SKYWARD SPECIALTY INSURANCE | Accident & Health

STOP-LOSS ADMINISTRATIVE GUIDE

Stop-Loss Administrative Guide

The purpose of this Administrative Guide is to assist the TPA or Claims Administrator in complying with Skyward Accident & Health's stop-loss policy requirements and obligations, including claim notification procedures, Specific and Aggregate claim filing requirements, Premium Remittance policies and other reporting requirements.

Our goal is to furnish information pertaining to the medical stop-loss provided to our mutual client. Being an administrator of a self-funded plan, you have the responsibility to adhere to the plan/policy and it is important that there is consistent and effective communication between your company and Skyward A&H. This information is provided to you as a guide. We suggest you provide this guide to any staff member that is involved with the self-funded administration.

This guide is intended to supplement the excess loss policy and does not replace or change any policy provisions. Should this guide conflict with any state laws or regulations, such law or regulation will take precedence.

Table of Contents

All Skyward A&H forms can be accessed at www.skywardinsurance.com/Resources/Agents-Resources/

Contact Sheet

For all premium correspondence, including completed worksheets for EFT payments, please use the following email address:

premiumaccounting@skywardinsurance.com

Send all claim submissions and reports (including electronic submissions) to:

ah-specific@skywardinsurance.com

ah-aggregate@skywardinsurance.com

ah-notification@skywardinsurance.com

Mike Remeika
Divisional President of Accident & Health
678-661-4634
mremeika@skywardinsurance.com

Kent Wedeven
Director of Finance
770-701-2659
kwedeven@skywardinsurance.com

Julie Bobak
Chief Underwriting Officer
239-350-2989
jbobak@skywardinsurance.com

Julie Dorweiler
Vice President Claims
763-265-9826
jdorweiler@skywardinsurance.com

Kimberly Welding
Vice President of Compliance
317-829-7275
kwelding@skywardinsurance.com

Robert Hill (FTP Site Contact)
Business Analyst
770-701-2588
rhill@skywardinsurance.com

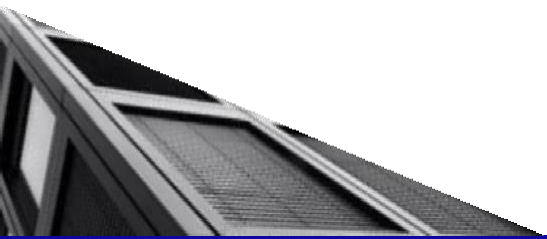
Skyward Accident & Health Offices

Kennesaw, GA
600 TownPark Lane, Suite 500
Kennesaw, GA 30144
Phone: 770.993.3420
Fax: 770.933.3419

Dallas, TX
14911 Quorum Drive, Suite 310
Dallas, TX 75254
Phone: 972.587.4074

Wakefield, MA
401 Edgewater Place, Suite 125-130
Wakefield, MA 01800
Phone: 888.658.3350
Fax: 888.340.4577

Minnetonka, MN
13100 Wayzata Blvd, Suite 340
Minnetonka, MN 55305
Phone: 952.666.6190



Introduction

Skyward Accident & Health is a leading provider of medical stop-loss, bringing creative stop-loss solutions to Third Party Administrators, Brokers and Consultants, through a variety of flexible stop-loss options.

Skyward A&H is led by a team of innovative specialty insurance professionals with decades of experience. Our leaders know all aspects of this business, which has shaped their vision and determination to make Skyward A&H the place where customers and partners want to bring their business. Owned by Skyward Specialty Insurance, Skyward A&H is a direct writer of medical stop-loss for employer groups and Taft-Hartley trusts that self-fund their medical benefits.

Skyward A&H writes stop-loss on Great Midwest Insurance Company (GMIC), a wholly-owned subsidiary of Skyward Specialty Insurance and rated A-(Excellent) by A.M. Best. We underwrite specific and aggregate stop-loss, issue policies, bill and collect premiums, help our partners manage large catastrophic losses, adjudicate claims and disburse both claim and commission payments. Our approach to underwriting is to be flexible, competitive, collaborative and client-centric. We provide direct access to a dedicated team of professionals as well as our executive decision-makers.

We sincerely thank you for being a valued partner of Skyward A&H. It is our goal as an organization to meet and exceed your expectations because we truly value our relationship and your business. Every client and policyholder is important to us regardless of the size.

If you have questions or need information that is not addressed in this document, please contact us.

Premium Accounting

Premium Payments

Premium Remittance Report forms are available for your convenience to report monthly enrollment, premium calculations, and total premium payable. Customized premium reporting forms are acceptable as long as they provide the following information:

- Group name and policy year and number
- 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 payments should be sent via **ACH/Wire Transfer**

ACH/Wire Transfer Information:
Detailed ACH/Wire Transfer info can be requested by sending an email to premiumaccounting@skywardinsurance.com

Email Address for Premium Remittance Form:

premiumaccounting@skywardinsurance.com

Premium Adjustments

We calculate premium for complete months only, no pro-rating.
Premiums are payable for the first month if the member's effective date is between the 1st and the 15th of the month.
For example:

- If the member's coverage is effective on any day between January 1-15, premiums are payable as of January 1.
- If the member's coverage is effective January 16-31, premiums are payable as of February 1.

Premiums are payable for the last month if the member's termination date is after the 15th of the month.
For example:

- If the member's coverage is terminated on any day between December 1-15, premiums are payable through November.
- If the member's coverage is terminated on December 16-31, premiums are payable for the month of December.

Positive retro adjustments for members that were inadvertently missed from the billing or added to the plan but not paid for, need to be paid for back to the beginning of their enrollment/effective date.

Negative retro premium adjustments are allowed back to the effective date of the in-force policy.

Late Premium Procedures

Premium payments are due on the first day of each month. Premiums are considered past due if not received by Skyward A&H by the end of the grace period (either 30 or 31 days) as outlined in the stop-loss policy. If premiums are not received by the end of the grace period, all coverage automatically terminates as of the premium due date.

As a matter of courtesy, Skyward A&H will notify TPAs (which is also deemed as notice to the policyholder) that premium is past due and that the policy has been terminated in accordance with policy provisions. This late pay notification does not extend the grace period and coverage may be terminated whether or not such letter is produced. The acceptance of any premium due beyond the grace period does not establish a precedent for acceptance of any future premiums received after the grace period expires. Acceptance of premium after the grace period is at the sole discretion of Skyward A&H.

The policyholder may be permitted to apply for reinstatement by submitting any forms, data or other requirements requested by Skyward A&H, including but not limited to, updated claims data through the date of the request for reinstatement and payment of any and all past due premiums.

Skyward A&H has the right to re-underwrite the terms of the stop-loss coverage based on the updated information provided if reinstatement is granted.

Any notification or warning letters are produced as a courtesy and are not a requirement under the policy provisions.

If the policy terminates for any reason, the policyholder is responsible for all premiums up to the date of termination.

Licensing, Appointments and Commissions

All producers, agents/agencies, sub-agents and soliciting TPAs, must be licensed and appointed in order to market stop-loss coverage, solicit stop-loss coverage and receive commissions through Skyward A&H. All entities involved in the sale of stop-loss coverage through Skyward A&H must complete and sign a Producer Agreement. They must also provide proof of current E&O coverage, Fidelity Bond coverage and a W-9.

Procedures for Appointment Process

- Complete the Producer Agreement which is an agreement between Skyward A&H and the producer.
- Complete a W-9 Form for the producer/agency, regardless of receiving commissions.
- Submit to Skyward A&H, the signed Producer Agreement, the declaration page for the current E&O policy, the declaration page for the current Fidelity Bond Policy and a current W-9. Skyward A&H will notify the producer/agency of appointment approval by providing an executed (countersigned) copy of the Producer Agreement.
- Producer entities located in CT, WV or FL will need to provide resident license(s) as well as licenses for states in which the producer entity has business with Skyward A&H. Individual agents soliciting business on behalf of any producer entity located in CT, WV or FL must provide resident license(s) as well as any other state licenses in which the individual wishes to be appointed. License copies are not required for any other states.
- Commissions will not be released by Skyward A&H until the appointment process has been successfully completed.

Commission Payments

Skyward A&H sends commission payments via ACH-Direct Deposit instead of issuing a check.
Benefits include the following:

- Improved Controls – No lost or stolen checks
- Prompt Payments – Deposit made directly to the designated bank account
- Detailed Commission Statement

Information will be provided to enroll in ACH for commission payments.

TPA Approval Process

Skyward A&H has a process for approving the Third-Party Administrators (TPA's) that administer the claims for the groups to which we issue policies. This process helps us gain an understanding of the TPA's policies regarding claims payment, disaster recovery procedures and insurance coverages to protect the group.

The TPA approval process must be completed before a policy can be issued. The following items are required:

- Completed SIIA questionnaire with attachments, updated through current.
- Copy of most current proof of E&O insurance and fidelity bond/crime/employee dishonesty.
- Copy of Disaster Recovery Plan.

Skyward A&H will notify the TPA upon initial approval. The TPA will be contacted annually to obtain updated E&O, Fidelity Bond and licensing and appointment information.

NOTE: Evidence of renewals (E&O, Fidelity Bond, TPA & producer licenses) will be required as appropriate.

Applications & Schedules

Schedule of Excess Loss Reinsurance

The Schedule of Excess Loss Reinsurance is a schedule of the terms of the policy. This schedule indicates: **The effective date of coverage and the termination date of coverage.** Please note that the specific dates as well as the aggregate dates may vary. The Benefit Period is the contract basis and defines the first and last date a claim can be incurred and the first and last date a claim can be paid/funded by the employer plan.

Aggregate Excess Loss Reinsurance

This section of the schedule identifies whether aggregate coverage was purchased and the type of claims that are eligible under this coverage. Lines of coverage that are available under aggregate (if selected at the time of underwriting) may include medical, dental, RX card, vision and short-term disability. It is important to be aware of the lines of coverage when calculating aggregate data. Rates for such coverage are identified in the schedule.

In addition, the schedule identifies the retention factors that must be used in calculating the monthly and yearly aggregate retention amount. At the time of underwriting, the **minimum** yearly aggregate retention amount is the annual aggregate deductible. The actual aggregate retention may vary throughout the year with enrollment. The actual retention amount is calculated by multiplying the monthly number of lives (single, family, composite, etc.) by the respective factors. If enrollment increases during the year, the calculated retention amount will increase. The minimum is just that; the aggregate retention amount will never fall below the minimum but can increase if enrollment increases.

The Aggregate section of the schedule may also include the dollar amount that may be included in run-in claims prior to the inception date. This is determined at the time of underwriting.

The reinsurer will reimburse the plan a percentage of covered benefits paid under your plan, subject to all terms and conditions of the policy. As previously stated, reimbursement is based on the expense payment period, aggregate retention amount, aggregate maximum limit, specific retention amount per covered person. This information is shown in the schedule.

Specific Excess Loss Reinsurance

This section of the schedule identifies the amount of the specific retention amount for any one eligible claimant. It also identifies the lines of coverage, rates and the reinsurers maximum liability per claimant.

If a particular member of the plan has a higher, separate deductible (aka laser), this person is identified and the applicable Specific Deductible is imposed.

It is important to remember that any claimant (member) must meet all eligibility requirements of the plan. Claims in excess of the group's specific deductible do not accumulate towards the aggregate attachment point (deductible).

The reinsurer will reimburse the plan a percentage of covered benefits under the plan, subject to all terms and conditions of the policy, to the extent such payments are incurred during the incurred contract basis, are paid in the paid contract basis and exceed the specific retention amount.

Claims Administration

In this section we will discuss the Claims Administrator's responsibilities for providing information to Skyward A&H pertaining to notifications and claim reimbursement submissions. Just as a first-dollar payer has the responsibility to follow contracts when adjudicating claims, Skyward A&H's responsibility is to validate those determinations. This should never be construed as adversarial.

The information we request is standard information that has been requested in this industry for decades. We are not questioning the ability of the Claims Administrator. We simply require information to substantiate determinations. An important responsibility of the Claims Administrator for an employer sponsored benefit plan, which includes a Specific Excess Loss contract, is the timely notification to Skyward A&H of any claimant who may have a potentially large claim.

Notification & Reporting Requirements (Specific and Aggregate)

1. SPECIFIC COVERAGE

The Excess Loss policyrequires that Skyward A&H be notified of potential large claims within 10 days of the policyholder or its TPAreceiving any information that a claim is potentially catastrophic. Initial notification must be provided in writing (e-mail, report, letter, etc.) to the Skyward A&H office in accordance with the stop-loss contract. Emails should be sent to ah-notification@skywardinsurance.com.

Timely notification of potential large claims provides the opportunity for Skyward A&H to offer resources that can assist the TPA and policyholder in managing claim dollars.

The TPA and/or policyholder must notify Skyward A&H of a large claim or potentially large claim that is expected to exceed the Specific Deductible. Examples of which may include but are not limited to:

- Claim exceeds 50% of the specific deductible
- Large case management is initiated
- Claimant is diagnosed with an ICD-10 code listed in the addendum

Prospective Claim Notification Form

Requirements apply to incurred, paid and/or pended claims.

There are two simple ways to identify potentially large claimants:

a. By Diagnosis

Identification of a potential large claim can be made through a request for eligibility or benefit verification for a serious diagnosis, through the process of pre-admission certification, utilization review or large case management. Such potential claims can also be identified by review of the claim and diagnosis when the claim is submitted for adjudication. If pre-admission certification, utilization review or large case management is performed by a third-party, please advise the contracted medical management firm of the importance of receiving immediate notification of an admission, outpatient procedure or request for sub-acute care.

b. By Amount Paid

The terms of the Excess Loss contract require that you provide written notice of a claim when a claim reaches 50% of the specific retention amount and/or (if required for a specific diagnosis) within 20 days of the date of the loss for which a claim is made (or as soon as is reasonably possible).
***Written proof of loss must be given to the Skyward A&H within ninety (90) days of such loss**.*

To begin the process of notification to Skyward A&H, the following information needs to be submitted:

- The group name
- The effective date of the Excess Loss policy in which the submission is in relation to
- The employee name, date of birth, effective date for coverage, SS# or their own identification number
- Claimant name, date of birth, relationship to employee
- Other insurance
- Primary diagnosis
- Prognosis
- Claims amounts; paid, pending or denied

We are providing forms for your use. However, if you are able to supply the required information in your own format, that would be acceptable.

The reason Skyward A&H requires this information is to properly reserve this case for the potential cost during the applicable policy period. In order for Skyward A&H to properly evaluate the notification, the above information is needed. We also appreciate additional details such as secondary diagnosis, prognosis, accident details, clinical information or case management reports. If during our review we believe we can assist in cost containment, we will contact you to discuss.

Please remember that we are in this together and it is our joint responsibility to ensure that the ultimate client, the self-funded plan, is properly reimbursed for claims that are in fact the plan's liability.

2. AGGREGATE COVERAGE

If the policyholder has purchased Aggregate coverage, the TPA must provide Skyward A&H with an Aggregate report on a monthly basis following the completion of each month. The report must include monthly and cumulative eligible paid claims totals and enrollment separated by covered benefit under the aggregate, if enrollment differs.

Catastrophic Trigger Conditions

A reference guide of some sample conditions and procedures that might result in a large claim are outlined in the Trigger diagnosis list *(Guide to Identifying Trigger Diagnosis)*. These conditions tend to be chronic, require extensive ongoing treatment, hospitalization, case management and/or high-cost medications.

Trigger Diagnosis List

Administrators are required to notify Skyward A&H of potentially large claimants who are diagnosed with any of the following conditions or are receiving any of the listed types of care or recommended for any of the listed procedures. To assist in the identification of potential large claims, the following list is provided.

Accidents	Head & spinal cord injury; burns requiring hospitalization; 2nd or 3rd degree covering 10% or more of the body; traumatic head/brain injury/ spinal cord injury; multiple crushing injuries and/or fractures
AIDS/HIV/related disorders amputations (major extremities) **blood disorders**	Aplastic anemia; hemophilia; thrombosis anemia; hemophilia; thrombocytopenia
Cancer	
Cardiac	Cardiomyopathy; congestive heart failure
Cerebral vascular accident congenital defects	Brain; spinal cord; nervous system vessels; kidney chromosome cystic fibrosis cerebral palsy
Diabetes mellitus (with complications) **Gene therapy growth hormone therapy Infectious diseases**	Tuberculosis; septicemia; bacterial meningitis; osteomyelitis
Hospital stays	14 days or more; multiple admissions in a 12-month period
IV therapy	Enzyme replacement home I.V. therapy antibiotic therapy; TPN/TPA
Kidney failure (end-stage renal disease)	Dialysis
Mechanical assistance dependency	Apnea monitors; ventilators; ventricular assist device; any other conditions requiring mechanical assistance to sustain life
Newborn with complications	Extreme immaturity; birth trauma; respiratory distress or disorders; congenital anomalies
Neurological complications	Amyotrophic lateral sclerosis (ALS); Muscular dystrophy; stroke; multiple sclerosis (MS)
Obstetrical complications	High-risk pregnancies; expected multiple birth (of 3 or more infants)
Psychiatric (resulting in hospital confinement)	
Severe respiratory conditions sickle cell anemia	
Transplants	Major organs; bone marrow; stem cell; any complications thereof/post transplant patients
Other	Patients in Medical Case Management; patients requiring skilled nursing facilities, home health care, hospice, daily private nursing; fibromyalgia and other fatigue/stress conditions; chronic pain management; interim hospital billings; intensive levels of home health care supplies and/or service

Other Large Claims and 50% of the Specific Deductible

Regardless of the medical condition, we must be notified of the following:

- When a claimant reaches 50% of the Specific Deductible
- Hospital inpatient stays of 7 days or greater
- Multiple hospital admissions
- Complications of surgery
- Treatment with Specialty Rx that cost more than $5,000/month

Potential Conditions to Case Manage

The following instances should be investigated for case management and cost containment:

- All transplants
- Premature births
- Drug infusion therapy
- Trauma/ multiple injuries
- Home ventilator
- Complex wound care
- Combination chemotherapy regimens
- Implanted devices
- Bleeding disorder
- Interim billings
- Home health care greater than 20 days
- Hyper alimentation/TPN or home IV antibiotics
- Initiation of dialysis (home or outpatient)
- Initiation of chemotherapy
- High-risk pregnancy (multiple births)
- Length of stay request more than 7 days
- Hospital acquired conditions
- Spinal fusion or complex spinal surgery
- Mental disorders requiring acute hospitalization
- Treatment at Cancer Treatment Centers of America
- Multiple hospitalizations of 3 or more per year
- Substance abuse hospitalization or residential care

The procedures listed below are Key Indicators of potential catastrophic claims:

Procedure	ICD-10 Procedure Code	CPT Code
Craniotomy	00J00ZZ	61304 - 61305
Hyperbaric oxygenation	0NH0352	99183
Plasmapheresis (Apheresis)	6A55023	36520 - 36521
Laryngectomy/radical neck dissection	0CTS0ZZ	31360 - 31382
Tracheostomy	0B110F4	31600 - 31605
Implant cardiac assist device	02HA0RS	33975
Dialysis	5AID00Z	90935, 90937, 90945-90947
Pancreatectomy	6F7D0ZZ	48154
Ventilator patient greater than 4 days	5A19552	94656 - 94657
Insertion shunt/fistula	03130JD	36821
TPN (Total Parenteral Nutrition)	3E03362	N/A

Transplant Type	ICD-10 Procedure Code	CPT Code
Bone marrow transplant	079T002	38240 - 38241
Heart	02YA020	33945
Heart-lung	0BYM0Z0, 02YA0Z0	33935
Small bowel	0DY8070	44135 - 44136
Liver	0FY00ZO	47136
Lung (single)	0BYC0Z0	32851 - 32852
Lung (double)	0BYM0Z0	32853 - 32854
Pancreas	0FYG0Z0	48160, 48550-48556

Skyward A&H - Cost Containment Vendors

Skyward A&H has agreements with a suite of claim management vendors who are willing to provide “Best in Class” catastrophic-care management networks and services to better manage the quality of care and cost effectiveness of a medical plan offering. Skyward A&H does not mandate the use of our respected vendors as we do not direct care or plan assets. However, our vendors are available if you would like to work together in this process to ensure an outcome that benefits our mutual clients (the policyholder and the patient). Our vendors have met our strict selection and on-going review criteria for quality and service.

Our commitment to catastrophic claim management augments our strong underwriting and claim administration competencies. We stand ready to provide the services, answers and direction that you and your clients require.

Fees/Cost Containment

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.

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

Admin Fees

Not covered under the specific excess loss policy/treaty. Examples are:

1. Medical/peer-review - fees for reviewing a claim of medical necessity
2. PPO access fees - fee charged by PPO
3. Network fees for access to their network. These fees are not covered unless specifically included in the Specific Excess Loss policy.
4. Legal fees

Editing/Unbundling Fees

Covered up to 25% of savings. Review the adjudication of the claim to ensure the savings amount was applied. We will not reimburse the vendor fee if savings were not applied. 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 charge a percentage of savings.

Large Case Management Fees

Large Case Management can result in claims dollar savings. 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.

Skyward A&H is always interested in finding a way to work with our policyholders to make sure their members get quality medical care with the best outcome possible at a reasonable and customary charge for the services provided.

Savings Fees

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.
- 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.

Request For Specific Reimbursement

Filing an Initial Claim

Once a claimant's eligible paid charges exceed the specific retention amount, a request for reimbursement should be made and sent to ah-specific@skywardinsurance.com. A fully completed *Request for Specific Excess Loss Reimbursement Form*, along with the appropriate boxes marked, including the following documentation should be submitted:

- Completed *Skyward A&H Eligibility Verification* worksheet.
- Copy of original enrollment card (documentation of eligibility) or other acceptable proof of eligibility.
- Excel file **(preferred)** or computer print-out which includes: date received by TPA, date of service, CPT codes to include modifiers, ICD-10 codes, date paid, date processed, amount billed, amount paid, coinsurance, deductible, co-payments; amount not covered (reason), & check number; or itemized bills & EOBs **(Submit complete claim file for all transplants.)**
- Pre-certification documentation.
- Copy of other insurance information/COB documentation.
- Copy of hospital bill(s) with a charged amount over $100,000 and itemization of charges.
- All accident claims require complete details (police reports for motor vehicle accidents.)
- Private duty nursing charges must include all nursing notes.
- Documentation confirming claims were funded (and proof of paid for end of policy payments.)
- Proof of deductible & coinsurance when met prior to current plan year.

Filing Supplemental Reimbursement Claims

Subsequent claims should be submitted by completing a *Request for Specific Excess Loss Reimbursement Form* and forwarding it, along with the documentation required to support the subsequent newly paid claims.

Specific Advance Requests- A Value Added Service

Specific Advance Funding is a value-added service that we provide to all of our clients. This feature enhances the cash flow for the policyholder to pay eligible high-dollar claims.
Advance Funding is available if the following criteria is met:

a. Advance funding is only available while the Excess Loss insurance policy is in force.

b. Advance funding is not available during the last month of the payment period as set forth on the application and schedule of benefits section of this policy. We, at Skyward, understand this may cause a financial burden especially on small groups. Therefore, we will allow advance funding during the last month when these provisions are met.

1) Notification is received during or prior to the final month of the policy.

2) Skyward has reviewed and approved the request.

c. The company must receive the request for advance funding and satisfactory proof of claim eligibility, including all information requested above and any other information as might be necessary to determine liability for the claim no later than one month prior to the end of the payment period of the contract.

d. Policyholder must fund, via mail or electronic transfer, the claim for which advance funding is requested by the policyholder within 10 business days of receipt of advance funding from the company. 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.

e. 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 the 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.

f. It is the policyholder's sole responsibility to request and apply advance funding in a manner consistent with all current Employee Benefits Plan and 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.

g. Skyward can assist with savings on large claims so please reach out to us prior to payment.

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.

Aggregate Claim Reimbursement Requests

Filing an Initial Claim

Aggregate claim submissions require the completion of a Skyward A&H *Request for Aggregate Reimbursement Form* or any other form providing equivalent information. Information should be sent to ah-aggregate@skywardinsurance.com. Required information is as follows:

- Monthly participation and claims paid (by line of coverage) versus monthly aggregate attachment (Loss Ratio Report.)
- Year-to-date detailed paid claims report itemized by check, subtotaled by the claimant.
- Previous year's individual stop-loss report at 100% level (if previous year's specific had advancement or 90 dayrun out.)
- Include paid claims report for each individual identified.
- If current year's aggregate is incurred & paid, previous year individual stop-loss report is not necessary.
- Voids and refunds not accounted for in paid claims report. Submit copies of overpayment letters for pending recoveries.

- Rx Rebates should be deducted from the aggregate claim as they are considered to be refunds.
- Rebate information should come directly from the Rx Vendor.
- Listing of claims processed during the plan year for which checks have not been released and/or funded if applicable.
- Enrollment and eligibility reports for all covered employees and dependents. The report should include participant(s), dates of hire, effective dates of coverage, dates of termination. Retroactive additions and terminations should be calculated back to the month they occur.
- Proof of required funding (i.e. bank statement, or funding statement). Monthly statements should include one month following the contract expiration date.
- Monthly check registers for each month of the policy contract.
- A benefit analysis report in summary format for the policy period, showing payments for out-of-contract or extra contractual claims, PPO fees, medical records payments, and other administrative fees.
- If applicable, monthly itemized billing statements, by the claimant, from prescription card vendor.
- Policyholder's monthly stop-loss premium billing statements.
- *Reports required for aggregate*

Aggregate Advance

If the policyholder has elected this option, Skyward A&H will provide aggregate funding assistance provided the premiums are paid through a current date and subject to the greater of the actual or minimum pro-rated aggregate retention amount. The aggregate retention must be processed, paid and released prior to requesting any advance. A payment summary to which the advance applies must be included with the advance funding request. Funds advanced must be released to the providers for which the advance payment was requested.

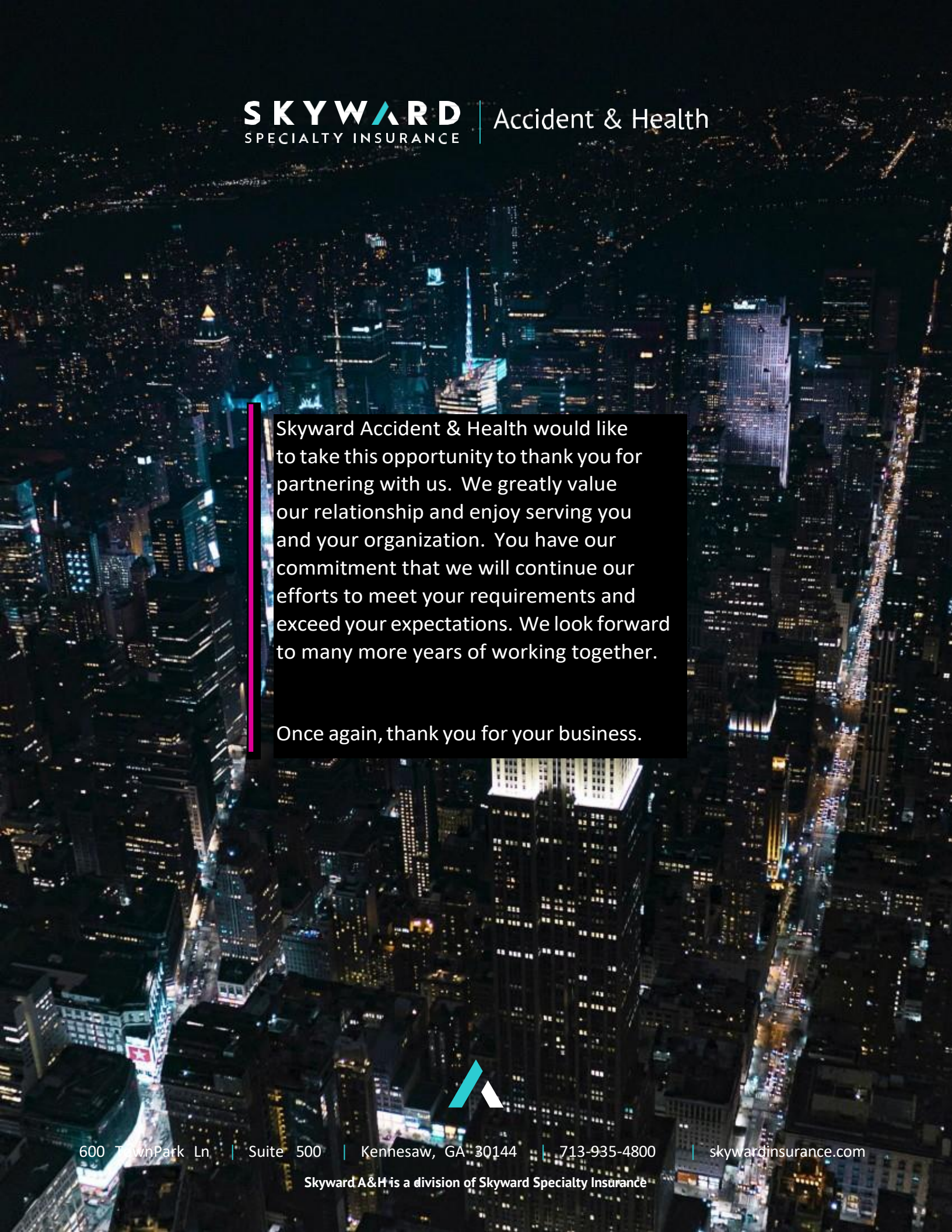
Aggregate advance requests are limited to one per month unless otherwise indicated by the policy.

ACH Claim Reimbursements

Skyward A&H sends claim payments via ACH-Direct Deposit instead of issuing a check.
Benefits include the following:

- Improved Controls – No lost or stolen checks
- Prompt Payments – Deposit made directly to the designated bank account
- Detailed Remittance Information – Listing all explanations of reimbursement (EOR) paid

Information will be provided to enroll in ACH for claims reimbursements.



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Skyward Accident & Health would like to take this opportunity to thank you for partnering with us. We greatly value our relationship and enjoy serving you and your organization. You have our commitment that we will continue our efforts to meet your requirements and exceed your expectations. We look forward to many more years of working together.

Once again, thank you for your business.

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