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ADMINISTRATIVE MANUAL

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INTRODUCTION

The philosopher, S. Gautama said, "Health is the greatest gift, contentment the greatest wealth, faithfulness the best relationship, a liberated mind is the greatest bliss." To mitigate risk and protect your business, these are the values that guide Kismet Risk Management Associates' (KRMA) consultative approach of working with you, your consultant, and your Third-Party Administrator (TPA). Our humanitarian principles enhance the quality of the protection you receive.

The entire team at KRMA thanks you for the opportunity to serve you.

We are providing this document for our Stop Loss Policyholders, their consultants, brokers, and designated claims administrators to use as a reference guide for questions pertaining to accounting, claims, policy administration, and underwriting of their Specific and Aggregate Stop Loss policies.

Please refer to your Stop Loss Policy and to this Administrative Guide for questions about your coverage. Nothing in this guide changes the terms of any Stop Loss policy. The Stop Loss policy language will take precedence if there is any conflict between this guide and the policy.

While it is our hope that this document will help to answer general questions for the most efficient processing of premiums and claims, if you need additional information, please contact us at:

Kismet Risk Management Associates, LLC
6500 Byron Center Ave, Ste 200
Byron Center, MI 49315
Phone: 317-288-3385
info@kismetrisk.com

You may also visit our website at www.KismetRisk.com

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AVAILABLE CARRIERS

American National Insurance Company

(all states, except New York)

Garden States Life Insurance Company

(A subsidiary of American National Insurance Company)

(all states, except New York)

Financial Strength Ratings:

A.M. Best……A (Excellent)

Standard & Poor's…… A (Excellent)

Amalgamated Life Insurance Company

(all states)

Financial Strength Ratings:

A.M. Best……A (Excellent)

Standard & Poor's…… A (Excellent)

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SALES & MARKETING

CONTACT INFORMATION:

MANJUSHA PRASAD SHEOBARAN, PRESIDENT

Direct No. 860-810-4186

Email msheobaran@Kismetrisk.com

THIRD PARTY ADMINISTRATOR APPROVALS

KRMA requires a completed TPA Questionnaire and a KRMA TPA Checklist with required attachments. You will be notified if your TPA requires review and approval. If you have completed another TPA Questionnaire within the last 2 years, KRMA will accept it, as long as it is submitted with the KRMA TPA Checklist and required attachments.

It is your responsibility as an Approved Administrator / Appointed Agent to:

- Keep accurate records available to be reviewed by KRMA if requested
- Maintain and provide proof of current Agent and TPA Licenses as required by the carrier and applicable laws
- Maintain and provide proof of Fidelity and Errors & Omissions Coverage
- Submit all items listed in 'Sold Case Submission' in a timely manner so the policy can be issued within 90 days of the group's Effective Date, as required by the carrier. (Note: claims cannot be processed for payment until the policy requirements have been satisfied, the policy has been issued and signed signature pages have been received by KRMA)
- Provide payment of premium by the 1st of each month
- Provide Monthly Aggregate Reports by the 20th of each month following the month in which the premium is due
- Notify KRMA if Claimant is reasonably expected to reach 50% of Specific Deductible
- Provide notice of an amendment to a client's Plan Document prior to the Effective Date of the amendment (Note: KRMA reserves the right to adjust rates and factors based on any material change to the benefit Plan).
- Immediately notify KRMA when aware of a Potential Specific Claim
- Notify KRMA immediately of any lawsuits or insurance department complaints.

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STOP LOSS PRODUCT REVIEW

SPECIFIC STOP LOSS

Specific Stop Loss provides financial protection for the Policyholder against high claims on any one individual Member. Under Specific Stop Loss insurance, a Specific Deductible and Specific contract basis is established for each Contract Period for each covered individual as detailed in the Stop Loss policy. Once a covered individual's paid claims exceed the applicable Specific Deductible, KRMA will review and reimburse the eligible amount paid that exceeds the Specific Deductible limited by the Individual Maximum Lifetime Benefit.

AGGREGATING SPECIFIC DEDUCTIBLE

An option available on Specific Stop Loss is an Aggregating Specific Deductible. Under an Aggregating Specific, the Deductible shown is an agreed to amount that the Policyholder pays for all claims above the Specific Individual Deductible, i.e., the amount is paid before KRMA pays for any claims above the Specific Individual Deductible.

STOP LOSS COINSURANCE

A Stop Loss Policy usually reimburses all eligible claims at 100%. However, a Policyholder may choose a lower percent to lower your Stop Loss premium. The applicable percent is stated in the Policy.

ACTIVELY AT WORK PROVISION

The Stop Loss Policy requires an employee be actively at work on the Effective Date to be eligible for coverage. However, KRMA recognizes that some health Plans extend benefits to employees on leaves of absence and allows a Policyholder to request a waiver of the actively at work provision (at an additional premium and with appropriate disclosure). The applicable provision is stated in the Policy.

DISCLOSURE

KRMA does require all Policyholders to complete a disclosure process. At inception, a formal disclosure statement must be completed and signed. This statement must identify all participants known to be disabled, not actively-at-work (employee) or actively-at-life (dependent), Claimant with high claim totals in the recent past or have the potential to incur high dollar claims based on the diagnosis and/or treatment. For additional guidance, please review Supplement A: Potential High Dollar Diagnoses.

The disclosure form must be completed and signed no more than 30 days prior to the proposed effective date of coverage or of the renewal effective date by the appropriate parties, as applicable, and received by the Company within five days of completion.

If a disabled or high-risk participant is identified, KRMA has the option to decline or accept the risk, offer a Laser (an amount up to which we will not recognize for payment) for that participant, or increase the cost of the stop loss coverage.

It is important to note that if a participant is not disclosed, KRMA reserves the right to re-underwrite the group, or rescind, or Laser coverage for the undisclosed individual.

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SPECIFIC ADVANCEMENT – ADVANCE FUNDING

Specific Advancement or Advance Funding is included in all our contracts at this time and is available to alleviate cash flow hardship that may be caused to a Policyholder when funding a large catastrophic claim.

The Advance Funding option permits a Policyholder to apply for Specific Stop Loss reimbursement before the Plan's claim is fully funded. These claims should be fully processed according to the terms of the benefit Plan and ready for payment. Advance Funding Request submission guidelines are detailed in the policy.

Policyholders are expected to use the advance funding to pay the Stop Loss claims within the ten (10) business days to be considered made on the KRMA date of payment. Upon receipt of the Specific Advanced Funding reimbursement, the Plan must release all Plan Benefit checks and submit documentation to KRMA as confirmation that payment(s) have been released to the corresponding providers.

AGGREGATE STOP LOSS

Aggregate Stop Loss provides protection for the employer against total group claims during a contract period.

ANNUAL AGGREGATE DEDUCTIBLE/ATTACHMENT POINT

The Annual Aggregate Deductible or Attachment Point is the amount of annual paid claims for all Plan participants that must be paid by the Policyholder/employer before the Aggregate Stop Loss coverage will reimburse claims.

The Annual Aggregate Deductible is calculated by multiplying the Deductible factors by the number of covered employee and dependent units each month. If total claims paid in a Plan year for eligible coverages under the employer's self-funded Plan exceed the Annual Aggregate Deductible, KRMA will reimburse the agreed upon amount and/or percentage of eligible claims more than the Deductible subject to any maximum payment stated in the Policy.

Only those eligible expenses that accumulated towards the Specific Deductible are counted towards the Aggregate. The following are also excluded from the total Aggregate claims eligible for reimbursement:

1. Claims reimbursed to the employer under Specific Stop Loss
2. Claims reimbursed under an Aggregating Specific Deductible
3. Claims paid up to any Laser amount.

MINIMUM AGGREGATE DEDUCTIBLE

The minimum Aggregate Deductible is 100% of the annual Aggregate Deductible and is stated in the Policy.

AGGREGATE ACCOMMODATION OR AGGREGATE CONDITIONAL REIMBURSEMENT

The Aggregate Accommodation is intended to aid the cash flow of the Plan to reimburse certain benefits otherwise reimbursable at the end of the Policy Period. Aggregate Accommodation is not intended to be a loan nor a cash advance. The Plan therefore must pay all claims prior to receiving an Aggregate Accommodation reimbursement.

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UNDERWRITING

CONTACT INFORMATION

KELLY DONICA, CHIEF UNDERWRITING OFFICER

Direct No. 317-979-6062

Email kdonica@kismetrisk.com

ANDREW EISENHUT, MARKETING UNDERWRITER

Direct No. 317-319-4873

Email aeisenhut@kismetrisk.com

UNDERWRITING GUIDELINES

Minimum Group Size	50 employees*
Minimum Specific Deductible	$35.000**
States Available	All States
Aggregating Specific Deducible (Option Available)	Yes
Specific Advance Funding (Option Available)	Yes
Monthly Aggregate Accommodation (Option Available to groups under 250 employees)	Yes
Aggregate Terminal Liability (Option Available to groups under 250 employees on 12/12 contract only)	Yes
Minimum % Participation	75%***
Reference Based Pricing	Yes
Level-Funded Option	No

. * groups between 50-150 employee lives must be currently self-funded with 3 years of claims experience.
** ISLs under $50,000 must be currently self-funded with 3 years of claims experience.
***groups under 100 employees require 85% participation of eligible employees

A more detailed copy of the underwriting guidelines may be reference at https://kismetrisk.com/underwriting-forms

Requests for Proposals may be sent to RFP@KismetRIsk.com

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REQUESTS FOR PROPOSALS ("RFPS"):

Forward your RFP requests to rfp@kismetrisk.com to ensure timely response.

REQUEST FOR PROPOSAL (RFP) CHECKLIST

- Company name, address (including zip code)
  - Subsidiaries, address (including zip code)
- SIC code and/or nature of business
- Current and requested Effective Date of coverage
- TPA/Broker/Consultant/Producer with contact information and requested commission level
- Current coverage type (fully insured; self-funded; etc.) and carrier name
- Current and/or renewal rates, terms (contract type; Lasers; etc.), commission, and factors when applicable
- Current TPA and Stop Loss carrier
- PPO network(s) by location/zip code to include employee counts by PPO network
- Utilization Review vendor
- Large Case Management vendor
- Participation percentage
- Requested coverage: Aggregate and/or Specific Deductible level(s)
- Coverage type: Medical, Prescription Drugs, Dental, Vision, STD
- Requested contract type(s): 12/12; 15/12; 12/15; etc.
- Current electronic census (for each location/subsidiary): including single and family count, gender, age or year of birth, zip code, active, retired, and COBRA participants
  - When being asked to cover retirees, the census should identify retirees under and over age 65 and show whether the group's Plan or Medicare is primary for retirees and their dependents
- Groups that are currently self-funded require 24 to 36 months of month-by-month paid claims and enrollment by coverage type (Medical, RX, Dental, etc.)
- Requested Schedule of Benefits including but not limited to:
  - Lifetime and/or Benefit Year Maximum
  - Deductibles
  - Coinsurance
  - Out of Pocket Maximum
  - Accident Benefit
  - Mental & Nervous
  - Co-Pays
  - Benefit details for RX, Dental, etc. when applicable
  - Notification of Plan and/or PPO network changes
- Large claims history: including total paid claims per individual, diagnosis, prognosis, and expected treatment Plan
- As stated in the Disclosure Statement, Claimants:
  - Currently disabled, confined, have been pre-certified within the last 3 months
  - Have received services that cost 50% of the lowest Specific Deductible amount or $50,000
  - Has been identified as a candidate for case management, having the potential to exceed 50% of the lowest Specific Deductible amount or $50,000
  - Have been diagnosed with a condition represented by the ICD-9 codes

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SOLD CASE SUBMISSION REQUIREMENTS

Disclosure of disabled and COBRA participants, potentially large claims, and claims in excess of 50% of Deductible (or reasonably expected to reach 50% based on diagnosis and/or prognosis) is required by KRMA prior to a firm and final offer to be presented for sale.

To bind coverage prompt submission of these documents within the listed time frames will expedite Stop Loss Policy issuance:

Immediately Upon Sale	Within 15 Days of the Effective Date	Within 30 Days of the Effective Date	Within 60 Days of the Effective Date
•Carrier Disclosure Statement completed and signed •Application Checklist •Deposit equivalent to 1st month's premium	•Signed Stop Loss Application •TPA Questionaire •TPA Checklist with attachments	•Claims Experience (as of the Effective Date) •Final Enrollment Census (as of Effective Date) •Qualifications Requested in Proposal Contingencies	•Signed Plan Document

Please Note: Our Carrier partners require that we issue policies within 90 days of the Effective Date of coverage. The Stop Loss Policy will not be issued until receipt of all above items, nor can claims be processed and paid until the Stop Loss Policy has been issued, and the appropriate signature pages have been signed, witnessed, and then returned to and received by our office.

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PREMIUM ACCOUNTING

CONTACT INFORMATION

AMBER TILLER, ACCOUNTING MANAGER

Direct 616.277.5857
Email atiller@kismetrisk.com

FOR PREMIUM AND/OR COMMISSION RELATED ITEMS:

- accounting@Kismetrisk.com

PREMIUM DUE DATES

The binder premium is due no later than the 1st day of the Contract Period.

Subsequent monthly premiums and reports with counts by tier are due the 1st day of each month.

PREMIUM PAYMENT METHODS

Checks	Made payable to **Kismet Risk Management Associates, LLC, LLC**	
	Mailed to the following address:	**Kismet Risk Management Associates, LLC** Attn: Accounting Department 6500 Byron Center Ave, Ste 200 Byron Center, MI 49315
Wire/EFT Transfers and ACH (updated effective 10/01/2021)	on American National/Garden State Life Insurance Company policies, please include the following:	**Account Name: Kismet Risk Management Associates, LLC FBO Garden State Life Insurance Company** Account Number: 01158491214 ABA/Routing Number: 072403473 Bank Name: Huntington Bank
	on Amalgamated Life Insurance Company policies, please include the following:	**Account Name: Kismet Risk Management Associates, LLC FBO Amalgamated Life Insurance Company** Account Number: 01158494473 ABA/Routing Number: 072403473 Bank Name: Huntington Bank

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PREMIUM PAYMENT SUBMISSIONS

When submitting premium using EFT/ACH, always include a copy of the KRMA Premium Accounting Worksheet. This may be mailed with the check or emailed to accounting@kismetrisk.com.

- TPA forms are acceptable provided they include all required information:
  - Policyholder name, Policy Number, and Effective Date of Coverage
  - Month for which premium remittance applies.
  - Number of covered units for each rate/tier category
  - Premium rates applicable to each rate/tier category (indicate whether rates are gross or net)
  - Documentation of retroactive adjustments, including number of units per rate tier and number of retroactive months.
  - Commission percent/amount withheld if remitting net of commission.
  - Calculation of total monthly premium

PREMIUM CALCULATION

Each monthly premium shall be computed by multiplying the Specific and/or Aggregate rate stated in the Schedule of Benefits by the number of respective employee and/or dependent units who are covered under the Plan at the beginning of each month.

Changes in the following should be reported to KRMA at accounting@kismetrisk.com immediately:

a) if there is a change in Plan benefits
b) if the location of the business or Members changes.
c) if the number of employees varies by more than 10%
d) if the nature of the Plan Sponsor's business changes; or
e) if prior claims experience submitted to KRMA as part of the underwriting process is inaccurate.

LATE PAYMENT PROCEDURE

The Stop Loss policy provides for a 30-day grace period for payments to be received. If it is not received by the end of the grace period, the policy can be considered lapsed retroactive to the last day of the month for which premium has been paid. Reinstatement of the lapsed policy will be considered only once, and at the sole discretion of the issuing Carrier.

If the policy terminates for any reason, the Policyholder is responsible for the greater of all premiums up to the date of termination or the minimum premium amount designated on the Schedule. We will be entitled to offset claim reimbursements against any due and unpaid premiums.

MINIMUM PREMIUM

The Minimum Premium amount is stated in the Schedule of Benefits. It will be applicable regardless of how long coverage remains in force with KRMA.

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CLAIMS

CONTACT INFORMATION

GLORIA BRISCO, CLAIM AUDITOR

Direct 317-362-4785

Email gbrisco@kismetrisk.com

FOR CLAIM SUBMISSIONS, PLEASE SUBMIT TO THE FOLLOWING:

- Pre-Certifications and/or 50% Notifications --- potentials@kismetrisk.com
- Monthly Aggregate Claims report --- potentials@kismetrisk.com
- Aggregate and/or Specific claims --- claims@kismetrisk.com

CLAIMS NOTIFICATIONS AND REPORTING

LARGE STOP LOSS CLAIM NOTIFICATION

All policies are underwritten with the requirement of Utilization Review and Large Case Management. Management of a claim begins with the Policyholder's TPA. We expect the TPA will have procedures in place to identify potential large claims through the TPA's benefit verification unit, customer service unit, reports reflecting 50% penetration of the Specific Deductible, and the group's Utilization Review Company. KRMA expects that potential large claim information identified through the TPA, Broker, or any Utilization Review vendors is submitted directly and promptly to us. Such notification must be made for an individual Claimant at the earliest of:

- Attaining **50%** of their Specific Deductible or **$100,000,** whichever is lesser;
- Identified with conditions or diagnoses listed in Supplement A: Potential High Dollar Diagnoses; or
- Has been identified through pre-certification of a hospital confinement, or other manner with a **potentially catastrophic diagnosis,** or is expected to be under **Large Case Management**

All notices should be submitted to potentials@kismetrisk.com in writing. The Stop Loss Notification and Initial Claim Form is available for your use. If the KRMA Notification form is not used, an approved written or electronic notification must include the following information:

- Policyholder name
- Employee name and SSN or unique Member identification number
- Name(s) of Claimant(s) and relationship to subscriber
- Diagnosis and Prognosis
- Date of on-set of diagnosis or condition
- Specific Deductible
- Total amount of self-funded claims paid to date
- Any pertinent information regarding Claimant's condition (pending transplant, hospital confinement, etc.)
- Name and phone numbers for any attending physicians and/or nurse case manager
- Type of notification (i.e., Trigger Diagnosis, 50% Notice, etc.)

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MONTHLY CLAIMS REPORTING

50% NOTIFICATIONS

High Dollar Claims Reports must be given to potentials@kismetrisk.com each month outlining the total amount of Plan Benefits paid on any covered individual equals or exceeds 50% of the Specific Deductible or $100,000 whichever is lesser.

This notification will allow the KRMA Clinical Analysis and Risk Assessment teams to review risk management and cost containment processes that are being applied, and/or make recommendations for cost saving vendor partner interventions. This will also allow KRMA to appropriately set up our reserves in the event that an actual claim occurs. KRMA's goal is build long-lasting relationships with our Policyholders and your partners.

Prompt claim notice, as defined by the policy, allows us to assist our Policyholders as best possible in managing their claims activities. Failure to give prompt notice may result in an adjustment of the reimbursement to the Policyholder, if any, to reflect any savings KRMA could have obtained had prompt 50% notification been given.

AGGREGATE REPORTING

Monthly Aggregate Reporting is due to KRMA at potentials@kismetrisk.com by the twentieth (20th) of the following month for which claims are being reported. For example, Aggregate claims for the period July 1st through July 31st should be reported to KRMA by August 20th.

Monthly Aggregate Reporting assists KRMA in documenting and monitoring potential Aggregate claims.

The following should be included with your Monthly Aggregate Reporting:

- The number of Covered Units by coverage type for each of the Plan, for each of the month of the Policy Period; and
- Monthly and Year-to-Date Total Claims Paid as well as deductions for ineligible claim expenses, such as Specific Claims, voids and/or refund and extra contractual benefit payment for each of the Plan, for each of the month of the Policy Period.

CLAIM FORMS

A zip file with the following forms will be attached:

- KRMA Notification of Claim Form
- KRMA Monthly Aggregate Reporting Form
- KRMA Specific Claim Form
- KRMA Aggregate Claim Form
- KRMA Request for SL Reimbursements via ACH

To keep up with the industry advances and changes in technology, forms may be updated periodically. For your convenience, we have made this guide and all current version of forms available online at www.KismetRisk.com

*Alternative TPA forms are acceptable provided they include all required information.

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SPECIFIC CLAIM REIMBURSEMENT REQUESTS

A Specific Stop Loss claim occurs when total PAID amount on Plan Benefits on behalf of a Covered Person exceeds the Specific Deductible. Such payment following receipt of a clean claim, should be made within the time allowed and falls under Incurred and Paid period as described under the Stop Loss Policy terms.

Specific Stop Loss claims will be reviewed, and a determination made within 15 calendar days from receipt of all required claim information.

Note: It is strictly the Policyholder's (or TPA on the Policyholder's behalf) responsibility to adjudicate claims and make all claim decisions. KRMA cannot advise, recommend, or otherwise direct the Policyholder's course of action on a claim. If a claim payment decision is contrary to the Plan Document, KRMA will adjudicate the claim according to the Plan Document (see Extra-Contractual Claims below). We cannot commit to claim reimbursement amounts prior to existence of a claim to us – to do so could possibly place KRMA in a Plan fiduciary role and may expose KRMA and our partners to unwarranted legal action.

TYPES OF SPECIFIC STOP LOSS CLAIMS

For the purposes of the Stop Loss reimbursement on the Specific Coverage, requests are identified as either:

A. Initial Claim – The first claim submitted during the contract period on behalf of an eligible individual, or

B. Supplemental Claim – Any additional claim(s) submitted during the contract period on behalf of an eligible individual, after reimbursement of the Initial Claim.

For the most expedient processing, requests for reimbursements should be sent to claims@kismetrisk.com.

Claim requests should be equal of greater than $1,000, unless filing for the final claim submission on behalf of an eligible insured.

Claim must be submitted to KRMA within ninety (90) days after the Plan Sponsor has paid eligible expense on behalf of the Covered Person. Any claims for reimbursement received by KRMA more than 90 days after the last date for which a claim can be reimbursed under the terms of the Excess Loss Contract will be denied, unless the Policyholder shows that timely submission was not possible, and that the Policyholder made the submission as soon as possible.

In no event will we reimburse claims submitted more than one (1) year after proof of loss was otherwise due. Consult your Stop Loss Policy for additional details.

Extra-contractual claims (i.e., claims that are not eligible for reimbursement under the submitted and approved Plan document and Stop Loss policy) are not covered unless prior approval has been received from the carrier.

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FILING AN INITIAL CLAIM

Once a Claimant's eligible paid charges exceed the Specific retention amount, a fully completed signed and dated Request for Specific Excess Loss Reimbursement Form, along with the appropriate boxes marked, including the following documentation should be submitted:

1. Eligibility Documentation
    a) Copy of employee's Enrollment Form(s), including the hire date and original Effective Date, and any enrollment changes. A screenshot of the payroll system, or a copy of the enrollment card/applicable change card may be submitted; however, if the enrollment card does not reflect the Claimant's original Effective Date on the Plan or if the name of the employer is omitted, a statement will be required from the employer verifying this information.
    b) Documentation showing type of coverage elected and covered dependents.
    c) Proof showing satisfaction of Waiting Period.
    d) Documentation of Hours Worked, including accumulated and used banked hours, if applicable.
    e) Itemized statement of any paid time off, including but not limited to FMLA, Disability, Leaves of Absence.
    f) If disabled, proof of how coverage was maintained while off work.
    g) For COBRA participants, a copy of the COBRA notification, election form, and proof of TIMELY receipt of premiums payment for all months.
    h) Copy of Medicare card (if applicable).
    i) For Dependents: Other Insurance (Coordination of Benefits – COB) information
        - Enrollment form that shows beginning date, employee signature, signature date
        - If the enrollment form does not correspond with the Plan's waiting period, please have the group's authorized representative explain eligibility.
        - Proof of any enrollment change such as change in status, etc.
        - If the claim is for a spouse, verify spouse's employment status and whether spouse has other coverage (if other coverage, verify effect on order of benefit determination)
        - If the claim is for an eligible child, verify child qualifies and if child has other coverage.
        - If the claim is for an eligible student, verify full-time status (official transcript or letter from the continuing education facility)
        - This information may include:
            - Recent form signed and dated by the employee showing Claimant has no other insurance.
            - Complete name, address, and phone number of the other employer, and copy of waiver.
            - Divorce decree or court order stating who must cover the dependent(s)
    j) If the Claimant is not on the last census that was supplied to us, we may require additional verification (e.g., premium payments or list premium billings, HIPAA Certificate of Credible Coverage, etc.)
2. Complete and signed Plan Document and all Plan Amendments, if not already submitted
3. Claim Information
    a) Paid Claim Listing/reports reflecting full claim data:
        - Employer/Group Name;
        - Employee Name;
        - Claimant Name;
        - Provider Name;
        - Dates of Service;
        - Payment information, including Amount Paid, Check numbers, Check Date, Status of Check
        - Types of Service – CPT/Revenue Codes

- Diagnosis – ICD-9/ICD -10
- Total Billed Amount
- Discounts [PPO, Negotiated, or Contractual]
- Ineligible or Denied benefits with reason for denial
- Deductibles, Copays, and Coinsurances
- Coordination of Benefit
- Denied or ineligible amount
- Total payment line calculation

b) Copies of Explanation of Benefits (EOBs)
- Copies of checks if not part of the EOBs

c) Proof of Deductible and coinsurance satisfied prior to this claim (if applicable).

d) Hospital bills
- UB-04 with corresponding DAILY itemized bills for charges in excess of $50,000

e) Physician bills
- HCFA-1500 with itemized bills in excess of $10,000.

f) PPO Discount/Repricing sheets. Please note that reimbursement of fees will be limited to the lesser of 25% of savings or $50,000.

g) Copy of pre-existing investigation or creditable coverage certificate (if applicable).

h) Copy of signed subrogation agreement, police report, accident details, and auto insurance information (if applicable).

i) Medical Management reports including, but not limited to the following:
- Pre-Certification documentation
- Case Management notes
- Medical Records/Operative notes (including hospital admission and discharge information)

Omitted information could delay reimbursement.

FILING A SUPPLEMENTAL CLAIM

Supplemental or Subsequent claims should be submitted by completing a Request for Specific Excess Loss Reimbursement Form, along with the documentation required to support the subsequent newly paid claims:

The requirements for filing a supplemental claim are the same as those for filing the initial claim. However, if there have been no changes since the Initial (or last Supplemental) Claim submission, items listed under the “Eligibility Documentation” may be waived.

Omitted information could delay reimbursement.

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ADVANCED FUNDING REQUESTS

To provide a value-added service to our clients, KRMA offers an advance funding option that can help to enhance the cash flow for our Policyholders when paying eligible high-dollar claims.

The advance funding option is available if the following criteria is met.

1. Advance funding is only available while the Excess Loss insurance policy is in force.
2. Each request for advance funding must total more than $2,500.00 per participant.
3. Advance funding is not available during the last thirty (30) days of the payment period as set forth on the Application and Schedule of Benefits section of this policy.
4. The request must be submitted within seven (7) days of a claims run.
5. The Company must receive the request for advance funding claim no later than 30 days prior to the end of the payment period of the contract, and satisfactory proof of claim eligibility, including all information requested above, as well as any other information as might be necessary to determine liability for the.
6. Policyholder must fund with 10 business day of receipt of the advance funding from the company via mail or electronic transfer. If such payment is not made by the Policyholder within 10 days, the Policyholder shall immediately refund to the Company the funds advanced by the Company to the Policyholder and the Company may revoke advance funding privileges.
7. It is the Policyholder's sole responsibility to request and apply advance funding in a manner that will secure appropriate provider discounts. In the event Policyholder cannot fund a claim in time to secure appropriate provider discounts, the Company will not be liable for the amount that the discounts would have been if the provider had been timely paid.
8. It is the Policyholder's sole responsibility to request and apply advance funding in a manner consistent with all current Employee Benefits Plan, Policy provisions, and applicable state and federal laws. In the event the Policyholder cannot request and receive advance funding from the Company in time to meet any provision of the Employee Benefits Plan, policy or applicable law, the Policyholder must immediately pay all claims for eligible expenses. No provision herein shall be deemed to alter the requirement contained in the policy that claims for eligible benefits be paid by Policyholder within the policy basis period.

Requests for Specific Advance should be submitted by completing a Request for Specific Excess Loss Reimbursement Form and forwarding it, along with the documentation required to support the adjudication of the newly processed claims.

Omitted information could delay reimbursement.

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AGGREGATE CLAIM REIMBURSEMENT REQUESTS

AGGREGATE EXCESS LOSS REIMBURSEMENT

If the Policyholder has purchased Aggregate Stop Loss Coverage, and the calculated attachment point as defined in the Stop Loss policy is exceeded (either on an annual basis or if an Aggregate Accommodation is in effect, on a monthly basis), they may be eligible for reimbursement.

Please submit the completed Aggregate Excess Loss Reimbursement Request along with:

1. A census which includes each insured covered at any point during the policy period: name, date of hire, relationship to employee, date of birth, Effective Date of coverage and, if applicable, termination date of coverage.
2. The complete Monthly Aggregate Report (including any run-in or run-out months)
3. A paid claims analysis report, with totals by Claimant, which displays for each EOB claim line the provider's name, inclusive dates of service, diagnosis code, CPT code, amount charged, PPO/negotiated discount, ineligible amounts, Deductible/coinsurance/co-pay applied, and amount paid.
4. If a run-in dollar limitation is indicated, a detailed report for the period.
5. Detailed Rx billings, (if Rx Plan covered under the Aggregate).
6. Detailed listing of all Rx rebates (if Rx Plan covered under Aggregate).
7. Copies of check registers from the beginning of the policy period through the last month for which the Aggregate claim is being filed. These copies are not needed if check numbers, and dates are reflected on the paid claims report.
8. A copy of the checking account bank statement for the entire policy period as well as a copy of the statement for the following month.
9. Documentation of any voids done and overpayments either already received or outstanding.
10. Claim Specific details regarding any extra-contractual payments made.
11. Subrogation details regarding closed as well as outstanding files.
12. Individual Specific Analysis.

After the initial review of the claim, additional documentation may be requested.

Omitted information could delay reimbursement.

AGGREGATE ACCOMMODATION

The Aggregate Accommodation is intended to aid the cash flow of the Plan to reimburse certain benefits otherwise reimbursable at the end of the Policy Period. If the Policyholder has elected this option, KRMA will provide Aggregate funding assistance provided the premiums are paid through a current date and when the Total Claims Paid, less ineligible claims, exceeds the sum of

1. the greater of:
    (a) the accumulated Annual Aggregate Attachment Point or
    (b) the pro rata of the portion of the Minimum Annual Aggregate Attachment Point; and
2. any previous advances; and
3. $1,000.

The following documentation is required when filing an Aggregate Accommodation reimbursement request:

1. Completed Monthly Accommodation Claim Form
2. Monthly Loss Summary Reports
   a) The number of Covered Units by coverage type for each of the Plan, for each of the month of the Policy Period; and
   b) Monthly and Year-to-Date Total Claims Paid, as well as deductions for ineligible claim expenses such as Specific Claims, voids and/or refund, and extra contractual benefit payment for each of the Plan, for each of the month of the Policy Period.
3. Paid Claims Analysis Report showing Claimant's name, date(s) of service, type of service, amount charged, and amount paid, date payment made, and the Payee.

Aggregate Accommodation is not intended to be a loan or a cash advance. The Plan, therefore, must pay all claims prior to receiving an Aggregate Accommodation reimbursement.

Omitted information could delay reimbursement.

EXTRA-CONTRACTUAL EXCEPTIONS

Claims paid outside the provisions of the Plan Document will not be reimbursable under the Specific or Aggregate Stop Loss coverage without prior approval.

Requests must be in writing and must provide the Claimant and Group name, summarize the claim situation, and state the out-of-plan proposal. Please include the reasoning for the action, medical necessity, and cost savings to the Plan. It is important to include the exact cost amounts, proposed frequency and duration of treatment.

PAYMENT EXTENSIONS

Claims paid outside the payment terms of the Stop Loss policy will not be reimbursable under the Specific or Aggregate Stop Loss coverage without prior approval.

Requests must be made in writing and dated by the end of the policy year or the run-out period. Provide the name of the Claimant and the group. Furnish the exact dollar amount of the pended charge, the name of the provider and the reason the charge has been pended. Requests will be reviewed promptly, and responses will be made in writing.

CLAIM APPEAL PROCESS

If additional information is required to complete the processing of a Stop Loss claim, a letter pending the reimbursement will be sent to the TPA with an Explanation and a listing of the items needed to complete the claim filing. If no response is received, a second letter will be sent to the TPA as a reminder. If still no response is received, a letter will be sent denying the claim.

Any denied claim can be appealed by submitting supporting documentation or by providing other evidence in writing within ninety (90) days of the claim denial. KRMA may enlist the services of qualified experts to support denials based on medical necessity or experimental and investigational provisions or other provisions in the Stop Loss policy.

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COST CONTAINMENT / RISK MANAGEMENT

KRMA strives to maintain **dozen**, a cost containment platform focused on Member advocacy tailored to fit the needs of each of our Policyholders' health Plans and deliver optimum results through lower healthcare costs and improved Member experiences.

We expect the TPA to have arrangements with cost saving vendors to manage claims. The following is a list of cost containment initiatives that we expect the TPAs to incorporate into their claim process:

- PPO Network Discounts
- Appropriate Multiple Surgery and Anesthesia Reductions
- Line-Item Hospital Bill Analysis (both in and out-of-network)
- Prospective and Retrospective Discount Negotiations
- Medical Necessity Reviews
- Reasonable and Customary Reviews
- Organ Transplant Networks – Centers of Excellence
- Subrogation Recovery
- Dialysis Reviews
- Case Management
- Utilization Review
- Implant Estimates
- Out-of-network outpatient hospital and professional claims should be reviewed for discounts through a secondary/wrap PPO network or direct negotiation.

If these services are not provided by the TPA to the Policyholder, KRMA can provide vendor recommendations to nationally recognized cost containment companies to assist in controlling medical costs.

Upon receipt of your potential claim notification to us, if you have not already contracted with one or more of these types of vendors, we may contact you and suggest one or more cost saving vendors become involved.

Where such methodologies are not applied, KRMA will adjudication reimbursements based on Reasonable and Customary charges for the services, treatments, or supplies rendered.

In the case of a large subrogation recovery, we reserve the right to have the claim managed by a vendor of our choice. All claims are still subject to the provisions and limitations set forth in the Stop Loss Policy and Plan Document Date.

REASONABLE AND CUSTOMARY

For the purposes of claim reviews and audits, Reasonable and Customary means the usual charge made by a group, entity, or person who renders or furnishes covered Services, treatments, or supplies provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatment or supplies to persons:

a) Who reside in the same geographical area; and
b) Whose illness or injury is comparable in nature and severity.

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COST CONTAINMENT FEES

The employer may be charged different types of fees that relate to the processing of a medical claim. These fees are referred to as administrative fees. Administrative fees are generally not covered under the Specific Excess Loss policy as they are services that the TPA should be providing to their customer.

However, realizing the savings to the Plan and carrier there are certain fees that are allowable. In these cases, Cost containment fees are generally reimbursed up to the lesser of 25% of the actual savings or $50,000.00.

Below is a list of certain types of fees and their treatment:

ADMINISTRATIVE FEES NOT COVERED

Administrative fees not covered or reimbursable under the Stop Loss policy include, but are not limited to:

1. Medical/peer-review - fees for reviewing a claim of medical necessity.
2. PPO access fees - fee charged by PPO.
3. Network access fees. These fees are not covered unless specifically included in the Specific Excess Loss policy.
4. Services provided by the Claims Administrator and/or its affiliates (Compensation for Claims Administration services must be addressed by the Employer/Claims Administrator contract)
5. Disease Management fees
6. Legal fees

REIMBURSEABLE COST CONTAINMENT FEES

These fees are billed by an outside vendor that reviews for billing errors by the provider. The vendor will review the claim and report any billing errors. These billing errors are considered savings to the Plan and carrier. The vendor will generally charge a percentage of savings. Commonly reinsured vendor fees include:

KIDNEY DISEASE AND DIALYSIS TREATMENTS.

Since individuals receiving dialysis for treatment of end stage renal disease (ESRD) are eligible for both Medicare Parts A & B, it is imperative that Plans are aware of the basics of this federally funded programs and its rules on Coordination of Benefits.

If possible, the TPA should also negotiate with the provider before treatments begin and get a signed release stating that the dialysis provider accepts the negotiated price in full and will not balance-bill the Claimant.

KRMA will assist and act as a resource in the management of dialysis claims. We can refer dialysis claims to our preferred vendors who will either negotiate directly with the providers to obtain deeper discounts or apply R&C allowances based on thorough review of the actual billed charges.

For KRMA non-preferred vendors, **fee amounts in excess of 35% of savings will be considered ineligible**.

We will not reimburse the vendor fee if savings were not applied.

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LARGE CASE MANAGEMENT (LCM) FEES

Large Case Management is intended to support Members with significant health risks or medical concerns by identifying, implementing, and monitoring the care required to help them in achieving the best possible health outcome. In doing so, LCM is also necessary to appropriately evaluate and direct the care of chronic, or catastrophic illness or injury. LCM can result in claims dollar savings and is a requirement of the Stop Loss contract. As such, associated fees are also a reimbursable expense subject to the following conditions:

- Case management reports must be provided for the time frame that is being billed by the large case management vendor.
- The impact of case management must be substantiated.
- A detailed invoice must be provided.
- Claim payments must exceed the Specific Deductible and the claims must be eligible in accordance with the Excess Loss policy.
- Case Management hourly charges will be **covered up to $125.00/hr**.

LCM fees associated with the management of an on-going catastrophic claim that are considered operational/administrative functions are NOT reimbursable under the Stop Loss policy. For example, the cost of sending follow up communications; internal claim services, or capitated fees that are charged to the Plan on a per member per month basis.

MEDICAL BILL REVIEWS AND LINE AUDIT REVIEWS

Medical Bill Reviews and Line Charge Audit Reviews are detailed, and organized processes used to examine health records and medical billing data submitted to ensure charge accuracy.

It is highly encouraged that Plan sponsors or their TPAs pre-screen all hospital bills, whether in or out-of-network, or refer them to us or a preferred vendors for further review and/or audit. We recommend that hospital bill review audits be conducted on claims where the hospital charge is in excess of $50,000.

KRMA can assist in the review of hospital audit results and has preferential pricing with select preferred vendors.

Fees associated with bill re-pricing and provider discount negotiations are a reimbursable expense covered under the Excess Loss policy subject to the following conditions:

- Use of a qualified industry vendor.
- The claims payments plus the fees must exceed the Specific Deductible and the claims must be eligible in accordance with the Excess Loss policy.
- Maximum reimbursable vendor expense is limited to **25% of documented savings with a cap of $50,000**.
- Review the adjudication of the claim to ensure the savings amount was applied. We will not reimburse the vendor fee if the savings were not applied.
- These fees are billed by an outside repricing vendor. The vendor will review the claim for potential discounting. Once discounting is obtained, the vendor will charge a percentage of savings.
- RX rebates are not covered under the Excess Loss policy.

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OUT OF NETWORK NEGOTIATION AND WRAP PPO FEES

Occasionally, patients may purposefully seek or inadvertently receive treatment from providers that are not a part of the Plan's selected PPO Network. Without negotiation, payment will be based upon the provider's billed charges. For these cases, Policyholder or their TPAs should utilize Out of Network Discount Negotiations to best manage the claims cost.

KRMA researches out of network repricing vendors and works to build relationships with them to bring cost savings options to TPAs on potential high dollar Stop Loss claim. We have various options including:

- Medical bill review
- Diagnosis-related review
- Reasonable & Customary (R&C) or Usual & Customary (U&C) reviews
- Reference Based Pricing analytics for both medical (Medicare) and drugs (AWP)

ultimately procuring a signed release from the provider showing that the provider accepts the negotiated price in full and will not balance-bill the Claimant.

In all cases, the maximum reimbursable vendor expense for non-network claims negotiation or PPO Wrap fee is **limited to 25% of documented savings.**

We will not reimburse the vendor fee if the savings were not applied.

PRENATAL AND NEONATAL SERVICES

Premature neonates, and birth complications or disease present in a newborn present a challenge because of the emotional experience, complex care needs and their associated cost. Treatment of high-risk newborns is a lengthy process that requires large amounts of personal and monetary resources.

KRMA will assist and act as a resource in the management of Prenatal/ Neonatal claims. We can refer such claims to our preferred vendors who will either negotiate directly with the providers to obtain deeper discounts or apply R&C allowances based on thorough review of the actual billed charges.

SPECIALTY PHARMACEUTICALS

Prescription drug prices are the single-highest contributor to rising healthcare expenses with 80% of the cost being driven by specialty drugs used to treat complex conditions.

KRMA defines Specialty Pharmaceuticals as any drugs, injections, and/or infusions costing $3,000.00 or more per dose.

Through our relationships with several Specialty Pharmacy Benefit Management companies who provide specialized patient management services, KRMA can provide you with access to lower cost of such specialty pharmaceuticals, often including an improved quality of care for the Member.

SUBROGATION RECOVERY / OTHER PARTY LIABILITY

In the event of any payment under the Plan to or on behalf of any covered person, KRMA shall, to the extent of such payment, be subrogated, to all the rights of recovery arising out of any claim or cause of action which may accrue because of alleged negligent conduct of a third party.

To review for reimbursement on cases involving subrogation or third-party liability, KRMA must have liability documentation that includes incident details such as date, location, details of the incident, and the parties involved. If applicable, a copy of the police report, and attorney correspondence should also be provided.

In the case of a large subrogation recovery, we reserve the right to have the claim managed by a vendor of our choice. All claims are still subject to the provisions and limitations set forth in the Stop Loss Policy and Plan Document Date.

TRANSPLANT CENTERS OF EXCELLENCE NETWORKS

KRMA has partnered with specialty access vendors for outcome-based care improvement programs through select Centers of Excellence Transplant Networks that provide case rate pricing wherever possible for the entire transplant continuum of care.

For the various network access fees associated with a transplant to be considered an eligible Loss, the Policyholder or TPA must make an immediate referral to one of the Cost Containment networks listed below and advise KRMA of the Loss:

- 6 Degrees
- Interlink
- Optum
- Cigna LifeSource
- LifeTrac
- In-Network Center of Excellence provided by BUCA

KRMA will assist and act as a resource in the management of transplant cases and claims. We can refer transplant cases and claims to our preferred vendors who will either negotiate directly with the providers to obtain deeper discounts or apply R&C allowances based on thorough review of the actual billed charges.

OTHER FEE NEGOTIATIONS

Other fee negotiations in which the vendor must calculate its fee based upon savings achieved beyond any PPO discount already applicable will be **limited to 25% of documented savings**.

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SUPPLEMENTS

SUPPLEMENT A: POTENTIAL HIGH DOLLAR DIAGNOSES

Please contact us immediately for any of the following diagnoses or diagnosis code(s) shown in the SIIA Standard Stop Loss Disclosure Form attached to this manual. Notification includes, but is not limited to, pre-certification, case management notes, benefits verification, or provider bills.

Diagnosis	ICD-10	ICD-9
A00 - B99 Infectious and Parasitic Diseases		
Streptococcal Sepsis/Other Septicemia	A40.0-A42.9	038.0-038.9
Viral Hepatitis	B15-B19.9	070.0-070.9
AIDS / HIV	B20	042.0
C00 - D49 Neoplasms		
Malignant neoplasm of Lip, Major Salivary Glands, Gum, Mouth, Oropharynx, and/or Hypopharynx	C00.0-C96	140.0-209.30
Myelodysplastic Syndromes	D46	238.72
D50 - D89 Diseases of the Blood & Blood-Forming Organs & Disorders involving the Immune Mechanism		
Sickle-Cell Anemia	D57-D57.1	282.60
Acquired Hemolytic Anemia	D59	283
Aplastic and Other Anemias	D60-D61.8; D63-D64	283.9-258.1
Coagulation Defects &/or Hemophilia/Defibrination Syndrome	D65-D69	286.0-286.9
Other Diseases of Blood & Blood Forming Organs	D70-D77	286.9-289.89
Certain disorders involving the immune mechanism/Sarcoidosis	D80-D89	135 & 289.9
E00 - E89 Endocrine, Nutritional & Metabolic Disease		
Diabetes and endocrine disorders	E10-E13	249.0-250.9
Other Disorders of Glucose Regulation & Pancreatic Internal Secretion	E15-E16	251.0-251.1
Nutritional deficiencies	E41-E43	261
Obesity/Hyperalimentation	E65-E69	278-278.8
Metabolic Disorders	E70-E89	272.7-348.9
F01 - F99 Mental, Behavioral & Neurodevelopmental Disorders		
Alcohol Abuse	F10.1	291
Opioid Abuse	F11.1	292

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Diagnosis	ICD-10	ICD-9
Schizophrenia	F20	295.4
Bipolar Disorder	F31	296
Depressive Psychosis- Severe; Reactive Depression Psychosis	F32.3	296.24-298.0
Recurrent Depressive Psychosis	F33.1-F33.3	296.32-296.34
Autistic Disorder - current & residual	F84	229.00-299.01
Rett's Syndrome	F84.2	330.8
Asperger's Syndrome	F84.5	299.8
G00 - G99 Diseases of the Nervous System		
Bacterial Meningitis	G00	321.2
Encephalitis Myelitis & Encephalomyelitis	G04	320.9
Intracranial & Intraspinal Abscess & Granuloma	G06-G07	324-324.9
Amyotrophic Lateral Sclerosis	G12.21	335.20-335.21
Multiple Sclerosis	G35	340
Other Acute Disseminated Demyelination	G36	341
Other Demyelinating Disease of Central Nervous System	G37	341.1
Paralysis/Quadriplegia	G82.5	344.0-344.09
Cauda Equina Syndrome	G83.4	344.60-344.61
Toxic Encephalopathy	G92	323.71-323.72; 349.82
Anoxic Brain Injury	G93.1	348.1
I00 - I99 Disease of the Circulatory System		
Angina Pectoris	I20	411.1
Acute Myocardial Infarction	I21.09-I22	410.00-410.92
Acute and Subacute Ischemic Heart Disease	I24	411.81
Chronic Ischemic Heart Disease	I25	414.00-414.07
Pulmonary Embolism	I26	415.0-415.19
Other Pulmonary Heart Disease	I27	416.0-416.9
Other Diseases of Pulmonary Vessels	I28	417.1
Acute and Subacute Endocarditis	I33	421.0-421.9
Heart Valve Disorders	I34.0-I38	424.0-424.9
Cardiomyopathy	I42-I43	425.0-425.9
Conduction Disorders	I44-I45	426.0-426.9
Cardiac Arrest	I46	427.5
Cardiac Dysrhythmias	I47-I49	427.0-427.9

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Diagnosis	ICD-10	ICD-9
Heart failure	I50	428-428.9
Subarachnoid / Intracerebral Hemorrhage	I60-I61	430, 431
Cerebral Infarction	I63	434.91
Occlusion of Pre-Cerebral/Cerebral Arteries	I65.8-I66.9	433.80-434.9
Other Cerebrovascular Accident (CVA)	I67	436
Atherosclerosis / Aortic Aneurysm	I70	440-441.9
J00 - J99 Diseases of the Respiratory System		
Chronic Obstructive Pulmonary Disease (COPD), etc.	J40-J44.9	490-496
Post-inflammatory Pulmonary Fibrosis	J84.10-J84.89	515
Pulmonary Collapse /Respiratory Failure	J98.11-J98.4	518-518.89
K00 - K95 Diseases of the Digestive System		
Esophageal Obstruction	K22.0	530
Ulcers	K25-K28	531.0-534.0
Other Diseases of Stomach & Duodenum	K31	536
Regional Enteritis (Crohn's Disease)	K50	555-555.9
Ulcerative Colitis	K51	556
Diseases of Intestines	K55-K64	557
Diseases of Peritoneum & Retroperitoneum	K65-K68	567-567.9
Liver Diseases and Cirrhosis	K70-K77	570-573.9
Diseases of Biliary tract/Cholangitis	K83	576.1
Diseases of Pancreatitis	K85-K86	577-577.9
Other Diseases of Digestive System/Complications of Bariatric Procedures	K90-K95	564.3; 579.0
M00 - M99 Diseases of the Musculoskeletal System & Connective Tissue		
Osteoarthrosis	M15.0-M19.90	715.0-715.9
Systemic Lupus Erythematosus	M32	710
Systemic Sclerosis	M34	710.1
Kyphoscoliosis and scoliosis	M41	737.3-737.39
Spondylolysis	M43	721
Cervical Disorders	M50	723.3
Thoracic, Thoracolumbar & Lumbosacral Intervertebral Disc Disorders	M51	722
Necrotizing Fasciitis	M72.6	728.86
Osteomyelitis and/or Periostitis	M86	730-730.9

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Diagnosis	ICD-10	ICD-9
N00 - N99 Disease of the Genitourinary System		
Acute & Rapidly Progressive Nephritic Syndrome	N00-N01	580.0-580.4
Chronic Nephritic Syndrome	N03	582.89
Nephrotic Syndrome	N04	581.3
Nephritis & Nephropathy	N05-N07	583.89
Glomerular Disorder Classified Elsewhere	N08	581.3-583.81
Acute Renal Failure	N17	584-584.9
Chronic renal failure	N18	585
Renal Failure, Unspecified	N19	586
O00 - 09A Pregnancy, Childbirth & the Puerperium		
High Risk Pregnancy	O09	V23
Pre-Existing Hypertension with Pre-Eclampsia	O11	642.21
Pre-Eclampsia & Eclampsia	O14-O15	642.5-642.7
Multiple Gestation	O30	651-651.93
Other Complications Specific to Multiple Gestations	O31	651.9
P00 - P96 Certain Conditions Originating in the Perinatal Period		
Disorders of Newborn Related to Short Gestation & Low Birth Weight	P07	765-765.19
Birth Trauma	P10-P15	767-767.8
Fetal Distress	P19	768.2
Other Respiratory Conditions of Newborn	P23.0-P28.9	770.0-770.9
Cardiovascular Disorders Originating in the Perinatal Period	P29	779.89
Bacterial Sepsis of Newborn	P36	771.81
Intracranial Hemorrhage of Newborn	P52-P53	772.11
Necrotizing Enterocolitis of Newborn	P77	777.5
Other Disturbances of Cerebral Status Newborn	P91	779.2
Q00 - Q99 Congenital Malformations, Deformations and Chromosomal Abnormalities		
Congenital Malformations of the Nervous System	Q07	740-742.2
Congenital Cardiac Malformations	Q20.0-Q26.9	745-747.4
Congenital Anomalies of Digestive System	Q41-Q45	751.6-751.9

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Diagnosis	ICD-10	ICD-9
Phakomatoses, not classified elsewhere	Q85	759.6
Congenital Malformation Syndromes Affecting Multiple Systems	Q87	755.55-756
Other and Unspecified Congenital Anomalies	Q89	759-759.9
R00 - R99 Symptoms, Signs and Abnormal Clinical & Laboratory Findings, not elsewhere classified		
Chest Pain	R07.1-R07.9	786.5-786.59
Coma	R40-R40.236	780.09
Shock, Hemorrhage	R57-R58	785.51
Severe Sepsis	R65.2-R65.21	785.52; 995.92
S00 - T88 Injury, Poisoning & Certain Other Consequences of External Cause		
Fracture of Skull & Facial Bones	S02	800-804.99; 853-854.1
Intracranial Injury	S06	850
Crushing injury	S07	925-929
Avulsion & Traumatic Amputation of Part of Head	S08	870.0-897.7
Fracture & Injuries of Cervical Vertebra & Other Parts of Neck	S12-S13	805-806.9; 952-953
Injury of Nerves & Spinal Cord at Neck Level	S14.0-S14.15	952.04
Fracture of Thoracic Vertebra	S22	805-805.9
Injury of Nerves & Spinal Cord at Thorax Level	S24	950-957
Injury of Blood Vessels of Thorax	S25	904-904.9
Injury of Heart	S26	861-861.10
Fracture of Lumbar Vertebra	S32.0-S32.2	805.00-805.9
Injury of Lumbar & Sacral Spinal Cord & Nerves	S34	952.2-953.3
Injury of Blood Vessels at Abdomen, Lower Back & Pelvis	S35	902.59
Injury of Intra-Abdominal Organs	S36-S37	929.9
Traumatic Amputation of Shoulder & Upper Arm	S48	887.2-887.3; V49.66-V49.67
Traumatic Amputation of Elbow & Forearm	S58	887.0-887.1
Traumatic Amputation of Hand at Wrist Level	S68.4-S68.7	880-887.7
Traumatic Amputation of Hip & Thigh	S78	890-890.2

Diagnosis	ICD-10	ICD-9
Traumatic Amputation of Leg	S88	897-897.7
Traumatic Amputation of Ankle & Foot	S98	896.0-896.3
Burns & Corrosions of Multiple Body Regions	T30-T32	949-949.5
Post-procedural Cardiogenic & Septic Shock	T81.11-T81.12	785.50-785.59
Complications of Cardiac & Vascular Prosthetic Devises, Implants & Grafts	T82	996.74
Complications of Prosthetic Devices, Implants & Grafts	T83-T85	996.3
Complications of Organ Transplants	T86.90-T86.899	996.8-996.89
Complications to Reattachment and amputation	T87	890.0-897.7
Z00 - Z99 Factors Influencing Health Status & Contact with Health Services		
Multiple Births	Z37.5-Z37.6	V27.5-V27.7
Multiple Births	Z38.3-Z38.8	V34.00-V37.01
Encounter for Aftercare Following Organ Transplant	Z48-Z48.298	V42-V58.9
Encounter for Care Involving Renal Dialysis	Z49	V56
Transplanted Organ & Tissue Status	Z94	V42.0
Presence of Cardiac & Vascular Implants & Grafts	Z95	V45.01
Transplanted Organ Removal Status	Z98.85	V45.87
Dependence of Respirator	Z99.1	V46.1-V46.11
Dependence of Dialysis	Z99.2	V45.11

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SUPPLEMENT B: APPLICATION CHECKLIST

APPLICATION CHECKLIST

*** Attach a signed copy of the proposal option that was sold.**

Description of Item	Information
Full Legal Name of Applicant:	
Address (street, city, state, zip):	
Tax ID #:	
Key Contact Name:	
Key Contact Telephone #:	
Key Contact Email address:	
* Please complete bottom section if group has any Affiliates or Subsidiaries.	
Full Name of Third-Party Administrator:	
Address (street, city, state, zip):	
Key Contact Name:	
Key Contact Telephone #:	
Key Contact Email address:	
Full Name of **LICENSED Agent or Broker #1** (required):	
Full name of **LICENSED Agency/Brokerage #1**:	
Tax ID #:	
License # / State:	
Address (street, city, state, zip):	
Telephone number:	
Email address:	
Full Name of LICENSED Agent or Broker #2 (if necessary):	
Full name of LICENCSED **Agency/Brokerage #2**:	
Tax ID #:	
License # / State:	
Address (street, city, state, zip):	
Telephone number:	
Email address:	
Full name of PPO Network:	
Address (street, city, state, zip):	
Full name of Utilization Review provider:	
Address (street, city, state, zip):	
Full name of Large Case Management provider:	
Address (street, city, state, zip):	

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SOLD OPTION NUMBER:	
Deductible Level Sold:	
Contracts Sold (i.e., 12/12, 12/15, 18/12):	
Sold Rate structure (i.e., single/family, 4-tier, Composite):	
EE only rate:	
EE + Spouse rate:	
EE + Children rate:	
Family rate:	
Composite rate:	
Sold with or Without OT Carve-out? **	
** If sold with OT carve-out, please attach a copy of the OT Policy with another carrier.	

OTHER ITEMS:

Claim Reimbursement	**Information**
The form of payment used for claims reimbursement will be:	(Click to view options)
If ACH or Wire payment is preferred, **the bank name is:**	
If ACH or Wire payment is preferred, **the bank address is:**	
If ACH or Wire payment is preferred, **the Account Name is:**	
If ACH or Wire payment is preferred, **the Account Number is:**	
If ACH payment is preferred, **the ABA/Routing Number is:**	
If Wire payment is preferred, **the ABA/Routing Number is:**	
If payment by check is preferred, **send check to this person (the contact person):**	
If Check payment is preferred, **the contact's address is:**	
If Check payment is preferred, **the contact's phone number is:**	
If Check payment is preferred, **the contact's email address is:**	
An Explanation of Reimbursement (EOR) will be provided to the contact person identified above. If you would like the EOR provided to a different person, complete the following:	
Provide the EOR to this person.	(Click to view options)
If completed, **name of person to receive EOR:**	
If completed, **address of person to receive EOR:**	
If completed, **phone number of person to receive EOR:**	
If completed, **email address of person to receive EOR:**	
Commission Payments	**Information**
The form of commission payment will be:	(Click to view options)
If ACH or Wire payment is preferred, **the bank name is:**	
If ACH or Wire payment is preferred, **the bank address is:**	
If ACH or Wire payment is preferred, **the Account Name is:**	
If ACH or Wire payment is preferred, **the Account Number is:**	
If ACH payment is preferred, **the ABA/Routing Number is:**	
If Wire payment is preferred, **the ABA/Routing Number is:**	
If payment by check is preferred, **send check to this person (the contact person):**	
If Check payment is preferred, **the contact's address is:**	
If Check payment is preferred, **the contact's phone number is:**	
If Check payment is preferred, **the contact's email address is:**	
Premium Payments	**Information**
Premium will be submitted:	(Click to view options)

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SUPPLEMENT C: PREMIUM ACCOUNTING WORKSHEET

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Kismet Risk Management Associates, LLC
6500 Byron Center Ave, Ste 200
Byron Center, MI 49315
Tel. No. (317) 288-3385
Fax No. (317) 288-3389

Premium Statement

Policyholder:		**Policy No:**	
Administrator:		**Report Period From:**	
Effective Date:		**Report Period To:**	
		Premium Due Date:	

Coverage	Current Units	Prior Units*	Difference	Total Units	Rates	Gross Premium Due
Specific						
Single				0		$ -
Family				0		$ -
Total Monthly Premiums						**$ -**

*Prior month's adjustments are limited to the preceding three months. You must attach documentation to receive consideration for any other months.

Make checks payable to: Kismet Risk Management Associates, LLC
Send checks to: Kismet Risk Management Associates, LLC; Attention: Accounting Department - 2464 Byron Station Drive Byron Center, MI 49315
Electronic payments via ACH or wire transfers are acceptable. Banking instructions will be provided upon receipt of request.

Premiums must be remitted by the end of the Grace Period at the latest. Policy is subject to termination without prior notice if premiums are received past the Grace Period.

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SUPPLEMENT D: NOTIFICATION OF CLAIM FORM

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NOTIFICATION OF CLAIM FORM
___50% Notification/Trigger Dx ___ Initial Submission

To: Kismet Risk Management Associates
Email: potentials@kismetrisk.com

From: _____ Date: _____

_____ Phone #: _____

_____ E-mail: _____

_____ Effective Date: _____

Policyholder: _____ Expiration Date: _____

Policy #: _____ Specific Deductible: $_____

Employee: _____ DOB: _____ SS#: _____

Claimant: _____ Sex: _____ Relationship: _____ DOB: _____

EE Effective Date w/Employer: _____ EE Date of Hire: _____ EE Term. Date: _____

Dep. Effective Date: _____ Dep. Term. Date: _____

Is COBRA Applicable? Yes ___ No ___ If yes, Eff. Date: _____ Termination Date: _____

Employee Actively at Work on the effective date: Yes ___ No ___ If no, date last worked: _____

Nature of Illness of Injury (Diagnosis): _____ Date of onset: _____

If Injury, when, where, and how did it occur? _____

Prognosis: _____

Physician: _____ Address: _____ Tel. #: _____

Date first Charge Incurred: _____ Date Last Charge Incurred: _____ Total Amount Paid to Date: _____ Estimate of Total Claim: _____

Is claimant covered under any other group insurance? Yes ___ No ___ If yes, Auto/No Fault: _____

Medicare: _____ Workers' Comp: _____ Other (Insured & Type of Coverage): _____

Is Subrogation applicable? Yes ___ No ___ If yes, has Subrogation Agreement been filed? Yes ___ No ___

Briefly comment on any Pre-screening, Auditing, or Medical Case Management performed (attach reports):

_____

Prepared by: _____ Print Name: _____

This form must be completed in full for all Initial Submissions only. The Specific Claim Reimbursement Form must be completed for both Initial and Subsequent Submissions.

Notification of Claim Form

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SUPPLEMENT E: REQUEST FOR SPECIFIC EXCESS LOSS REIMBURSEMENT FORM

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SPECIFIC CLAIM REIMBURSEMENT FORM

To: Kismet Risk Management Associates
Email: claims@kismetrisk.com

From: _____ Date: _____

_____ Phone #: _____

_____ Email: _____

_____ Effective Date: _____

Policyholder: _____ Expiration Date: _____

Policy #: _____ Specific Deductible: $_____

Employee: _____ DOB: _____ SS#: _____

What is employee's work status?

Actively working the required number of hours per week to be considered full-time

Retired on: _____

Disabled and has been out of work from: _____ to _____

Coverage is being continued under the following means (complete as applicable):

Sick Time: _____ to _____ Vacation Time: _____ to _____

FMLA: _____ to _____ Leave of Absence: _____ to _____

_____ Terminated coverage on: _____ Is COBRA applicable? _____

COBRA effective date: _____ COBRA termination date: _____

Claimant: _____ Sex: ___ Relationship: _____ DOB: _____

Total Benefits Paid: _____

Less Specific Deductible: _____

Balance: _____

Reimbursement Requested: _____ Estimated Future Expenses: _____

☐ Check if Simultaneous Specific Reimbursement Request

Please include legible copies of the following:

1. A copy of the Enrollment Card including documentation of the employee's original effective date and date of hire
2. Documentation that the employee/dependent meets the eligibility requirements at time of claim (i.e., hours worked, Actively-at-Work)
3. Itemized provider billings
4. Explanation of Benefits and/or checks indicating that the claims have been paid (match with itemized bill copies - do not staple)
5. If the deductible and co-insurance were previously met, please submit documentation
6. Documentation that no other insurance was available at the time of claim (COB)
7. Operative reports and the calculation of the reasonable and customary fees
8. Accident details and Subrogation Agreements, when appropriate
9. Summary report of all claims paid in this contract period
10. COBRA election and proof of COBRA payment, when appropriate
11. Precertification documentation and LCM reports

Prepared by: _____ Print Name: _____

Title: _____

Specific Claim Reimbursement Form W/Specific Reimbursement

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SUPPLEMENT F: AGGREGATE EXCESS LOSS REIMBURSEMENT REQUEST

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Kismet Risk Management Associates

Aggregate Claim Request Form

2464 Byron Station Drive, Byron Center, MI 49315
Phone: Claims' Direct: (317) 288-3385 x106 Email: claims@kismetrisk.com

Insured: _____

Policy Period: _____ Basis: _____ Specific Deductible: $_____

Administrator: _____

Coverage(s): Medical: X Dental: _____ Vision: _____ Rx Card: _____ Other: _____

Minimum Aggregate Retention: $_____

Aggregate Retention Factors: Single[1]: $_____ Family[2]: $_____ Composite[3]: $_____ Other: $_____

Census X Factors							Loss Fund		Total Paid Claims	
Month	Single Census	Single [1]	Family Census	Family [2]	Total Census	Composite [3]	Month	Accumulative[B]	Month	Accumulative[A]
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$

Aggregate Claim Calculation

Paid Claims Year-to-Date: $_____
Less Specific Excess Claims: $_____
Less Claims Paid Outside Aggregate Contract: $_____
Less Aggregate Deductible: $_____
Less Refunds/Voids: $_____
Less Previous Monthly Accommodations: $_____
Reimbursement Due Group: $_____
Refund Due Carrier: $_____

Signed: _____

Title: _____

Date: _____ Phone #: _____ Fax #: _____ Email: _____

PLEASE PROVIDE THE FOLLOWING TO AVOID DELAY:

1. Paid Claims Analysis Report showing name of claimant, incurred date, charge, payment amount and date, claim #, ICD9/ICD10, CPT code
2. Eligibility listing which identifies birth date, effective date, termination date and coverage type
3. Proof of Funding. This must include monthly bank statements and/or deposit slips
4. Void/Refund report
5. Benefit/Service Code report
6. Aggregate Report – Monthly Loss Summary Report
7. Specific Report showing claimants have exceeded the Specific Deductible/Loss Limit
8. Payments made outside the Aggregate Contract (i.e. Dental, Weekly Income, Vision, PPO Fees, Medical Records Fees, Rx Admin.)
9. Year to Date Check Register
10. Outstanding overpayments and subrogation issues
11. Detailed Rx Itemizations and Invoices (if covered under Aggregate)

Aggregate Claim Request Form

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SUPPLEMENT G: MONTHLY AGGREGATE ACCOMMODATION FORM

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Kismet Risk Management Associates
Aggregate Excess Activity Summary

(Submit monthly to Kismet Risk Management Associates)
E-mail: potentials@kismetrisk.com

Insured: _____

Policy Period: _____ Basis: _____ Specific Deductible: $ _____

Administrator: _____

Coverage(s): Medical: X Dental: _____ Vision: _____ Rx Card: _____

Other: _____

Minimum Aggregate Retention: $ _____

Aggregate Retention Factors: Single[1]: $ _____ Family[2]: $ _____ Composite[3]: $ _____ Other: $ _____

Census X Factors							Loss Fund		Total Paid Claims	
Month	Single Census	Single [1]	Family Census	Family [2]	Total Census	Composite [3]	Month	Accumulative[B]	Month	Accumulative[A]
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$
						$				$

Aggregate Claim Calculation

Paid Claims Year-to-Date[A]: $ _____

Specific Excess Claims: (_____)

Net Claims: $ _____

Aggregate Deductible[B]: (_____)

Aggregate Excess: $ _____

Signed: _____ Title: _____ Date: _____

Phone #: _____ Fax#: _____ Email: _____

Aggregate Excess Activity Summary Form

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