' Compensation (DOWC): 5,301

Contested claims that are medical-only: 1,327

Contested claims that are indemnity claims: 79

The number of claims Pinnacol admitted or contested (denied) within 20 days decreased by 7.52 percent in 2017 compared to 2016. The percent of claims we provide notice of to the DOWC has held steady at 12-14 percent of total claims filed for a number of years.

The total number of claims Pinnacol contested (denied) and reported to the DOWC decreased in 2017 from 2016 by 4.5 percent. Both the number of contested indemnity claims and contested medical-only claims decreased by 33 claims in each category. Pinnacol's most common basis for contesting claims in 2016 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 2017 with explanations to follow.

1.	Claims processed with no filing required with DOWC	= 37,476 (87.6 percent)
2.	Claims admitted within 20 days with DOWC	= 3,895 (9.1 percent)
3.	Claims contested (denied) within 20 days with DOWC	= 1,406 (3.3 percent)
	Subtotal of items 2 and 3	= 5,301
	Total claims in fiscal year 2015	= 42,777 (100 percent)

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. These claims are processed by Pinnacol and do not require a filing of admission or contest with the DOWC. These claims represent 87.6 percent of all claims received by Pinnacol in 2017.

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 was found to have a permanent disability due to the injury
- 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 12–14 percent of total claims filed for the last few years.

Item 3: Contested Claims:
The 1,406 contested claims (3.3 percent of total claims in 2017) stemmed from one or more of the following reasons:

- Injury or illness was not work-related – 816 (58 percent)
- Pending further investigation or information – 298 (21 percent)
- Other – 292 (21 percent) This category includes such things as no insurance policy or the injured worker is covered by another carrier.

Pinnacol's percentage of claims contested remained at 3.3 percent in 2017, the same as 2016.

G. Medical procedures denied: 2,606

Pinnacol's percentage of medical procedures denied compared to total bills received was 0.41 percent for 2017. 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 is the procedure was found not to be medically necessary.

Medical procedures denied are in accordance with Rule 16 of the Colorado Division of Workers' Compensation's Rules of Procedure. Some medical procedures require prior approval from the insurance company. Once a request for prior authorization is received, Pinnacol has seven 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	2017 Total Compensation
President and CEO	$724,174
Senior Vice President, Insurance Operations	$459,577
Vice President, General Counsel and Corporate Secretary	$446,267
Vice President, Strategic Development	$413,313
Vice President, Chief Investment Officer	$378,679
Chief Financial Officer	$354,175
Vice President, Human Resources	$322,817
Vice President, Agency Relations and Safety Services	$306,480
Vice President, Chief Information Officer	$297,506
Vice President, Communications and Public Affairs	$290,693
Vice President, Marketing (hired 8/1/2017)	$113,599
Average total compensation for 9 Associate Vice Presidents	$210,933

I. Amount spent on commissions: $82,070,087

J. Amount paid to trade associations for marketing fees: $208,911

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 2017 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

EXECUTIVE PERFORMANCE PLAN
(As Amended and Restated January 1, 2017)

SUMMARY

The Executive Performance Plan ("Performance Plan") is hereby amended and restated effective for Plan Years commencing on or after January 1, 2017. The Performance Plan is intended to recognize the achievement of major company objectives and individual objectives, measured on an annual basis.

This Performance Plan appropriately emphasizes individual and group accountability for making specific contributions to Pinnacol Assurance's overall business results. Based on Board of Directors of Pinnacol Assurance ("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 for meeting or exceeding annual performance objectives for pre-established company metrics 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 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" 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 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 Due to Error

The Board may increase or decrease the amount of an award subsequent to an Initial Determination Date (a "Subsequent Adjustment Due to Error"), provided, however, that a Subsequent Adjustment Due to Error 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 Due to Error shall be a Subsequent Determination Date with respect to such adjustment.

4. Determination Dates

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 Due to Error 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 Due to Error). In the event that a Subsequent Adjustment Due to Error reduces an award that has already been paid, Pinnacol Assurance may recoup such Subsequent Adjustment Due to Error 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 Due to Error 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 Due to Error) 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 Due to Error) 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 90% on achievement of company objectives and 10% on Individual Strategic Goals.

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

	Threshold	Commendable	Maximum
Associate Vice Presidents	20.0%	32.5%	45.0%
Senior Vice President and Vice Presidents	22.5%	37.5%	52.5%
CEO	32.24%	45.67%	59.10

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 for Combined Ratio Before General Dividends, New Business Policyholder Satisfaction, Original Premium Retention, Injured Worker Satisfaction, and Individual Strategic Goals (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.

A. "Combined Ratio Before General Dividends" is the combined ratio results for insurance operations, excluding other income/expense, as determined by the company's financial statements. The numerator of the ratio is total expenses (all losses incurred, loss adjustment expenses, underwriting expenses and safety group dividends). The denominator of the ratio is net underwriting premiums earned (underwriting premiums earned minus program dividends (but not minus association and general dividends).

B. "New Business" will be based upon the premium generated by policies that are new business to Pinnacol Assurance during the Plan Year.

C. "Policy Holder Satisfaction" 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.

D. "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.

E. "Original Premium Retention" will be based on the average percentage of premium Pinnacol Assurance retains during the Plan Year.

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

The weighting of the objectives shall be:

- Combined Ratio - 6 0%
- Growth - New Business: 5%
- Policy Holder Satisfaction -5 %
- Injured Worker Satisfaction - 5%
- Original Premium Retention - 5%
- Individual Strategic Goals: 20%

2. Discretionary Adjustment

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

The final results pertaining to any objective may be adjusted at the discretion of 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, significantly better than expected performance results, and Board-approved budget adjustments.

3. Calculation of the Award 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. If an Eligible Employee has been employed in an eligible position for less than the full twelve calendar months of the Plan Year and was hired prior to October 1 of the Plan Year, the award will be calculated based on the Eligible Employee's base salary on December 31 of the Plan Year or if the Eligible Employee moves from an Eligible Position to a non-eligible position, on the Eligible Employee's base salary on the last day in the eligible position in the Plan Year, in either case prorated based on the number of months in the eligible position.

C. If an Eligible Employee has been employed in more than one classification eligible for an award under this Performance Plan (e.g., as both an Associate Vice President and a Vice President) during a Plan Year, the award will be calculated based on the Eligible Employee's base salary in each eligible classification, using the base salary on the day prior to any eligible classification change during the year and the base salary on December 31 of the Plan Year in the additional eligible classification, in each case prorated based on the number of months in the eligible classification and multiplied by the Eligible Employee's Performance Plan Award Range for each eligible classification.

D. The principles of B. and C. above are illustrated by the following examples.

Dakota is hired (or promoted) on July 1 into an AVP position with a base salary of $100,000 per year. He performs at a commendable level for the Plan Year.

Dakota's award = $50,000 x 32.5% = $16,250

Montana is an AVP on January 1 with a base salary of $100,000 per year. She is promoted to a VP with a base salary of $150,000 on July 1. She performs at a commendable level for the Plan Year.

Montana's award = ($50,000 x 32.5%) + ($75,000 x 37.5%) = $44,375

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 Adjustment Due to Error 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, 2017) effective January 1, 2017, by the signature of its duly authorized officers.

PINNACOL ASSURANCE

By: Barbara Brannen

Name: Barbara Brannen

Title: Vice President, Human Resources

Date: 12/16/16

PINNACOL ASSURANCE

By: Philip Kalin

Name: Philip B. Kalin

Title: President and Chief Executive Officer

Date: 12/16/16

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, 2017 and 2016

(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

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Chair

Senator Kerry Donovan
Vice Chair

Representative Tracy Kraft-Tharp
Representative Timothy Leonard
Representative Lori Saine
Senator Jim Smallwood
Senator Nancy Todd
Representative Faith Winter

Office of the State Auditor Staff

Dianne E. Ray
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Kerri Hunter
Deputy State Auditor

Crystal Dorsey
Contract Monitor

KPMG LLP
Contract Auditors

An electronic version of this report is available at
www.Colorado.gov/auditor

A bound report may be obtained by calling the
Office of the State Auditor
303.869.2800

Please refer to report number 1710F when
requesting this report

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Chair

Jeffrey L. Cummings
Barbara M. Davis
Bonnie B. Dean
Mark D. Goodman
Joseph A. Hoff
Geraldine A. Lewis-Jenkins
Joshua L. (Luke) McFarland
Patricia L. Peterson

PINNACOL ASSURANCE

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PINNACOL ASSURANCE

Report Summary

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 financial 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 and for the year ended December 31, 2017, 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 U.S. generally accepted accounting principles.

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, 2017.

Audit Opinion and 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).

We issued a report on Pinnacol's compliance and internal control over financial reporting based on an audit of the financial statements performed in accordance with Government Auditing Standards. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be deficiencies, significant deficiencies, or material weaknesses. A deficiency in internal control over financial reporting 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 significant deficiency is a deficiency, or combination of deficiencies, in internal control over financial reporting that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting, 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.

We noted no matters involving the internal control over financial reporting and its operation that we consider to be material weaknesses.

Summary of Current Year Findings and Recommendations

There were no reported findings and recommendations resulting from the audit for fiscal year 2017.

PINNACOL ASSURANCE

Report Summary

Summary of Prior Year Findings and Recommendations

There were no reported findings and recommendations resulting from the audit for fiscal year 2016.

PINNACOL ASSURANCE

Description of Pinnacol Assurance

December 31, 2017

Pinnacol Assurance (Pinnacol or the Company) was established as a political subdivision of the State of Colorado (the State) 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 revenue, monies, and assets of Pinnacol belong solely to Pinnacol. The State of Colorado has no claim to, nor any interest in, such revenue, monies, and assets and shall not borrow, appropriate, or direct payments from such revenue, monies, and assets for any purpose.

Pinnacol developed a new digital platform designed to market, underwrite, and service small direct policyholders with annual premiums of less than $10,000 that are not considered high risk. Cake Insure, Inc. (Cake) was incorporated on September 20, 2017 as a subsidiary of Pinnacol and will help small businesses quote and purchase a workers' compensation insurance policy from Pinnacol. With the launch of Cake, Pinnacol became subject to Title 10, Article 3, Part 8, of the C.R.S. Insurance Holding Company Systems and holds 90% of the voting shares ownership in Cake. During 2017, Pinnacol sold software and intellectual property to Cake.

Policyholders' Surplus

Pinnacol had policyholders' surplus of $1,276,308,000 and $1,086,349,000 as of December 31, 2017 and 2016, respectively. The increase in surplus is primarily related to current year net income and unrealized capital gains.

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

Independent Auditors' Report

The Members of the Legislative Audit Committee and
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, 2017 and 2016, and the related statutory statements of operations and changes in policyholders' surplus, and cash flow for the years 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 audits. We conducted our audits 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 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 financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

The effects on the 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, 2017 and 2016, or the results of its operations or its cash flow for the years 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, 2017 and 2016, 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.

Other Matters

Supplemental Schedule

Our audits were conducted for the purpose of forming an opinion on the 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 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 financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the 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 financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated May 24, 2018 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 24, 2018

PINNACOL ASSURANCE

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

December 31, 2017 and 2016

(In thousands)

Admitted Assets		2017	2016
Cash and invested assets:			
Bonds at adjusted carrying value, fair value of $2,060,911 in 2017 and $1,926,469 in 2016 (note 4)	$	2,017,524	1,902,064
Preferred stock at adjusted carrying value, fair value of $8,232 in 2017 and $1,114 in 2016 (note 4)		8,158	1,094
Common stock at fair value, adjusted cost of $409,072 in 2017 and $426,752 in 2016 (note 4)		544,752	498,600
Real estate at cost – net of accumulated depreciation of $15,776 in 2017 and $14,358 in 2016		16,854	17,162
Cash, cash equivalents, and short-term investments		76,899	64,798
Other invested assets (note 4)		70,490	45,155
Receivables for securities sold		842	770
Total cash and invested assets		2,735,519	2,529,643
Uncollected premiums – net of allowance		78,771	84,308
Funds held by or deposited with reinsurers		1,792	1,792
Electronic data processing equipment – at cost – net of accumulated depreciation of $8,003 in 2017 and $7,034 in 2016		985	1,600
Receivables from subsidiaries and affiliates		751	—
Accrued investment income		15,893	15,516
Total admitted assets	$	2,833,711	2,632,859
Liabilities and Policyholders' Surplus			
Reserve for unpaid losses and loss adjustment expenses:			
Reserve for unpaid losses (note 2)	$	815,521	829,731
Reserve for unpaid loss adjustment expenses (note 2)		107,574	105,981
Total reserve for unpaid losses and loss adjustment expenses		923,095	935,712
Unearned premiums		83,431	81,067
Advance premiums		10,786	10,882
Dividends payable to policyholders		78,600	74,644
Commissions payable		39,307	32,834
Structured settlement liability (note 3)		384,790	378,736
Payable to subsidiaries and affiliates		24	—
Credit balances due policyholders		8,566	9,416
Payable for securities purchased		5,183	4,340
Other liabilities		23,621	18,879
Total liabilities		1,557,403	1,546,510
Surplus notes (note 7)		100,000	100,000
Special surplus fund for unfunded pension benefits (notes 1 and 7)		350,883	180,271
Unassigned policyholders' surplus (note 7)		825,425	806,078
Total liabilities and policyholders' surplus	$	2,833,711	2,632,859

See accompanying notes to statutory-basis financial statements.

PINNACOL ASSURANCE

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

Years ended December 31, 2017 and 2016

(In thousands)

	2017	2016
Underwriting income:		
Premiums earned	$ 625,619	634,640
Deductions:		
Losses incurred (note 2)	303,662	319,696
Loss adjustment expenses incurred (note 2)	79,047	74,618
Other underwriting expenses incurred	152,004	139,968
Total underwriting deductions	534,713	534,282
Net underwriting gain	90,906	100,358
Investment income:		
Net investment income earned (note 4)	77,446	67,189
Net realized capital gain (note 4)	17,890	15,263
Total investment income	95,336	82,452
Other income (loss):		
Provision for uncollectible premiums	(2,595)	(2,092)
Structured settlement expense (note 3)	(7,908)	(7,720)
Other income	856	541
Dividends to policyholders	(52,430)	(54,094)
Net income	124,165	119,445
Change in nonadmitted assets	(1,898)	(3,687)
Change in net unrealized gains on investments	67,692	35,293
Policyholders' surplus – beginning of year	1,086,349	935,298
Policyholders' surplus – end of year	$ 1,276,308	1,086,349

See accompanying notes to statutory-basis financial statements.

PINNACOL ASSURANCE

Statutory-Basis Statements of Cash Flow

Years ended December 31, 2017 and 2016

(In thousands)

	2017	2016
Cash flow from operations:		
Premiums collected – net of reinsurance	$ 629,312	623,428
Losses and loss adjustment expenses paid – net of reinsurance and deductibles	(395,326)	(398,726)
Other underwriting expenses paid	(141,056)	(142,935)
Dividends paid to policyholders	(48,474)	(30,815)
Investment income received, net of investment expenses paid	80,757	68,584
Miscellaneous proceeds	857	541
Net cash provided by operations	126,070	120,077
Cash flow from investments:		
Proceeds from sale, maturity, or redemption of investments:		
Bonds	493,543	589,720
Stocks	99,597	31,767
Other invested assets	6,114	2,225
Miscellaneous proceeds	842	—
Total proceeds from sale or redemption of investments	600,096	623,712
Cost of investments acquired:		
Bonds	(609,754)	(643,941)
Stocks	(72,400)	(48,709)
Other invested assets	(27,802)	(22,333)
Miscellaneous proceeds (applications)	(1,182)	(3,311)
Total investments acquired	(711,138)	(718,294)
Net cash used in investments	(111,042)	(94,582)
Cash flow used in financing and miscellaneous sources:		
Cash used in other miscellaneous sources	(2,927)	(3,516)
Net cash used in financing and miscellaneous sources	(2,927)	(3,516)
Net increase in cash, cash equivalents, and short-term investments	12,101	21,979
Cash, cash equivalents, and short-term investments – beginning of year	64,798	42,819
Cash, cash equivalents, and short-term investments – end of year	$ 76,899	64,798

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 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.

Pinnacol developed a new digital platform designed to market, underwrite, and service small direct policyholders with annual premiums of less than $10,000 that are not considered high risk. Cake Insure, Inc. (Cake) was incorporated on September 20, 2017 as a subsidiary of Pinnacol and will help small businesses quote and purchase a workers' compensation insurance policy from Pinnacol. With the launch of Cake, Pinnacol became subject to Title 10, Article 3, Part 8 of the C.R.S., Insurance Holding Company Systems, and holds 90% of the voting shares ownership in Cake. During 2017, Pinnacol sold software and intellectual property to Cake.

(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 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 surcharges 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.

- Pinnacol's investment in preferred stock of Cake, a subsidiary, is reported at the lower of cost or fair value. Under GAAP, it would be included in the consolidated financial statements and all significant intercompany balances and transactions would be eliminated in consolidation.

- 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, or those items not meeting the definition of an asset, 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, 2017 and 2016 comprised the following (in thousands):

		2017	2016
Receivables	$	16,894	15,344
Fixed assets		578	948
Prepaids		2,771	2,053
Total nonadmitted assets	$	20,243	18,345

- 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 surplus note is reported as a component of surplus, increasing policyholders' surplus under NAIC SAP. Under GAAP the surplus note is recorded as long term debt. The related interest expense may not be accrued under NAIC SAP until approved for payment by the commissioner of the state of domicile while under GAAP, the interest expense is recorded as incurred.

- Governmental Accounting Standards Board (GASB) Statement No. 68, *Accounting and Financial Reporting for Pensions*, which is effective for fiscal years ended June 30, 2014 or later, requires employers that are part of a cost sharing multiple employer pension fund to record their portion of the unfunded liability, while under NAIC SAP, the employer must only record the cost of the contribution and any liability for any contributions due and unpaid.

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 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. Other invested assets, including partnerships, are recorded at the underlying audited equity value. For those investments in which the audited financial statements are not available in a timely manner, the unaudited equity value is used. Unrealized capital gains on common stocks, preferred 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, 2017 and 2016 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.

Bond premium or discount is recognized 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 $1,418,000 and $1,266,000 for the years ended December 31, 2017 and 2016, respectively, and is included in net investment income earned in the statutory basis statements of operations and changes in policyholders' surplus.

(e) Investment in subsidiary

Cake was incorporated on September 20, 2017 as a subsidiary of Pinnacol. Pinnacol purchased 2,000,000 voting shares of preferred stock in Cake on September 28, 2017. Pinnacol's ownership percentage in Cake based on voting interests of the security is 90% and Pinnacol maintains control of Cake. The remaining 10% ownership is in the form of 222,222 founder shares of common stock with

voting rights. Pinnacol's ownership percentage based on par value or economic value at the time of purchase is 99%.

Pinnacol does not consolidate their financial results with Cake. Pinnacol and Cake issue standalone financial statements that are each independently audited.

Perpetual preferred stock of Cake is reported at the lower of book value or fair value. Cake preferred shares are not publicly priced. Therefore, the per share cost is being used by Pinnacol for carrying value and fair value for the year in which the preferred stock of Cake was purchased.

(f) Cash, Cash Equivalents, and Short-Term Investments

For purposes of the statement of cash flow, 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, 2017, cash, cash equivalents, and short term investments of approximately $76,899,000 include $(3,095,000) of book overdrafts, $79,794,000 of cash equivalents, and $200,000 of short term investments. As of December 31, 2016, cash, cash equivalents, and short term investments of approximately $64,798,000 include $(11,339,000) of book overdrafts, $19,988,000 of cash equivalents, and $56,149,000 of short term investments.

(g) Receivables for Securities Sold

As of December 31, 2017 and 2016, receivables for securities sold were approximately $842,000 and $770,000, respectively. Receivables for securities arise when sales of securities are recorded as of the trade date. A receivable due from the custodian 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 stated settlement date are nonadmitted.

(h) Uncollected Premiums

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

All receivables for canceled policies and billed receivables that relate to balances outstanding for a period exceeding 90 days are not admissible according to the Manual.

Pinnacol independently estimates the realizable amounts of premiums receivable and records an allowance for any uncollectible balances that were not already non-admitted. During 2017 and 2016, Pinnacol recorded a provision of approximately $2,595,000 and $2,092,000, 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, 2017 and 2016 were from companies operating in the construction and services industries in Colorado. The construction industry represents approximately 37% of premiums earned as of December 31, 2017 and 36% as of December 31, 2016. The services industry represents approximately 40% of premiums earned as of December 31, 2017 and 40% as of December 31, 2016, with all other individual industries constituting the remainder of premiums receivable balances.

(i) 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 a net estimated audit premiums receivable in 2017 and 2016 of approximately $43,610,000 and $48,950,000, respectively. The increase in the receivable is due to increased covered payroll.

(j) 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 2017 and 2016, such amounts are approximately $8,566,000 and $9,416,000, respectively.

(k) 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, 2017 and 2016 was approximately $985,000 and $1,600,000, respectively. Related depreciation expense of approximately $969,000 and $1,246,000 was incurred during 2017 and 2016, respectively, and is included in LAE and other underwriting expenses incurred in the statutory basis statements of operations and changes in policyholders' surplus.

(l) Office Furniture, Equipment, Software, Art, Automobiles, and Leasehold Improvements

Office furniture, equipment, software, art, automobiles, and leasehold improvements are recorded at cost and depreciated on a straight line basis. Equipment and software are depreciated over an estimated useful life of three years. Office furniture, art, and automobiles are depreciated over an estimated useful life of five years. Leasehold improvements are depreciated over the shorter of the term of the lease or the useful life. In accordance with the Manual, these are nonadmitted assets. The net book value of these assets at December 31, 2017 and 2016 was approximately $578,000 and $948,000, respectively. Related depreciation expense of approximately $530,000 and $613,000 was incurred in 2017 and 2016, respectively, and is included in LAE and other underwriting expenses incurred in the statutory basis statements of operations and changes in policyholders' surplus.

(m) Safety Group Dividend Program

Pinnacol has a safety group 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 $2,303,000 in 2017 and $3,278,000 in 2016. As of December 31, 2017 and 2016, safety group dividends payable of $3,651,000 and $3,500,000, 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 recorded as dividends to policyholders in the statutory basis statements of operations and changes in policyholders' surplus.

(n) Individual Loss Control Dividend Program

Pinnacol has an individual loss control dividend (ILCD) program that is designed for policyholders who are committed to effective loss control in their business operations. If the policyholder meets the

minimum premium requirements and pays an additional 5% premium charge as a buy in to the plan, the policyholder may receive a reduction of premium based on the policy premium and the loss ratio. Pinnacol paid out ILCDs of $16,483,000 in 2017 and $15,163,000 in 2016. As of December 31, 2017 and 2016, ILCD payable of $24,882,000, and $21,093,000, respectively, are included as dividends payable to policyholders in the statutory-basis statements of operations and changes in policyholders' surplus.

(o) 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 has declared general policyholder dividends to its policyholders in good standing of approximately $50,000,000 in 2017 and 2016. This is included in dividends payable to policyholders.

(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, 2017 and 2016. 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. Subrogation claims (claims against third parties) are recognized as a reduction of losses incurred when collections are received.

Internal structured settlement liabilities represent obligations to claimants and dependents on cases that have been closed by contract.

(q) Revenue Recognition and Unearned Premiums

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.

Unearned premiums represent amounts either collected or billed and due from policyholders at December 31, 2017 and 2016 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, 2017 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 effective period 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 $0 at December 31, 2017 and 2016. Pinnacol considered anticipated investment income at 3.5% when evaluating the premium deficiency reserve for 2017.

(s) Multiemployer Pension Plans and Other Postretirement Benefits

Pinnacol participates in the State Division Trust Fund (SDTF), a cost sharing multiple-employer defined benefit pension and health care trust fund plan administered by the Public Employees' Retirement Association (PERA). SDTF provides retirement, disability, and survivor benefits. All employees of Pinnacol are members of the SDTF.

As a participant in a multiple-employer 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.

(t) 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. Premiums earned are reported net of reinsurance (note 5).

(u) 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 by the Colorado Department of Labor and Employment Division of Workers' Compensation annually, approximately 1.03% and 0.63% at December 31 2017 and 2016, respectively. Such amounts are included in other underwriting expenses incurred.

(v) Surplus Note

Pinnacol issued a $100,000,000 surplus note on June 25, 2014. Before issuing this debt, the Company obtained approval from the Commissioner of the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado (the Division) for the transaction and approval to classify the debt as a component of policyholders' surplus (note 7).

(w) Special Surplus Fund for Unfunded Pension Benefits

Pinnacol participates in a cost sharing multiple-employer defined benefit pension plan administered by PERA. PERA has a net pension liability which represents the unfunded pension benefits. Statutory accounting does not allow Pinnacol's portion of the net pension liability to be recorded as a liability but allows a company to establish a special surplus fund to provide for contingencies. GASB No. 68, *Accounting and Financial Reporting for Pensions* is effective for fiscal years beginning after June 15, 2014. The statement requires cost sharing employers participating in defined benefit plans to record their proportionate share of the collective net pension liability in their GASB financial statements. PERA

provides Pinnacol with the audited schedule of employers' allocations and net pension liability. The total pension liability used to calculate the net pension liability is determined by an actuarial valuation as of December 31, 2015. PERA uses standard update procedures to roll-forward the total pension liability to December 31, 2016. The total pension liability is reduced by the plan's fiduciary net position to obtain the collective net pension liability. Revised economic and demographic actuarial assumptions were adopted by PERA's Board on November 18, 2016 to more closely reflect PERA's actual experience and are effective December 31, 2016. A discount rate of 5.26% is being used. PERA also provides the employer allocation percentage for purposes of calculating Pinnacol's proportionate share of the collective net pension liability.

(x) Application of Recent Statutory Accounting Pronouncements

During 2017 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

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 currently estimated reserves 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.

Unpaid Losses and Loss Adjustment Expenses

Activity in the liability for unpaid losses and loss adjustment expenses in 2017 and 2016 is summarized as follows (in thousands):

	Unpaid losses and loss adjustment expenses	
	2017	**2016**
Balance at January 1	$ 935,712	940,124
Additional amounts incurred related to:		
Current year	432,960	434,309
Prior years	(50,251)	(39,995)
Total incurred	382,709	394,314
Reductions relating to payments for:		
Current year	131,868	127,091
Prior years	263,458	271,635
Total paid	395,326	398,726
Balance at December 31	$ 923,095	935,712

During the year ended December 31, 2017, approximately $263,458,000 was paid for unpaid losses and loss adjustment expense attributable to insured events of prior years. Reserves for prior years unpaid losses and loss adjustment expense were reduced by $50,251,000 and are now $622,003,000 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 initiatives to improve claims handling practices and reduce claims handling expenses when prudent and a reduction of ultimate claim frequency in Colorado. 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 $4,094,000. Such reduction is collateralized generally with letters of credit for the benefit of Pinnacol. The Company received $7,133,000 and $6,575,000 in subrogation as of December 31, 2017 and 2016, respectively

(3) Internal Structured Settlements

Pinnacol 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 internal structured settlement liability is actuarially valued. The internal structured settlement liability is reported as a financing liability separate from unpaid losses and loss adjustment expenses on the statutory-basis statements of admitted assets, liabilities, and policyholders' surplus.

Activity in the liability for internal structured settlements in 2017 and 2016 is summarized as follows (in thousands):

	2017	2016
Beginning balance	$ 378,736	373,371
Amounts incurred:		
Change in valuation	7,908	7,720
Amounts paid	(25,377)	(24,241)
New internal structured settlements	23,523	21,886
Ending balance	$ 384,790	378,736

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, 2017 and 2016.

The amount of the discount for unpaid internal structured settlements as of December 31, 2017 and 2016 is approximately $152,555,000 and $154,280,000, respectively. The discount amounts for internal structured settlement reserves at December 31, 2017 and 2016 are distributed over the years in which the losses were incurred as follows (in thousands):

2017		2016	
Loss year	**Discount**	**Loss year**	**Discount**
Prior	$ 92,498	Prior	$ 97,739
2007	8,526	2007	9,109
2008	10,336	2008	10,888
2009	10,414	2009	11,058
2010	5,591	2010	6,010
2011	7,149	2011	7,153
2012	4,320	2012	4,204
2013	5,287	2013	4,634
2014	6,019	2014	2,319
2015	1,979	2015	1,110
2016	418	2016	56
2017	18	2017	—
Total	$ 152,555	Total	$ 154,280

(4) Investments

Estimated fair value of investments in bonds is based on quotations provided by widely accepted third party data providers. In 2017 and 2016, Interactive Data Corporation (IDC), Reuters, and Markit Partners were used to obtain fair market values. Additionally, in 2017 and 2016, the fair value of certain common trust funds were primarily determined by net asset value and warrants were 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.

(Continued)

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 2017 and 2016, Pinnacol had investments in long term bonds, which the SVO assigned a 3 or higher designation. Carrying values are equal to the lower of amortized cost or fair value for these bonds.

The carrying value and the fair value of investments in long term bonds in 2017 and 2016 are summarized as follows (in thousands). The carrying value includes investment grade bonds that are reported at amortized cost and low rated bonds that are reported at the lower of cost or fair value:

	2017			
	Carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
Government obligations:				
Nonloan-backed bonds	$ 103,710	4,115	(487)	107,338
Loan-backed bonds	11,945	500	—	12,445
U.S. political subdivisions:				
Nonloan-backed bonds	11,268	691	(24)	11,935
Loan-backed bonds	—	—	—	—
U.S. special revenue:				
Nonloan-backed bonds	51,227	3,588	(81)	54,734
Loan-backed bonds	349,008	1,168	(2,846)	347,330
Hybrid Securities:				
Nonloan-backed bonds	7,607	275	—	7,882
Loan-backed bonds	—	—	—	—
Industrial and miscellaneous:				
Nonloan-backed bonds	1,241,051	37,379	(3,848)	1,274,582
Loan-backed bonds	241,708	3,082	(125)	244,665
	$ 2,017,524	50,798	(7,411)	2,060,911

(Continued)

	2016			
	Carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
Government obligations:				
Nonloan-backed bonds	$ 109,570	4,008	(525)	113,053
Loan-backed bonds	21,223	1,108	—	22,331
U.S. political subdivisions:				
Nonloan-backed bonds	11,288	536	(75)	11,749
Loan-backed bonds	—	—	—	—
U.S. special revenue:				
Nonloan-backed bonds	46,262	1,398	(598)	47,062
Loan-backed bonds	268,406	1,447	(2,580)	267,273
Hybrid Securities:				
Nonloan-backed bonds	5,390	10	(13)	5,387
Loan-backed bonds	—	—	—	—
Industrial and miscellaneous:				
Nonloan-backed bonds	1,201,947	28,284	(12,052)	1,218,179
Loan-backed bonds	237,978	3,719	(262)	241,435
	$ 1,902,064	40,510	(16,105)	1,926,469

The book/adjusted carrying value and estimated fair value of investments in long term bonds at December 31, 2017, 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.

	2017	
	Book/adjusted carrying value	Fair value
Due in one year or less	$ 195,073	195,290
Due after one year through five years	612,920	618,364
Due after five years through ten years	830,821	843,436
Due after ten years	378,710	403,821
	$ 2,017,524	2,060,911

Proceeds from sales of investments in long term bonds during 2017 and 2016 were approximately $227,717,000 and $428,205,000, respectively. Realized gains on long term bonds of approximately $4,885,000 and $14,628,000 and realized losses of approximately $(1,908,000) and $(2,643,000) were recognized during 2017 and 2016, respectively.

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Investments in partnerships are stated at the underlying audited equity value. For those investments in which the audited financial statements were not available by the March 1, 2018 statutory annual statement filing deadline, the unaudited equity value was used. These assets totaled $70,490,000 and $45,155,000 in 2017 and 2016, respectively. The Company has contributed $66,667,000 in net capital (capital contributions – capital distributions) since investing in partnerships and may be responsible for up to an additional $125,248,000.

In 2017, the Company became a member of the Federal Home Loan Bank (FHLB) of Topeka. Through its membership, the Company may borrow an amount which is dependent on the market value and risk related to investments that are held at FHLB. The Company has not conducted any borrowings with the FHLB as of December 31, 2017. As a requirement of the membership, Pinnacol purchased FHLB Class A and Class B Capital Stock. In 2017, these assets totaled $500,000 and $1,000, respectively.

Unrealized gains on investments in common stocks, mutual funds, and common trust funds are reported as a component of policyholders' surplus. Equities, excluding private equities, in an unrealized loss position are deemed to be other than temporarily impaired, with the resulting loss recognized in the statement of operations. OTTI 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, 2017	$	445,397	409,072	135,680	544,752
December 31, 2016	$	467,245	426,752	71,848	498,600

The following table provides the length of impairment for those investments in long term bonds with an unrealized loss as of December 31, 2017 (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	$ 40,156	(258)	30,741	(229)	70,897	(487)
U.S. political subdivisions	2,453	(24)	—	—	2,453	(24)
U.S. special revenue	183,505	(1,142)	79,568	(1,785)	263,073	(2,927)
Hybrid securities	522	(6)	496	(5)	1,018	(11)
Industrial and miscellaneous	277,899	(2,460)	141,478	(3,233)	419,377	(5,693)
Total	$ 504,535	(3,890)	252,283	(5,252)	756,818	(9,142)

(Continued)

The following table provides the length of impairment for those investments in long term bonds with an unrealized loss as of December 31, 2016 (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	$ 79,828	(525)	—	—	79,828	(525)
U.S. political subdivisions	2,423	(74)	—	—	2,423	(74)
U.S. special revenue	184,432	(3,178)	—	—	184,432	(3,178)
Hybrid securities	2,000	(13)	—	—	2,000	(13)
Industrial and miscellaneous	438,727	(12,588)	22,614	(1,694)	461,341	(14,282)
Total	$ 707,410	(16,378)	22,614	(1,694)	730,024	(18,072)

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.

The assessment of whether an OTTI 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 flow 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.
- The present value of projected cash flows expected to be collected is less than amortized cost of loan-backed and structured securities.

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

At December 31, 2017 and 2016, 10.4% and 10.8% of long term bonds held by the Company were rated noninvestment grade, respectively. At December 31, 2017 and 2016, the Company had approximately $9,056,000 and $17,935,000, 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.

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 multiclass 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 OTTI should be recognized at year end. At December 31, 2017 and 2016, Pinnacol did not recognize any OTTI on loan backed securities. 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):

	2017	
	Aggregate amount of unrealized loss	**Aggregate fair value of securities with unrealized loss**
Less than twelve months	$ 1,182	226,537
Twelve months or longer	1,789	85,124
	$ 2,971	311,661

Other-Than-Temporary Impairment – During 2017 and 2016, the Company recognized $1,689,000 and $3,592,000, respectively, in OTTI on long term bonds, $8,000 and $1,000, respectively, in OTTI on preferred stock, and $2,255,000 and $2,234,000, respectively, in OTTI on common stocks, mutual funds, and common trust funds.

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 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 for items measured at fair value includes common stock, common stock warrants, preferred stock, and long-term bonds. The estimated fair value of common stock warrants and long-term bonds was determined by internal ratings in the absence of observable inputs.

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 and 2 were required.

The following table represents (in thousands) information about the Company's financial assets measured at fair value in Level 3 as of December 31, 2017.

	Fair value measurements – Level 3 December 31, 2017						
Assets	**Beginning balance January 1, 2017**	**Amortization accretion**	**Current realized net income**	**Change in unrealized surplus**	**Purchases/ Transfers into Level 3**	**Sales/ Settlements/ Transfers Out of Level 3**	**Ending balance December 31, 2017**
Common stocks-Industrial and miscellaneous	$ 159	—	(45)	86	160	(124)	236
Perpetual preferred stocks	—	—	(8)	—	28	—	20
Bonds							—
Bank loans	—	56	(190)	163	6,078	(4,072)	2,035
CDOs/CBOs/CLOs	—	—	—	7	1,000	(1,007)	—
All other bonds	2,187	2	(41)	22	27	(2,197)	—
Total bonds	2,187	58	(231)	192	7,105	(7,276)	2,035
Total assets	$ 2,346	58	(284)	278	7,293	(7,400)	2,291

The following table represents (in thousands) information about the Company's financial assets measured at fair value in Level 3 as of December 31, 2016.

	Fair value measurements – Level 3 December 31, 2016						
Assets	**Beginning balance January 1, 2016**	**Amortization accretion**	**Current realized net income**	**Change in unrealized surplus**	**Purchases/ Transfers into Level3**	**Sales/ settlements**	**Ending balance December 31, 2016**
Common stock	$ 167	—	(22)	14	17	(17)	159
Bonds	—	1	(9)	(61)	2,289	(33)	2,187
Total assets	$ 167	1	(31)	(47)	2,306	(50)	2,346

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, 2017 and 2016, 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, 2017			
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				
Industrial & miscellaneous	$ 131,561	—	236	131,797
Common trust funds	—	79,088	—	79,088
Mutual funds	333,867	—	—	333,867
Total Common stocks	465,428	79,088	236	544,752
Perpetual preferred stocks	—	—	20	20
Short-term bonds & cash equivalents	24,000	199	—	24,199
Total assets	$ 489,428	79,287	256	568,971

	Fair value measurements – recurring basis December 31, 2016			
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	$ 124,772	—	159	124,931
Common trust funds	—	62,000	—	62,000
Mutual funds	311,669			311,669
Preferred stocks	541	—	—	541
Total assets	$ 436,982	62,000	159	499,141

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 amortized cost, which resulted in an unrealized loss of $2,984,000 at December 31, 2017 and $1,877,000 at December 31, 2016.

The Company did not have any significant concentrations by industry or by issuer as of December 31, 2017 or 2016.

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, 2017 and 2016, respectively. The fair values are also categorized into the three level fair value hierarchy as described above.

	December 31, 2017				
Type of financial instrument	**Fair value**	**Admitted value**	**Level 1**	**Level 2**	**Level 3**
Financial instruments-assets:					
Long-term bonds					
Bank loans	$ 135,218	133,626	—	118,496	16,722
CDOs/CBOs/CLOs	35,171	34,900	—	35,171	—
Private placements	29,535	29,232	—	—	29,535
All other bonds	1,860,986	1,819,765	—	1,846,639	14,347
Total long-term bonds	2,060,910	2,017,523	—	2,000,306	60,604
Preferred stocks					
Perpetual preferred	485	422	465	—	20
Perpetual preferred-subsidiary Cake	7,571	7,571	—	—	7,571
Redeemable preferred	176	165	176	—	—
Total Preferred stocks	8,232	8,158	641	—	7,591
Common stocks					
Industrial & misc.	131,797	131,797	131,561	—	236
Common trust funds	79,088	79,088	—	79,088	—
Mutual funds	333,867	333,867	333,867	—	—
Total Common stocks	544,752	544,752	465,428	79,088	236
Cash, cash equivalents and short-term investments	76,899	76,899	60,720	16,179	—
Total assets	$ 2,690,793	2,647,332	526,789	2,095,573	68,431

	December 31, 2016				
Type of financial instrument	**Fair value**	**Admitted value**	**Level 1**	**Level 2**	**Level 3**
Financial instruments-assets:					
Long-term bonds	$ 1,926,469	1,902,064	—	1,911,664	14,805
Preferred stocks	1,114	1,094	1,114	—	—
Common stocks	124,931	124,931	124,772	—	159
Common trust funds	62,000	62,000	—	62,000	—
Mutual funds	311,669	311,669	311,669	—	—
Cash, cash equivalents and short-term investments	64,798	64,798	31,846	32,952	—
Total assets	$ 2,490,981	2,466,556	469,401	2,006,616	14,964

(Continued)

Investment Income – Major categories of net investment income for the years ended December 31, 2017 and 2016 are summarized as follows (in thousands):

		2017	2016
Investment income:			
Corporate and miscellaneous bonds	$	66,848	62,258
U.S. government bonds		2,736	4,283
Cash and other investments		464	80
Real estate		5,983	5,187
Other invested assets		3,237	2,072
Equity securities		16,081	10,589
Surplus note interest expense		(8,625)	(8,625)
Investment expenses		(9,278)	(8,655)
Net investment income earned		77,446	67,189
Net realized capital gain (loss):			
Corporate and miscellaneous bonds		1,294	7,589
U.S. government bonds		(6)	805
Equity securities		16,602	6,869
Net realized capital gains		17,890	15,263
Net investment income	$	95,336	82,452

(5) Reinsurance

Ceded Reinsurance – Pinnacol purchases excess of loss reinsurance with two layers and terrorism coverage. 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
- Terrorism Only – Limit of $50,000,000 in excess of retention of $80,000,000 per occurrence

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 prior 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, 2017:

Reinsurer	AM Best Rating
Arch Reinsurance Company	A+
Partner Reinsurance Company of the U.S.	A
Endurance Assurance Corporation	A+
IOA Re, Inc. for and on behalf of Cincinnati Insurance Company	A+
Partner Reinsurance Company Ltd.	A
Endurance Specialty Insurance Limited	A+
Lloyd's Syndicate 2003 (Catlin Underwriting Agencies Limited)	A
Lloyd's Syndicate 3000 (Markel Syndicate Management 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, 2017. 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.

Funds have been placed on deposit as collateral with Argonaut Insurance Company and Zurich American Insurance Company in the amount of $1,792,000 in 2017 and 2016.

Pinnacol held unearned premium reserves related to assumed business of $811,000 and $872,000 for the years ended December 31, 2017 and 2016, respectively. Pinnacol had loss and loss adjustment expense reserves related to assumed business of $27,003,000 and $29,271,000 for the years ended December 31, 2017 and 2016, respectively.

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

		2017	2016
Direct premiums written	$	620,980	624,536
Premiums ceded		(1,336)	(1,359)
Premiums assumed		8,340	9,015
Net premiums written	$	627,984	632,192
Direct premiums earned	$	618,554	626,809
Premiums ceded		(1,336)	(1,359)
Premiums assumed		8,401	9,190
Net premiums earned	$	625,619	634,640
Direct losses incurred	$	300,649	313,758
Losses ceded		—	—
Losses assumed		3,013	5,938
Net losses incurred	$	303,662	319,696
Direct loss adjustment expenses incurred	$	77,982	73,226
Loss adjustment expenses ceded		—	—
Loss adjustment expenses assumed		1,065	1,392
Net loss adjustment expenses incurred	$	79,047	74,618

(6) Employee Benefits

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

Pensions – Pinnacol participates in the State Division Trust Fund (SDTF), a cost-sharing multiple-employer defined benefit pension fund administered by the Public Employees' Retirement Association of Colorado (PERA). The net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, pension expense, information about the fiduciary net position and additions to/deductions from the fiduciary net position of the SDTF have been determined using the economic resources measurement focus and the accrual basis of accounting. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Plan Description – All Pinnacol employees are provided with pensions through the SDTF-a cost-sharing multiple-employer defined benefit pension plan administered by PERA. Plan benefits are specified in Title 24, Article 51 of the C.R.S., administrative rules set forth at 8 C.C.R. 1502 1, and applicable provisions of the federal Internal Revenue Code. Colorado State law provisions may be amended from time to time by the Colorado General Assembly. PERA issues a publicly available comprehensive annual financial report that can be obtained at www.copera.org/investments/pera-financial-reports.

Benefits provided – PERA provides retirement, disability, and survivor benefits. Retirement benefits are determined by the amount of service credit earned and/or purchased, highest average salary, the benefit structure(s) under which the member retires, the benefit option selected at retirement, and age

at retirement. Retirement eligibility is specified in tables set forth at C.R.S. § 24-51-602, 604, 1713, and 1714.

The lifetime retirement benefit for all eligible retiring employees under the PERA benefit structure is the greater of the:

- Highest average salary multiplied by 2.5% and then multiplied by years of service credit.
- The value of the retiring employee's member contribution account plus a 100% match on eligible amounts as of the retirement date. This amount is then annuitized into a monthly benefit based on life expectancy and other actuarial factors.

In all cases the service retirement benefit is limited to 100% of highest average salary and also cannot exceed the maximum benefit allowed by federal Internal Revenue Code.

Members may elect to withdraw their member contribution accounts upon termination of employment with all PERA employers; waiving rights to any lifetime retirement benefits earned. If eligible, the member may receive a match of either 50% or 100% on eligible amounts depending on when contributions were remitted to PERA, the date employment was terminated, whether 5 years of service credit has been obtained and the benefit structure under which contributions were made.

Benefit recipients who elect to receive a lifetime retirement benefit are generally eligible to receive post retirement cost-of-living adjustments (COLAs), referred to as annual increases in the C.R.S. Benefit recipients under the PERA benefit structure who began eligible employment before January 1, 2007 receive an annual increase of 2%, unless PERA has a negative investment year, in which case the annual increase for the next three years is the lesser of 2% or the average of the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) for the prior calendar year. Benefit recipients under the PERA benefit structure who began eligible employment after January 1, 2007 receive an annual increase of the lesser of 2% or the average CPI-W for the prior calendar year, not to exceed 10% of PERA's Annual Increase Reserve (AIR) for the SDTF.

Disability benefits are available for eligible employees once they reach five or more years of service credit and are determined to meet the definition of disability. The disability benefit amount is based on the retirement benefit formula shown above considering a minimum 20 years of service credit, if deemed disabled.

Survivor benefits are determined by several factors, which include the amount of earned service credit, highest average salary of the deceased, the benefit structure(s) under which service credit was obtained, and the qualified survivor(s) who will receive the benefits.

Contributions – Eligible employees and Pinnacol are required to contribute to the SDTF at a rate set by Colorado statute. The contribution requirements are established under C.R.S. § 24-51-401, *et seq*. Eligible employees are required to contribute 8% of their PERA-includable salary. The employer contribution requirements for Pinnacol are summarized in the table below:

	For the Year Ended 12/31/15	For the Year Ended 12/31/16	For the Year Ended 12/31/17
Employer contribution rate (includes 1.02% allocation to the Health Care Trust Fund – see note 6c) [1]	10.15%	10.15%	10.15%
Amortization Equalization Disbursement (AED) as specified in C.R.S. §24-51-411 [1]	4.20	4.60	5.00
Supplemental Amortization Equalization Disbursement (SAED) as specified in C.R.S., §24-51-411 [1]	4.00	4.50	5.00
Total employer contribution rate [1]	18.35%	19.25%	20.15%

[1]Rates are expressed as a percentage of salary as defined in C.R.S. § 24-51-101(42).

Employer contributions are recognized by the SDTF in the period in which the compensation becomes payable to the member and Pinnacol is statutorily committed to pay the contributions to the SDTF. Employer contributions recognized by the DDTF for the years ending December 31, 2017 and 2016 were $12,030,000 and $10,474,000, respectively. These contributions met the contribution requirement for each year.

(b) Voluntary Tax-Deferred Retirement Plans

Plan Description – Employees of Pinnacol that are also members of the SDTF may voluntarily contribute to the Voluntary Investment Program, an Internal Revenue Code Section 401(k) defined contribution plan administered by PERA. Title 24, Article 51, Part 14 of the C.R.S., as amended, assigns the authority to establish the Plan provisions to the PERA Board of Trustees. PERA issues a publicly available comprehensive annual financial report for the Program. That report can be obtained at www.copera.org/investments/pera-financial-reports.

Funding Policy – The Voluntary Investment Program is funded by voluntary member contributions up to the maximum limits set by the Internal Revenue Service, as established under Title 24, Article 51, Section 1402 of the C.R.S., as amended. In addition, Pinnacol has agreed to match employee's elective contributions into the PERA 401(k) Plan at 50% up to the first 6% of employees' elected deferrals. Employees are immediately vested in their own contributions, employer contributions and investment earnings. For the years ended December 31, 2017 and 2016, Pinnacol contributed approximately $1,449,000 and $1,358,000, respectively, in matching contributions to the PERA 401(k) Plan. Pinnacol also offers a 457 deferred compensation plan.

(Continued)

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

Health Care Trust Fund

Plan Description – Pinnacol contributes to the Health Care Trust Fund (HCTF), a cost sharing multiple-employer healthcare trust administered by PERA. The HCTF benefit provides a health care premium subsidy and health care programs (known as PERACare) to PERA participating benefit recipients and their eligible beneficiaries. Title 24, Article 51, Part 12 of the C.R.S., as amended, establishes the HCTF and sets forth a framework that grants authority to the PERA Board to contact, self-insure and authorize disbursements necessary in order to carry out the purposes of the PERACare program, including the administration of health care subsidies. PERA issues a publicly available comprehensive annual financial report that includes financial statements and required supplementary information for the HCTF. That report can be obtained at www.copera.org/investements/pera-financial-reports.

Funding Policy – Pinnacol is required to contribute at a rate of 1.02% of PERA-includable salary for all PERA members as set by statute. No member contributions are required. The contribution requirements for Pinnacol are established under Title 24, Article 51, Part 4 of the C.R.S., as amended. The apportionment of the contributions to the HCTF is established under Title 24, Article 51, Section 208(1)(f) of the C.R.S., as amended. For the years ending December 31, 2017 and 2016, Pinnacol contributions to the HCTF were approximately $609,000 and $555,000, respectively, equal to the required contributions for each year.

(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. Employer contributions in 2017 and 2016 were $7,721,000 and $6,197,000, respectively.

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 $2,609,000 and $2,274,000 at December 31, 2017 and 2016, respectively, is included in other liabilities in the statutory basis statements of admitted assets, liabilities, and policyholders' surplus.

(7) Policyholders' Surplus

Pinnacol declared general policyholder dividends in 2017 and 2016 of $50,000,000 and subsequently paid them in March 2018 and March 2017.

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 $183,310,000 for 2017.

A surplus note in the amount of $100,000,000 was issued on June 25, 2014, to an unaffiliated third party in exchange for cash. Each payment of principal and interest on the surplus note may be made only with the prior approval of the Commissioner of the Colorado Division of Insurance and only to the extent Pinnacol has sufficient policyholders' surplus to make such payment. The interest on the unpaid principal amount of

this note will be paid in semiannual installments at the rate of 8.625% per annum. In 2017, $8,625,000 of interest was paid on the note and recorded as investment expense. The note, which is subordinate to the prior payment of all other liabilities of the Company, will be due and payable twenty years from the issuance date, with an optional pre-payment date in whole or part in fifteen years with no penalty. The surplus note was issued to partially cover Pinnacol's estimated proportionate share of PERA's unfunded liability for vested service of Pinnacol employees and retirees. This liability is not required to be recorded in the statutory basis financial statements as of December 31, 2017, but it reduces the capital adequacy assessments of outside rating agencies, such as A.M. Best. In accordance with the note agreement, Pinnacol may apply the proceeds for general corporate purposes.

The surplus note agreement contains customary affirmative and negative covenants and requires that Pinnacol maintain certain specified ratios and thresholds. Among others, these covenants include maintaining a maximum writing ratio, debt to capitalization ratio and interest coverage ratio. Management believes that at December 31, 2017 Pinnacol is in compliance with such covenants, ratios and thresholds.

The Company participates in a cost-sharing multiple-employer defined benefit pension plan administered by PERA. PERA has a net pension liability which represents the unfunded pension benefits. The funded portion of PERA's total pension liability as of December 31, 2016 is 42.6%. The Company has a special surplus fund to identify its portion of the unfunded pension benefits. Based on information provided by PERA as of June 30, 2017, the Company's special surplus fund for the unfunded pension benefits has increased by $170,612,000 from $180,271,000 in 2016 to a new balance of $350,883,000 for 2017. There was a discount rate reduction from 7.25% to the use of a blended discount rate of 5.26% that is a blend of an assumed investment rate of return of 7.25% and a municipal bond index rate of 3.86%.

(8) Commitments and Contingencies

The Company has made total commitments of $125,248,000 to provide additional funds as needed to the following partnerships: Kayne Credit Opportunities Fund LP $1,304,000, North Haven Credit Partners LP $5,540,000, GCM Grosvenor Opportunistic Credit Fund IV LTD $348,000, GCM Grosvenor Opportunistic Credit Fund V LTD, $4,702,000, Entrust Special Opportunities Fund III LTD $95,000, Blackstone Tactical Opportunities Fund II LP $4,631,000, Warburg Pincus Private Equity XII LP $4,330,000, NB Strategic Co-Investment Partners III LP $6,298,000, and NB Pinnacol Assurance Fund LP $98,000,000.

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, 2017 and 2016, Pinnacol had a letter of credit for the benefit of Argonaut Insurance Company under an assumed reinsurance agreement for approximately $7,468,000 and $10,077,000, respectively. This reinsurance agreement allows Argonaut Insurance Company 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 $13,595,000 and $23,146,000, compared to a requirement of $7,468,000 and $10,077,000, as of December 31, 2017 and 2016, respectively.

At December 31, 2017 and 2016, Pinnacol had a trust for the benefit of Zurich American Insurance Company under an assumed reinsurance agreement. This reinsurance agreement allows Zurich American Insurance Company, the beneficiary, to claim the trust assets at any time to secure any of Pinnacol's obligations under the agreement. Included in long term bonds are amounts held in the trust of approximately $45,006,000 and $45,442,000, compared to a requirement of $39,000,000 as of December 31, 2017 and 2016.

(Continued)

Pinnacol is contingently liable for approximately $47,721,000 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 net pension liability. If Pinnacol were to partially or fully leave the PERA program, the unfunded net pension liability for the vested service of Pinnacol employees and retirees would become immediately due to PERA. Title 24, Article 51, Section 316 of the C.R.S. requires a company to calculate the reserve transfer necessary when an employer disaffiliates from PERA. The formula to calculate the termination liability differs significantly from the formula used to calculate Pinnacol's share of the unfunded pension obligation under GASB 68. Therefore, the amount of a possible termination liability is unknown but is expected to exceed $100,000,000. Currently, the possibility of the Company partially or fully leaving the PERA program is remote and would require legislative action.

(9) Related Party Transactions

Pinnacol acquired 2,000,000 shares of preferred stock in a non-insurance subsidiary, Cake Insure, Inc.(Cake), for $10,000,000 on September 28, 2017.

Cake purchased various intellectual property (brand, software, trademark, etc.) from Pinnacol for $5,598,000. $3,169,000 represented software capitalized by Pinnacol for Cake's operating software. The remaining $2,429,000 represents organization and startup expenses that could not be capitalized by Cake because of the common control between Pinnacol and Cake. Therefore, Pinnacol recorded the $2,429,000 as a deemed dividend from Cake to Pinnacol which reduced the cost basis of its preferred stock in Cake from $10,000,000 to $7,571,000. There was no change to the 2,000,000 shares owned by Pinnacol.

At December 31, 2017 Pinnacol reported $24,000 due to subsidiary and $751,000 due from subsidiary for commissions due Cake as an agent and management fees due Pinnacol under the management service agreement, respectively.

Under a management service agreement approved by the Colorado Division of Insurance, Pinnacol provides certain personnel services to its subsidiary for a set monthly fee and receives reimbursement for costs Cake incurred. At December 31, 2017, Pinnacol received $1,765,000 in management fees and reimbursed costs from its subsidiary.

Under a program administrator agreement approved by the Colorado Division of Insurance, Cake writes policies for Pinnacol through its digital platform that potential policyholders can utilize to receive a quote and bind a policy. Pinnacol makes payments to Cake monthly as policies are generated.

There were no transactions with affiliates in amounts that exceeded 0.5% of the total admitted assets of Pinnacol.

(10) Subsequent Events

The Board of Directors declared general dividends on November 1, 2017 in an amount to be approximately $50,000,000. The final dividend amount of $50,000,000 was confirmed in February 2018 and subsequently paid in March 2018.

Effective April 30, 2018, there is a loan agreement between Pinnacol and Cake. Cake, as the borrower, can draw down up to $4,000,000 over a period of up to two years at an interest rate of LIBOR plus 3.00%. Interest is due upon maturity. There is no pre-payment penalty.

Subsequent events have been evaluated through May 24, 2018, 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, 2017

(In thousands)

1. Pinnacol's total admitted assets as reported on page 2 of its annual statement are: $ 2,833,711
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
2.01	FNMA POOLS	LONG–TERM BONDS	$ 195,462	6.898%
2.02	FHLMC	LONG–TERM BONDS, COMMON STOCK	83,571	2.949
2.03	FREDDIE MAC	LONG–TERM BONDS, COMMON STOCK	35,522	1.254
2.04	FANNIE MAE	LONG–TERM BONDS, COMMON STOCK	20,813	0.734
2.05	GUGGENHEIM PRIVATE DEBT FUND NOTE ISSUER 2.0, LLC	OTHER LONG-TERM ASSETS, LONG–TERM BONDS	20,297	0.716
2.06	FGLMC POOLS	LONG–TERM BONDS	16,068	0.567
2.07	WELLS FARGO	LONG–TERM BONDS, COMMON STOCK	12,782	0.451
2.08	CITIGROUP INC	LONG–TERM BONDS, COMMON STOCK, PREFERRED STOCK	12,310	0.434
2.09	UNION PACIFIC CORP	LONG–TERM BONDS, COMMON STOCK	11,698	0.413
2.10	GCM GROSVENOR OPPORTUNISTIC CREDIT FUND IV, LTD	OTHER LONG-TERM ASSETS	11,549	0.408

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	$ 1,437,575	50.731%
NAIC-2	386,762	13.649
NAIC-3	85,555	3.019
NAIC-4	98,378	3.472
NAIC-5	23,473	0.828
NAIC-6	1,961	0.069
Preferred stocks:		
P/RP-1	—	—
P/RP-2	—	—
P/RP-3	8,070	0.285
P/RP-4	54	0.002
P/RP-5	14	0.000
P/RP-6	20	0.001
	$ 2,041,862	

4. Assets held in foreign investments are $231,384 and assets held in foreign-currency-denominated investments are $0, which is approximately 8.2% and 0.0% 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	$ 197,755	6.979%
Countries designated NAIC-2	26,380	0.931
Countries designated NAIC-3 or below	7,249	0.256
	$ 231,384	

See accompanying independent auditors' report.

(Continued)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Investment Risks Interrogatories

Year ended December 31, 2017

(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:	CAYMAN ISLANDS	$ 33,033	1.166%
Country 2:	AUSTRALIA	31,996	1.129
Countries designated NAIC-2:			
Country 1:	MEXICO	20,854	0.736
Country 2:	INDONESIA	3,504	0.124
Countries designated NAIC-3 or below:			
Country 1:	BRITISH VIRGIN ISLANDS	6,963	0.246
Country 2:	MARSHALL ISLANDS	111	0.004
		$ 96,461	

7. Aggregate unhedged foreign currency exposure is $0, which is approximately 0.000% 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
10.01 PETROLEOS MEXICANOS	2	$ 10,483	0.370%
10.02 MACQUARIE BANK LTD	1	9,999	0.353
10.03 UBS AG STAMFORD CT	1	9,999	0.353
10.04 BNP PARIBAS SA	1	9,993	0.353
10.05 ACTAVIS FUNDING SCS	2	8,837	0.312
10.06 JOHNSON CONTROLS INTL PL	2	7,900	0.279
10.07 STATOIL ASA-SPON ADR	1	7,891	0.278
10.08 GE CAPITAL INTL FUNDING	1	7,273	0.257
10.09 SCENTRE GROUP TRUST	1	6,986	0.247
10.10 SINOPEC GRP OVERSEA 2015	1	6,963	0.246

See accompanying independent auditors' report.

(Continued)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Investment Risks Interrogatories

Year ended December 31, 2017

(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
13.01	HARDING LOEVNER INTERNATIONAL EQUITY FUND & EMERGING MARKETS FUND	$	55,705	1.966%
13.02	BLACKROCK EQUITY INDEX FUND B CTF		50,765	1.791
13.03	VANGUARD INST INDEX FUND		40,367	1.425
13.04	WESTWOOD INCOME OPPORTUNITY FUND		38,952	1.375
13.05	DODGE & COX INTERNATIONAL STOCK FUND		36,825	1.300
13.06	FRANKLIN INTERNATIONAL GROWTH FUND		32,322	1.141
13.07	T. ROWE PRICE INSTITUTIONAL SMALL-CAP STOCK FUND		28,385	1.002
13.08	WELLINGTON INTERNATIONAL SMALL CAP OPPORTUNITIES CTF		28,323	1.000
13.09	GMO BENCHMARK-FREE ALLOCATION FUND-III		27,005	0.953
13.10	FIRST EAGLE OVERSEAS FUND		22,126	0.781
14.	Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:			
14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?		Yes [ ]	No [X]
14.02	Aggregate statement falue of investments held in nonaffiliated, privately placed equities	$	79,589	2.809%
	Largest three investments held in nonaffiliated, privately placed equities:			
14.03	BLACKROCK EQUITY INDEX FUND B CTF	$	50,765	1.791%
14.04	WELLINGTON INTERNATIONAL SMALL CAP OPPORTUNITIES CTF		28,323	1.000
14.05	FEDERAL HOME LOAN BANK CAPITAL STOCK		501	0.018

Items 15 through 23 are not applicable.

See accompanying independent auditors' report.

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Summary Investment Schedule

December 31, 2017

(In thousands)

Investment categories	Gross investment holdings* Amount	Gross investment holdings* Percentage of gross investment holdings	Admitted assets as reported in the annual statement Amount	Admitted assets as reported in the annual statement Percentage of total admitted assets
Bonds:				
U.S. Treasury securities	$ 93,189	3.4%	$ 93,189	3.4%
U.S. government agency obligations (excluding mortgage-backed securities):				
– Issued by U.S. government agencies	—	—	—	—
– Issued by U.S. government-sponsored agencies	—	—	—	—
Non U.S. government (including Canada, excluding mortgage-backed securities)	10,521	0.4	10,521	0.4
Securities issued by states, territories, and possessions and political subdivisions in the U.S.:				
– States, territories, and possessions general obligations	—	—	—	—
– Political subdivisions of states, territories, and possessions and political general obligations	11,268	0.4	11,268	0.4
– Revenue and assessment obligations	51,227	1.9	51,227	1.9
– Industrial development and similar obligations	—	—	—	—
Mortgage-backed securities (includes residential and commercial MBS):				
Pass-through securities:				
– Issued or guaranteed by GNMA	3,115	0.1	3,115	0.1
– Issued or guaranteed by FNMA and FHLMC	315,520	11.5	315,520	11.5
– All other	—	—	—	—
CMOs and REMICs:				
– Issued or guaranteed by GNMA, FNMA, FHLMC, or VA	42,318	1.5	42,318	1.5
– Issued by non-U.S. government issuers and collateralized by mortgage-based securities issued by above	—	—	—	—
– All other	125,123	4.6	125,123	4.6
Other debt and other fixed income securities (excluding short term):				
– Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	1,129,479	41.3	1,129,479	41.3
– Unaffiliated non-U.S. securities (including Canada)	235,764	8.6	235,764	8.6
– Affiliated securities	—	—	—	—
Equity interests:				
– Investments in mutual funds	333,868	12.2	333,868	12.2
Preferred stocks:				
– Affiliated	7,571	0.3	7,571	0.3
– Unaffiliated	587	0.0	587	0.0
Publicly traded equity securities (excluding preferred stocks):				
– Affiliated	—	—	—	—
– Unaffiliated	131,193	4.8	131,193	4.8
Other equity securities:				
– Affiliated	—	—	—	—
– Unaffiliated	79,691	2.9	79,691	2.9
Other equity interests including tangible personal property under lease:				
– Affiliated	—	—	—	—
– Unaffiliated	—	—	—	—

(Continued)

PINNACOL ASSURANCE

Supplemental Schedule of Investment Information
Summary Investment Schedule

December 31, 2017

(In thousands)

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	16,854	0.6	16,854	0.6
– Property held for production of income	—	—	—	—
– Property held for sale	—	—	—	—
Contract loans	—	—	—	—
Derivatives	—	—	—	—
Receivables for securities	842	0.0	842	0.0
Securities lending	—	—	—	—
Cash, cash equivalents, and short-term investments	76,899	2.8	76,899	2.8
Other invested assets	70,490	2.6	70,490	2.6
Total invested assets	$ 2,735,519	100.0%	$ 2,735,519	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
Suite 800
1225 17th Street
Denver, CO 80202-5598

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

The Members of the Legislative Audit Committee and
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, 2017, and the related statutory statements of operations and changes in policyholders' surplus, and cash flow for the year then ended, and the related notes to the statutory financial statements, and have issued our report thereon dated May 24, 2018. 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.

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 24, 2018

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

The Members of the Legislative Audit Committee and
Audit Committee of the Board of Directors
Pinnacol Assurance
Denver, Colorado

Ladies and Gentlemen:

We have audited the statutory-basis financial statements of Pinnacol Assurance (the Company) as of December 31, 2017 and 2016 and for each of the years then ended, and issued our report thereon dated May 24, 2018. Under our professional standards, we are providing you with the accompanying information related to the conduct of our audits.

Our Responsibility Under Professional Standards

We are responsible for forming and expressing an opinion about whether the financial statements, that have been prepared by management with the oversight of the Pinnacol Assurance Risk and Audit Committee are presented fairly, in all material respects, in conformity with accounting practices prescribed or permitted by the Division of Insurance of the Department of Regulatory Agencies of the State of Colorado (the Division), which are the statutory accounting practices (SAP) codified in the NAIC's *Accounting Practices and Procedures Manual*. We have a responsibility to perform our audit of the financial statements in accordance with auditing standards generally accepted in the United States of America, and the standards applicable to financial statement audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. In carrying out this responsibility, we planned and performed the audit to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether caused by error or fraud. Because of the nature of audit evidence and the characteristics of fraud, we are to obtain reasonable, not absolute, assurance that material misstatements are detected. We have no responsibility to plan and perform the audit to obtain reasonable assurance that misstatements, whether caused by error or fraud, that are not material to the financial statements are detected. Our audit does not relieve management or the Pinnacol Assurance Risk and Audit Committee of their responsibilities.

In addition, in planning and performing our audit of the financial statements, we considered internal control over financial reporting (internal control) as a basis for designing 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 the Company's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control.

We also have a responsibility to communicate significant matters related to the financial statement audit that are, in our professional judgment, relevant to the responsibilities of the Pinnacol Assurance Risk and Audit Committee of the Board of Directors in overseeing the financial reporting process. We are not required to design procedures for the purpose of identifying other matters to communicate to you.

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

Other Information in Documents Containing Audited Financial Statements

Our responsibility for other information in documents containing the Company's financial statements and our auditors' report thereon does not extend beyond the financial information identified in our auditors' report, and we have no obligation to perform any procedures to corroborate other information contained in these documents. We have, however, read the other information included in the Company's annual report, and no matters came to our attention that cause us to believe that such information, or its manner of presentation, is materially inconsistent with the information, or manner of its presentation, appearing in the financial statements.

Accounting Practices and Alternative Treatments

Significant Accounting Policies

The significant accounting policies used by the Company are described in note 1 to the statutory-basis financial statements.

Unusual Transactions

Pinnacol purchased 2,000,000 shares of preferred stock in a non-insurance subsidiary, Cake, for $10,000,000 on September 28, 2017.

Cake purchased various intellectual property (brand, trademark, etc.) from Pinnacol for $5,598,000. $3,169,000 represented software capitalized by Pinnacol for Cake's operating software. $2,429,000 represented the expenses Pinnacol incurred for the organization and startup of Cake including establishing its brand. The $2,429,000 of organization and startup expenses could not be capitalized by Cake because of the common control between Pinnacol and Cake. Instead, Pinnacol recorded the transaction as a deemed dividend from Cake to Pinnacol of $2,429,000 that reduced the cost basis of its investment in Cake from $10,000,000 to $7,571,000. There was no change to the 2,000,000 shares owned by Pinnacol.

Qualitative Aspects of Accounting Practices

We have discussed with the Risk and Audit Committee and management our judgments about the quality, not just the acceptability, of the Company's accounting principles as applied in its financial reporting. The discussions generally included such matters as the consistency of the Company's accounting policies and their application, and the understandability and completeness of the Company's statutory-basis financial statements, which include related disclosures.

Management Judgments and Accounting Estimates

The preparation of the statutory-basis financial statements requires management of the Company to make a number of estimates and assumptions relating to the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the statutory-basis financial statements and the reported amounts of revenues and expenses during the period. 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 2017 statutory basis financial statements include the following:

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, 2017, Pinnacol has recorded $923,095,000 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 2017 and in prior years.

Structured Settlement Liability – Pinnacol discounts internal structured settlement liabilities on a tabular basis using a discount rate of 2.5% for 2017. 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. To assist management in estimating the internal structured settlement liability, Pinnacol retains the assistance of an actuarial consulting firm. At December 31, 2017, Pinnacol has recorded an internal structured settlement liability of $384,790,000.

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 a net estimated earned but unbilled receivable of approximately $43,610,000 in 2017.

Individual Loss Control Dividends Payable to Policyholders – Pinnacol has an individual loss control dividend (ILCD) program that is designed for policyholders who are committed to effective loss control in their business operations. If the policyholder meets the minimum premium requirements and pays an additional 5% premium charge as a buy in to the plan, the policyholder may receive a return of premium based on the policy premium and the loss ratio. For 2017, ILCD payable of $24,882,000 are included in dividends payable to policyholders.

Agent Loss Control Bonus – Pinnacol offers an agent contingency commission that is based upon each agency's estimated loss ratio. It is calculated as of June 30th for the preceding accident year. For 2017, an agent loss control bonus accrual of $26,876,000 is included in commissions payable.

Uncorrected and Corrected Misstatements

In connection with our audit of the Company's statutory-basis financial statements, we have not identified any significant financial statement misstatements that have not been corrected in the Company's books and records as of and for the year ended December 31, 2017 and have communicated that finding to management.

Disagreements with Management

There were no disagreements with management on financial accounting and reporting matters that would have caused a modification of our auditors' report on the Company's statutory-basis financial statements.

Management's Consultation with Other Accountants

To the best of our knowledge, management has not consulted with or obtained opinions, written or oral, from other independent accountants during the year ended December 31, 2017.

Significant Issues Discussed, or Subject to Correspondence, with Management

Major Issues Discussed with Management Prior to Retention

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

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with you and management each year prior to our retention by the Company's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Material Written Communications

The following material written communications between management and us have been provided:

1. Management representation letter

2. Internal legal letter

Significant Difficulties Encountered During the Audit

We encountered no significant difficulties in dealing with management in performing our audit.

Independence

We are not aware of any additional relationships between our firm and the Company and persons in a financial reporting oversight role at the Company that may reasonably be thought to bear on independence.

Confirmation of Audit Independence

We hereby confirm that as of May 24, 2018 we are independent accountants with respect to the Company under relevant professional and regulatory standards.

* * * * * * *

This letter to the Risk and Audit Committee is intended solely for the information and use of the Risk and Audit Committee and management and is not intended to be and should not be used by anyone other than these specified parties. However, upon release by the Legislative Audit Committee, this report is a public document.

Very truly yours,

KPMG LLP

Denver, Colorado
May 24, 2018

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, 2017. 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 – identified and Medicare-certified by the Colorado Department of Public Health and Environment.

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

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

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

(J) Free-Standing Facility – an entity that furnishes healthcare services and is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or provider –based entity.

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

(L) Long-Term Care Facility –licensed 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) 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.

(S) Psychiatric Hospital – licensed by the Colorado Department of Public Health and Environment.

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

(U) Rural Health Clinic Facility – 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) "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.

(X) Telehealth – a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of an injured worker's health care while the injured worker is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and-forward transfers. The term does not include the delivery of health care services via telephone with audio only function, facsimile machine, or electronic mail systems. .

(Y) Veterans' Administration Medical Facilities – all medical facilities overseen by the United States Department of Veterans' Affairs.

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 or rely 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. Requesters and reviewers should consider how their decision will affect the overall treatment plan for the individual patient. In all instances of contest appropriate processes to deny are required. Refer to applicable sections of 16-10, 16-11 and/or 16-12.

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) Providers must accurately report their services using codes and modifiers listed in the National Relative Value File, as published by Medicare in January 2016 Resource Based Relative Value Scale (RBRVS). Providers also must use codes, modifiers, instructions, and parenthetical notes listed in the American Medical Association's Current Procedural Terminology (CPT®) 2016 edition. Finally, providers must use codes, modifiers, and billing instructions listed in Rule 18, Medical Fee Schedule. 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 Medical Board;

2) Colorado Board of Chiropractic Examiners;

3) Colorado Podiatry Board; or

4) Colorado Dental Board.

Only physicians licensed by the Colorado Medical Board may be included as individual physicians on the employer's or insurer's designated provider list required under § 8-43-404(5)(a)(I), C.R.S.

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

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

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

3) Anesthesiologist Assistant (AA) – licensed by the Colorado Medical Board, Colorado Department of Regulatory Agencies;

4) Athletic Trainers (ATC) –registered by the Office of Athletic Trainer Registration, Colorado Department of Regulatory Agencies;

5) Audiologist (AU.D. CCC-A) – licensed by the Office of Audiology and Hearing Aid Provider Licensure, Colorado Department of Regulatory Agencies;

6) Certified Registered Nurse Anesthetist (CRNA) – licensed by the Colorado Board of Nursing;

7) Clinical Social Worker (LCSW) – licensed by the Board of Social Work Examiners, Colorado Department of Regulatory Agencies;

8) Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Supplier – licensed by the Colorado Secretary of State;

9) Marriage and Family Therapist (LMFT) – licensed by the Board of Marriage and Family Therapist Examiners, Colorado Department of Regulatory Agencies;

10) Massage Therapist (MT) –licensed as a massage therapist by the Office of Massage Therapy Licensure, Colorado Department of Regulatory Agencies;

11) Nurse Practitioner (NP) – licensed as an APN and authorized by the Colorado Board of Nursing;

12) Occupational Therapist (OTR) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies,;

13) Optometrist (OD) – licensed by the Board of Optometry, Colorado Department of Regulatory Agencies;

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

15) Pharmacist – licensed by the Board of Pharmacy, Colorado Department of Regulatory Agencies;

16) Physical Therapist (PT) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

17) Physical Therapist Assistant (PTA) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

18) Physician Assistant (PA) – licensed by the Colorado Medical Board;

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

20) Professional Counselor (LPC) – licensed by the Board of Professional Counselor Examiners, Colorado Department of Regulatory Agencies;

21) Psychologist (PsyD, PhD, EdD) – licensed by the Board of Psychologist Examiners, Colorado Department of Regulatory Agencies;

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

23) Respiratory Therapist (RTL) – certified by the National Board of Respiratory Care and licensed by the Office of Respiratory Therapy Licensure, Colorado Department of Regulatory Agencies;

24) Speech Language Pathologist (CCC-SLP) – certified by the Office of Speech-Language Pathology Certification, Colorado Department of Regulatory Agencies; and

25) Surgical Technologist (CST) – registered by the Office of Surgical Assistant and Surgical Technologist Registration, Colorado Department of Regulatory Agencies.

(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 section 16-5(A)(1)(a) or (b) must comply with section 16-10, 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 claim.

(6) Use of PAs and NPs in Colorado Workers' Compensation Claims:

(a) All Colorado Workers' Compensation claims (medical only or lost time claims) shall have an "authorized treating physician" responsible for all services rendered to an injured worker by any PA or NP.

(b) The authorized treating physician provider must be immediately available in person or by telephone to furnish assistance and/or direction to the PA or NP while services are being provided to an injured worker.

(c) The service is within the scope of the PA's or NP's practice and complies with all applicable provisions of the Colorado Medical Practice Act or the Colorado Nurse Practice Act, and all applicable rules promulgated by the Colorado Medical Board or the Colorado Board of Nursing.

(d) For services performed by an NP or a PA, the authorized treating physician must counter sign patient records related to the injured worker's inability to work resulting from the claimed work injury or disease, and the injured worker's ability to return to regular or modified employment. The authorized treating physician also must counter sign Form WC 164. The signature of the physician provider shall serve as a certification that all requirements of this rule have been met.

(e) The authorized treating physician must evaluate the injured worker within the first three visits to the physician's office.

(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 section 16-10, 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 in the Medical Fee Schedule shall require prior authorization from the payer as set forth in section 16-10, 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.

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 section 16-11, Contest of a Request for Prior Authorization, or section 16-12, Payment of Medical Benefits.

(E) International Classification of Diseases (ICD) codes 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. Health care providers shall provide their name and credentials in the appropriate box of the CMS-1500.

(a) Non-hospital based ASCs may bill on the CMS-1500, however an SG modifier must be appended to the technical component of services to indicate a facility charge and to qualify for reimbursement as a facility claim.

(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 section 16-2, when billing for

hospital services or any facility fees billed by any other provider, such as hospital-based ASCs.

(a) Some outpatient hospital therapy services (Physical, Occupational, or Speech) may also be billed on UB-04. For these services, the UB-04 must have Form Locator Type 013x, 074x, 075x, or 085x, and one of the following revenue code(s):

- Revenue Code 042X Physical Therapy
- Revenue Code 043X Occupational Therapy
- Revenue Code 044X Speech/Language Therapy

(b) CAHs designated by Medicare or Exhibit # 3 to Rule 18 may use UB-04 to bill professional services if the professional has reassigned his or her billing rights to the CAH using Medicare's Method II. The CAH shall list bill type 851-854, as well as one of the following revenue code(s) and Health Care Common Procedure Coding System (HCPCS) codes in the HCPCS Rates field number 44:

- 0960 - Professional Fee General
- 0961 - Psychiatric
- 0962 - Ophthalmology
- 0963 - Anesthesiologist (MD)
- 0964 - Anesthetist (CRNA)
- 0971 - Professional Fee For Laboratory
- 0972 - Professional Fee For Radiology Diagnostic
- 0973 – Professional Fee - Radiology - Therapeutic
- 0974 - Professional Fee - Radiology - Nuclear
- 0975 - Professional Fee - Operating Room
- 0981 - Emergency Room Physicians
- 0982 - Outpatient Services
- 0983 - Clinic
- 0985 - EKG Professional
- 0986 - EEG Professional
- 0987 - Hospital Visit professional (MD/DO)
- 0988 - Consultation (Professional (MD/DO)

All professional services billed by a CAH are subject to the same coding and payment rules as professional services billed independently. The following modifiers shall be appended to HCPCS codes to identify the type of provider rendering the professional service:

GF Services rendered in a CAH by a NP, clinical nurse specialist, certified registered nurse, or PA

SB Services rendered in a CAH by a nurse midwife

AH Services rendered in a CAH by a clinical psychologist

AE Services rendered in a CAH by a nutrition professional/registered dietitian

AQ Physician services in a physician-scarcity area

(c) No provider except those listed above shall bill for the professional fees using UB-04.

(3) American Dental Association's Dental Claim Form, Version 2012 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 benefit managers (PBM). Physicians may use the CMS-1500 billing form as described in section 16-7(B)(1).

Physicians shall list the "repackaged" and the "original" NDC numbers in field 24 of the CMS-1500. List the "repackaged" NDC number first and the "original" NDC number second, with the prefix 'ORIG' appended.

(C) International Classification of Diseases (ICD) Codes

All provider bills, including outpatient hospital bills, shall list the appropriate diagnosis codes using the current ICD-10-Clinical Modification (CM) code(s). If a seventh character is required by ICD-10-CM, it must be applied in accordance with ICD-10-CM Chapter Guidelines provided by the Centers for Medicare and Medicaid Services (CMS).

(D) Required Billing Codes

All billed services shall be itemized on the appropriate billing form as set forth in sections 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.

(E) Inaccurate Billing Forms or Codes

Payment for any services not billed on the forms identified in this Rule, and/or not itemized as instructed in sections 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 section 16-12, Payment of Medical Benefits.

(F) 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 section 16-7(F), 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 section 16-12, the payer may contest payment for billed services until the provider completes and submits the relevant required accompanying documentation as specified by section16-7(F).

(G) 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.

(H) All services provided to patients are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. Amendments, corrections and delayed entries must comply with Medicare's widely accepted recordkeeping principles as outlined in the July 2016 Medicare Program Integrity Manual Chapter 3, section 3.3.2.5. (This section does not apply to patients' requests to amend records as permitted by the Health Insurance Portability and Accountability Act (HIPAA)).

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 NOTIFICATION

(A) The Notification process is for treatment consistent with the Medical Treatment Guidelines that has an established value under the Medical Fee Schedule. Providers may, but are not required to, utilize the Notification process to ensure payment for medical treatment that falls within the purview of the Medical Treatment Guidelines. Therefore, lack of response from the payer within the time requirement set forth in section 16-9 (D) shall deem the proposed treatment/service authorized for payment.

(B) Notification may be made by phone, during regular business hours.

(1) Providers can accept verbal confirmation; or

(2) Providers may request written confirmation of an approval, which the payer should provide upon request.

(C) Notification may be submitted using the "Authorized Treating Provider's Notification to Treat" (Form WC 195).

(1) The completed form shall include:

(a) Provider's certification that the proposed treatment/service is medically necessary and consistent with the Medical Treatment Guidelines.

(b) Documentation of the specific Medical Treatment Guideline(s) applicable to the proposed treatment/service.

(c) Provider's email address or fax number to which the payer can respond.

(D) Payers shall respond to a Notification submission within five (5) business days from receipt of the request with an approval or contest of the proposed treatment. Payers may contest the proposed treatment only for the following reasons:

(1) For claims which have been reported to the Division, no admission of liability or final order finding the injury compensable has been issued:

(2) Proposed treatment is not related to the admitted injury;

(3) Provider submitting Notification is not an Authorized Treating Provider (ATP), or is proposing for treatment to be performed by a provider who is not eligible to be an ATP;

(4) Injured worker is not entitled to proposed treatment pursuant to statute or settlement;

(5) Medical records contain conflicting opinions among the ATPs regarding proposed treatment;

(6) Proposed treatment falls outside the Medical Treatment Guidelines (see section 16-9(E).

(E) If the payer contests Notification under sections (16-9(D)(2), (5) or (6) above, the payer shall notify the provider, allow the submission of relevant supporting medical documentation as defined in section 16-10 (F), and review the submission as a prior authorization request, allowing an additional seven (7) business days for review.

(F) Contests for denied Notification by a provider shall be made in accordance with the prior authorization dispute process outlined in 16-11(C).

(G) Any provider or payer who incorrectly applies the Medical Treatment Guidelines in the Notification/prior authorization process may be subject to penalties under the Workers' Compensation Act.

16-10 PRIOR AUTHORIZATION

(A) Granting of prior authorization is a guarantee of payment when in accordance with Rule 18, RBRVS and CPT® for those services/procedures requested by the provider per section16-10 (F).

(B) Prior authorization for payment shall only 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 section 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 section16-10(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 indications of the Medical Treatment Guidelines are met, no prior authorization is required. When prior authorization for payment is indicated, the following documentation is required:

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

(b) Identification of the appropriate Medical Treatment Guideline application to the requested service, if applicable; and

(c) 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 RBRVS, 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 section 16-11.

(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 required by section 16-10(F) for any unlisted valued service or procedure for payment.

(J) All medical records should be signed by the rendering provider. Electronic signatures are accepted.

16-11 CONTEST OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If the payer contests a request for prior authorization for non-medical reasons as defined under section 16-12(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 section 16-10(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 section 16-11(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 section 16-10(F) reviewed by a physician or other health care professional, as defined in section 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 physicians or chiropractors performing this review shall be Level I or Level II accredited.

(2) After reviewing all the submitted documentation and other documentation referenced in the prior authorization request and available to the payer, 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 section 16-11(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 section 16-11(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 section 16-11(A) or (B) and the requesting provider is notified accordingly. A request for hearing shall not relieve the payer from conducting a medical review of the requested treatment, as set forth in section 16-11(B); or

(2) The payer has scheduled an independent medical examination (IME) within the time prescribed for responding as set forth in section 16-11(B).

(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.

16-12 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 submit corrected bill or appeal 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 sections 16-12(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 sections 16-12(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 sections 16-12(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 medical documentation; 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 section 16-12(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 section 16-12(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 section 16-12(B) or 16-12(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 section 16-12(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 section 16-10(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 section 16-12(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 section 16-7(F) reviewed by a physician or other health care professional as defined in section 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 physicians or chiropractors performing this review shall be Level I or Level II accredited. 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 section 16-12(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 sections 16-12(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 section 16-12(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 section 16-12(D)(1), the payer shall:

(a) When contesting for medical reasons, have the bill and all supporting medical documentation and reasoning under section16-7(F) and, if applicable, section 16-12(D)(1) reviewed by a physician or other health care professional as defined in section 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 section 16-7(F) and, if applicable, section 16-12(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 section 16-12(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 section 16-12(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 section 16-12(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 date the original bill should have been processed in compliance with section 16-12, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(E) 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 section 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 section 16-12(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 section 16-12(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.

(F) 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.

(G) 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 section 16-12.

16-13 DISPUTE RESOLUTION PROCESS

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, C.R.S. 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.

16-14 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.