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I. Introduction

medTRANS Insurance, Ltd. (medTRANS) is providing this document as a reference guide for our clients and their designated Third Party Administrators (TPA), who are responsible for the administration of the Plans' Specific and Aggregate Stop Loss claims. We highly encourage the TPA personnel to become familiar with the requirements and processes outlined on this guide to facilitate an efficient claims handling process for the benefit of our mutual client, the Policyholder.

The purpose of this guide is to provide administrative instructions for proper and timely submissions of Notifications of potentially catastrophic claims; and Specific and Aggregate claims.

This guide also aims to provide guidance to our clients and their designated TPA on how to utilize the services of our cost-containment vendors. Please refer to your Stop Loss Policy and to this Guide when you have questions about your coverage. The Language contained in this document is provided as a guide and in no way binds medTRANS Insurance Ltd. (medTRANS) or Policyholder in any matter that differs from the coverage expressly stated within the Policy. In the event that there is any conflict between this Guide and the Policy, the language of the Policy will take precedence and control.

If you need additional information, please contact us at:

medTRANS Insurance Ltd.
C/O Frontrunner Captive Management, Inc.
300 West Main St
Suite 303
Freehold, NJ 07728
Attention: Stop Loss Claims Unit
Phone: 732.414.2942
Email: rbeckie@frontrunnercaptive.com

Our hours of operation are Monday to Friday from 8:00 a.m. to 4:30 p.m., Eastern time.
You may also visit us at the web at www.frontrunnercaptive.com.

II. Specific Stop Loss Claim Notification

Early identification and notification of potential catastrophic claims are essential to providing quality claims management. This will allow implementation of large case management and other cost containment strategies, which can be mutually beneficial to all parties by preserving Plan Benefits and saving claims dollars.

Potential Large Stop Loss Claim Notification

medTRANS Insurance, Ltd requires that potential large claim information identified through the TPA, Broker, or any Utilization Review vendors is submitted directly and promptly to medTRANS Insurance Ltd. Such notification must be made for an individual claimant at the earliest of:

A. Attaining **50%** of their Specific Deductible or **$50,000**, whichever is lesser;
B. Identified with conditions or diagnosis listed in our **Trigger Diagnosis Listing**; or
C. 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 in writing. The Stop Loss Notification and Initial Claim Form is available for your use. Please refer to the Stop Loss Forms section of this guide. If medTRANS Insurance, Ltd. notification form is not used, an approved written or electronic notification must include the following information:

☐	Policyholder name	☐	On-set date of diagnosis or condition
☐	Employee name, Social Security or unique member ID number	☐	Specific deductible
☐	Plan number (or) type	☐	Total amount of self-funded claims paid to date
☐	Claimant's name & relationship to employee	☐	Any pertinent information regarding claimant's condition
☐	Diagnosis	☐	Name & phone numbers for any attending physicians and/or nurse case manager
☐	Prognosis	☐	Type of notification (trigger diagnosis, 50% notice, etc)

50% Notifications

Notification must be given monthly to medTRANS Insurance Ltd. when the total amount of Plan Benefits paid on a Covered Person equals or exceeds 50% of the specific deductible or $50,000, whichever is lesser. This notification will allow medTRANS Insurance Ltd.'s Risk Assessment team to review the cost saving policies and procedures that are being applied

by the TPA. This will also allow medTRANS Insurance Ltd. to properly set appropriate reserves in the event that an actual claim occurs. Failure to give prompt notice, as defined by the Stop Loss Policy, may result in an adjustment of the reimbursement to the Plan Sponsor, if any, to reflect any savings medTRANS Insurance Ltd. could have obtained had prompt 50% notification been given.

Trigger Diagnosis Notification

A Trigger Diagnosis is a condition which tends to be chronic in nature, requiring extensive on-going treatment, hospitalization, case management and/or high cost medications. These types of conditions have the potential for high dollar claims. The TPA must give immediate notification to medTRANS Insurance Ltd. **as soon** as a catastrophic diagnosis on a covered employee or eligible dependent has been identified.

medTRANS Insurance Ltd. adheres to the Self Insurance Institute of American (SIIA) Endorsed ICD-°©-10 listing – September 2005 and those identified by the Stop Loss Carrier, for identifying catastrophic diagnoses.

Similarly, this notification will allow medTRANS Insurance Ltd. to review the cost saving policies and procedures that are being applied by the TPA and assist them by providing cost containment tools as deemed necessary. This will also allow medTRANS Insurance Ltd. to set appropriate reserves in the event that an actual claim occurs. Failure to give prompt notice, as defined by the Stop Loss Policy, may result in an adjustment of the reimbursement to the Plan Sponsor, if any, reflect any savings medTRANS Insurance Ltd. could have obtained had prompt Trigger Diagnosis notification been given.

Large Case Management Notification

medTRANS Insurance Ltd. must be notified immediately of any known claimant who is currently or expecting to be under the care of the Plan's designated Case Management firm or through the pre-certification of a hospital confinement, was identified with a potentially catastrophic diagnosis or is expected to be under Large Case Management.

TRIGGER DIAGNOSIS AND POTENTIAL CATASTROPHIC CASES LIST

The specific diagnoses listed below are key trigger indications of potentially catastrophic losses and should be referred to medTRANS. The following should also be explored for potential Case Management.

- Transplants -liver, renal, heart, lung, pancreas, bone marrow and any combinations
- Hospitalization request of fourteen (14) days or greater
- Trauma/Multiple Injuries
- Request for transfer to a rehabilitation facility
- Hyperalimentation (TPN)
- Home IV antibiotic therapy
- High Risk Pregnancy (Multiple Births)
- Initiation of hemodialysis

- Home Health Care request that is greater than 20 days

ICD 10 Code range	Description
390-459	Disease of the Circulatory System
411 - 411.89	Acute & Sub acute Ischemic Health Disease
414 - 414.05	Coronary Atherosclerosis (ASHD)
415 - 415.19	Acute Pulmonary Heart Disease
416 - 416.9	Chronic Pulmonary Heart Disease
417.1	Aneurysm of Pulmonary Artery
421 - 421.9	Acute and Subacute Endocarditis
424 - 424.9	Valve Disorders
425 - 425.9	Cardiomyopathy
426 - 426.9	Conduction Disorders
427 - 427.9	Cardiac Dysrhythmias
428 - 428.9	Heart Failure
430, 431	Subarachnoid / Intracerebral Hemorragia
434.9	Occlusion of Cerebral Arteries
436	Acute Cerebrovascular Accident (CVA)
440 - 441.9	Atherosclerosis / Aortic Aneurysm

ICD 10 Code range	Description
460 - 519	Disease of the Respiratory System
480 - 486	Pneumonia
490 - 496	Chronic Obstructive Pulmonary Disease (COPD)
515	Postinflammatory Pulmonary Fibrosis
518 - 518.89	Pulmonary Collapse and/or Respiratory Failure

ICD 10 Code range	Description
555 - 555.9	Regional Enteritis (Crohn’s Disease)
560.0 - 560.9	Intestinal Obstruction

ICD 10 Code range	Description
562.1	Diverticulitis of Colon
567 - 567.9	Peritonitis
569.0 - 569.9	Other Disorders of Intestine
570 - 571.9	Liver Diseases and Cirrhosis
572.8	Other Sequela of Chronic Liver Disease
573 - 573.9	Other Liver Disorders
577 - 577.9	Pancreas Diseases
578 - 578.9	Gastrointestinal Hemorrhage

ICD 10 Code range	Description
580 - 629	Disease of the Genitourinary System
584 - 584.9	Acute Renal Failure
585	Chronic Renal Failure
586	Renal Failure, Unspecified
588	Disorders resulting from impaired renal function
592	Calculus of Kidney & Uerter

ICD 10 Code range	Description
630 - 677	Complications of Pregnancy, Childbirth
641.1	Placenta Previa
642.5 - 642.7	Eclampsia, Pre-Eclampsia
644.0 - 644.2	Premature Labor
648.0	Gestational Diabetes
651	Multiple Gestation
654.5	Cervical Incompetence

ICD 10 Code range	Description
710 - 739	Disease of the Musculoskeletal System & Connective Tissue
715.0 - 715.9	Osteoartrhosis

ICD 10 Code range	Description
721.3	Lumbosacrel Spondylosis
722.0 - 722.9	Intervertebral Disc Disorders
730 - 730.9	Osteomyelitis and/or Periostitis
737.3	Kyphoscoliosis and Scoliosis

ICD 10 Code range	Description
740 - 759	Congenital Anomalies
747.2	Aortic Atresia / Stenosis
751.6	Biliary Altresia
759 - 759.9	Other and Unspecified Congential Anomalies
416 - 416.9	Chronic Pulmonary Heart Disease

ICD 10 Code range	Description
760 - 779	Conditions Originating in the Perinatal Period
765 - 765.1	Prematurity
769	Respiratory Distress Syndrome
770.0 - 770.9	Other Respiratory Conditions of Newborn

ICD 10 Code range	Description
780 - 799	Symptoms, Signs and Ill-Defined Conditions
785 - 785.9	Symptoms Involving Cardiovascular System
786.5 - 786.59	Chest Pain

ICD 10 Code range	Description
800 - 999	Injury and Poisoning
800 - 804.9	Fracture of Skull
805 - 805.9	Fracture of Vertebral Column
806 - 806.9	Fracture of Vertebral Column with Spinal Cord Injury
828 - 828.1	Multiple Fractures

ICD 10 Code range	Description
853 - 854.1	Intracranial Injury
869 - 869.1	Internal Injury
887 - 887.7	Traumatic Amputation of Arm and Hand
897 - 897.7	Traumatic Amputation of Leg
949 - 949.5	Burns
952 - 952.9	Spinal Cord Injury
428 - 428.9	Heart Failure
996 - 997.0	Complications peculiar to certain specified condition
V23	Supervision of High Risk Pregnancy
V42 - V58.9	Transplants, etc

In addition to the Trigger Diagnosis that were listed above, the following specific procedures listed below are further indicators of potential catastrophic cases and should be referred to medTRANS Insurance Ltd.

Description	ICD 10	CPT Code
Craniotomy	1.24	61304 - 61305
Hyperbaric Oxygenation	93.59	99183
Plasmapheresis (Apheresis)	99.71	36520 - 36521
Laryngectomy / Radical Neck Dissection	30.4	31360 - 31382
Tracheostomy	31.2	31600 - 31605
Implant Cardiac Assist Device	37.6	92970
Hemodialysis	39.95	90935 - 90937
Pancreatectomy	52 - 52.99	48140 - 48146, 48150 - 48154
Ventilator patient greater than 4 days	96.72	94656 - 94657
Insertion shunt / fistula	39.93	36821
Gastric Bypass	44.3 - 44.39	43842 - 43843, 43846 - 43847
TPN (Total Parenteral Nutrition)	99.15	N/A

Description	ICD 10	CPT Code
Transplants		
Bone Marrow Transplant		38240 - 38241
Heart		33945
Heart - Lung		33935
Small Bowel	V42 Codes	44135 - 44136
Liver		47136
Lung (Single)		32851 - 32852
Lung (Double)		32853 - 32854
Pancrease		48160, 48550 - 48556
Kidney		50360

III. SPECIFIC CLAIM REIMBURSEMENT PROCESS

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 should be made within the time allowed following receipt of a clean claim and falls under Incurred and Paid period as described under the Stop Loss Policy terms.

For the purpose of claim filing, the Stop Loss Notification/Initial Claim and the Stop Loss Subsequent Claim Forms can be found in the Forms section of this document. Specific Stop Loss claims will be reviewed and a determination made within 30 calendar days from receipt of all required claim information.

TYPES OF SPECIFIC STOP LOSS CLAIMS

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

B. Subsequent Claim – Also referred to as a Supplemental Claim, this is submitted during the contract period on behalf of an eligible individual, after reimbursement of the Initial Claim.

1. Initial Claim

Filing Guidelines

1. You can submit completed, signed and dated claim forms with all supporting documents:

   By mail to:

   medTRANS Insurance Ltd.
   C/O Frontrunner Captive Management, inc.
   300 West Main St, Suite 303
   Freehold, NJ 07728
   Attention: Stop Loss Claims Unit
   Or via email to: rbeckie@frontrunnercaptive.com

2. Claim requests should be equal of greater than $1,000.00, unless filing for the final claim submission on behalf of an eligible individual.

3. Claim must be submitted to medTRANS Insurance Ltd. within ninety (90) days after the Plan Sponsor has paid eligible expense on behalf of the Covered Person. Any claims for reimbursement received by medTRANS Insurance Ltd. more than 90 days after the last date for which a claim can be reimbursed under the terms of the Stop Loss Contract, will

be denied, unless the Plan Sponsor shows that timely submission was not possible, and that the Plan Sponsor 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.

4. Documentation Requirements:

    1) medTRANS Insurance Ltd. Specific Stop Loss Claim Form (Notification/Initial or Subsequent Claim Form) – completed, signed and dated;
    2) Eligibility Documentation:

        a. Copy of employee's Enrollment Form(s), including the hire date and original effective date, and any enrollment changes;

        b. Documentation showing type of coverage elected and covered dependents;

        c. Proof showing satisfaction of **Waiting Period**;

        d. Documentation of accumulated and used **Banked Hours**;

        e. Documentation of **Hours Worked**;

        f. **If disabled**: Proof of how coverage was maintained while off work

        g. **For COBRA participants**: Copy of the COBRA notification, election form and proof of timely receipt of premium payments for all months;

        h. **For Dependents**: Other Insurance (COB) information

        i. **For Plans that cover dependent children after age 26**: Copy of proof of eligibility, as required in the Plan Document.

    3. Claim Information:

        a. Copies of Explanation of Benefits (EOB's) attached to:

        b. Standard medical bills:

            i. HCFA -1500 (Physicians and other professional providers);or
            ii. UB-04 (Hospitals, Facilities and other institutional providers) -with corresponding DAILY itemized bills for charges in excess of $50,000;

        c. Copies of checks if not part of the EOB's;

        d. PPO Discount/Repricing sheets;

        e. System-generated claim detail report containing the following information:
            i. Employer/Group Name;
            ii. Employee name;

iii. Claimant name;
iv. Provider Name;
v. Dates of Service;
vi. Payment information, including Amount Paid, Check numbers, Check Date, Status of Check
vii. Types of Service – CPT/Revenue Codes
viii. Diagnosis – ICD-9/ICD -10
ix. Total Billed Amount
x. Discounts [PPO, Negotiated, or Contractual]
xi. Ineligible or Denied benefits with reason for denial
xii. Deductibles, Co-pays and co-insurances
xiii. Coordination of benefit
xiv. Denied or ineligible amount
xv. Total payment line calculation

4. Other applicable Miscellaneous Information/Documentation:

   a. Complete accident details, including how, when and where the accident occurred:

   b. Police Report for Motor Vehicle Accidents or for any services for which a Law Enforcement Agency is involved;

   c. Competed and Signed Subrogation and Right of RecoveryReimbursement Agreement if charges were incurred as a result of a third party liability:

   d. Coordination of Benefits (COB) documentation;

   e. Medical Management Reports including, but not limited to the following, as applicable:
      i. Pre-Certification documentation
      ii. Case Management notes
      iii. Medical Records/Operative Notes (including hospital admission and discharge summaries)

2. Subsequent Reimbursement Claims

Filing Guidelines

The requirements for Subsequent Claims are the same as those of the Initial Claim. However, if there has been no changes since the Initial (or last Subsequent) Claim submission, items a g listed under the “Eligibility Documentation” described under the “Documentation Requirements” are waived.

ADVANCED FUNDING REQUESTS

Funding a large catastrophic claim may present a hardship to some Plans who may not have the cash flow available to cover an extremely large provider bill. To alleviate such hardship, medTRANS Insurance Ltd. offers an Advance Funding option to provide cash-flow assistance. The Advance Funding option permits a self-funded Plan to apply for Specific Stop Loss reimbursement before the Plan's claim is fully funded.

A written notice of Specific Advanced Funding request must be received by medTRANS Insurance Ltd. no more than thirty (30) days prior to the end of the Specific Benefit Period. A fully completed and signed Stop Loss Notification/Initial Claim or the Stop Loss Subsequent Claim Form is required for each Advanced Funding request, include the amount of the Specific Advance Funding that is being requested, and should be in the amounts equal to or greater than $1,000. medTRANS Insurance requires that the following conditions are satisfied when filing a claim for Specific Advanced Funding,:

1. The Policyholder's premium payments must be current through the month in which the claim is submitted.

2. The Plan must have Paid and fully funded all Plan Benefits up to the Specific Deductible Amount, prior to the expiration of the Specific Stop Loss Policy.

3. All claims submitted for Specific Advance Funding must be fully processed according to the Plan Document and the Stop Loss Policy, and must be ready for payment.

4. The Plan must **include all required documentation in requesting reimbursements** as described on this document and the Stop Loss Notification/Initial Claim or the Stop Loss Subsequent Claim Form'

5. Upon receipt of the Specific Advanced Funding reimbursement, the Plan must release all Plan Benefit check(s) within five (5) working days and submit documentation to medTRANS Insurance Ltd. as confirmation that payment(s) have been released to the corresponding provider(s).

Special Note:

The Stop Loss Policy is written on reimbursement basis only. This means the Plan is responsible for paying all eligible claim expenses prior to filing a reimbursement request. Specific Advance Funding reimbursement assists clients with payment of large medical charges only and does not change any of the terms or provisions of the Policy.

Therefore, if requesting Specific Advance Funding, it is critical that **all guidelines outlined above are carefully followed**. If these guidelines are not followed, your Specific Claim Reimbursement submission will be handled strictly on a reimbursement basis only.

Furthermore if, for any reason, the Plan Sponsor does not use the advance funding or any portion of it to Pay the Eligible Expense within five (5) working days of receipt of the advance funding, the Plan Sponsor will return the unused portion of the advanced funding to the Company within five (5) working days.

The amount owed to the Plan Sponsor as the Specific Stop Loss Reimbursement will be reduced by any amounts provided as advance funding under this Policy for the same Benefit Period. At the end of the Benefit Period, any advance funding amounts that exceed the Specific Stop Loss Reimbursement must be repaid within thirty (30) days of written notice from Us.

IV. AGGREGATE CLAIM REIMBURSEMENT REQUESTS

An Aggregate Claim occurs when Plan Benefits Paid on behalf of all Covered Persons exceed the Minimum Annual Aggregate Deductible (Minimum Aggregate Attachment Point). Aggregate claims are typically filed after the Aggregate Benefit Period has expired and the total Eligible Claim Expenses can be determined.

A. Reporting Requirements

medTRANS Insurance Ltd. requires Monthly Aggregate Reporting by the fifteenth (15th) day following the end of each month of the Policy Period. Monthly Aggregate Reporting assists medTRANS Insurance Ltd. in documenting and monitoring potential Aggregate claims.

The following should be included with your Monthly Aggregate Reporting:

1. The number of Covered Units by coverage type for each of the Plan, for each of the month of the Policy Period; and

2. 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.

B. 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. 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.

If the Policy allows medTRANS Insurance Ltd. may make an Aggregate Accommodation upon the Plan Sponsor's proper filing of an Aggregate Accommodation reimbursement request if in any month during the Policy Period, 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.

Filing Guidelines
The following documentations are required when filing an Aggregate Accommodation reimbursement request:

a. Completed Monthly Accommodation Claim Form (please refer to the Forms section of this Guide);
b. Monthly Loss Summary Reports as described under the Monthly
c. Aggregate Reporting requirement on Section IV. A;
d. Paid Claims Analysis Report showing claimant's name, date(s) of service, type of service, amount charged, and amount, date and Payee for each Payment made.

For the purpose of Aggregate Accommodation Reimbursement, the following conditions apply:

1. All claims must be Paid by the Plan Sponsor prior to applying for an Aggregate Accommodation Reimbursement.

2. Aggregate Accommodation Reimbursement must be equal or greater than $1,000.

3. Aggregate Accommodation Reimbursement is not available in the final month of the Aggregate Benefit Period.

4. The amount owed to the Plan Sponsor as the Aggregate Stop Loss Reimbursement will be reduced by any amounts paid under the Policy for the same Plan Period as Aggregate Accommodations that were not repaid as overpayments and were not offset against the Specific Stop Loss Reimbursement. At the end of the Plan Period, any Aggregate Accommodations or any portion thereof that exceed the Aggregate Stop Loss Reimbursement must be repaid within thirty (30) days of written notice from Us.

C. Year End Aggregate Claims

Year End Aggregate Claims must be filed with medTRANS Insurance Ltd. within 90 days after the end of the time specified for payment of claims under the Stop Loss Policy.

Filing Guidelines

1. The following documentations are required when filing a Year End Aggregate Claim:

    a. Completed Year End Aggregate Claim Form (please refer to the Forms section of this Guide);
    b. Paid Claims Analysis Report indicating claimant's name, Incurred date, charged amount, Paid amount and Paid data;
    c. Eligibility listing which identifies birth date, effective date, termination date and coverage type;
    d. Proof of funding including monthly bank statements or other documentation of claims account funding;
    e. List of Voids, Refunds, Credits, Reversals and extra-contractual claims;
    f. Specific report showing which claimants have exceeded the Specific Deductible or loss limit;
    g. Benefit/Service Code report;
    h. Monthly Loss Summary Reports as described under the Monthly Aggregate Reporting requirement on Section IV. A;
    i. Listing of payments made outside the Aggregate contract (i.e. Dental, Weekly Income, Vision, PPO Fees – Capitated, etc);

j. Outstanding overpayment and subrogation log;
k. If prescription drug charges are included, itemized monthly invoices and verification of Payment, if not included on the monthly check registers;
l. COBRA documentation for COBRA participants; and
m. Other documentation We may request.

We may also request this information the month following the expiration date of the Policy to review for retroactive adjustments.

D. Right to Audit

Depending on several factors, medTRANS Insurance Ltd. may require an “on site” verification of a year-end Aggregate claim. Upon receipt of the complete submission, we will perform a preliminary review of the request. medTRANS Insurance Ltd will then determine if we will do an “in-house” desk audit or an “on-site” audit, performed in the office of the TPA.

In the event of an “onsite” audit, an auditor will be assigned to the claim. The auditor will contact the TPA for any required additional information and to schedule an audit date. If the audit is done “in-house,” the complete, fully documented Aggregate Stop Loss claim will be reviewed, the audit process completed, and claim determination made within 30 to 60 calendar days.

V. General Provisions

A. Eligibility

medTRANS Insurance Ltd. strictly adheres to the Eligibility requirements as defined under the Plan Document or Summary Plan Description (SPD). It is extremely important that all parties understand the Plan benefits and that medTRANS Insurance Ltd. be provided with information that clearly and precisely indicates how a person has been determined to be eligible under the Plan. It is for this reason that our Stop Loss Notification and Initial Claim Form and our Stop Loss Subsequent Claim Form request detailed information on how a claimant has been and continues to be eligible under the Plan. In order for medTRANS Insurance Ltd. to perform a complete and thorough review, these questions must be answered and the required documents listed on the forms be submitted in their entirety. Failure to do so may delay the review process.

For your convenience, we have included a Work Status Questionnaire under the Form section of this Guide.

B. Third Party Liability and Subrogation Procedures

Third Party Liability/Subrogation involves situations where another (third) party is responsible for payment of health care expenses he/she incurs because of someone else's act or omission. It provides the Plan with an opportunity to shift the cost of the claimant's medical care onto another responsible party. The other party may be an individual, insurance company or some other public or private entity. The Subrogation provision allows for the right of recovery for payments made under the Plan from the other party.

In order for us to review and issue reimbursement on cases involving Third Party Liability/ Subrogation, we must first have the following documentation:

1. medTRANS Insurance Ltd. Liability Questionnaire Form (or similar TPA form) completed by either the TPA or the Policyholder. Please include any appropriate attachments; and

2. A Subrogation and Right to Recover Reimbursement Agreement signed by the Policyholder.

C. Overpayments & Refunds

All Specific and Aggregate claim refunds should be forwarded to medTRANS Insurance Ltd. immediately. Although refunds may not have been identified by the Policyholder immediately, once they are identified to be due to an overpayment of a Specific or Aggregate claim, such refunds rightfully belong to the Company and should be sent to medTRANS Insurance Ltd. at once.

D. Claims to Appeal

Any claim that has been denied can be appealed within 90 days after the determination has been made by submitting supporting documentation or by providing additional evidence in writing to:

medTRANS Insurance Ltd.
C/O Frontrunner Captive Management, Inc.
300 West Main St, Suite 303
Freehold, NJ 07728
Attention: Stop Loss Claims Unit (APPEALS)
Or
Via E-Mail at: rbeckie@frontfunnercaptive.com

medTRANS Insurance Ltd. may enlist the services of qualified outside physician consultants to support denials based on medical necessity or experimental and investigational provisions in the Stop Loss Policy.

medTRANS Insurance Ltd. will adhere to the following appeal levels.

Level I -First appeal -performed by Claim Management

Level II -Second and final appeal -performed by the Claim Review Committee.

All decisions made by the Claims Review Committee are final. Additional requests for appeal will be denied.

In the event that the Plan requests for an external review by an Independent Review Organization (IRO) , due to an Adverse Benefit Determination as required by law, and such review resulted to a reversal or modification of the Adverse Benefit Determination, the Paid date of the claims will be the date that such Adverse Benefit Determination was made. Please refer to the Stop Loss Policy for additional information and conditions affecting Adverse Benefit Determination.

E. Contract Terms

Stop Loss claims are reimbursed depending on when the eligible charges are Incurred and Paid. The Incurred and Paid dates represent the essence of the Stop Loss coverage. It is critical that the Policyholder understands what “Incurred” and “Paid” means. Please refer to the Definition section of this guide.

medTRANS Insurance Ltd. offers the following Specific and Aggregate Contract Terms based on the Policyholder’s Incurred and Paid date parameters:

12/12	Incurred in the Policy Period & Paid in the Policy Period
12/15	Incurred in the Policy Period & Paid in the Policy Period or within three (3) months thereafter
12/18	Incurred in the Policy Period & Paid in the contract period or within six (6) months thereafter
12/24	Incurred in the Policy Period & Paid in the contract period or within twelve (12) months thereafter

15/12	Incurred in the Policy Period or within three (3) months PRIOR to the Policy Period and Paid in the Policy Period
PAID	Any eligible charges that were Paid in the Policy Period, regardless of incurred date, as long as the claim(s) were incurred since policy effective date

F. Split Funding or Aggregate Specific Deductible Option

medTRANS Insurance Ltd. offers pricing alternatives designed to help Policyholders manage Premium increases. This funding arrangement provides the Policyholder an opportunity to reduce Specific Stop Loss Premium cost by sharing in the claims risk of the Aggregated Specific in return for reduced premium.

If there is an individual(s) that exceeds the Specific Attachment Point, the Policyholder forgoes reimbursement until a predetermined risk corridor, the Aggregated Specific Deductible, has been satisfied. It is important that the Policyholder submit all specific claims during the Policy Period even if they are still within the corridor for record keeping purposes. The minimum premium amount plus the corridor will typically match the traditional premium charged.

This premium methodology can be a valuable tool for Policyholders to reduce fixed premium costs, especially for those with favorable loss experience and solid cash flow. Based on the level of risk assumed by the Policyholder, this product provides the opportunity to keep their fixed costs flat during subsequent renewals.

G. Summary plan Description (SPD) and its Amendments

medTRANS Insurance Ltd. relies on the Summary Plan Description (SPD) in determining Eligible Expense as it is the basis on which claims are paid. It is significantly important that medTRANS Insurance Ltd. receives the latest version of the Summary Plan Description (SPD) for approval in accordance with the provisions of the Stop Loss Policy.

Any changes, amendments or modifications to the SPD should be submitted to medTRANS Insurance Ltd. for prior approval and will be in effect on the first day of the month following the Company's approval of the proposed amendment. In the absence of the Company's prior written consent of the amendment, benefits will be payable under this Policy as though the Plan Document had not been amended.

VI. COST CONTAINMENT INITIATIVES

Advances in medical technology have increased healthcare costs and have created the opportunity for providers to shift higher charges for such services to health insurance payers and self-funded Plan Sponsors. medTRANS Insurance Ltd. adheres to providing your members with high quality of care while applying a series of initiatives that supports cost effective solutions through our Cost Containment Programs, including:

1. Large Case Management (LCM) services;

2. Hospital Bill Review and line-item audits;

3. Bill re-pricing & Prompt Payment Discount Negotiations;

4. Specialty Vendor Access for:

    a. Outcome-based Centers of Excellence Transplant Network
    b. Evidence-based Cancer Program
    c. Dialysis treatments
    d. Prenatal/neonatal services; and
    e. Pharmacies: specialty drugs, injections and infusions

Through relationships with leading cost containment vendors, medTRANS Insurance Ltd. has developed this program to control medical claim costs which will not only protect the assets of the Plan Sponsor, but also allow our Company to offer more competitive, preferred pricing on Stop Loss renewals. In order for the program to maximize savings opportunities, a collaborative effort is necessary between the Plan, its claims administrator (TPA) and medTRANS Insurance Ltd..

The TPA/Administrator should forward claims which meet the claims submission criteria as listed below to medTRANS Insurance Ltd for review and cost containment opportunities. The submission criteria includes both in and out of network claims as well as specialized potential high dollar situations such as transplant cases, dialyses and cancer treatments.

While the utilization of our cost containment services is voluntary, we strongly encourage submission of your claims for cost containment review prior to claims payment to ensure the greatest cost savings.

Medical Records may not necessarily be required as part of your claim submissions. However medTRANS Insurance Ltd reserves the right to request this documentation, as it is often invaluable in providing key information in our investigational phase.

Should the TPA/Administrator opt not to utilize the cost containment services, there will be no penalty or other type of reduction as a result of such decision. However, medTRANS Insurance ltd. reserves the right to retain such services and by doing so, may produce a lower than expected Stop Loss reimbursement.

All reimbursements remain subject to the provisions of the Stop Loss Policy.

A. Large Case Management (LCM)

Large Case Management (LCM) as defined by the Case Management Society of America (CMSA) is a "collaborative process of assessing, planning, facilitation and advocacy for options and services to meet an individual's health need through communication and available resources to promote quality cost-effective outcomes."

medTRANS Insurance Ltd. promotes the use of Large Case Management (LCM) services and will work with the Policyholder's case manager(s) or refer the case to LCM vendors, which have been chosen for their quality services and clinical specialties, for specialized management once a case has been identified.

Since Large Case Management is directly associated with the management of an on-going catastrophic claim, 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 Contract. This includes the cost for sending e-mails, faxes, etc; internal claim services, including eligibility determination; clerical fees; or capitated fees that are charged to the Plan on a per member, per month basis.

Proper management results in savings and the cost of such management is reimbursable under the Stop Loss Policy provided that:

1. the claim payments in addition to the LCM fees exceed the Specific Deductible, and LCM is warranted;
2. medTRANS Insurance Ltd. requested for LCM implementation; and
3. The fees are incurred and paid in accordance to the Policy's Terms.

If the Plan or its TPA opens a case to LCM and the Policyholder's Specific Deductible is eventually exceeded, those fees will be reimbursed above the Specific Deductible as part of the overall claims needed to be reimbursed, once such Claim is submitted to medTRANS Insurance Ltd for reimbursement. Copies of the LCM reports must be submitted with the Claim.

B. Hospital Bill Review and Line Item Audits

Although we found that significant savings are realized through preferred providers organizations (PPO) network discounts, we have also found some preferred providers are taking advantage of loop holes in their PPO contracts, especially when the contract included provisions which exempt them from standard bill reviews for inappropriate coding combinations, also known as "unbundling" and "upcoding", or reasonable and customary (R&C) allowances. Moreover, there has recently been a resurgence of hospital audit within the cost containment arena as a result of hospital over billing, particularly in the area of pharmacy charges.

medTRANS Insurance Ltd. encourages the Plans or their TPAs to pre-screen all hospital bills, whether in or out-of-network, or refer them to us or your 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. medTRANS Insurance Ltd. can assist in the review of hospital audit results.

If an audit is requested, a provider agreement outlining the adjusted charges must be obtained. The agreement should also establish a definitive timeframe for payment and include an agreement not to balance bill the patient.

Once the Specific Deductible is exceeded, fees associated with the audit will be considered an eligible claim for the purpose of Stop Loss. Reimbursement of audit fees is limited to 25% of savings. Copies of the audit result and the agreement must be submitted with the Claim.

C. Bill Re-Pricing & Prompt Payment Discount Negotiations

Oftentimes, when charges are believed to be excessive, the result of a hospital audit can be utilized as benchmark for provider negotiation. We have found that providers are more inclined to accept bill re-pricing and prompt payment discount negotiations in lieu of hospital audit agreements. Negotiating prompt payment discounts has demonstrated plan savings equal to or greater that those found through the standard PPO contract as providers may be willing to accept the negotiated amounts in order to ensure timely recovery of their receivables.

medTRANS Insurance Ltd. recommends the Plan or its TPA to pursue Bill Re-Pricing & Prompt Payment Discount Negotiations as actively as possible, on their own or through a preferred vendor.

The fee for this service is generally charged at a percentage of savings averaging at 30%. Vendors do not normally charge if they are unsuccessful in the negotiations. medTRANS Insurance Ltd. maintains valuable relationships with such vendors and will be happy to assist you.
If a Bill Re-Pricing & Prompt Payment Discount Negotiations is requested, a signed agreement with the provider outlining the adjusted charges must be obtained. The agreement should also establish a definitive timeframe for payment and include an agreement not to balance bill the patient.

Once the Specific Deductible is exceeded, fees associated with the Bill Re-Pricing & Prompt Payment Discount Negotiations will be reimbursed above the Specific Deductible as part of the Specific claim, once such Claim is submitted to medTRANS Insurance Ltd. for reimbursement. Reimbursement of audit fees is limited to 30% of savings. Copies of the agreement must be submitted with the Claim.

D. Speciality Vendor Access

Outcome-ˇbased Centers of Excellence Transplant Network . medTRANS Insurance Ltd maintains special relationship with innovators in outcome based care-improvement programs. Focusing on high cost, low frequency procedures, intensive credentialing, procedure outcome collection methods and evidence-based treatment protocols, thus achieving lower care costs through good medical outcomes. Through the Centers of Excellence Transplant Network patients can access nearly 80 of the nation’s most noted

transplant centers at great contract rates to health plans, candidate education tools and case manager support programs.

The Transplant Program will typically offer case rate pricing for the entire transplant continuum of care.

Evidence-ˇbased Cancer Program. Recognizing that cancer treatment is a large and growing expense for health plans, through our preferred vendor, the Plan can access this program which offers the total cancer care solution, featuring experienced oncology care coordinators, specialized cancer care management and a network of leading cancer centers across the country.

Dialysis treatments. Managing dialysis claims remains a challenge since dialysis providers rarely participate in PPO networks, yet billed charges for dialysis treatments can total up to $70,000 per month. Dialysis claims can be devastating to a self-°©-funded Plan without proper cost containment. Roughly 80% of all renal dialysis costs are paid by Medicare, 10% by Medicaid and Veterans Programs and 10% by the commercial market. With Medicare, Medicaid and Veterans Programs price-controlled by the government and fully insured markets using their buying power to negotiate significant discounts, it's easy to understand why costs have risen so dramatically for the self-funded population.

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.

medTRANS Insurance Ltd 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.

Prenatal/Neonatal services. Premature and severely ill neonates present a challenge because of the 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.

medTRANS Insurance Ltd. 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.

Pharmacies: specialty drugs, injections and infusions. The rising cost of pharmaceuticals is a major concern in healthcare today. This is especially critical for people with chronic conditions who are on multiple high cost medications. Plans today rely heavily on their Pharmacy Benefit Manager (PBM) to control their prescription drug costs, but most expensive drug therapies, those typically biotech in nature, cannot be delivered through traditional PBM channels. Because there is limited competition and typically no cost controls in place, specialty pharmaceuticals are often a safe haven for cost shifting within the healthcare provider chain. Through our relationships with several Specialty Pharmacy Benefit Management companies who provide specialized patient management services,

medTRANS Insurance Ltd. is able to provide you with access to lower cost of such specialty drugs, injections and infusions.

VII. Definition of Terms

The following terms are commonly used by both the TPA and Stop Loss claim staff. This list does not represent all Policy definitions. Please refer to the Policy if there are any questions regarding coverage or terms.

Advanced Funding -Also commonly referred to a Simultaneous Funding, the Advanced Funding option permits a self-funded Plan to apply for Specific Stop Loss reimbursement before the Plan's claim is fully funded.

Adverse Benefit Determination means a determination made by the Plan, its Administrator, or its designee utilization review organization that a health care service or supply has been reviewed and was determined as not meeting the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or supply, or payment for the service or supply is therefore denied, reduced or terminated.

Aggregated Specific Deductible -An Aggregated Specific Deductible is an additional corridor deductible amount that must be satisfied by one or more plan participants after they have exceeded their individual specific deductible. Once this additional corridor deductible has been satisfied, then the Plan may submit a claim for reimbursement under the Stop Loss Policy.

Aggregate Stop Loss -Aggregate Stop Loss is protection for the Plan against catastrophic losses when the total claims for all covered members and dependents exceed the Aggregate Attachment Level for the contract year. Benefit Period – The period of time during which the Eligible Expenses must be Incurred by a Covered Person and Paid by the Policyholder to be eligible for reimbursement under the Policy.

Contract Basis -The "Contract Basis" (or "Claims Basis") defines which claims are eligible for reimbursement under the Stop Loss contract in a specific year. The Stop Loss contract basis falls into two general categories, depending on whether the claims above the Stop Loss attachment level are covered on an "incurred" or "paid" basis. Variations of each approach exist.

Covered Person – The individual covered under the Plan Covered Unit – An individual, an individual with dependents or such other defined unit as agreed upon and shown on the Application

Eligible Expenses – The eligible charges payable under the Plan and for which the Plan is liable to pay. It does not include expenses specifically excluded or limited by the Policy, Application for Policy, Schedule of Insurance or any Endorsements.

Explanation of Benefit (EOB) -A detailed summary of medical expenses submitted, allowed, disallowed and paid by the Claims Administrator or the TPA on behalf of the Plan. Explanation of

Reimbursement (EOR) A detailed summary of the medical expenses submitted, allowed, disallowed and paid by the Stop Loss Carrier to the Plan.

Large Claim This means Paid or pending claims reaching or with the potential to reach 50% of the Specific Deductible or a Potentially Catastrophic Loss.

Minimum Annual Aggregate Deductible – Also known as the Minimum Attachment Point, the Minimum Annual Aggregate Deductible is the amount as shown in the Policy schedule or, if the schedule does not show such amount or shows such amount as zero, is the amount equal to the product of the number of months into the Policy Year times the Monthly Attachment Limit for the first Policy Month of the applicable Policy Year. It is established to protect medTRANS Insurance Ltd. against unfavorable Aggregate experience that may be generated by a shrinking or downsizing self-funded plan.

Paid (Payment) – This means that a claim has been adjudicated by the TPA and the funds are actually disbursed by the Plan prior to the end of the Benefit Period. Payment of a claim is the unconditional direct payment of a claim to the Covered Person or their health care provider(s). Payment will be deemed made on the date that both:

1. The payer directly tenders payment by mailing (or by other form of delivery) a draft or check; and
2. The account upon which the payment is drawn contains and continues to contain, sufficient funds to permit the check or draft to be honored by the institution upon which it is drawn.

Plan Benefits -This means the health benefits covered by the Plan during the Policy Period which are:

1. Incurred on or after the Effective Date of the Policy; and
2. Incurred while the Policy is in force; and
3. Incurred and Paid during the Policy Period.

Plan Benefits will also include those health benefits covered by the Plan during the Policy Period which are Paid during any Run-Out period or Incurred during any Run-n Period applicable to this Policy. Plan Benefits do not include:

1. deductibles of the Plan;
2. co-insurance or co-°©-payment amounts of the Plan;
3. any expenses that are not covered by the Plan or this Policy;
4. any amount recoverable from any other source; or
5. any amount Paid under a previous Policy or arrangement or excess loss coverage, whether issued by SLG Benefits, on behalf of the insurance company or another entity.

Policy Period -This means the time period beginning on the Effective Date and ending on the Expiration Date.

Run-in Limit -This means the maximum benefit amount Paid by the Policyholder under the Plan for Eligible Expenses Incurred by a Covered Person during the Run-in Period will be considered when determining benefit payments under this Policy.

Run-in Period -This means the period of time shown in the Schedule of Insurance immediately prior to the first day of a Policy Period during which Eligible Expenses Incurred by a Covered

Person, which are Paid by the Policyholder during the Policy Period, will be considered when determining benefit payments under this Policy.

Run-out-Period -This means the period of time shown in the Schedule of Insurance immediately following the Policy Expiration Date during which Plan Benefits Paid by the Policyholder for Eligible Expenses Incurred by a Covered Person during the Policy Period will be considered when determining benefit payments under this.

Specific Deductible means the amount which is wholly retained by the Plan Sponsor as shown in the Schedule of Stop Loss. The Specific Deductible applies separately to each Plan Participant for each Plan Period. The Specific Deductible for each subsequent Plan Period will be determined by medTRANS Insurance ltd..

Specific Payable Percentage -The Stop Loss Policy reimburses eligible claims at a pre-determined percentage. Depending on the product purchased, the Stop Loss Policy may reimburse all claims at a single percentage (normally 100%) or may provide reimbursement at a percentage up to a certain dollar level, and another percentage for claims exceeding the established dollar level. The applicable percentages are stated in the Policy.

Summary Plan Description (SPD) – Sometime referred to as the Plan Document means the written form of the Benefit Plan, which must be filed with and approved by medTRANS Insurance Ltd.. The SPD is the basis on which claims are paid under this Policy. Without such document on file, claims will not be paid. The SPD includes any amendments that are approved in accordance with the provisions of this Policy.

(Usual or) Reasonable and Customary Charges - The amount calculated by Us with reference to the charges for the same service by such providers in the same or similar geographic area in which the care is provided. To determine this amount, medTRANS Insurance Ltd. uses an industry-wide data system that collects data on providers' charges by zip code and procedure code. The industry-wide data system arrays these charges and calculates percentiles. The prevailing fee is the 90_{th} percentile of these charges. This means that 90% of the charges are at or below the prevailing fee for the same service in the same or similar geographic area.
The prevailing fee is developed from a statistically valid sample which:

1. equitably recognizes geographic variations;
2. is produced every six months; and
3. is collected on the basis of procedure codes developed and maintained by recognized authorities.

VIII. Privacy Notice

This Privacy Notice is sent to our customers who have received or continue to receive products and services provided by the following companies associated medTRANS Insurance Ltd.

1. medTRANS Insurance Ltd.
2. Frontrunner Captive Management Inc.

Your Privacy is Important to Us

We value you as a customer and we want you to know that protecting your privacy is very important to us. We also want you to know the types of information we collect and how we use it in the course of our business. We are also required by law to inform you of our policies and procedures for collecting, protecting, using and sharing your nonpublic personal information. You will receive a copy of our privacy notice when you first become one of our customers, whenever we change our notice, and annually each year that you remain one of our customers. If you have any questions concerning this notice, or our privacy practices, please contact us using the information listed at the end of this notice.

Information We Collect

We collect and use nonpublic personal information to notify you of products and services that we offer, to provide customer service to you, and in the normal course of our business operations. “Nonpublic personal information” includes all information we obtain about you in connection with providing a financial service or product to you, and it may come from the following sources:

1. Information provided on applications, or other forms as part of the application process. This information is received either directly from you or through one of our representatives.

2. Information provided during our business transactions with you, such as your claims history or payment history.

3. Information provided by third parties, including medical records, credit reports and eligibility records.

Information We Share With Others

We share nonpublic personal information about our customers and our former customers within the associated Companies and to selected third parties as permitted or required by law in conjunction with our normal business operations. This may include processing a claim, administering or enforcing a transaction, servicing your account, billing, auditing, reinsuring, or providing information to industry regulators, enforcement agencies or required by a court of law in connection with a legal proceeding. We may also disclose information to third parties that assist us in marketing our products and services to you.

We do not sell or rent nonpublic personal information to third parties.

We Protect Your Information

We maintain physical, electronic and procedural security standards to ensure that access to your nonpublic personal information is limited to our employees, agents and to third parties who work with us and have a legitimate need for the information in order to provide products and services to you. Third parties are also required to know and to comply with our privacy policies and practices.

Questions

Please contact us at the following address or phone number, if you would like more information concerning our privacy policies.

Contact Office Mailing Address:
medTRANS Insurance Ltd
C/O Frontrunner Captive Management, inc.
300 West Main, Suite 303
Freehold NJ, 07728
Attn: Privacy Officer
Telephone: 732.414.2942
Website: www.frontrunnercaptive.com

IX. Forms

A. Specific Stop Loss reimbursement Request
B. Monthly Aggregate Accommodation Request
C. Year End Aggregate Request
D. Work Status Questionnaire

X. Fraud Policy and Procedures

Overview

The purpose of these procedures is to provide a guideline to detect, investigate and refer suspected fraudulent insurance activities. It is expected that the adoption and implementation of these procedures will serve to protect the Company's assets and control insurance costs by providing a framework for the appropriate investigation of questionable claims and other potentially fraudulent acts perpetrated against the Company. These procedures are only a guide and do not purport to address all of the types of fraudulent activity that can occur in insurance transactions. In addition, they are not intended to detract from the prerogatives of those in a management position in making sound decisions. The intent of these procedures is to provide a guide that will assist in the decision making process and form the basis for consistent action in the detection, investigation and referral of suspected fraudulent claims and insurance transactions.

1. Fraud Policy

It is the policy of medTRANS Insurance (the "*Company*") to proactively and aggressively deter, detect, and investigate internal and external insurance fraud. The Company recognizes that insurance fraud can have a significant impact on the cost of doing business and that reducing both the cost and frequency of fraudulent activity is in the best interest of both the Company and its members. We are steadfast in providing thorough training to our captive management staff to increase their knowledge and awareness in the detection and prevention of fraudulent insurance acts, which may include, but is not limited to the following: staging phony accidents, filing fraudulent claims, exaggerating an injury or loss, billing for services not rendered, billing for unwarranted services, premium avoidance, internal fraud and misclassification of workers or concealment of payroll.

We will take a proactive approach in thoroughly investigating suspicious claims and submitting suspected fraud files to the appropriate Department of Insurance Fraud Bureau and/or law enforcement agency designated by specific state regulation; or in the absence of a state regulation and/or fraud bureau to the appropriate federal, state or local prosecuting authority.

Our fraud policy applies to all lines of coverage written by medTRANS or it's cells which make up medTRANS the Protected Cell Captive (PCC). In furtherance of this policy, we have developed and implemented a corporate anti-fraud strategy that is aimed at effectively combating insurance fraud.

The Company has contracted with an anti-fraud investigative service provider that shall act as its Special Investigations Unit (SIU). The Company will first identify those matters that exhibit fraud related indicators, red-flag events, and situations or behaviors indicative of fraud schemes. Those matters identified will then be directed to the SIU for specialized handling.

The Company, together with the SIU, will review, analyze and investigate potentially fraudulent activities. The Company will then use its professional discretion to ascertain the validity of the claims presented. Where state mandates exist as to reporting, investigation, and preparation of fraud referrals, the Company will ensure that all mandates are fulfilled.

2. Fraud

2.1 Definition of Fraud

The definition of insurance fraud may vary slightly from state-to-state but it is typically defined as "An act or omission committed by a person who knowingly, and with intent to defraud, commits, or conceals any material information" in order to obtain a benefit or advantage to which that person is not otherwise entitled. Fraudulent activity can include but is not limited to, presenting false information concerning a fact material to one or more of the following: (1) an application for the issuance or renewal of an insurance policy or reinsurance contract; (2) the rating of an insurance policy or reinsurance contract; (3) a claim for payment or benefit pursuant to an insurance policy or reinsurance contract; (4) premiums paid on an insurance policy or reinsurance contract; (5) payments made in accordance with the terms of an insurance policy or reinsurance contract; (6) a document filed with the commissioner or the chief insurance regulatory official of another jurisdiction; (7) the financial condition of an insurer or reinsurer; (8) the reinstatement of an insurance policy.

2.2 Integral Anti-Fraud Personnel

Integral anti-fraud personnel include company personnel who are not directly assigned to its SIU but whose duties may include the processing, investigating, payment or denial of a claim, the processing of applications for insurance and the processing of general insurance transactions. Such personnel may include claims handlers, underwriters, policy handlers, call center staff within the claims or policy function, legal staff, and other insurer employee classifications that perform similar duties. The Company's integral anti-fraud personnel, as part of their regular duties, are responsible for identifying suspected insurance fraud during the handling of insurance transactions, and referring such suspicious activity to their supervisor and/or compliance department.

2.3 Detecting Suspected Fraud

This refers to the ability to detect evidence of possible insurance fraud. Integral anti-fraud personnel must be knowledgeable of the various state and federal insurance anti-fraud laws and regulations as well as laws related to other conduct commonly associated with fraudulent insurance transactions. More fundamentally, the identification component refers to the ability to recognize which claims and other insurance transactions reflect circumstances or events that support an inference that insurance fraud may have or might be occurring.

Once evidence of suspected fraud has been properly confirmed, the representatives handling the claim or insurance transaction, in conjunction with their supervisor and compliance department, should determine whether the suspicion is reasonable and appropriate for referral to the SIU.

2.4 Referral of Suspected Fraud

All suspected fraudulent activity must be referred to the SIU for investigation and reporting to the appropriate state bureau and/or agency.

3. Special Investigations Unit (SUI)

3.1 Definition of SIU

A SIU is a unit or division established by an insurer to investigate suspected insurance fraud. A SIU should be adequately staffed with individuals who are knowledgeable and experienced in general insurance practices, analysis of claims for patterns of fraud, current fraud trends, fraud education and training and any other criteria indicating possible fraud. The SIU should have the ability to conduct effective investigations of suspected insurance fraud, be familiar with state fraud regulations and be able to perform all functions and activities set forth in such regulations.

4. Detection of Company Related Fraud

medTRANS' Fraud Department, acting under the supervision of Frontrunner Captive Management, Inc., (the "*captive manager*") is responsible for the detection of Company-related fraud, including insurance fraud. The captive manager reports such matters to the Company's Board of Director and/or Underwriting and Audit Committee as applicable. The captive manager in cooperation with law officials and the Human Resources Department is charged with the responsibility of overseeing the investigation of suspected theft, embezzlement and other fraudulent business practices found within medTRANS, any of the cells within medTRANS or any captive manager employees. The captive manager is responsible for notifying law enforcement agencies of suspected theft, embezzlement and other fraudulent incidents. The captive manager and legal Counsel is responsible for cooperating with law enforcement agencies in the investigation and prosecution of referred matters. medTRANS requests restitution in criminal cases.

The Underwriting and Audit Committee in conjunction with the captive manager periodically audits claims and underwriting procedures and conducts random reviews of closed claims files. The Underwriting and Audit Committee also conducts periodic audits of the claims adjudicative process, including audits of the processes employed to detect suspicious claims activity. The audits are intended to ensure that proper procedures and controls are in place to detect and prevent fraud. Such audits also are intended to aid related criminal prosecutions and civil litigation in which restitution is sought. The Underwriting and Audit Committee coordinates the scheduling and preparation of such audits.

medTRANS Board of Directors and/or Underwriting and Audit Committee periodically audits underwriting procedures of all its claims processes of its Third Party Administrators (TPAs). The captive manager performs voluntary premium audits to verify reported accuracy. These audits are intended to ensure that all underwriting and claims procedures are being followed and proper procedures and controls are in place to detect and prevent fraud.

Frontrunner Captive Management conducts background investigations of prospective employees prior to hiring. The background investigations focus on such diverse areas as the prospective employees' financial affairs, employment histories, criminal records, if any, participation as a party in civil litigation and personal references.

To protect data integrity and to prevent fraud, Frontrunner Captive Management requires that its employees change their passwords at 60-day intervals and automatically expires unchanged

passwords every 60 days. In addition, Frontrunner Captive Management check stock is kept in a locked and secure cabinet. All Company checks require two signatures. Instances where insurance fraud or suspect activity is identified are referred to our contracted SIU.

5. Fraud Indicators ("Red Flags")

Determining the possibility of fraud in any insurance transaction is facilitated when the integral anti-fraud personnel is familiar with various fraud indicators. The indicators in the appendices should help isolate those insurance transactions that merit closer scrutiny. No one indicator by itself is necessarily suspicious. Even the presence of several indicators, while suggestive of possible fraud, does not mean that fraud has been committed. Indicators of possible fraud are "Red Flags" only, not actual evidence.

A current list of medTRANS adopted "Red Flags" is available at anytime for your reference. Some common fraud indicators are:

A. The Employer misrepresents the employee's status
B. The provider bills for service not rendered, falsifies bill, overfills and upcodes or unbundles charges
C. Claims costs unexpectedly increase and it is identified that multiple individuals in the same family are incurring costs for the same drug
D. Information provided warrants further investigation as to cause and cost of claim (injury may have been sustained while performing an illegal act)
E. The employer intentionally does not disclose individuals with potential catastrophic events during the underwriting process
    a. *Underwriting fraud can also be called "Rate Evasion" due to the simple fact that the rating factors are misrepresented in order to obtain a better rate.*
F. Underwriting Red Flags include
    a. The group wants to backdate the effective date
    b. The group's principal place of business is a P.O. box, Suite number or room number
    c. The claimant's occupation is inconsistent with the employer's stated business
    d. The number of employees, classifications and payroll are inconsistent
    e. On-going large claims information is not provided during underwriting process
G. Underwriting Fraud also includes Premium Fraud, which occurs when an employee knowingly misrepresents payroll, number of employees and class codes in order to obtain a lower rate
    a. Premium Fraud is also known as "*larceny by false pretense*."
    b. Consequences of Premium Fraud
        I. Financial loss as collected premiums do not reflect the risk presented
        II. Incorrect premium tax remitted
        III. The consumer picks up the difference in the form of higher costs for goods and services
    c. The most common Premium Fraud Red Flags include:
        i. Inconsistencies with prior policies
        ii. Hidden ownership
        iii. New business
        iv. Misinformation
        v. Business location
        vi. Non-cooperation

vii. Business operations coverage request is inconsistent with work being performed.

H. Provider Fraud is the most common and the most expensive, such as the following:
   a. Services not Rendered (the most common type of provider fraud)
   b. Non-Covered services as covered services
   c. Misrepresenting dates of service
   d. Misrepresenting locations of service
   e. Misrepresenting provider of service
   f. Waiving of deductible and/or Co-Payments
   g. Incorrect reporting of diagnosis or procedure codes
   h. Overutilization of services
   i. Corruption
   j. False or unnecessary issuance of prescription drugs