Dear Valued Customer,

Please take a few minutes to review the following documents for your claims kit. It provides instructions for identifying and reporting specific and aggregate claim informatino to Innovative Stop Loss Solutions as well as information relative to expediated reimbursements.

General Information and Instructions

Filing Deadlines: All requests for reimbursement for specific claims should be filed within 30 days of the known loss. Aggregate claims ora ccommodations should be filed within 30 days of the accommodation month or end of the policy period. In no event will ISLS reimburse claims submitted more than one year after the Expiration Date of the policy.

Delivery Method

ISLS recommends ACH for all claim reimbursements. This allows for the safest and fastest mothod of reimbursement to our mutual clients. Please see the ACH form included within this kit. If there is a claim refund due back to ISLS, please forward to the attention of our Accounting Department at the following mailing address:

Innovative Stop Loss Solutions
1 City Center, Suite 4155
Portland, ME 01401

All reporting, including monthly aggregate reports, trigger and clinical notifications, and specific and aggregate claims, should be sent to the following email address: claims@getisls.com.

All reporting, including monthly aggregate reports, trigger and clinical notifications, and specific and aggregate claims, should be sent to the following email address:

The following information is included within this kit:

Specific Coverage

- Notification – Form
- ICD-10 Codes for Trigger Notification
- Standard requirements for Specific claim submission
- Request for remibursement – Form
- Specific Advanced Funding information

Aggregate Coverage

- Standard requiremtns for Aggregate Accommodation and Aggregate claim submission
- Aggregate Claim Submission – Form
- Aggregate Report – Sample Form

Please contact us with any questions or concerns you may have. We look forward to our continued relationship with you.

Peggy Richardson
Vice President, Claims
1-260-438-9497
peggy.richardson@getisls.com
getisls.com

Innovative Stop Loss Solutions

Notification Form

Policyholder:

Specific Deductible: Contract: Policy Year:

Employee: Employee D.O.B: Employee ID#:

Claimant: Relationship to employee: Claimant D.O.B:

Active: ☐ Yes ☐ No If "No" termination date:

COBRA: ☐ Yes ☐ No If "Yes" effective date:

Retiree: ☐ Yes ☐ No If "Yes" effective date:

Medicare: ☐ Yes ☐ No If "Yes" effective date:

Is the claimant covered under any other Insurance? If ☐ Yes ☐ No

yes, please describe:

Date claim incurred: Subrogation applicable? ☐ Yes ☐ No

If injury, please describe:

Has Large Case Management been initiated? ☐ Yes ☐ No Name of LCM Firm:

Primary Diagnosis ICD-10 Code:

Secondary Diagnosis ICD-10 Code:

Prognosis:

Total claims paid to date: Estimated future claims:

Is the provider in a Network? ☐ Yes ☐ No Network:

Additional comments:

TPA/Company name:

Address:

Contact: Title:

Phone: Ext:

Email: Fax:

Signature: Date:

This form may be used for trigger diagnosis, early/potential notices, or 50% notices. Any questions regarding the use of this please reach out to us.
Please send to: claims@getisls.com

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ICD-10-CM Diagnosis Codes for Disclosure Notification

This list should be referred to for completion of trigger notifications. Please send notice for all plan participants who have been diagnosed or treated for any of the code ranges listed under the following categories:

A00-B99 Certain infectious and parasitic disease

A40	Streptococcal sepsis
A41	Other Sepsis
B15-B19	Viral hepatitis
B20	Human immunodeficiency virus [HIV] disease

C00-D49 Neoplasms

C00-C96	Malignant neoplasms
D46	Myelodysplastic syndromes

D50-D89 Diseases of the blood and blood-forming organs & disorders involving the immune mechanism

D57	Sickle-cell disorders
D59	Acquired hemolytic anemia
D60-D64	Aplastic and other anemias
D65-D69	Coagulation defects, purpura and other hemorrhagic conditions
D70-D77	Other diseases of blood and blood-forming organs
D80-D89	Certain disorders involving the immune mechanism

E00-E89 Endocrine, nutritional and metabolic diseases

E10-E13	Diabetes mellitus
E15-E16	Other disorders of glucose regulation and pancreatic internal secretion
E65-E68	Obesity and other hyper alimentation
E70-E89	Metabolic disorders

F01-F99 Mental, Behavioral and Neurodevelopmental disorders

F10.1	Alcohol Abuse
F11.1	Opioid Abuse
F20	Schizophrenia
F31	Bipolar Disorder
F32.3	Major depressive disorder, single episode, severe with psychotic feature
F33.1-F33.3	Major Depressive Disorder, recurrent
F84.0	Autistic Disorder
F84.2	Rett's Syndrome
F84.5	Asperger's syndrome

G00-99 Diseases of the nervous system

G00	Bacterial Meningitis
G04	Encephalitis Myelitis and Encephalomyelitis.
G06-G07	Intracranial and intraspinal abscess and granuloma
G12.21	Amyotrophic Lateral Sclerosis
G35	Multiple Sclerosis
G36	Other Acute Disseminated Demyelination
G37	Other Demyelinating disease of central nervous system
G82.5	Quadraplegia
G83.4	Cauda Equina Syndrome
G92	Toxic Encephalopathy
G93.1	Anoxic Brain Injury

I00-I99 Diseases of Circulatory System

I20	Angina Pectoris
I21.09-I22	Acute myocardial infarction
I24	Acute and Subacute Ischemic Heart Disease
I25	Chronic ischemic heart disease
I26	Pulmonary embolism
I27	Other pulmonary heart disease
I28	Other diseases of pulmonary vessels
I33	Acute & Subacute Endocarditis
I34-I38	Heart Valve Disorders
I42-I43	Cardiomyopathy
I44-I45	Conduction Disorders
I46	Cardiac Arrest
I47-I49	Cardiac Dysrhythmias
I50	Heart Failure
I60-161	Subarachnoid Hemorrhage / Intercerebral Hemorrhage
I63	Cerebral infarction
I65.8-I66	Occlusion of Precerebral /Cerebral Arteries
I67	Other cerebrovascular disease
I70	Atherosclerosis / Aortic Aneurysm

J00-J99	**Diseases of Respiratory System**
J40-J44	Chronic Obstructive Pulmonary Disease (COPD)
J84.10-J84.89	Postinflammatory Pulmonary Fibrosis
J98.11-J98.4	Pulmonary Collapse / Respiratory Failure

K00-K95	**Diseases of Digestive System**
K22	Esophageal obstruction
K25-K28	Ulcers
K31	Other diseases of stomach & duodenum
K50	Crohn's disease
K51	Ulcerative colitis
K55-K64	Diseases of intestine
K65-K68	Diseases of peritoneum & retroperitoneum
K70-K77	Diseases of liver
K83	Diseases of biliary tract
K85-K86	Diseases of pancreatitis
K90-K95	Other diseases of digestive system/Complications of bariatric procedures

M00-M99	**Diseases of Musculoskeletal System & Connective Tissue**
M15-M19	Osteoarthritis
M32	Systemic lupus erythematosus
M34	Systemic sclerosis
M41	Scoliosis
M43	Spondylolysis
M50	Cervical disc disorders
M51	Thoracic, thoracolumbar & lumbosacral intervertebral disc disorders
M72.6	Necrotizing Fasciitis
M86	Osteomyelitis

N00-N99	**Diseases of the Genitourinary System**
N00-N01	Acute and Rapidly Progressive Nephritic Syndrome
N03	Chronic Nephritic Syndrome
N04	Nephrotic Syndrome
N05-N07	Nephritis and Nephropathy
N08	Glomerular Disorders classified elsewhere
N17	Acute Kidney Failure
N18	Chronic Kidney Disease (CKD)
N19	Renal Failure, Unspecified

O00-O9A	**Pregnancy, childbirth and the puerperium**
O09	High Risk Pregnancy
O11	Pre-Existing Hypertension with Pre-Eclampsia
O14-O15	Pre-Eclampsia and Eclampsia
O30	Multiple Gestation
O31	Other complications specific to Multiple Gestations

P00-P96	**Certain conditions originating in the perinatal period**
P07	Disorders of newborn related to short gestation and low birth weight
P10- P15	Birth Trauma
P19	Fetal distress
P23-P28	Other respiratory conditions of newborn
P29	Cardiovascular disorders originating in the perinatal period
P36	Bacterial sepsis of newborn
P52-P53	Intracranial hemorrhage of newborn
P77	Necrotizing enterocolitis of newborn
P91	Other disturbances of cerebral status newborn

Q00-Q99	**Congenital malformations, deformations and chromosomal abnormalities**
Q00-Q07	Congenital malformations of the nervous system
Q20- Q26	Congenital Cardiac malformations
Q41-Q45	Congenital Anomalies of Digestive system
Q85	Phakomatoses, not classified elsewhere
Q87	Congenital malformation syndromes affecting multiple systems
Q89	Other Congenital malformations

R00-R99	**Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified**
R07.1-R07.9	Chest Pain
R40-R40.236	Coma
R57-R58	Shock, Hemorrhage
R65.2-R65.21	Severe sepsis

S00-T88	Injury, Poisoning and Certain Other Consequences of External Causes
S02	Fracture of skull and facial bones
S06	Intracranial injury
S07	Crush injury to head
S08	Avulsion and traumatic amputation of part of head
S12-S13	Fracture and injuries of cervical vertebra and other parts of neck
S14.0-S14.15	Injury of nerves and spinal cord at neck level
S22.0	Fracture of thoracic vertebra
S24	Injury of nerves and spinal cord at thorax level
S25	Injury of blood vessels of thorax
S26	Injury of heart
S32.0-S32.2	Fracture of lumbar vertebra
S34	Injury of lumbar and sacral spinal cord and nerves
S35	Injury of blood vessels at abdomen, lower back and pelvis
S36-S37	Injury of intra-abdominal organs
S48	Traumatic amputation of shoulder and upper arm
S58	Traumatic amputation of elbow and forearm
S68.4-S68.7	Traumatic amputation of hand at wrist level
S78	Traumatic amputation of hip and thigh
S88	Traumatic amputation of lower leg
S98	Traumatic amputation of ankle and foot
T30-T32	Burns and corrosions of multiple body regions
T81.11-T81.12	Postprocedural cardiogenic and septic shock
T82	Complications of cardiac and vascular prosthetic devices, implants and grafts
T83-T85	Complications of prosthetic devices, implants and grafts
T86	Complications of transplanted organs and tissue
T87	Complications to reattachment and amputation

Z00-Z99	Factors Influencing Health Status and Contact with Health Services
Z37.5-Z37.6	Multiple births
Z38.3-Z38.8	Multiple births
Z48-Z48.298	Encounter for aftercare following organ transplant
Z49	Encounter for care involving renal dialysis
Z94	Transplanted organ and tissue status
Z95	Presence of cardiac and vascular implants and grafts
Z98.85	Transplanted organ removal status
Z99.1	Dependence on respirator
Z99.2	Dependence on dialysis

Standard Requirements for Specific Claim Submission

Eligibility:

- **Employee's dated enrollment form** which must include original effective date of coverage, date of hire, listing of all dependents covered, and employee's signature.
- **Continued eligibility** including documentation of how the employee remained covered under the provisions of the Plan Document while out of work because of but not limited to vacation time, sick time, FMLA, and the like.
- **COBRA Election Form** which must also include date of the qualifying event, date of election, effective date, and proof of COBRA premium payments in the form of copies of checks.
- **Documentation of the coordination of benefits** f the claim is for a dependent, along with any other health insurance coverage and effect on the order of benefits as determined.

Documentation regarding investigation results:

- **Subrogation**, which includes details of accident, police report if applicable, signed subrogation agreement, all attorney correspondence, Worker's Compensation

Forms and more - Include the following with your claim submission:

- **Request for reimbursement form**, fully completed, signed and dated
- **Ancillary provider bills** in excess of $100,000
- **Paid claim detail report** which must include incurred dates, paid dates, claim number, provider, billed amounts, all deductions (such as PPO discounts, co-pays, coinsurance, deductibles, etc.), and net paid amounts
- **Pre-certification documentation and copies of all UB92 forms for hospital bills** in excess of $250,000
- **Large Case Management reports**

NOTE: These requirements apply to most specific claim submissions. Additional information may be requested to complete the review of the claim. This can include, but is not limited to, itemized invoices, semi-private room rates, proof of funding, medical records, usual & customary calculations, transplant repricing sheets, etc. These additional items will be requested as identified by ISLS.

Please send all claim submissions to: claims@getisls.com.

Innovative Stop Loss Solutions

claims@getisls.com

Request for Reimbursement

☐ Initial Claim ☐ Supplemental Claim # ☐ Advanced Claim ☐ Other

Employer name:

Policy number: Policy period: Plan type:

Employee name: Employee ID: Employee D.O.B.:

Employee effective date: Hire date: Termination date:

Last day worked: COBRA date: Premium paid to:

Current status: Lifetime maximum paid to date:

Claimant name: Claimant D.O.B.: Relationship:

Claimant effective date:

Diagnosis/ICD-10:

Prognosis:

Case Management ☐ Yes ☐ No Vendor:

Total amount paid last year	
Total eligible benefits this submission	
Less specific deductible	
Balance	
Percent to be reimbursed	
Reimbursement requested	
Estimated future liability	

Your reimbursement request should include the following information (if applicable)*:

☐ Enrollment form (initial/current)
☐ COBRA election form/payments
☐ EOBs/claim detail report
☐ Deductible/coinsurance proof
☐ Continued eligibility
☐ Precertification forms
☐ Hospital bills over $250,000
☐ Ancillary bills over $100,000
☐ Worker compensation
☐ Coordination of benefits
☐ Pre-Existing
☐ LCM reports
☐ Subrogation
☐ Accident details/police reports

* Additional information may be required depending upon the nature of the claim request.

TPA/Company name:

Address:

Contact: Title:

Phone: Ext.:

Email: Fax:

Authorized signature Date:

I certify that the above information is correct and that the claims have been paid in accordance with the plan document.

Specific Advanced Funding

The "Specific Advanced Funding" product is standard in all cases for ISLS clients. Under Advanced Funding, specific reimbursement is available to the policyholder for eligible expenses upon meeting the following requirements:

- The specific deductible must be paid in full by the policyholder prior to any claims being considered for Advanced Funding. Payment of the Specific Deductible must be made at least ten (10) business days prior to the end of the Specific Benefit Period.
- The claim amount must be equal to or greater than $1,000.
- Claims submitted for Advanced Funding must have been fully processed according to the terms of the Plan by the Administrator and must be ready for payment.
- Normal Specific claim audit procedures will be implemented prior to any checks being issued by ISLS.
- The employer's payment for Eligible Expenses must be released to the provider within five (5) days of receiving the reimbursement check from ISLS. If these payments are not made within five (5) business days, the reimbursement check must be returned to ISLS.
- Any portion of the reimbursement check not used to reimburse Eligible Expenses, due to additional discounts or any other reason, must be returned to ISLS within five (5) business days.
- All initial or subsequent Advanced Funding claim requests must be received by the Company ten (10) business days prior to the end of the Specific Benefit Period. Any requests received after that date are not eligible for Advanced Funding and therefore, must be fully Paid by the Plan in order to be eligible for reimbursement under this policy.

Subject in all other respects to the policy terms, conditions and limitations.

Standard Requirements for Aggregate Claim Submission

The following listing is required for all Aggregate claims. Requirement for Aggregate Accommodations are identified with a designated (A). Some aggregate claims will be audited by a contracted outside auditor. You will be notified of those situations and additional information may be requested for those audits. The standard information is as follows:

- A completed Aggregate Claim Submission Form (A)
- Final or Monthly Aggregate Report (A)
- Attachment point calculation (A)
- Check register
- Paid Claim Detail Report (A) – Should include the following information:
    - Claimant name
    - Claim number
    - Billed Amount
    - PPO Discounts
    - Employee Responsibility (coinsurance, co-pay, or deductibles)
    - Any Other Deductions
    - Paid Amount
    - Provider name
    - Incurred dates of service
    - Paid date
- Rx Detail Report by Claimant with drug name listed, ingredient cost, dispensing fee, co-pays, and any administrative fees (A)
- Rx Invoices that support the amount submitted under the aggregate
- Schedule of Rx Rebates – even if the group isn't the ultimate recipient. Rebates are refunds and not reimbursed per the policy. An estimate of 15% of Paid Rx Claims can be used in lieu of actual rebates if not yet known. (A)
- Benefit Code Analysis (A)
- Policy year eligibility listing with effective dates, term dates and COBRA status
- Bank Statements – to show proof of adequate claim funding throughout the policy period
- Calculation of specific claims (A)
- Voids/Refunds/Reissued Claims
- Outstanding over-payments
- Description of the funding process and any vendors used to issue payment
- Listing of any subrogation cases pertaining to the policy period

A = Required for aggregate accommodation. At the end of the policy period, all accommodations are subject to a complete audit.

Please send to: claims@getisls.com.

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Aggregate Claim Submission Form

Carrier:

Employer Name:

Policy Period:

Total Paid Claims Under the Policy:	
Less: Specific Claims Paid or Payable:	
Less: Ineligible or Extra-Contractual Claims:	
Less: Refunds, Recoveries, and Voids:	
Less: Outstanding Overpayments:	
Less: Any Other deductions:	
Less: Attachment Point (will be the higher of the Minimum Attachment Point* or the Year-to-date attachment point):	
Less: Any previous advancement/accommodations:	
Amount Requested:	

*Refer to policy for definition of Minimum Attachment Point

Completed by: Completed Date:

Phone: Email:

Please send to: claims@getisls.com

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Innovative Stop Loss Solutions SAMPLE MONTHLY AGGREGATE REPORT

TPA:

MINIMUM ATTACHMENT POINT:

CARRIER:

MONTHLY AGGREGATE FACTOR: Single Family Composite

POLICYHOLDER:

AGGREGATE CONTRACT BASIS:

AGGREGATE PERIOD:

COVERAGES: Med Rx Dental Other

Month & Year	# Single	# Family	Monthly Aggregate Attachment Point	Year to Date Aggregate Attachment Point	Gross Monthly Paid Claims	Gross Year To Date Paid Claims	Out of Contract Payments	Adjustments: Void or Returned Checks	Specific Excess Claim Payments	Net Adjusted Monthly Paid Claims	Year to Date % Over / Under Agg. Att. Pt.

*Please indicate the % of Claims vs. the Aggregate Attachment Point in the last column

Please submit all monthly aggregate reports to: claims@getisls.com

Innovative Stop Loss Solutions
Primary Contacts

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