95848200220100100 2002 Document Code: 201

ANNUAL STATEMENT

For the Year Ending December 31, 2002

OF THE CONDITION AND AFFAIRS OF THE

McLAREN HEALTH PLAN, INC

NAIC Group Code 0000 (Current Period), 0000 (Prior Period) NAIC Company Code 95848 Employer's ID Number 383383640

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

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health[ ] Propery/Casualty[ ] Hospital, Medical & Dental Service or Indemnity[ ]
Dental Service Corporation[ ] Vision Service Corporation[ ] Health Maintenance Organization[X]
Other[ ] Is HMO Federally Qualified? Yes[ ] No[X]

Date Incorporated or Organized 09/12/1997 Date Commenced Business 08/01/1998

Statutory Home Office 401 SOUTH BALLENGER HIGHWAY (Street and Number), FLINT, MI 48532-3685 (City, or Town, State and Zip Code)

Main Administrative Office 401 SOUTH BALLENGER HIGHWAY (Street and Number)
FLINT, MI 48532-3685 (City or Town, State and Zip Code) (810)342-1008 (Area Code) (Telephone Number)

Mail Address 401 SOUTH BALLENGER HIGHWAY (Street and Number or P.O. Box), FLINT, MI 48532-3685 (City, or Town, State and Zip Code)

Primary Location of Books and Records 401 SOUTH BALLENGER HIGHWAY (Street and Number)
FLINT, MI 48532-3685 (City, or Town, State and Zip Code) (810)342-1008 (Area Code) (Telephone Number)

Internet Website Address

Statement Contact JEFF ASH (Name) (810)342-1052 (Area Code)(Telephone Number)(Extension)
JEFFAS@MCLAREN.ORG (E-Mail Address) (810)342-1089 (Fax Number)

Policyowner Relations Contact (Street and Number)
(City, or Town, State and Zip Code) (Area Code) (Telephone Number)(Extension)

OFFICERS

President KATHY KENDALL
Secretary DENNIS KRZEMINSKI
Chief Financial Officer JEFF ASH

VICE PRESIDENTS

DIRECTORS OR TRUSTEES

KATHY KENDALL
TOM DONALDSON
DENNIS KRZEMINSKI
CAROLYN DUFFINEY
RICK WYLES
RONALD SHAHEEN D.O.
EDWIN DELANGE D.O.

State of Michigan
County of Genesee ss

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

(Signature)	(Signature)	(Signature)
KATHY KENDALL	RICK WYLES	JEFF ASH
(Printed Name)	(Printed Name)	(Printed Name)
President	Treasurer	Chief Financial Officer

a. Is this an original filing? Yes[X] No[ ]
b. If no, 1. State the amendment number
2. Date filed
3. Number of pages attached

Subscribed and sworn to before me this
_____ day of _____, 2003

(Notary Public Signature)

EXHIBIT 3 - ACCIDENT AND HEALTH PREMIUMS DUE AND UNPAID

1 Name of Debtor	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 Over 90 Days	6 Nonadmitted	7 Admitted
NONE						
0599999 Accident and health premiums due and unpaid (Page 2, Line 10)						

EXHIBIT 4 - HEALTH CARE RECEIVABLES

1 Name of Debtor	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 Over 90 Days	6 Nonadmitted	7 Admitted
Receivables not inidvidually listed						
MATERNITY CASE RATE RECEIVABLE	88,555	84,690	28,230	42,345		243,820
RISK SHARING RECEIVABLE	269,175					269,175
0499999 Total - Receivables not inidvidually listed						
0599999 Health care receivables	357,730	84,690	28,230	42,345		512,995

EXHIBIT 5 - CLAIMS PAYABLE (Reported and Unreported)

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
0299999 Aggregate Accounts Not Individually Listed - Uncovered						
0399999 Aggregate Accounts Not Individually Listed - Covered	2,278,526	1,789,921	1,013,329	690,439	1,837,322	7,609,537
0499999 Subtotals	2,278,526	1,789,921	1,013,329	690,439	1,837,322	7,609,537
0599999 Unreported claims and other claim reserves						
0699999 Total Amounts Withheld						1,661,574
0799999 Total Claims Payable						9,271,111
0899999 Accrued Medical Incentive Pool						

EXHIBIT 6 - AMOUNTS DUE FROM PARENT, SUBSIDIARIES AND AFFILIATES

1	2	3	4	5	6	Admitted	
						7	8
Name of Affiliate	1 - 30 Days	31 - 60 Days	61 - 90 Days	Over 90 Days	Nonadmitted	Current	Non-Current
Individually listed receivables							
MCLAREN HEALTH CARE CORPORATION	390,743					390,743	
0199999 Total - Individually listed receivables	390,743					390,743	
0299999 Receivables not inidvidually listed	145					145	
0399999 Total gross amounts receivable	390,888					390,888	

EXHIBIT 7 - AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES

1 Affiliate	2 Description	3 Amount	4 Current	5 Non-Current
Individually listed payables				
MCLAREN MEDICAL MANAGEMENT INC	PROFESSIONAL SERVICES	72,962	72,962	
MCLAREN HEALTH CARE CORPORATION	PROFESSIONAL SERVICES	144,348	144,348	
MCLAREN REGIONAL MEDICAL CENTER	PROFESSIONAL SERVICES	746,789	746,789	
0199999 Total - Individually listed payables	X X X	964,100	964,100	
0299999 Payables not individually listed	X X X			
0399999 Total gross payables	X X X	964,100	964,100	

EXHIBIT 8 - PART 1 - SUMMARY OF TRANSACTIONS WITH PROVIDERS

Payment Method	1 Direct Medical Expense Payment	2 Column 1 as a % of Total	3 Total Members Covered	4 Column 3 as a % of Total	5 Column 1 Expenses Paid to Affiliated Providers	6 Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups						
2. Intermediaries						
3. All other providers	2,073,306	6.807	20,830	100.000	1,223,251	850,055
4. Total capitation payments	2,073,306	6.807	20,830	100.000	1,223,251	850,055
Other Payments:						
5. Fee-for-service			X X X	X X X		
6. Contractual fee payments	28,385,667	93.193	X X X	X X X	12,773,550	15,612,117
7. Bonus/withhold arrangements - fee-for-service			X X X	X X X		
8. Bonus/withhold arrangements - contractual fee payments			X X X	X X X		
9. Non-contingent salaries			X X X	X X X		
10. Aggregate cost arrangements			X X X	X X X		
11. All other payments			X X X	X X X		
12. Total other payments	28,385,667	93.193	X X X	X X X	12,773,550	15,612,117
13. Total (Line 4 plus Line 12)	30,458,973	100.000	X X X	X X X	13,996,801	16,462,172

EXHIBIT 8 - PART 2 - SUMMARY OF TRANSACTIONS WITH INTERMEDIARIES

1 NAIC Code	2 Name of Intermediary	3 Capitation Paid	4 Average Monthly Capitation	5 Intermediary's Total Adjusted Capital	6 Intermediary's Authorized Control Level RBC
	NONE				
9999999			X X X	X X X	X X X

EXHIBIT 9 - FURNITURE, EQUIPMENT AND SUPPLIES OWNED

	Description	1 Cost	2 Improvements	3 Accumulated Depreciation	4 Book Value Less Encumbrances	5 Assets Not Admitted	6 Net Admitted Assets
1.	Administrative furniture and equipment						
2.	Medical furniture, equipment and fixtures						
3.	Pharmaceuticals and surgical supplies						
4.	Durable medical equipment						
5.	Other property and equipment						
6.	Total						

NONE

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

REPORT FOR: 1. CORPORATION: 2. DIVISION:

NAIC Group Code 0000 BUSINESS IN THE STATE OF **GRAND TOTAL** DURING THE YEAR NAIC Company Code 95848

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	15,881								15,881	
2. First Quarter	16,986								16,986	
3. Second Quarter	17,757								17,757	
4. Third Quarter	20,575								20,575	
5. Current Year	20,830								20,830	
6. Current Year Member Months	224,742								224,742	
Total Member Ambulatory Encounters for Year:										
7. Physician	34,676								34,676	
8. Non-Physician	4,283								4,283	
9. Total	38,959								38,959	
10. Hospital Patient Days Incurred	6,405								6,405	
11. Number of Inpatient Admissions	1,647								1,647	
12. Premiums Collected	35,732,472								35,728,472	4,000
13. Premiums Earned	36,118,494								36,035,296	83,198
14. Amount Paid for Provision of Health Care Services	30,173,729								30,173,729	
15. Amount of Incurred for Provision of Health Care Services	30,458,973								30,458,973	

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

REPORT FOR: 1. CORPORATION: 2. DIVISION:

NAIC Group Code 0000 BUSINESS IN THE STATE OF **MICHIGAN** DURING THE YEAR NAIC Company Code 95848

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	15,881								15,881	
2. First Quarter	16,986								16,986	
3. Second Quarter	17,757								17,757	
4. Third Quarter	20,575								20,575	
5. Current Year	20,830								20,830	
6. Current Year Member Months	224,742								224,742	
Total Member Ambulatory Encounters for Year:										
7. Physician	34,676								34,676	
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13. Premiums Earned	36,118,494								36,035,296	83,198
14. Amount Paid for Provision of Health Care Services	30,173,729								30,173,729	
15. Amount of Incurred for Provision of Health Care Services	30,458,973								30,458,973	

SCHEDULE A - VERIFICATION BETWEEN YEARS

1.	Book/adjusted carrying value, December 31, prior year (prior year statement)	
2.	Increase (decrease) by adjustment:	
	2.1 Totals, Part 1, Column 10	
	2.2 Totals, Part 3, Column 7	
3.	Cost of acquired, (Totals, Part 2, Column 6, net of encumbrances (Column 7) and net of additions and permanent improvements (Column 9))	62,000
4.	Cost of additions and permanent improvements:	
	4.1 Totals, Part 1, Column 13	
	4.2 Totals, Part 3, Column 9	
5.	Total profit (loss) on sales, Part 3, Column 14	
6.	Increase (decrease) by foreign exchange adjustment:	
	6.1 Totals, Part 1, Column 11	
	6.2 Totals, Part 3, Column 8	
7.	Amounts received on sales, Part 3, Column 11 and Part 1, Column 12	
8.	Book/adjusted carrying value at the end of current period	62,000
9.	Total valuation allowance	
10.	Subtotal (Lines 8 plus 9)	62,000
11.	Total nonadmitted amounts	
12.	Statement value, current period (Page 2, real estate lines, current period)	62,000

SCHEDULE B - VERIFICATION BETWEEN YEARS

1.	Book value/recorded investment excluding accrued interest of mortgages owned, December 31 of prior year		
2.	Amount loaned during year:		
	2.1 Actual cost at time of acquisitions		
	2.2 Additional investment made after acquisitions		
3.	Accrual of discount and mortgage interest points and commitment fees		
4.	Increase (decrease) by adjustment		
5.	Total profit (loss) on sale		
6.	Amounts paid on account or in full during the year		
7.	Amortization of premium		
8.	Increase (decrease) by foreign exchange adjustment		
9.	Book value/recorded investment excluding accrued interest on mortgages owned at end of current period		
10.	Total valuation allowance		
11.	Subtotal (Lines 9 plus 10)		
12.	Total nonadmitted amounts		
13.	Statement value of mortgages owned at end of current period		

NONE

SCHEDULE BA - VERIFICATION BETWEEN YEARS

1.	Book/adjusted carrying value of long-term invested assets owned, December 31 of prior year		
2.	Cost of acquisitions during year:		
	2.1 Actual cost at time of acquisitions		
	2.2 Additional investment made after acquisitions		
3.	Accrual of discount		
4.	Increase (decrease) by adjustment		
5.	Total profit (loss) on sale		
6.	Amounts paid on account or in full during the year		
7.	Amortization of premium		
8.	Increase (decrease) by foreign exchange adjustment		
9.	Book/adjusted carrying value of long-term invested assets at end of current period		
10.	Total valuation allowance		
11.	Subtotal (Lines 9 plus 10)		
12.	Total nonadmitted amounts		
13.	Statement value of long-term invested assets at end of current period		

NONE

37 Schedule D Part 1A Sn 1 - #1 - . . . . . NONE

38 Schedule D Part 1A Sn 1 - #2 - . . . . . NONE

39 Schedule D Part 1A Sn 1 - #3 - . . . . . NONE

40 Schedule D Part 1A Sn 2 - #1 - . . . . . NONE

41 Schedule D Part 1A Sn 2 - #2 - . . . . . NONE

42 Schedule D Part 1A Sn 2 - #3 - . . . . . NONE

43 Schedule DA Part 2 - . . . . . NONE

44 Schedule DB Part A Verification -. . . . . NONE

44 Schedule DB Part B Verification -. . . . . NONE

45 Schedule DB Part C Verification -. . . . . NONE

45 Schedule DB Part D Verification -. . . . . NONE

45 Schedule DB Part E Verification -. . . . . NONE

46 Schedule DB Part F Sn 1 - Sum Replicated Assets -. . . . . NONE

47 Schedule DB Part F Sn 2 - Recon Replicated Assets - . . . . . NONE

48 Schedule S - Part 1 - Section 2 - . . . . . NONE

SCHEDULE S - PART 2

Reinsurance Recoverable on Paid and Unpaid Losses Listed by Reinsuring Company as of December 31, Current Year

1 NAIC Company Code	2 Federal ID Number	3 Effective Date	4 Name of Company	5 Location	6 Paid Losses	7 Unpaid Losses
Accident and Health, Non-Affiliates						
24767	41-0406690	01/01/2002	St Paul Fire & Marine Ins Co	New York, New York	326,504	
0599999 Total - Accident and Health, Non-Affiliates					326,504	
0699999 Totals - Accident and Health					326,504	
0799999 Totals - Life, Annuity and Accident and Health					326,504	

SCHEDULE S - PART 3 - SECTION 2

Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year

1	2	3	4	5	6	7	8	9	Outstanding Surplus Relief		12	13
								Reserve Credit Taken Other than for Unearned Premiums	10	11		
NAIC Company Code	Federal ID Number	Effective Date	Name of Company	Location	Type	Premiums	Unearned Premiums (estimated)		Current Year	Prior Year	Modified Coinsurance Reserve	Funds Withheld Under Coinsurance
Non-Affiliates												
24767	41-0406690	01/01/2002	St Paul Fire & Marine Ins Co	New York, New York	SSL/A	673,380						
0299999 Total - Non-Affiliates						673,380						
0399999 Totals						673,380						

SCHEDULE S - PART 4

Reinsurance Ceded To Unauthorized Companies

1 NAIC Company Code	2 Federal ID Number	3 Effective Date	4 Name of Reinsurer	5 Reserve Credit Taken	6 Paid and Unpaid Losses Recoverable (Debit)	7 Other Debits	8 Totals (Cols. 5 + 6 + 7)	9 Letters of Credit	10 Trust Agreements	11 Funds Deposited by and Withheld from Reinsurers	12 Other	13 Miscellaneous Balances (Credit)	14 Sum of Cols. 9+10+11+12+13 But Not in Excess of Col. 8
				NONE									
1199999 Totals (General Account and Separate Accounts combined)													

SCHEDULE S - PART 5

Five-Year Exhibit of Reinsurance Ceded Business

(000 Omitted)

	1 2002	2 2001	3 2000	4 1999	5 1998
A. OPERATIONS ITEMS					
1. Premiums					
2. Title XVIII-Medicare					
3. Title XIX - Medicaid	673	530	365	165	
4. Commissions and reinsurance expense allowance					
5. Total medical and hospital expenses					
B. BALANCE SHEET ITEMS					
6. Premiums receivable					
7. Claims payable			353		
8. Reinsurance recoverable on paid losses	327	214	200	212	
9. Experience rating refunds due or unpaid					
10. Commissions and reinsurance expense allowances unpaid					
11. Unauthorized reinsurance offset					
C. UNAUTHORIZED REINSURANCE (DEPOSITS BY AND FUNDS WITHHELD FROM)					
12. Funds deposited by and withheld from (F)					
13. Letters of credit (L)					
14. Trust agreements (T)					
15. Other (O)					

SCHEDULE S - PART 6

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

		1 As Reported (net of ceded)	2 Restatement Adjustments	3 Restated (gross of ceded)
ASSETS (Page 2, Col. 3)				
1.	Cash and invested assets (Line 9)	15,679,534		15,679,534
2.	Amounts recoverable from reinsurers (Line 12)	326,504		326,504
3.	Accident and health premiums due and unpaid (Line 10)			
4.	Net credit for ceded reinsurance	X X X		
5.	All other admitted assets (Balance)	992,529		992,529
6.	Total assets (Line 23)	16,998,567		16,998,567
LIABILITIES, CAPITAL AND SURPLUS (Page 3)				
7.	Claims unpaid (Line 1)	9,271,112		9,271,112
8.	Accrued medical incentive pool and bonus payments (Line 2)			
9.	Premiums received in advance (Line 6)			
10.	Reinsurance in unauthorized companies (Line 14)			
11.	All other liabilities (Balance)	1,424,572		1,424,572
12.	Total liabilities (Line 18)	10,695,684		10,695,684
13.	Total capital and surplus (Line 26)	6,302,883	X X X	6,302,883
14.	Total liabilities, capital and surplus (Line 27)	16,998,567		16,998,567
NET CREDIT FOR CEDED REINSURANCE				
15.	Claims unpaid			
16.	Accrued medical incentive pool			
17.	Premiums received in advance			
18.	Reinsurance recoverable on paid losses			
19.	Other ceded reinsurance recoverables			
20.	Total ceded reinsurance recoverables			
21.	Premiums receivable			
22.	Unauthorized reinsurance			
23.	Other ceded reinsurance payables/offsets			
24.	Total ceded reinsurance payables/offsets			
25.	Total net credit for ceded reinsurance			

SCHEDULE Y (continued)

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 Federal ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/(Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/ (Liability)
				NONE								
9999999 Totals									X X X			

Schedule Y Part 2 Explanation:

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Response
MARCH FILING	
1. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	No
2. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	Yes
3. Will an actuarial certification be filed by March 1?	Yes
4. Will the Risk-based Capital Report be filed with the NAIC by March 1?	Yes
5. Will the Risk-based Capital Report be filed with the state of domicile, if required by March 1?	Yes
6. Will the SVO Compliance Certification be filed by March 1?	Yes
APRIL FILING	
7. Will Management's Discussion and Analysis be filed by April 1?	Yes
8. Will the Long-term Care Experience Reporting Forms be filed with the state of domicile by April 1?	No
9. Will the Investment Risks Interrogatories be filed by April 1?	Yes
JUNE FILING	
10. Will an audited financial report be filed by June 1 with the state of domicile?	Yes

Explanations:

Bar Codes:

Medicare Supplement Insurance Experience Exhibit

95848200236000000 2002 Document Code: 360

LTC Experience Reporting Form C

95848200233000000 2002 Document Code: 330

OVERFLOW PAGE FOR WRITE-INS

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT
FOR THE STATE OF **MICHIGAN**

NAIC Group Code: 0000 NAIC Company Code: 95848
Address (City, State and Zip Code): FLINT, MI 48532-3685
Person Completing This Exhibit:
Title: Telephone:

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 1999				Policies Issued in 2000, 2001, 2002			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
0299999 Total Experience on Group Policies																	

NONE

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details:
2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address:
   2.2 Contact Person and Phone Number:
3. Billing address and contact person for user fees established under 42 U.S.C. 1395u(h)(3)(B)
   3.1 Address:
   3.2 Contact Person and Phone Number:
4. Explain any policies identified above as policy type "O":

MS Michigan

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