The Union Labor Life Insurance Company

Stop Loss Claims // TPA Administration Guide

Table of Contents

Part One

ADMINISTRATOR'S GUIDE

I. INTRODUCTION

The Union Labor Life Insurance Company (Ullico) 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.

This guide provides administrative instructions for proper and timely submissions of Notifications of potentially catastrophic claims and of 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 (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 The Union Labor Life Insurance Company 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:

The Union Labor Life Insurance Company
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910
Attention: Stop Loss Claims Unit

Toll Free Number: 1-800-328-5837
Fax Number: 1-202-682-6920
Email: StopLossClaims@ullico.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.ullico.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

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

a. Attaining **50%** of their Specific Deductible or **$100,000,** 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 The Union Labor Life Insurance Company notification form is not used, an approved written or electronic notification must include the following information:

- Policyholder name
- Employee name, Unique member identification number
- Plan number (or type)
- Claimant's name & relationship to employee
- Diagnosis
- Prognosis
- On-set date of diagnosis or condition
- Total amount of self-funded claims paid to date
- Any pertinent information regarding claimant's condition (pending transplant, hospital confinement, etc.)
- Name and phone numbers for any attending physicians and/or nurse case manager
- Total amount of any pending claims

50% Notifications

Notice must be given monthly to Ullico when the total amount of Plan Benefits paid on a Covered Person equals or exceeds **50% of the specific deductible or $100,000, whichever is lesser**. This notice will allow Ullico Risk Assessment team to review the cost saving initiatives that are or can be applied to the case. This will also allow Ullico to properly set appropriate reserves in the event that an actual claim occurs. Failure to give prompt notice, as defined by the Policy, may result in an adjustment of the reimbursement to the Plan Sponsor, if any, to reflect any savings Ullico could have obtained had prompt Trigger Diagnosis 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 Ullico **as soon as** a catastrophic diagnosis on a covered employee or eligible dependent has been identified.

Ullico adheres to the Self-Insurance Institute of America (SIIA)-Endorsed ICD-10 (October 2015) Code Lists and those identified by Us to be catastrophic diagnoses.

Similarly, this notification will allow Ullico 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 Ullico 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, if any, to reflect any savings Ullico could have obtained had prompt Trigger Diagnosis notification been given.

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 Ullico. The following should also be explored for potential Case Management.

Gene and Cell Therapies
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 LIST

A00-B99	***Certain Infectious and Parasitic Disease***
A40	Streptococcal sepsis
A41	Other Sepsis
B15-B19	Viral hepatitis
B20	Human immunodeficiency virus [HIV] disease
C00-D49	***Neoplasms***
C00-C96	Malignant neoplasms
D46	Myelodysplastic syndromes
D50-D89	***Diseases of the Blood and Blood-forming Organs & Disorders Involving the Immune Mechanism***
D57	Sickle-cell disorders
D59	Acquired hemolytic anemia
D60-D64	Aplastic and other anemias
D65-D69	Coagulation defects, purpura and other hemorrhagic conditions
D70-D77	Other diseases of blood and blood-forming organs
D80-D89	Certain disorders involving the immune mechanism
E00-E89	***Endocrine, nutritional and metabolic diseases***
E10-E13	Diabetes mellitus
E15-E16	Other disorders of glucose regulation and pancreatic internal secretion E65-E68 Obesity and other hyper alimentation
E70-E89	Metabolic disorders
F01-F99	***Mental, Behavioral and Neurodevelopmental disorders***
F10.1	Alcohol Abuse
F11.1	Opioid Abuse
F20	Schizophrenia
F31	Bipolar Disorder
F32.3	Major Depressive disorder, single episode, severe with psychotic feature
F33.1-F33.3	Major Depressive Disorder, recurrent
F84.0	Autistic Disorder
F84.2	Rett's Syndrome
F84.5	Asperger's syndrome
G00-99	***Diseases of the nervous system***
G00	Bacterial Meningitis
G04	Encephalitis Myelitis and Encephalomyelitis.
G06-G07	Intracranial and intraspinal abscess and granuloma
G12.21	Amyotrophic Lateral Sclerosis
G35	Multiple Sclerosis
G36	Other Acute Disseminated Demyelination
G37	Other Demyelinating disease of central nervous system
G82.5	Quadraplegia
G83.4	Cauda Equina Syndrome
G92	Toxic Encephalopathy
G93.1	Anoxic Brain Injury
I00-I99	***Diseases of Circulatory System***
I20	Angina Pectoris
I21.09-I22	Acute myocardial infarction
I24	Acute and Subacute Ischemic Heart Disease
I25	Chronic ischemic heart disease
I26	Pulmonary embolism
I27	Other pulmonary heart disease
I28	Other diseases of pulmonary vessels
I33	Acute & Subacute Endocarditis
I34-I38	Heart Valve Disorders
I42-I43	Cardiomyopathy
I44-I45	Conduction Disorders
I46	Cardiac Arrest
I47-I49	Cardiac Dysrhythmias
I50	Heart Failure
I60-161	Subarachnoid Hemorrhage/Intercerebral Hemorrhage
I63	Cerebral infarction
I65.8-I66	Occlusion of Precerebral/Cerebral Arteries
I67	Other cerebrovascular disease
I70	Atherosclerosis / Aortic Aneurysm

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

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

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

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

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

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

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

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

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

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

In addition to the Trigger Diagnosis that were listed on the previous pages, the procedures listed below are further indicators of potential catastrophic cases and should be referred to Ullico.

	CPT Code
Gene & CAR-T Cell Therapy services	0537T, 0538T, and 0539T
Craniotomy	61304 - 61305
Hyperbaric Oxygenation	99183
Plasmapheresis (Apheresis)	36520 - 36521
Laryngectomy/Radical Neck Dissection	31360 - 31382
Tracheostomy	31600 – 31605
Implant Cardiac Assist Device	92970
Hemodialysis	90935 – 90937
Pancreatectomy	48140 – 48146, 48150 – 48154
Ventilator patient greater than 4 days	94656 – 94657
Insertion shunt/fistula	36821

Gastric Bypass	43842 - 43843, 43846 – 43847
TPN (Total Parenteral Nutrition)	N/A
Transplants[1]	Various
Bone Marrow Transplant	38240 – 38241
Heart	33945
Heart – Lung	33935
Small Bowel	44135 - 44136
Liver	47136
Lung (single)	32851 – 32852
Lung (double)	32853 – 32854
Pancreas	48160, 48550 – 48556
Kidney	50360

Large Case Management Notification

Ullico 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.**

[1] The transplants that are listed above should be reported to Ullico immediately for cost containment review and strategies.

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 periods as described under the Stop Loss Policy terms.

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

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:

   The Union Labor Life Insurance Company
   8403 Colesville Road, Suite 1300
   Silver Spring, MD 20910
   Attention: Stop Loss Claims Unit

   By fax to: Fax Number: 1-202-682-6920

   Or via email to: StopLossClaims@ullico.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 Ullico within ninety (90) days after the Plan Sponsor has Paid eligible expense on behalf of the Covered Person. Any claim received by Ullico after the last date for which a claim can be reimbursed under the terms of the Excess 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 twelve (12) months from the end of the Plan Period or six (6) months after the end of the Benefit Period, whichever is later. Consult your Stop Loss Policy for additional details.

4. Documentation Requirements:
    1) The Union Labor Life Insurance Company's 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 <u>all</u> months;
        h. **For Dependents:** Other Insurance (COB) information
        i. **For Plans that cover dependent children *<u>after</u>* <u>age 26</u>:** Copy of proof of eligibility to continue coverage.
    3) Claim Information:
        a. Copies of Explanation of Benefits (EOB's)
        b. Standard medical bills:
            i. HCFA -1500 (Physicians and other professional providers); or
            ii. UB-04 (Hospitals, Facilities and other institutional providers) - <u>with corresponding DAILY itemized bills with Paid amount in excess of $250,000</u> (or lesser if requested);
        c. Copies of checks if not part of the EOB's or claim detail report;
        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 -10
ix. Total Billed Amount
x. Discounts [PPO, Negotiated, or Contractual]
xi. Ineligible or Denied amounts with reason for denial
xii. Deductibles, Co-pays and co-insurance
xiii. Other Insurance information (Coordination of Benefit)
xiv. 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 Recovery Reimbursement 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. Physicians' notes
      iii. Case Management notes
      iv. 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 for the Initial Claim. However, if there has been no eligibility changes since the Initial (or last Subsequent) Claim submission, and the dates of service are within the scope of the eligibility documents that were previously provided, items 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, Ullico 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 Ullico ***no less than thirty (30) days prior*** to the end of the Specific Benefit Period. A fully completed and signed Stop Loss 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.

Ullico requires that the following conditions are satisfied for Advanced Funding to be considered:

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 plus $1,000***.
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 Claim must **include all required documentation in requesting reimbursements** as described above.
5. Upon receipt of the Specific Advanced Funding reimbursement, the Plan must release all Plan Benefit check(s) within five (5) business days and submit documentation to Ullico 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 must return the unused portion of the advanced funding to the Ullico 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

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

The following should be included with your Monthly Aggregate Reporting:

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

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, Ullico 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 Aggregate Reporting requirement on Section IV. A;
c. 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 Ullico within 90 days after the end of the time specified for payment of claims under the Stop Loss Policy.

Filing Guidelines

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. Census/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, rebates, and verification of Payments, 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, Ullico 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. Ullico 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 "on-site" 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

Ullico 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 Ullico 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 Claim Form* requests detailed information on how a claimant has been and continues to be eligible under the Plan. In order for Ullico 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. The Union Labor Life Insurance Company 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 The Union Labor Life Insurance Company 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 The Union Labor Life Insurance Company at once.

D. Claims to Appeal

Any claim that has been denied can be appealed within 180 days after the determination has been made by submitting supporting documentation or by providing additional evidence **in writing** to the attention of: *Stop Loss Claims Unit (APPEALS)*

The Union Labor Life Insurance Company
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910

Or via E-Mail at: StopLossClaims@ullico.com

Ullico 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.

Ullico will adhere to the following appeal levels.

Level I - First appeal – review and determination is made by the VP of Operations and the AVP of Compliance, in consult with the VP, Deputy Chief Compliance Officer;

Level II - Second and final appeal – Within 90 days after the First Appeal has been denied, a Second appeal can be submitted. The Second and final appeal review and determination is made by the President of The Union Labor Life and the President and Chief Operating Officer of Ullico, in consult with Ullico's General Counsel.

All decisions made at Level II are final.

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.

Ullico offers the following Specific and Aggregate Contract Terms based on the Policyholder's Incurred and Paid date parameters:

Paid	Any eligible charges that were Paid within the Policy Period, regardless of incurred date (unless otherwise defined in the Policy) as long as the claims were incurred since the inception of the policy (original effective date)
12/12	Incurred within the Policy Period Paid within the Policy Period
15/12	Incurred within the Policy Period or within three (3) months prior to the Policy Period and Paid within the Policy Period
12/15	Incurred within the Policy Period Paid within the Policy Period or within three (3) months thereafter
12/18	Incurred within the Policy Period Paid within the contract period or within six (6) months thereafter
12/24	Incurred within the Policy Period Paid within the contract period or within twelve (12) months thereafter

F. Split Funding or Aggregated Specific Deductible Option

Ullico 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

Ullico relies on the Summary Plan Description (SPD) in determining Eligible Expense as it is the basis on which claims are paid. It is imperative that Ullico 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 Ullico for prior approval and will be in effect on the *first day of the month following* the Company's approval of the proposed amendment, unless otherwise specified.

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. Ullico 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:

- Large Case Management (LCM) services;
- Hospital Bill Review and line-item audits;
- Bill re-pricing & Prompt Payment Discount Negotiations;
- Specialty Vendor Access for:
    - Outcome-based Centers of Excellence Transplant Network
    - Evidence-based Cancer Program
    - Dialysis treatments
    - Prenatal/neonatal services; and
    - Pharmacies: specialty drugs, injections and infusions

Through relationships with leading cost containment vendors, Ullico developed this program to control medical claim costs which will not only protect the assets of the Plan Sponsor, but also allow the 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 Ullico.

The TPA/Claims Administrator should forward claims which meet the claims submission criteria as listed below to Ullico 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 Gene and Car-T cell therapies, 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 Ullico reserves the right to request these documents, 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, Ullico 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."

Ullico 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- such as 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:

a. the claim payments in addition to the LCM fees exceed the Specific Deductible, and LCM is warranted;
b. Ullico requested for LCM implementation; and
c. The fees are incurred and paid in accordance to the Stop Loss 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 Ullico for reimbursement. Copies of all 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 audits within the cost containment arena as a result of hospital over-billing, particularly in the area of pharmacy charges.

Ullico strongly recommends 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 $100,000. Ullico 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 Repricing & 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.

Ullico recommends that the Plan or its TPA pursue Bill Repricing & 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 25%. Vendors do not normally charge if they are unsuccessful in the negotiations. Ullico maintains valuable relationships with such vendors and will be happy to assist you.

If a Bill Repricing & 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 Repricing & Prompt Payment Discount Negotiations will be reimbursed above the Specific Deductible as part of the Specific claim, once such Claim is submitted to Ullico for reimbursement. ***Reimbursement of fees is limited to 25% of savings***. Copies of the agreement must be submitted with the claim.

D. Specialty Vendor Access

Outcome-based Centers of Excellence Transplant Network. Ullico 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 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-based 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, despite the ever-increasing billed charges for these treatments.

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. Since prices for Medicare, Medicaid and Veterans Programs are controlled by the government, it's easy to understand why costs have risen so dramatically for the commercial market (self-funded population).

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

Ullico 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 costs. The treatments of high-risk newborns are lengthy and require large amounts of personal and monetary resources.

Ullico 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 rely heavily on their Pharmacy Benefit Manager (PBM) to control their prescription drug costs, but most expensive drug therapies, 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 vendor relationships, Ullico 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 - determination made after review of a health care service or supply that it does not meet 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 is eligible for reimbursement of eligible claims.

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.

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.

Incurred – the date when a covered sentence was rendered to or when a supply was received by the Plan participant

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 or Minimum Attachment Point - 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. This is established to protect Ullico 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. 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 - 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-In 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.

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

Specific Deductible - is 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 Ullico.

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 Ullico. 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.

VIII. STOP LOSS UNIT CONTACT INFORMATION

The Union Labor Life Insurance Company
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910
Attention: Stop Loss Claims Unit

Toll Free Number:	1-800-328-5837
Fax Number:	1-202-682-6920
Email Address:	StopLossClaims@ullico.com
Web Address:	http://www.ullico.com/

Hours of Operation: Monday – Friday 8:00 a.m. to 4:30 p.m. (Eastern Time)

For information regarding our cost-containment vendors and transplants network contact:

AVP of Claims	Stop Loss Claims Manager	Case Manager Nurse
(202) 682-4696	(202) 682-6763	(202) 962-8987

For other inquires pertaining to Premium Billing and Policy Issues:

Premium Billing: 1-888-222-8573
E-mail: premiumbilling@ullico.com

Policy Issues:
Please contact your Account Manager or send your inquiry via email to
ULLAccountManagement@ullico.com

IX. FORMS

A. Specific Stop Loss Claim Form (includes Notification)
B. Monthly Aggregate Accommodation Reimbursement Form
C. Year End Aggregate Claim Form
D. Work Status Questionnaire

SPECIFIC STOP LOSS CLAIM

INITIAL FILING *OR* NOTIFICATION FORM

Please submit this form to:
The Union Labor Life Insurance Company
Stop Loss Claims Unit
8403 Colesville Rd., 13th Floor • Silver Spring, MD 20910
Toll free: 800-328-5837 • Fax: 1.202.682.6920
StopLossClaims@ullico.com

Submission Date: _____

☐ Claim Notification (50% Notice or trigger diagnosis) ☐ Initial Claim ☐ Subsequent Claim # ____ ☐ Final Claim

POLICYHOLDER INFORMATION:

Plan Sponsor (Group) Name: _____ Policy # _____

Policy Period:_____ Contract Type: _____ Specific Deductible: _____

MEMBER INFORMATION:

Member Name: _____ Group ID/Soc Sec #_____ Date of Birth: _____

WORK STATUS: ***** Please provide copies of Hour Bank Report or Premium Payments, whichever applies *****

☐ Actively working Date of Hire: _____ Original Effective Date: _____ Medical Plan: _____

☐ Retired Retirement Date: _____ ☐ Under 65 ☐ 65 & over

☐ Not actively working Date last worked: _____ Return to Work date: _____

☐ Disabled and unable to work Date last worked: _____ Return to Work date: _____

☐ Is member terminated ☐ Yes ☐ No Termination Date: _____

If coverage is being continued, please mark all that apply:	From Date	To Date
☐ Sick Leave		
☐ Vacation		
☐ Leave of Absence		
☐ FMLA		
☐ COBRA		

CLAIMANT INFORMATION:

Claimant Name: _____ Date of Birth: _____

Gender: _____ Relationship to Member: ☐ Spouse ☐ Child ☐ Other _____

Original Effective Date: _____ Termination Date: _____

COBRA? ☐ Yes ☐ No COBRA Effective Date: _____- _____ COBRA Premium Paid Thru Date: _____

Is Claimant covered by any other insurance plan? ☐ Yes ☐ No

If yes, type of coverage (Auto, Work Comp, Group Plan, Medicare): _____

Carrier: _____ Effective Date: _____ Termination Date: _____

CLAIM INFORMATION:

Diagnosis: _____ Date of Onset: _____ Prognosis: _____

Claimant injured? ☐ Yes ☐No Date of Injury: _____ Place Injury Occurred: _____

How did injury occur? _____

Subrogation applicable? ☐ Yes ☐ No If "Yes", please provide details: _____

Case Management? ☐ Yes ☐ No Vendor Name & Phone: _____

Claims Paid to Date: $ _____ Claims Pending: $ _____

SOLUTIONS FOR THE UNION WORKPLACE

SPECIFIC STOP LOSS CLAIM

INITIAL FILING *OR* NOTIFICATION FORM

Please submit this form to:
The Union Labor Life Insurance Company
Stop Loss Claims Unit
8403 Colesville Rd., 13th Floor • Silver Spring, MD 20910
Toll free: 800-328-5837 • Fax: 1.202.682.6920
StopLossClaims@ullico.com

SPECIFIC STOP LOSS CLAIM

Total Eligible Benefits this Submission: $ _____

Less Specific Deductible: ($ _____)

Balance: $ _____

Less Previous Claim Submission ($ _____)

Reimbursement Amount Requested (this claim): $ _____

Simultaneous (Advanced) Funding Requested: ☐ Yes ☐ No

Simultaneous Funding Amount being Requested: $ _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ATTACHED *FRAUD NOTICE*, THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

Authorized Signature: _____ Date: _____

Printed Name: _____ E-Mail: _____

Title: _____ Phone: _____

Company Name_____ Relation to Policyholder: _____

Mailing Address: _____

_____

To expedite your request, please include copies of the following Documents (as applicable):

Proof of Eligibility
- Enrollment Form (initial/current)
- Copy of Hour Bank/Dollar Bank
- Proof of Premium Payments
- COBRA Election form & Proofs of payments
- Court Orders
- Election Form/Medicare Card
- Coordination of Benefits/Other Insurance

Complete Paid Claims Detail/History Report
Deductible/Coinsurance - Proof of satisfaction
Facility Universal Bill/DRG Code
Itemized Bills/Electronic Claim Data
R&C Calculations for Out of Network Claims
Copy of Contracted/Case rates
Proof of Precertification/Approval
Hospital Audits/Reviews findings
Hospital Records/Medical Reports
Large Case Management Reports
Proofs of Payment
Cumulative paid claims report
Investigative materials to support claim:
- Subrogation information
- Work Comp information
- Accident Details (police report, etc.)

Please submit this form to:
The Union Labor Life Insurance Company
Stop Loss Claims Unit
8403 Colesville Rd., 13th Floor • Silver Spring, MD 20910
Toll free: 800-328-5837 • Fax: 1.202.682.6920
StopLossClaims@ullico.com

FRAUD NOTICE TO INCLUDE ON EACH CLAIM/APPLICATION FORM

California: For your protection, California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

MONTHLY AGGREGATE ACCOMMODATION
REIMBURSEMENT FORM

Please submit this form to:
The Union Labor Life Insurance Company
Stop Loss Claims Unit
8403 Colesville Rd., 13th Floor • Silver Spring, MD 20910
Toll free: 800-328-5837 • Fax: 1.202.682.6920
StopLossClaims@ullico.com

Plan Sponsor (Group) Name: _____ **Policy #:** _____

Contract Basis: _____ **Effective Date:** _____ **Expiration Date:** _____

A.	**Total Paid Claims through** ___ / ___ / _____	$ _____
B.	Less: Claims paid outside the Aggregate Contract	$ _____
C.	Less: Claims exceeding specific deductibles/loss limit	$ _____
D.	**Net Claim**	$ _____
E.	Year-To-Date Attachment Point through ___ / ___ / _____	$ _____
F.	Year-To-Date Minimum Annual Attachment Point* through ___ / ___ / _____	$ _____ *
G.	**Excess of attachment Point**	$ _____
H.	Less: Total Previous Reimbursements	$ _____
I.	**Total amount of accommodation requested****	$ _____ **

* To calculate the Year-To-Date Minimum Annual Attachment Point (F), divide the annual Minimum Attachment Point (Minimum Aggregate Deductible) by 12, then multiply by the number of months that the accommodation has been in effect.

** Total amount of accommodation requested (I) will be line D less the higher of line E of F, less any amounts listed on H.

PLEASE READ BEFORE SIGNING

Monthly Deductible Advance Reimbursement [MDAR] requests must be received within 15 days following the end of the month for which the accommodation is requested.

Enclosed are our Paid Claims Analysis (showing the incurred date of each loss, date of payment, amount of each payment and payee) and the Monthly Loss Summary Report (showing monthly census and claims).

I hereby certify that all checks totaling the amount entered on item A above, have been mailed to the payee.

I CERTIFY FURTHER THAT I HAVE READ AND UNDERSTAND THE ATTACHED *FRAUD NOTICE*, THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

_____ _____
Authorized Signature Date

_____ _____
Printed Name Title

_____
TPA/Administrator & Address

_____ _____
Phone Email Address

Please submit this form to:
The Union Labor Life Insurance Company
Stop Loss Claims Unit
8403 Colesville Rd., 13th Floor • Silver Spring, MD 20910
Toll free: 800-328-5837 • Fax: 1.202.682.6920
StopLossClaims@ullico.com

FRAUD NOTICE TO INCLUDE ON EACH CLAIM/APPLICATION FORM

California: For your protection, California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application
for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

YEAR END AGGREGATE
CLAIM FORM

Please submit this form to:
The Union Labor Life Insurance Company
Stop Loss Claims Unit
8403 Colesville Rd., 13th Floor • Silver Spring, MD 20910
Toll free: 800-328-5837 • Fax: 1.202.682.6920
StopLossClaims@ullico.com

Plan Sponsor (Group) Name: _____ **Policy #** _____

Contract Basis: _____ **Effective Date:** _____ **Expiration Date:** _____

A.	**Total Paid Claims**	$ _____
B.	Less: Claims paid outside the Aggregate Contract	$ _____
C.	Less: Claims exceeding specific deductibles/loss limit	$ _____
D.	**Net Claim**	$ _____
E.	Year-To-Date Attachment Point [Monthly Accommodations]	$ _____
F.	Minimum Annual Attachment Point [Minimum Aggregate Deductible]	$ _____
G.	**Excess of attachment Point**	$ _____
H.	Less: Total Previous Reimbursements	$ _____
I.	**Reimbursement Due**	$ _____

PLEASE INCLUDE THE FOLLOWING TO AVOID DELAY:

1. Paid Claim Analysis Report showing name of claimant, incurred date, charge, payment amount and date
2. Eligibility listing which identifies birth date, effective date, termination date and coverage type
3. Proof of funding (including monthly bank statements and/or deposit slips)
4. Void / Refund report
5. Benefit / Service Code report
6. Aggregate Report – Monthly Summary Report
7. Specific Report showing claimants have exceeded the Specific Deductible/Loss Limit
8. Payments made outside the Aggregate Contract (i.e., Dental, Weekly Income, Vision, etc)
9. Yearly Check Register
10. Outstanding overpayments and subrogation issues
11. Rx invoices with detail listing (if covered under the aggregate contract)

PLEASE READ BEFORE SIGNING

I hereby certify that, to the best of my knowledge, after reasonable inquiry: (1) that the information stated herein is correct; (2) that the claim has been processed and is eligible in accordance with the Schedule of Benefit/Employee Benefit Plan; and (3) that all the indicated expenses have actually been unconditionally paid on behalf of the Plan as required by the Stop Loss Contract.

I CERTIFY FURTHER THAT I HAVE READ AND UNDERSTAND THE ATTACHED *FRAUD NOTICE*, THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

YOU MUST FILE REIMBURSEMENT REQUESTS WITHIN 90 DAYS AFTER THE END OF THE TIME SPECIFIED FOR PAYMENT OF CLAIMS UNDER THE STOP LOSS POLICY. FAILURE TO DO SO WILL RESULT IN CLAIM DENIAL.

_____ _____
Authorized Signature Date

_____ _____
Printed Name Title

_____
TPA/Administrator & Address

_____ _____
Phone Email Address

Please submit this form to:
The Union Labor Life Insurance Company
Stop Loss Claims Unit
8403 Colesville Rd., 13th Floor • Silver Spring, MD 20910
Toll free: 800-328-5837 • Fax: 1.202.682.6920
StopLossClaims@ullico.com

FRAUD NOTICE TO INCLUDE ON EACH CLAIM/APPLICATION FORM

California: For your protection, California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false,
incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application
for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

WORK STATUS QUESTIONNAIRE

Please submit this form to:
The Union Labor Life Insurance Company

8403 Colesville Road
Silver Spring, MD 20910
202.682.0900

The Ullico Family of Companies

This information is needed in order to verify that the claimant's benefit continuation during the absence from work was in accordance with the continuation of coverage requirements outlined in the Summary Plan Description (SPD). Please review the information below and provide the necessary documentation.

Date: _____

RE: Claimant: _____ , [Employee or Dependent]

Employer /Fund Name [Policyholder]
Stop Loss Group Number [Policyholder Group Number]
Stop Loss Effective Date [Policyholder Effective Date]

This information is needed in order to verify that the claimant's benefit continuation during the absence from work was in accordance with the continuation of coverage requirements outlined in the Summary Plan Description (SPD). Please review the information below and provide the necessary documentation.

1) Has the employee missed any work due to illness/injury within the last 12 months? Please check: ☐ Yes ☐ No

If yes, please provide the actual dates [MM/DD/YY] for the following:

a. When was the last day the employee was actively at work? _____/_____/_____
b. What was the date the employee returned to work? _____/_____/_____
c. What is the employee's Hire Date? _____/_____/_____
d. What is the employee's Original Effective Date of Coverage? _____/_____/_____

2) Sick Days: For the time missed from work, what were the number of sick days used and what were the dates of the sick time?

a. Total # sick days used _____
b. **Dates of sick time**:
   i. From _____/_____/_____ To: _____/_____/_____
   ii. From _____/_____/_____ To: _____/_____/_____
   iii. From _____/_____/_____ To: _____/_____/_____

3) Vacation Days: For the time missed from work, what were as the number of vacation days used and what were the dates of the vacation time?

a. Total # vacation days used _____

WORK STATUS QUESTIONNAIRE

Please submit this form to:
The Union Labor Life Insurance Company

8403 Colesville Road
Silver Spring, MD 20910
202.682.0900

The Ullico Family of Companies

b. **Dates of vacation time**:

i. From _____/_____/_____ To: _____/_____/_____

ii. From _____/_____/_____ To: _____/_____/_____

iii. From _____/_____/_____ To: _____/_____/_____

4) How is the employee's coverage being continued under the Plan during his/her illness or injury? (Please select from one of the following:)

a. **Employee is Actively at Work** Yes_____ No_____

b. **Employee is Retired** [Indicate Date Retired:] _____/_____/_____

i. Premiums are paid by: (Please check only one)

□ Employee □ Employer □ Both

c. **Family Medical Leave Act (FMLA)** [Indicate]

i. Effective Date _____/_____/_____

ii. End Date _____/_____/_____

iii. Total Hours Scheduled to Work: _____ Hours

iv. *Premiums are paid by: (Please check only one)

□ Employee □ Employer □ Both

d. **Medical/Disability Leave of Absence (LOA);**

i. Effective Date _____/_____/_____

ii. End Date _____/_____/_____

iii. *Premiums are paid by: (Please check only one)

□ Employee □ Employer □ Both

e. **COBRA**

i. Effective Date _____/_____/_____

ii. End Date _____/_____/_____

iii. Qualifying Event _____

iv. How are Premiums paid? (Please check only one)

□ Monthly □ Quarterly □ Annually

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

WORK STATUS QUESTIONNAIRE

Please submit this form to:
The Union Labor Life Insurance Company

8403 Colesville Road
Silver Spring, MD 20910
202.682.0900

The Ullico Family of Companies

Please supply supporting documentation if employee is on FMLA, Leave of Absence (LOA) or COBRA, including any of the following that apply:

- ☐ Employee Handbook which explains the FMLA or LOA policy;
- ☐ Proof of Premium Payments during leave
- ☐ COBRA Election Form
- ☐ Proof of COBRA Premium Payments.
- ☐ Banked Hours – Please provide copy of Banked Hours and/or verification of self-pay premiums.

_____

Signature & Date

_____

Authorized Signatory (Company & Title)

_____

Telephone Number

Part Two:

A P P E N D I X

Appendix A: PRIVACY NOTICE

Facts	**WHAT DOES ULLICO DO WITH YOUR PERSONAL INFORMATION?**
Why?	Ullico values you as a customer and wants you to know that protecting your privacy is very important to us. We are required by law to inform you of our policies and procedures for collecting, protecting, using and sharing your nonpublic personal information. Please read this notice carefully to understand what we do.
What?	• 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. • Information provided during our business transactions with you, such as your claims history or payment history. • Information provided by third parties, including medical records, credit reports and eligibility records.
How?	Financial services companies, like the Ullico Inc. family of companies, need to share customers' personal information for everyday business. We list those reasons below, the reasons we choose to share customers' personal information, and whether you can limit this sharing.

Reasons Ullico can share your personal information	**Does Ullico share**	**Can this sharing be limited**
In the normal course of our business operations – to selected third parties as permitted or as required by law. 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.	Yes	No
Ullico Marketing – We collect and use nonpublic personal information to notify you of products and services that we offer and to third parties that assist us in marketing our products and services to you.	Yes	No
For nonaffiliates to market to you.	Yes	Yes

To limit our sharing	Call us at 800-820-2740 our menu will prompt you through your choices. Or Visit us online at https://www.unioncare.com/Opt-Out Please note: If you are a new customer, we can begin sharing your information 30 days from the date we sent this notice. When you are no longer our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions	Call 800-820-2740 or go to Ullico.com if you would like more information concerning our privacy policies.

Who We are	
Who is providing this notice?	The Ullico family of companies. A list of its companies is located at the end of this document.
What We do	
How does Ullico protect my personal information?	We maintain physical, electronic and procedural 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 comply with our privacy policies and procedures.
How does Ullico collect my personal information?	We collect information from you from the following sources: • Information provided on applications • Information provided through claims and payments • Information provided by third parties, including medical records, credit reports and eligibility records
Why can't I limit all sharing?	Federal law gives you the right to limit only • Sharing for affiliates' everyday business purposes – information about your creditworthiness • Affiliates from using your information to market to you • Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more information on your rights under state law.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and non-financial companies
Nonaffiliates	Companies not related by common ownership or control. They can be financial and non-financial companies. • We do not share nonpublic personal information with nonaffiliates.

Other Important Information
State Laws: VT: Accounts with a Vermont mailing address are automatically treated as if they have limited the sharing as described on page 1. For joint marketing, we will only disclose your name, contact information and information about your transactions. NV: We are providing you this notice pursuant to Nevada law. If you prefer not to receive marketing calls from us, you may be placed on our Internal Do Not Call List by calling 1–800–820–2740, or by writing to us at 8403 Colesville Road, Silver Spring, MD 20910 Attn: Privacy Officer or see www.ullico.com. For more information, contact us at the address above. You may also contact the Nevada Attorney General's office: Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington St., Suite 3900, Las Vegas, NV 89101; telephone number: 1–702–486–3132; email BCPINFO@ag.state.nv.us. CA: We will not share information we collect about you with nonaffiliated third parties, except as permitted by California law, such as to process your transactions or to maintain your policies or accounts.

Who is providing this notice?

The Union Labor Life Insurance Company UnionCare, LLC

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:

The Union Labor Life Insurance Company

8403 Colesville Road

Silver Spring, MD 20910

Attn: Privacy Officer

Telephone: 1-800-431-5425

Email: Compliance@ullico.com

Website: www.ullico.com

Appendix B: INSURANCE FRAUD AND FRAUDULENT ACTIVITIES

It is the policy of The Union Labor Life Insurance Company to detect, investigate and refer suspected fraudulent insurance activities. The Union Labor Life Insurance 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 customers.

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.

The Union Labor Life Insurance Company has contracted with an anti-fraud investigative service provider that acts as its Special Investigative Union (SIU). The Company will first identify those matters that exhibit fraud related indicators, red-flag event, and situations or behaviors indicative of fraud schemes. Those matters identified will then be directed to the SIU for specialized handling. The list of fraud related indicators and red-flag events and the procedures for referring suspected fraudulent activity are included in the attached Fraud Policies and Procedures.

Fraud Policy and Procedures

The Union Labor Life Insurance Company - NAIC# 69744

(The above will hereinafter be referred to as "the Company")

Contacts:

Richard LaRocque VP Deputy Chief Compliance Officer Ullico Inc.	8403 Colesville Road Silver Spring, MD 20910 Ph:202-962-8951 Fax: 202-682-6784 Email: rlarocque@ullico.com
Christine Mullen AVP, Compliance The Union Labor Life Insurance Company	8403 Colesville Road Silver Spring, MD 20910 Ph: 202-682-7928 Fax: 202-682-4682 Email: cmullen@ullico.com
Sarah Whigham, CIFI, FCLA AVP - SIU Compliance Allied Universal Compliance and Investigations	910 Paverstone Drive Raleigh, NC 27645 Ph: 336-631-6554 Email: sarah.whigham@aus.com

Table of Contents

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 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 customers. We are steadfast in providing thorough training to our personnel 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 business written by the Company, which currently include Life, Accidental Death & Dismemberment, Disability, Stop Loss, Hospital Indemnity, and others. 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.

The Integral Anti-Fraud Personnel's Investigation Responsibilities may include:

- Identify and document suspected insurance fraud during the handling of insurance transactions
- Refer suspected insurance fraud to the SIU
- Ensure fair claims handling and ensure compliance with policy and state statutes
- Be aware of all indicators and profiles/follow up as required
- Be a claims professional
- Confirm coverage, liability
- Be the Point of Contact on all matters regarding the reported claim
- Schedule, coordinate and conduct interviews and statements
- Develop an investigation plan
- Control claim (Diary, Follow-up, Consultation, and Resolution)
- Review prior claim history and policy information
- Review the results of the investigation and process the claim in a fair and appropriate manner

- Comparison of any insurance transaction against patterns or trends of possible fraud, red flags, events, or circumstances present on a claim, behavior, or history of person(s) submitting a claim or application and other criteria that may indicate possible fraud

The SIU provides notice to all integral anti-fraud personnel of fraud indicators, guidelines for investigations, information disclosures, procedures for reporting to the SIU and DOI Fraud Division, statement-taking techniques, state statutes and regulations, as well as ever changing case law, and the extent and limitation of SIU authority.

The integral anti-fraud personnel specifically receive scenario indicators which can assist in the detection of fraud at all levels, from the application to the claims process. The integral anti-fraud personnel are advised that indicators are not conclusive of fraudulent activity but demand a higher level of scrutiny. All SIU and integral anti-fraud personnel are educated as to the value of the indicators and timely and accurate recognition of questionable claims. The integral anti-fraud personnel have been advised of the specific areas to review to determine the possibility of a fraudulent application. These areas include, but may not be limited to, previous claims history, a previously cancelled or non-renewed insurance policy and financial information on the insured to include bankruptcy, liens, and judgments.

Underwriting Guidelines

The opportunity to detect and prevent fraud in the application process is the responsibility of The Company's underwriting department. Steps are taken in each line of insurance to verify the information supplied on the application. These procedures are periodically reviewed and refined to enhance the current workflow procedures and to ensure compliance.

Underwriters are instructed to contact Allied Universal immediately when suspicious occurrences are detected.

Group Life and Health

The Underwriting Department screens personal Lines applications, renewals and endorsements

The following is an example of the steps taken to verify information submitted and, therefore, to control potential fraud in the application process.

A. Group must exist for reasons other than that of obtaining insurance and be financially sound (length of time in business). The individual who signs the application must be authorized to contract for the group.

B. The group must have a central location in a state where Ullico is both licensed and is selling Life and Health Insurance. The group will assume responsibility for administrative duties such as: enrollment, premium collection and payroll deduction, remittance of premium, record keeping and assistance with claims.

C. A minimum of ten lives are required (100 for Stop Loss).

D. Only active, full-time employees who receive a regular salary and work a minimum of 30 hours per week are covered. This includes partners and owners.

Our clients may utilize the SIU to assist with the prevention and detection of application fraud.

The above underwriting steps are an illustration of some of the practices used to determine the accuracy of information submitted at the time of application and renewal. While they are not all inclusive of the investigation done to reduce application fraud potential, they are routine and show the commitment of the Company to maintain the integrity of policies. Underwriters are instructed to contact Allied Universal immediately when suspicious occurrences are detected.

Most applicants for insurance coverage are trustworthy, but some are dishonest. Therefore, agents are expected to review all applications for possible fraud. Determining the "fraud potential factor" of any application is facilitated when the agent is familiar with various fraud indicators.

These indicators should help isolate those applications which 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 a fraud is being committed. Indicators of possible fraud are "red flags" only, not actual evidence.

Suspicious applications may have to be accepted for lack of conclusive evidence of fraud; however, the underwriter should be made aware of the agent's suspicions, and subsequent referral for further review may be appropriate.

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.

Compliance with State Regulations

California Statute - 10 CCR § 2698.35 **Detecting Suspected Insurance Fraud.**
(a) An insurer's integral anti-fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.
(b) The SIU shall establish, maintain, distribute and monitor written procedures to be used by the integral anti-fraud personnel to detect, identify, document and refer suspected insurance fraud to the SIU. The written procedures shall include a listing of the red flags to be used to detect suspected insurance fraud for the insurer. The red flags listed pursuant to the immediately preceding sentence shall be specific to each line of insurance, or each insurance product, transacted in or issued by the insurer.

(c) The procedures for detecting suspected insurance fraud shall provide for comparison of any insurance transaction against red flags and other criteria that may indicate possible fraud.

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. California Mandatory Reporting Statutes

It is the SIU's responsibility to document in the file the suspected insurance fraud identified by the insurance professional (i.e., red flag indicators). The SIU is then responsible to conduct an effective investigation to determine if reasonable belief is established by confirming if the red flag indicators are still present or if the red flag indicators were resolved. If the red flag indicators remain after the investigation, the SIU has now established "reasonable belief." When the SIU has confirmed "reasonable belief" that a person has committed insurance fraud, the SIU will file the eFD-1 to the CDI and/or applicable District Attorney's office within 60 days of discovery for all lines of business.

CCR §2938.37(c) points out that referrals shall be made within the period specified by statute. The specific statute is located at *California Insurance Code (CIC) Sections* 1872.4 (all insurance except for Automobile and Workers' Compensation. This insurance code section addresses when a referral must be made to the Fraud Division (and district attorney, when applicable):

- *CIC Section 1872.4* requires a referral within 60 days of determining reasonable belief for all lines of insurance.

CA Insurance Code 1872.4

(a) Any company licensed to write insurance in this state that has determined, after the completion of the insurer's special investigative unit investigation, that it reasonably suspects or knows an act of insurance fraud may have occurred or might be occurring shall, within 60 days after that determination by the insurer, send to the Fraud Division, on a form prescribed by the department, the information requested by the form and any additional information relative to the factual circumstances regarding the alleged insurance fraud and person or entity that may have committed or is committing insurance fraud, as specified in Section 2698.38 of Title 10 of the California Code of Regulations. The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations. Whenever the commissioner is satisfied that fraud, deceit, or intentional misrepresentation of any kind has been committed in the submission of the claim, claims, application, or other insurance transaction, the commissioner shall report the violations of law to the insurer, to the appropriate licensing agency, and to the district attorney of the county in which the offenses were committed, as provided by Sections 12928 and 12930. If the commissioner is satisfied that fraud, deceit, or intentional misrepresentation has not been committed, the commissioner shall report that determination to the insurer. If prosecution by the district attorney concerned is not begun within 60 days of the receipt of the commissioner's report, the district attorney shall inform the commissioner and the insurer as to the reasons for the lack of prosecution regarding the reported violations.

(b) This section shall not require an insurer to submit to the Fraud Division the information specified in subdivision (a) in either of the following instances:

(1) The insurer's initial investigation indicated a potentially fraudulent claim but further investigation revealed that it was not fraudulent.

(2) The insurer and the claimant have reached agreement as to the amount of the claim and the insurer does not have reasonable grounds to believe that claim to be fraudulent.

(c) Nothing contained in this article shall relieve an insurer of its existing obligations to also report suspected violations of law to appropriate local law enforcement agencies.

(d) Any police, sheriff, disciplinary body governed by the provisions of the Business and Professions Code, or other law enforcement agency shall furnish all papers, documents, reports, complaints, or other facts or evidence to the Fraud Division, when so requested, and shall otherwise assist and cooperate with the division.

(e) If an insurer, at the time the insurer, pursuant to subdivision (a) forwards to the Fraud Division information on a claim that appears to be fraudulent, has no evidence to believe the insured on that claim is involved with the fraud or the fraudulent collision, the insurer shall take all necessary steps to assure that no surcharge is added to the insured's premium because of the claim.

CA Insurance Code 1872.41

(a) An agent or broker who, before placing an insurance application with an insurer, reasonably suspects or knows that a fraudulent application is being made shall, within 60 days after the determination by the agent or broker that the application appears to be fraudulent, submit to the Fraud Division, using the electronic form within Fraud Division's Consumer Fraud Reporting Portal, the information requested by the form and any additional information relative to the factual circumstances of the application and the alleged material misrepresentations contained in the application. All data fields within the Fraud Division's Consumer Fraud Reporting Portal electronic form shall be completed accurately, to the best of the agent or broker's ability. An agent or broker shall not submit a fraud referral anonymously. The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations.

(b) An agent or broker who, after an insurance application has been placed with an insurer, reasonably suspects or knows that fraud has been perpetrated shall report that information directly to the insurer's special investigative unit. An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to the insurer's special investigative unit upon request, and shall otherwise assist and cooperate with the insurer's special investigative unit.

(c) An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to the department upon request, and shall otherwise assist and cooperate with the department.

(d) (1) For purposes of this section, an "agent or broker" is a natural person licensed to transact insurance in a capacity described in Section 1625, 1625.5, 1625.55, 1626, or 1758.1 and is not the employee of an insurer.

(2) An agent or broker is not considered a "contracted entity" or "integral antifraud personnel" pursuant to Section 2689.30 of Title 10 of the California Code of Regulations.

CA Insurance Code 1872.51

(a) An agent or broker who furnishes written or oral information pursuant to Section 1872.41, or an authorized governmental agency, or its employees, that furnishes or receives written or oral information pursuant to Section 1872.41 or assists in an investigation of a suspected insurance fraud violation conducted by an authorized governmental agency, shall not be subject to any civil liability in a cause or action if the insurer, authorized agent, agent or broker, or authorized governmental agency acted in good faith, without malice, and reasonably believes that the action taken was warranted by the then-known facts, obtained by reasonable efforts.

(b) This chapter does not abrogate or lessen the existing common law or statutory privileges and immunities of an insurer, agent authorized by that insurer to act on its behalf, agent or broker, licensed rating organization, or any authorized governmental agency or its employees.

Title 10 of the California Code of Regulations. Section 2698.35 Detecting Suspected Insurance Fraud

(a) An insurer's integral anti-fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.

(b) The SIU shall establish, maintain, distribute and monitor written procedures to be used by the integral anti-fraud personnel to detect, identify, document and refer suspected insurance fraud to the SIU. The written procedures shall include a listing of the red flags to be used to detect suspected insurance fraud for the insurer. The red flags listed pursuant to the immediately preceding sentence shall be specific to each line of insurance, or each insurance product, transacted in or issued by the insurer.

(c) The procedures for detecting suspected insurance fraud shall provide for comparison of any insurance transaction against red flags and other criteria that may indicate possible fraud.

Title 10 of the California Code of Regulations. Section 2698.37 Referral of Suspected Insurance Fraud.

(a) The SIU shall provide for the referral of acts of suspected insurance fraud to the Fraud Division and as required, district attorneys.

(b) Referrals shall be submitted in any insurance transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud.

(c) Referrals shall be made within the period specified by statute.

(d) The SIU shall complete as much of its investigation as is reasonable prior to the time the referral is made to the Fraud Division. Each referral of suspected insurance fraud shall indicate whether the investigation is complete or further investigation is needed.

(e) The requirements of this section do not affect the immunity granted under California Insurance Code section 1872.5 or other such similar codes contained in the Insurance Frauds Prevention Act.

(f) The requirements of this section do not diminish statutory requirements contained in the Insurance Frauds Prevention Act regarding the confidentiality of any information provided in connection with an investigation.

4. SPECIAL INVESTIGATIONS UNIT (SIU)

4.1 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.

4.2 The Company SIU

To fulfill its statutory requirements, and exceed its quality standards, the Company contracts with **Allied Universal Compliance and Investigations (Allied Universal)**, an international anti-fraud investigative service provider, that shall act as its Special Investigation Unit (SIU).

Company representatives, integral to the insurance fraud detection and identification process, will identify those matters that exhibit fraud related indicators, red flags, red flag events, and situations or behaviors demonstrative of suspected fraud schemes and activities. Those matters identified are directed to the SIU for specialized handling to be completed in accordance with the Detection, Review and Referral Policy outlined in this Plan.

The Company's Special Investigation Unit program is a comprehensive strategy designed to assist our integral anti-fraud professionals, including claims, underwriting, and other designated personnel with preventing, detecting, and investigating insurance transactions containing suspected fraud. The Fraud Prevention & Detection Plan also intends to minimize claim exposures through enhanced information verification and intelligence capabilities.

The Special Investigation Unit was created to provide the integral personnel with a national investigative program managed and staffed by experienced professionals. The Company's contracted and outsourced investigations company, Allied Universal, provides Special Investigation Services,

Surveillance, Fraud and Claim Investigation Training, SIU Compliance & Reporting, Auditing and Consulting, and other related services.

The Company, including its SIU, shall review, analyze, and investigate suspected fraudulent activities. The Company will utilize its experience and professional discretion to validate the information presented and the accuracy of the claim, application, or other suspect insurance transaction.

Where mandated by state statute and/or regulations for the reporting of suspected insurance fraud, filing of fraud plans or annual reports, and anti-fraud education, the Company will ensure good faith compliance to fulfill the requirements.

The VP Deputy Chief Compliance Officer and the Assistant Vice President Compliance act as the liaisons to the SIU. They monitor the referral of any suspicious activity to the SIU. The SIU is responsible for thoroughly investigating these matters and reporting such matters to the appropriate law enforcement authorities.

The SIU's investigations of suspicious activity may include:

- Analysis of referred case files and development of an investigation plan;
- Perform a thorough analysis of the claim file, application, or insurance transaction by reviewing every document within the file;
- Compiling of relevant information for the commencement of civil litigation and/or the referral to the appropriate regulatory and/or law enforcement agency;
- Documentation of all investigative activity;
- Identification of relevant witnesses and quality statements secured from those witnesses who may provide information on the accuracy of the claim or application;
- Physical evidence is identified, collected, safeguarded, documented and preserved;
- Conducting of interviews and recorded statements of insureds, claimants, witnesses, and other persons who may have information relevant to the suspected fraudulent activity;
- Preparation of investigative reports;
- Attending examinations and supporting legal counsel involved in SIU investigations;
- Creation and delivery of anti-fraud education/training.

Investigating Suspected Insurance Fraud – CA Best Practices

An investigation of possible suspected insurance fraud shall include:

(1) A thorough analysis of a claim file, application, or insurance transaction that includes consideration of factors indicating insurance fraud by reviewing every document within the file.

(2) Identification and interviews of potential witnesses who may provide information on

the accuracy of the claim or application. SIU will ensure quality statements are secured from those witnesses who may provide information on the accuracy of the claim or application.

(3) Utilizing one or more industry-recognized databases to assist in all SIU investigations when appropriate for use during the investigation specifically relating to the particular line of business and suspected fraud. (See Pages 13-14 for full list of databases used by the SIU).

(4) Identification, collection, safeguarding documenting and preserving all evidence and documentation obtained during the investigation.

(5) Writing a concise and complete summary of the entire investigation, which is specific to the investigation at hand, including the investigator's findings regarding the suspected insurance fraud and the basis for their findings. The Summary will be a separate report from any other document prepared in connection with each investigation. (See below for Workflow for SIU Investigations).

Workflow for SIU Investigations:

- Initial Referral comes into the SIU.
- SIU referral is accepted or rejected by SIU depending on suspected fraud.
- If red flags are present, we will classify as a SIU referral. All referrals to SIU will be classified as a SIU referral if the referring party clearly identifies the fraud indicators.
- If no red flags are present or other non-suspect reason for a referral, we will classify the referral as an SIU assist investigation, also known as a claim assist investigation.
- SIU will thoroughly analyze the insurance documents and determine the proper investigative steps needed which may include interviews of potential witnesses who may provide information on the accuracy of the claim or application, surveillance or utilizing databases and will conduct an effective investigation to determine if reasonable belief is established or if the red flag indicators can be resolved.
- On all referrals that come to the SIU with red flags present, SIU will write a clear and concise summary of the findings noting they have either substantiated reasonable belief or ruled it out.

The Clear & Complete Summary will include answers to all of the following questions:

(A) What facts caused the reporting party to believe insurance fraud occurred or may have occurred?

(B) What are the suspected misrepresentations and who allegedly made them?

(C) How are the alleged misrepresentations material and how do they affect the claim or insurance transaction?

(D) Who are the pertinent witnesses to the alleged misrepresentation if there are pertinent witnesses?

(E) What documentation is there of the alleged misrepresentation, if documented?

(F) In addition, the summary prepared shall include a statement as to whether or not the investigation is complete.

Each investigation of suspected insurance fraud shall include performing at least the procedures specified pursuant to subdivision (a) of this Section 2698.36, to the extent they are applicable.

The SIU shall investigate each credible referral of suspected insurance fraud that it receives from integral anti-fraud personnel, including automated or system-generated referrals via. PartnerLink. Note: SIU will only identify a referral as an SIU assignment only if credible referral of suspected insurance fraud is one that includes a red flag or red flag events. In the event that upon a preliminary review the SIU determines that it is reasonably clear that the red flag or red flag events contained in the referral is not or are not the result of suspected insurance fraud, the SIU will not open an investigation and the SIU file shall be documented for the reasons supporting its conclusion that the red flag or red flag events contained in the referral is not or are not the result of suspected insurance fraud.

- If reasonable belief was established, an eFD-1 will be filed within 60 days for all lines of business. If red flags are resolved by the investigation, a clear and concise summary will be written and the SIU file closed. The eFD-1 will be submitted at the conclusion of the SIU investigation if reasonable belief has been established effective January 1, 2023. Note: The Summary of the investigation will be written at the case level, not the individual task assignment level as the summary must address the SIU investigation in its entirety regardless of individual objectives and must include a statement as to whether or not the investigation is complete or further investigation is needed.
- Effective January 1, 2023, the 60-day time limit on filing an eFD-1 begins after the completion of an SIU investigation, that it reasonably suspects or knows an act of insurance fraud may have occurred or might be occurring. The 60-day time limit does not start at the time an adjuster, underwriter or other individual notes red flags and does not start at the time the red flags are initially reported to the SIU.

Action plan results shall be communicated in a timely, relevant and factual report. All written reports to our clients shall be professional and supported by relevant documents that are logically organized and all evidence will be properly saved and preserved. Necessary follow-up investigations shall be aggressively pursued and reported in a timely manner.

Fraud Detection Technology - Instruction on the Utilization of Industry Recognized Databases

The SIU utilizes numerous web-based electronic solutions for accessing information from public records and subscription databases. The SIU utilizes various sources of intelligence and data to support and assist the claim examiners in their efforts to detect, investigate, and prosecute fraudulent activities.

In addition to direct access into various local and state governmental record repositories, the SIU utilizes various subscription databases to obtain legally permissible information and public record information from a variety of sources, including but not limited to:

Accurint
Lexis Nexis (Risk Management Solutions)
Verisk ISO Claimsearch
Choicepoint/Orderpoint
Criminal Record Check.com
Denspri
Edex
Records Research
Pacer
FACIS
Carfax
Transunion/TLO
Various state DMVs (AR, CA, IN, KS, NV, NJ, NY, NC, OR, PA, SC, UT, VA)
Social and Professional Networking sites
Various social media searching web crawlers
Miscellaneous resources of the Internet via Search Engines

Comprehensive Nationwide Background Investigation: The Comprehensive Background includes verifying existing or developing new information regarding current employment, 7 year Criminal &

Civil History in current County of residence and up to (3) additional counties identified in a Comprehensive Profile Search, public records check for Bankruptcy, Liens & Judgments, State Driving Record and Vehicle Registrations (where available), Statewide Professional Licenses, a statewide Real Property Ownership Asset Search and a Comprehensive Profile Report.

Skip Tracing: Individual Locate – Allied Universal database researchers use a variety of public and private databases in addition to other investigative methods to locate that individual that just doesn't want to be found.

Real Property Search: Statewide / Nationwide – This comprehensive search for Real Property (real estate) owned by an individual involves a thorough check of Tax Assessor and Deed Transfer records available online. The subject's full name and social security number, at minimum, must be provided. This search can be done for a single state or as a nationwide search of available records.

Social Security Number Search: - A comprehensive search of databases including credit headers, consumer databases, etc., that will return names of individuals associated with the social security number, addresses, phone numbers, and other related information.

Various state DMVs (AR, CA, IN, KS, NV, NJ, NY, NC, OR, PA, SC, UT, VA) – Motor Vehicle Registration records searched by subject's name or by address. Returns information on file with the state DMV and usually includes year, make, model, VIN, owner name and address, and on occasion provides the vehicle tag number, owner's phone number, and lien holder information. (Available in most states)

State Driver's History Record: Transcript of a subject's state motor vehicle driving record. Available in most states.

5. DETECTION OF COMPANY-RELATED FRAUD

Ullico's Audit Department, acting under the supervision of Ullico's Risk Management Group, is responsible for the detection of company-related fraud, including insurance fraud. The Audit Department reports such matters to the Vice President of Enterprise Risk Management, the Chief Compliance Officer and General Counsel and the Audit Committee of the Ullico Board of Directors as applicable. The Audit Department in cooperation with the Law Department and the Human Resources Department is charged with the responsibility of overseeing the investigation of suspected theft, embezzlement, and other fraudulent business practices. The Chief Compliance Officer and the Vice President of Enterprise Risk Management are responsible for notifying law enforcement agencies of suspected theft, embezzlement, and other fraudulent incidents. The Chief Compliance Officer and General Counsel and the Vice President of Enterprise Risk Management are responsible for cooperating with law enforcement agencies in the investigation and prosecution of referred matters. Ullico requests restitution in criminal cases.

The Audit Department periodically audits claims and underwriting procedures and conducts random reviews of closed claims files. The Audit Department 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.

Union Labor Life's group field auditors audit the premium and eligibility information of the group policyholders and insurance producers to verify proper amounts are calculated and remitted to the Company.

Ullico also 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.

Ullico also maintains a third-party vendor web-based ethics site that allows employees to report anonymously any irregular or fraudulent issues as they arise. These issues may be reported through the web site or by telephone using the Compliance Hotline.

To protect data integrity and to prevent fraud, Ullico requires that its employees change their passwords at 60-day intervals and automatically expires unchanged passwords every 60 days. In addition, Ullico 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, Allied Universal Compliance and Investigations.

6. EDUCATION AND TRAINING

All of the Company's employees, MGUs and TPAs must receive new employee anti-fraud training within 90 days of their first day of employment. The SIU also provides annual anti-fraud training and educational materials about the prevention, identification, and detection of insurance fraud to the Company's integral anti-fraud personnel, including its MGUs and TPAs. Anti-fraud training also addresses the objectives, functions and responsibilities of the SIU, and its interaction with government entities such as state insurance departments and law enforcement agencies.

The SIU makes available to the Company personnel such resources as investigative techniques, database information, analysis of insurance fraud practices and fraud trends. The SIU also provides information regarding applicable state and federal law and responds to individual requests for assistance and support.

The Company also reviews and monitors the fraud detection, anti-fraud training and management program of its MGUs and TPAs.

7. DETECTION, REVIEW & REFERRAL POLICY

The Detection Review and Referral Process works as follows:

A. As integral anti-fraud personnel, you have the duty to recognize and investigate suspected fraud activity. Through training, you will recognize potentially fraudulent activity including any "Red Flags". When this occurs, you must immediately notify your supervisor or the appropriate compliance contact of the circumstances leading you to believe a fraud is being committed. Your supervisor or the compliance coordinator will assist you in your initial investigation and where appropriate refer the matter to the SIU for further action as outlined below.

Cases may be assigned via one of the following methods:

1. Allied Universal PartnerLink® (preferred) - https://partnerlink.cni-aus.com
2. Phone 800-927-0456, and report to a SIU Manager (immediate/rush cases)
3. E-mail request to cases@aus.com

***** NOTE: Ullico requires management approval prior to submission of all SIU assignments. *****

B. The following information should be provided by the referrer upon assignment to maximize the benefit of performing an investigation and to protect the adjuster from accusation of potential malicious prosecution charges by the suspect. A Fraud Referral Checklist identifying additional information that may be included in the referral is attached as Appendix 4.

1. Claim Number /Policy Number
2. Red Flags/reason for suspicion of possible fraudulent activity

C. Allied Universal will confirm receipt of each electronic assignment via an email to the requesting adjuster or referrer.

D. Allied Universal will then arrange to review a complete copy of the policy, application and/or claim file, either in person (preferred method) or by having a complete copy of the file, both paper and electronic, sent to the SIU Investigator.

8. 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 “Red Flags” is available at anytime for your reference. Some common fraud indicators are included in Appendix 3 as a reference.

For any additional questions, please contact your supervisor and/or your compliance department.

Appendix 1 – Example Investigative Referral Form

ALLIED UNIVERSAL®
COMPLIANCE AND INVESTIGATIONS

Thank you for choosing Allied Universal for your investigative needs!

We would like to make it as easy as possible to refer your files to Allied Universal. Please find below three **EASY** ways to submit your referrals to Allied Universal:

1. Fill in this form and email to: **cases@aus.com**
2. Allied Universal PartnerLink® (preferred) - https://partnerlink.cni-aus.com
3. Phone 800-927-0456, and report to a SIU Manager (immediate/rush cases)

If you have any questions regarding this form or your investigation, please feel free to call your local Account Manager for assistance.

Client Information:

Your Name:	
Company:	
Address:	
City/State/Zip:	
Phone:	
Fax:	
Email:	

Due Date:	
Today's Date:	
Budget:	
Date of Loss:	
Insured:	
Insurance Carrier:	
Claim/File #:	
Policy #:	
Policy Effective Dates (xx/xx/xxxx - xx/xx/xxxx):	

Assignment Type (Double-Click the box below to check off your type):

☐ State Fraud Referral Only	
☐ SFR and additional SIU Investigation	
☐ I want to talk to the SIU Manager	
☐ Other	

Dollar Amount Paid To Date	
Dollar Amount of Reserves:	
Dollar Amount of suspected fraud:	
Is this file in litigation	
Do you suspect organized ring activity:	
Do you suspect attorney involvement:	
Do you suspect Medical Provider involvement:	

Additional Notes:	

Claim Type (Double-Click the box below to check off your type):

☐ Workers' Compensation	☐ Commercial Liability
☐ Auto Liability	☐ Commercial Theft/Fire/Damage
☐ Auto Property Damage	☐ Disability
☐ Auto Theft/Fire	☐ Life/Health
☐ Homeowner Liability	☐ General Liability
☐ Homeowner Theft/Fire/Damage	☐ Other (Please explain)

FACTS OF LOSS	
LOSS LOCATION	_____ _____ Street Address or Parish County _____ City/State/Zip

Please provide the below information on the Insured

Name:		SSN:	
Address:		DL # & State:	
City/State/Zip:		Sex:	
Home Phone:		Race:	
Cell Phone:		Occupation:	
Work Phone:		Employer:	
State of Loss:		Address:	
DOB:		City/State/Zip:	

Involved Party #2 (Double-Click the box below to check off all that applies):

☐ Claimant	☐ Insured	☐ Witness	☐ Attorney	☐ Medical Provider	☐ Other
☐ I suspect this person or company is committing insurance fraud.					

Name:		SSN:	
Address:		DL # & State:	
City/State/Zip:		Sex:	
Home Phone:		Race:	
Cell Phone:		Occupation:	
Work Phone:		Employer:	
State of Loss		Address:	
DOB:		City/State/Zip:	

Involved Party #3 (Double-Click the box below to check off all that applies):

☐ Claimant	☐ Insured	☐ Witness	☐ Attorney	☐ Medical Provider	☐ Other
☐ I suspect this person or company is committing insurance fraud.					

Name:			SSN:	
Address:			DL # & State:	
City/State/Zip:			Sex:	
Home Phone:			Race:	
Cell Phone:			Occupation:	
Work Phone:			Employer:	
Pager:			Address:	
DOB:			City/State/Zip:	

Involved Party #4 (Double-Click the box below to check off all that applies):

☐ Claimant	☐ Insured	☐ Witness	☐ Attorney	☐ Medical Provider	☐ Other
☐ I suspect this person or company is committing insurance fraud.					

Name:			SSN:	
Address:			DL # & State:	
City/State/Zip:			Sex:	
Home Phone:			Race:	
Cell Phone:			Occupation:	
Work Phone:			Employer:	
Pager:			Address:	
DOB:			City/State/Zip:	

PROVIDE A DETAILED SUMMARY OF WHY YOU SUSPECT THE CLAIM OR UNDERWRITING FILE IS SUSPICIOUS:	

Appendix 2 – SIU Program Contacts

Allied Universal SIU Program Contacts

Please contact the individuals listed below with any questions concerning the Special Investigation Unit and/or the Company Anti-Fraud Plan & Program.

Allied Universal Compliance and Investigations
910 Paverstone Drive
Raleigh, NC 27615
(800) 927-0456
www.aus.com/cni

Sarah Whigham, CIFI, FCLA
Assistant Vice President - SIU Compliance
Allied Universal - SIU
sarah.whigham@aus.com
(336) 613-6554

SIU Leadership Team

Larry G. Henning, CFE CIFI
Senior Vice President
larry.henning@aus.com
Phone: (336) 830-9660

Brett Douglas, CFE, CIFI
Executive Vice President – Operations
bretton.douglas@aus.com
Phone: (919) 334-9278

Appendix 3 – "Red Flags"

Identifying a Claimant for Covert Surveillance

- The claimant has a history of malingering in prior claims
- The claimant has discontinued medical treatment for extended periods but still claims total disability
- The medical provider Rehab reports indicate a healthy-looking claimant with no current medical complaints
- Medical providers fail to provide an objective basis for the disability
- The claimant has detailed knowledge of the insurance claims process
- The claimant can never be directly reached at home
- Tips received from neighbors, co-workers, and friends that the claimant is exaggerating their medical condition
- The claimant was employed in an industry or company experiencing current lay-offs and/or downsizing
- The claimant's time to reach maximum medical improvement is beyond the standard without any objective medical rationale
- The claimant's demands for payment and or lump sum settlement are excessive and/or premature
- The claimant refuses to provide a home telephone number and only utilizes a cellular phone and or pager for adjuster contact
- The claimant only provides a P.O. Box for receiving mail and refuses to provide a physical street address
- The claimant's occupation is a seasonal type of job and the active labor season is coming to a close
- The claimant is disgruntled with their current employment, facing disciplinary action or imminent termination, or is retiring in the near future
- The claimant is facing disciplinary action and/or revocation of their professional licensing
- Adjuster receives conflicting medical opinions from medical providers as to the claimant's disability and/or extent of restrictions
- Claimant recently purchased new disability policy or had recently increased the coverage limits
- The claimant has multiple disability policies
- The claimant has more than one active workers' compensation claim pending at the same time that arise from different incidents
- The treatment being provided the claimant is inconsistent with the report diagnosis
- The claimant is utilizing a medical provider and/or attorney with a reputation of handling suspect claims
- The claimant's medical provider is providing "boiler plate" or "template" medical reports and findings
- The claimant is receiving immediate referrals for "psychological counseling" and/or stress at the on-set of the disability
- Information is learned that the claimant is possibly engaged in active employment although they claim a total disability
- The claimant is actively involved in a physical sport or hobby although they claim their disability prevents them from engaging in sedentary employment

Application/Underwriting Fraud Indicators

Most applicants for insurance coverage are trustworthy, but some are dishonest. Therefore, it is appropriate for the agent to review all applications for possible fraud. Determining the "fraud potential factor" of any application is facilitated when the agent is familiar with various fraud indicators.

These indicators should help isolate those applications which 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 a fraud is being committed. Indicators of possible fraud are "red flags" only, not actual evidence.

Suspicious applications may have to be accepted for lack of conclusive evidence of fraud; however, the underwriter should be made aware of the agent's suspicions, and subsequent referral to the appropriate State Department of Insurance Fraud Bureau (if applicable) or local, state or federal law enforcement agency for further review may be appropriate.

General Indicators of Application Fraud

- Unsolicited, new walk-in business, not referred by existing policyholder
- Applicant walks into agent's office at noon or end of day when agent and staff may be rushed
- Applicant neither works nor resides near the agency
- Applicant's given address is inconsistent with employment/income
- Applicant gives post office box as an address
- Applicant has lived at current address less than six months
- Applicant has no telephone number or provides a mobile/cellular phone number
- Applicant cannot provide driver's license or other identification or has a temporary, recently issued, or out-of-state, driver's license
- Applicant wants to pay premium in cash
- Applicant pays minimum required amount of premium
- Applicant suggests price is no object when applying for coverage
- Applicant's income is not compatible with value of vehicle to be insured
- Applicant is never available to meet in person and supplies all information by telephone
- Applicant is unemployed or self-employed in transient occupation (e.g. roofing, asphalt)
- Applicant questions agent closely on claim handling procedures
- Applicant is unusually familiar with insurance terms or procedures
- Application is not signed in agent's view (e.g. mailed in)
- Applicant is reluctant to use mail
- Applicant works through a third party
- Applicant returns the completed application unsigned
- Applicant has had driver's license for significant period, but not prior vehicle ownership and/or insurance

Indicators Associated With Coverage

- Name of previous insurance carrier or proof of prior coverage cannot be provided
- No prior insurance coverage is reported although applicant’s age would suggest prior
- Significant break-in coverage is reported under prior coverage
- Question about recent prior claims is left unanswered
- Full coverage is requested for older vehicle

- No existing damage is reported for older vehicle
- Exceptionally high liability limits are requested for older vehicle inconsistent with applicant's employment, income or lifestyle

General Fraud Indicators

General Fraud Indicators

- Recently increased limits
- History of claims activity
- Familiar with insurance claims terms and procedures
- Refrains from using the mail - conducts business in person
- No police report or on-scene police report
- Aggressive demands for quick settlement, sometimes for less than full value
- Threatens to contact higher company authority to push demands
- Recently issued policy; walk-in business
- Photocopies of supporting documentation
- Subject reports P.O. Box or Private Mailbox [PMB] as home physical address
- Unreasonable delay in reporting loss
- Refuses to give recorded or written statement
- Self-employed in vague occupation; reluctant to produce tax records
- First notice of claim and/or immediate representation by attorney
- Recent changes in coverage/inquiries with agent
- Loss occurs immediately before or after policy renewal/inception dates
- Claimant is experiencing declining financial conditions
- Discrepancies exist between official reports of incidents and statements made by insured/claimant
- Lifestyle inconsistent with observations and facts
- Insured/claimant wants a friend or relative to pick up check
- Over-documentation of loss
- Insured/claimant has no phone
- Claimant is transient or out-of-towner
- Loss occurs after recent uninsured loss
- No witnesses to accident
- No police investigation
- Single car accident
- Accident involving an unidentified third party
- Claimant's witness overly enthusiastic
- Loss reported by claimant, third party, or attorney
- Documentation provided as photocopies

Disability Fraud Indicators

Claimant Indicators

- Extensive medical/insurance knowledge
- Claimant difficult to reach at home
- Claimant receives mail at post office box or address different than address on policy or application
- Claimant uncooperative or evasive
- Injury duration appears longer than normal for extent

Claim File Indicators

- Disability claimed inconsistent with injury or illness
- Independent medical examination contradicts illness or injury claimed
- Details of illness or injury are vague or difficult to comprehend

Dental Care Indicators

- Preexisting Temporomandibular Joint Syndrome (TMJ)
- TMJ claim not supported by medical records
- Chiropractic care for TMJ but no other symptoms
- Billing different calendar years; assures coverage is not maximized in one year
- Padding to reimburse co-payments or deductible clause
- Billing for services not rendered; bill for crown and bridge work, root canal performed

Treatment Indicators

- Treatment unrelated to or inconsistent with diagnosis
- Consecutive dates of treatment
- Treat family members who were not involved in accident; particularly in mental health claims
- Treatment on days just prior to policy termination date
- Medical or rehabilitation reports reference muscle tone, calluses, tanning, etc., indicating physical activities

Prescription Drug Indicators

- Number of prescriptions or quantity is unusually large
- Many prescriptions for scheduled controlled substances identified in the Physician's Desk Reference (PDR)
- Drugs not directly related to injury or illness
- Pharmacy in different geographical area from home/work
- Phoned prescriptions, but doctor has no record of calls
- Generic drugs dispensed; brand name drugs billed

Medical Bill Indicators

- Different/overlapping billing dates from same date of service
- Dates in doctor's notes do not match dates of serviced on bill
- Office visits not itemized by date and type of service
- Duplicate of unbundled procedures
- Inconsistent type-styles or handwriting on one bill
- Services billed but not rendered
- Bills for multiple providers who are not specialists
- Bills addressed to claimant's attorney
- Photocopies submitted instead of originals

- Durable Medical Equipment
  - rental fee exceeds actual cost of item
  - billed for upgrade, but a lower quality item provided
  - electric/no electric wheelchair
  - TNS (tens) unit quantity padded:
- More diabetic, hosiery, orthodontics, etc. than provided

Altered Documents

- Dates changed
- Writing or typing inconsistent
- Signatures altered or obliterated
- Poor quality photocopies
- Claimant is approaching retirement age would like to retire is ill
- Financial obligations in arrears; taxes, payroll, loans, etc.
- Renovation loan approved before loss, but work not begun

Life Insurance Fraud Indicators

- The policy's effective date is close to the date of death
- The deceased is not well-known by relatives
- There are many small policies with coverages that are available in mass offerings, *i.e.,* in magazines and mail-in and television advertisements
- The agent's "loss ratios" are unusually skewed considering the size of the market and the types of people insured
- There are numerous life insurance policies purchased on the deceased
- There were different carriers used in securing coverage for no apparent reason
- The coverage amount is excessive considering the social position of the deceased
- The claim is made shortly after the expiration of the contestability period
- Any indication that the insured did not know about the policy
- Death in another country, especially with death certificate and related documentation in another language
- Increase in coverage amount shortly before death
- Change of beneficiary shortly before death
- Death certificate shows a home address that is a great distance from the deceased's place of work.
- Any death within a contestable period
- Any death with no body recovered
- Any accidental death under less than open and shut circumstances
- High dollar policy
- Policies without investigative confirmation of income
- Any discrepancies in any document
- Excessive documentation provided
- Any doubts about the cause of death
- Multiple policies not requiring an exam
- Any possible suicide motives
- Roommate or boarder arrangements
- Marital problems – separation or divorce
- Financial issues
- Legal issues

- Group insurance - Employer records show Date Last Worked is the same as date of death, if inconsistent with circumstances of death (cancer diagnosis; died in a nursing home)
- Group insurance - Deceased's occupation on the death certificate is inconsistent with employer records.

Indicators of Stranger-Originated Life Insurance (Stoli)

- The insured is between the ages of 65 and 85 years old
- The beneficiary is changed immediately after the contestable period
- The address and premium payer change immediately after the contestable period
- The insured or policyholder is not the one making the initial premium payments
- The same agent or agency force has a significant number of policies that are sold to a Settlement/Viatical company shortly after the contestable period

- The same exam company or physician administered the exam for a significant number of policies which are sold to a Viatical/Settlement company shortly after the contestable period
- The same Viatical/Settlement company is showing up on a significant number of policies shortly after the contestable period
- The Viatical/Settlement company is not licensed in the state where the insured resides
- The Viatical/Settlement Co. initiates the sale
- Not having a transparent transaction about how many parties received commissions and how much was paid out in undisclosed fees
- See all of the indicators for application fraud

Wage Loss Fraud Indicators

Employee Indicators

- Employment began shortly before the date of the accident
- Self-employed claimant
- Income level incompatible with claimant's standard of living
- Other sources of claimant's income not documented
- Tax returns not provided by claimant
- Claimant filed no tax return

Employer Indicators

- Employer is a small or unfamiliar business
- Business address is a P.O. Box, mail drop or residential area telephone number answered by a machine or service
- Employer cannot provide claimant's most recent W-2 (Form 1099 claimant's FICA statement for the last fiscal quarter

Wage Documentation Indicators

- Documentation is not on employers' letterhead provided in a form letter provided by claimant's attorney poorly written or typed on a blank sheet of paper on poor quality business stationery not centered on a page and/or misspellings, grammatical errors, etc.
- Dates include weekends, holidays, plant closures, etc.

Medical Provider Fraud / Claim Information Fraud Indicators

- There are three or more occupants in the struck vehicle; all of them report similar subjective soft tissue injuries; treat at same medical provider
- There are conflicting medical reports
- Medical claim is extensive but collision is minor with little physical damage to vehicles
- Medical records show different handwriting on same date of service, patient gender or names are wrong or not noted
- Medical records show different inks on same dates of service, or same ink and handwriting covering lengthy period of time
- When medical records are requested, adjuster is notified records are lost, stolen, destroyed
- Unexpected high costs (special supplies, home therapies, diagnostic testing) begin very early for a minor injury, soft tissue or subjective findings
- Medical provider is reluctant to communicate with the insurer but initiates calls to claimant's attorney
- A single medical provider with a high percentage of represented claimant's, especially if same plaintiff attorney
- Medical provider refers claimants unnecessarily to specific medical specialists
- Medical records consist of "template" style reports or consist of "canned" notes
- Consistent improper billing practices, such as unbundling, up-coding, and or double billing
- Medical provider holds bills and submits them all at one time, especially if submitted only through an attorney
- No emergency room treatment or emergency response on extensive injury claim
- Medical treatment begins after attorney involvement in the claim

Treatment

- No injuries claimed at time of accident
- Claimant waited weeks before seeking medical treatment, then underwent extensive chiropractic treatment
- Recovery is prolonged without objective medical findings
- Injury unrelated to accidental trauma
- Attorney and/or treating doctor are located great distance from claimant's home/work
- Medical provider's physical address cannot be confirmed
- Disability is not substantiated by objective medical findings
- Medical reports appear to be photocopied with name, employer, etc. typed in
- Bill submitted with "summary" medical report without dates or description of treatment
- Claimant cancels/misses a lot of appointments or refuses diagnostic test to confirm injury
- Treatment dates are on holidays or weekends when facilities normally would not be open
- Claimant referred for psychological tests when the original injury involved only trauma
- The same doctor/lawyer pair routinely handle claims together

Health Insurance Fraud Indicators

Medical Provider Indicators

- Billing for services or supplies never received by insured
- Billing for services outside the provider's scope of practice
- Upcoding or unbundling of billing codes
- Frequency or duration of treatment inconsistent with injury/illness

- Billing for non-emergency services on weekends or holidays

Claimant Indicators

- Extensive medical/insurance knowledge
- Claimant difficult to reach at home
- Claimant receives mail at post office box or address different than address on policy or application
- Claimant uncooperative or evasive
- Injury duration appears longer than normal for extent
- Income seems inconsistent with occupation

Claim File Indicators

- Disability claimed inconsistent with injury or illness
- Independent medical examination contradicts illness or injury claimed
- Details of illness or injury are vague or difficult to comprehend
- Employer downsizing, planning layoff, or closing a plant or office around the time of the claim

Dental Care Indicators

- Preexisting Temporomandibular Joint Syndrome (TMJ)
- TMJ claim not supported by medical records
- Chiropractic care for TMJ but no other symptoms
- Billing different calendar years; assures coverage is not maximized in one year
- Padding to reimburse co-payments or deductible clause
- Billing for services not rendered; bill for crown and bridge work, root canal performed

Treatment Indicators

- Treatment unrelated to or inconsistent with diagnosis
- Consecutive dates of treatment
- Treat family members who were not involved in accident; particularly in mental health claims
- Treatment on days just prior to policy termination date
- Medical or rehabilitation reports reference muscle tone, calluses, tanning, etc., indicating physical activities

Prescription Drug Indicators

- Number of prescriptions or quantity is unusually large
- Many prescriptions for scheduled controlled substances identified in the Physician's Desk Reference (PDR)
- Drugs not directly related to injury or illness
- Pharmacy in different geographical area from home/work
- Phoned prescriptions, but doctor has no record of calls
- Generic drugs dispensed; brand name drugs billed

Medical Bill Indicators

- Different/overlapping billing dates from same date of service
- Dates in doctor's notes do not match dates of serviced on bill
- Office visits not itemized by date and type of service
- Duplicate of unbundled procedures
- Inconsistent type-styles or handwriting on one bill
- Services billed but not rendered
- Bills for multiple providers who are not specialists

- Bills addressed to claimant's attorney
- Photocopies submitted instead of originals
- Durable Medical Equipment
- rental fee exceeds actual cost of item
- billed for upgrade, but a lower quality item provided
- electric/no electric wheelchair
- TNS (tens) unit quantity padded:
- More diabetic, hosiery, orthodontics, etc. than provided

Altered Documents

- Dates changed
- Writing or typing inconsistent
- Signatures altered or obliterated
- Poor quality photocopies
- Claimant is approaching retirement age would like to retire is ill
- Financial obligations in arrears; taxes, payroll, loans, etc.
- Renovation loan approved before loss, but work not begun

Medical Billing Fraud Indicators

Regarding Attorney Involvement

- Attorney is listed as the insurer on the medical bill
- Legal representation is contacted/obtained immediately after the accident/incident is reported
- Medical bills and narrative reports are sent from the attorney's office
- The same attorney appears in all BI/WC cases involving a particular medical provider

Regarding Claim

- Damages/losses presented by one or more parties are inconsistent with facts of loss/accident (lack of injury/damage causing mechanism, etc.)

Regarding Diagnosis

- A test or series of diagnostic imaging tests is given to all patients at a clinic or medical office regardless of injury
- Alleged injury relates to a pre-existing injury or health problem
- Bills for diagnostic imaging are submitted without supporting documentation such as reports
- Commonly refer patients for a "second opinion"
- Comparison diagnostic tests are ordered by provider (e.g. performing a diagnostic test on an uninjured joint so the results can be "compared" to the diagnostic test results from the injured joint)
- Diagnosis in the bill is not supported by other documentation
- Diagnostic imaging is not consistent with the nature of the injury or treatment
- Diagnostic imaging is performed on several separate visits rather than one
- Diagnostic testing (X-rays, EMG testing, MRIs, etc.) is performed often and early in the treatment
- Diagnostic testing is billed repeatedly without a report of a worsening condition in objective findings or a report of a new injury
- Discrepancies exist between the locations of diagnostic imaging testing (and other types of tests) and the person interpreting the test
- EKGs are administered to patients with no complaints or conditions
- Evidence exists of payments/commissions from a diagnostic test provider to the ordering practitioner
- Injuries are subjective (e.g. pain, headaches, nausea, inability to sleep, depression, dizziness and soft tissue)
- Insured questions the amount of diagnostic imaging tests ordered
- Medical records do not explain excessive, expensive medical testing/treatment
- Mobile unit performs neurological or other tests, which are read at remote locations
- Multiple diagnoses are indicated
- Multiple diagnostic procedures are billed with separate CPT codes when there is a CPT code that includes all of the billed procedures
- Patient does not know the result of the diagnostic test(s)
- Patient's account of diagnosis process is inconsistent with the actual test
- Range of motion (ROM) tests are conducted frequently
- Specialized equipment is required for diagnosis but the injured person cannot describe the equipment or procedure
- Surface EMGs (SEMG) are used for diagnoses

Regarding Facility/Operation

- Claims representative receives a sudden flood of medical bills from one new center/clinic

- Clinic/Center was recently incorporated
- Contact with clinic/center is difficult
- Equipment and treating facility is out-of-date, broken or inconsistent with treatment billed
- New or unknown diagnostic clinic/center
- No request, reports, or any indication the treatment was needed or conducted prior to receiving the medical bill
- Office/building has no furniture
- Ownership of clinic is questionable
- Provider utilizes established and trusted files, members, insured, patients, and doctor's information without their knowledge
- Telephone for the clinic/center is not listed on the medical bills
- The Tax ID number provided is real, but medical identity theft is suspected
- The building is too small to operate a clinic/center
- The clinic/center address is a P.O. Box number
- The date(s) of medical service(s) is prior to the date the clinic/center was established
- The location of the clinic/center is in a deteriorating or unsafe part of town
- The physical address of the clinic has inadequate, inconvenient, or no parking for patients and staff
- The word "Diagnostic" appears in the name of the facility submitting the medical bill

Regarding Incident

- Vehicle has numerous passengers claiming the same type of injuries

Regarding Medical Bills

- 1500 Bill does not show the injury as auto accident or workplace related
- A physician bills out of multiple offices on one day (treatment time is more than possible for one day)
- Amounts billed for are much more than other providers (of the same specialty) charge
- Billing for daily treatment for an extended period of time
- Bills are submitted by billing or medical finance companies and not the provider
- Bills are submitted in "bulk" just before the time deadline
- Bills are submitted months after treatment is rendered
- Bills are submitted without appropriate supporting documentation (e.g. PT worksheets or diagnostic imaging reports)
- Bills are templates or prepared forms that do not document the actual facts of a patient's case
- Bills for E&M provide little or no detail but the CPT code billed reflects an office visit of high complexity, comprehensive history/exam, etc.
- CPT codes are billed for the treatment which is usually not associated with the particular diagnosis/ICD
- code
- Continuous billing for comfort modalities for an extended period of time
- Contradictions are revealed when comparing the bills to other documents or sources of information.
- DME billed for multiple patients is the same
- Duplicate bills for same type of treatment with a different procedural name (e.g. electrical stimulation and
- TENS unit)
- Durable medical equipment (DME) bill shows charges for equipment not in the doctor's order or patient's receipt

- Durable medical equipment (DME) bill shows markups for equipment in excess of your state's standards for such markups
- Emergency services are billed by providers (providers say they provided services on a day when their office is routinely closed)
- MRI bills appear early on in the treatment and repeated again in later treatment
- Medical bills accrued for the injury have a higher dollar value compared to the other providers treating patients for similar injuries
- Medical bills are not on a standard HCFA form or CMS 1500 form
- Medical provider bills for new patient visit, but insured/claimant advised that the doctor only spent a few minutes with them or they didn't see the doctor
- Multiple providers in one office all treat the patient on the same day
- Multiple time-based modalities are billed for the same treatment session, resulting in the patient being in treatment for two or more hours (including acupuncture and massage)
- Patient cannot describe the physical aspects of items appearing on the bill (e.g. ROM test exercises)
- Patient indicates the provider listed on the bill is not the same person providing treatment
- Patient is quoted a treatment price but the bill shows a much higher amount
- Patient refutes charges
- Provider bills a referral fee for medical services that were never rendered
- Provider bills cancellation charges for office visits that were not originally scheduled
- Provider bills for an examination and treatment when in fact no treatment was provided
- Provider bills for medical supplies that were not used
- Provider bills for medical tests or evaluations that were not conducted
- Provider bills for office visits that were not made
- Provider bills for treatment that was not provided
- Rehabilitation or physical therapy bills are not supported by worksheets showing the who, what, when, where, effectiveness of the treatment program, and/or modification if not successful
- Repeated billing by the medical provider for extensive established patient visits (e.g. repeated bills for
- X-rays on a soft tissue injury)
- Summary medical bills are submitted without dates and descriptions of office visits and treatments, or treatment extends for a lengthy period without any interim bills
- TENS unit bills are very expensive (often billing for more advanced units without attempting treatment with basic, less expensive units first)
- TENS unit bills include frequently billed supplies such as electrodes and batteries (charges may also be excessive)
- The physician's bill and report, regardless of the varying accident circumstances, is always the same
- The treatment requires a licensed medical professional, but the provider is not licensed

Regarding Medical Fraud/Claim Inflation

- Boilerplate and matching reports from providers are present in claim file during review
- CPT codes appear "inflated" or "up-coded"
- Clinic has continued billing or treatment irregularities
- Clinic/Medical facility does not have patient sign-in sheets or patient signatures appear to be signed all at one time
- Doctor's notes contain no indication of checking the patient's treatment progress/improvement of symptoms
- Injured party's address is located unusually far from the clinic/center

- Medical bills indicate routine treatment being provided on Sundays, holidays, or other days that facilities would not normally be open
- Minor accident produces major medical costs and often lost wages, household help, transportation and unusually expensive demands for pain and suffering
- Narrative reports submitted appear to be templates
- No changes in treatment plan after several treatment sessions have been rendered and extensive diagnostic testing (EMG, NCV, MRI etc.) is performed
- Office visits extend daily for more than five consecutive days or continue for more than one week
- Patients are at or near the age of eligibility for Medicare when they are first injured and begin treating
- Patient is unable to describe the doctor or office location
- Patient's residence is not near treatment facility
- Reports for initial exams, follow-ups, consultations, etc. provide little or no detail, but the CPT code billed reflects high complexity, comprehensive history/exam, etc.
- Same treatment prescribed for all patients in spite of different accident facts
- Significant lapse between when the alleged service was provided and when the medical bill is received
- The date(s) the medical service(s) was provided is on a weekend or holiday or during hours the clinic is not open
- The patient decides to go back to work on their own despite the doctor classifying them with a total disability
- The patient's signature appears several times on the same sign in sheet
- Treatment extends for a lengthy period without interim bills

Regarding Medical Treatment

- Chiropractic treatment extends beyond the typical number of visits (approx. 30-34) for simple soft tissue injuries
- Claimant is receiving treatment from a "known" medical provider
- Clinic treats injured family members on different days
- Clinic treats several or all of the claimants on same day
- Doctor's initial exam reports are "fill in the blank" boilerplate reports
- Durable medical equipment (DME) given to all injured persons is the same regardless of diagnosis
- Durable medical equipment (DME) is dispensed without instructions for use
- Injury progression is atypical and seems to require extended treatment (often extending beyond estimated
- "discharge date")
- Medical treatment is given by receptionists or other non-medical personnel
- Minor injury results in a network of treatment providers, diagnostic procedures, and treatments
- Multiple treatment procedures are billed using separate CPT codes when there is a CPT code that includes all of the billed procedures
- No referral is made to another specialist for evaluation when no progress is made after four weeks of treatment
- Pain management protocol is not modified (treatment is continued) even when not effective
- Passive treatment modalities are used exclusively without encouraging use of a home program of exercises/activity
- Patient is seen multiple days in a row
- Patient's account of the treatment process is inconsistent with bill

- Patients are seen only by a chiropractor on the initial visit, yet proceed to get treatment and multiple modalities (acupuncturist, physical therapist, neurologist, etc.) before seeing a medical doctor
- Patients in one claim all receive the same treatment (same treatment dates, same examination/progress reports, etc.)
- Patients who are members of the same family are treated on different days
- Pharmaceutical bills indicate repackaging or compounding on the part of the treating provider
- Provider only treats patients that are represented by an attorney
- Provider repeatedly uses x-rays, ultrasounds, nerve conduction tests, or spinal video fluoroscopy to check treatment progress
- Same type of treatment is given to children and adults
- The employee/individual is unaware of or has no recollection of receiving the medical treatment being billed for
- The frequency or number of therapy modalities does not decrease after four weeks of treatment
- The treatment plan does not change over time (especially if additional diagnostic tests have been done)
- Time dependent procedures don't match what was billed (more treatments than possible in a 24-hour day)
- Treatment begins prior to the accident date
- Treatment continues with no changes in plan
- Treatment dates on the bill indicate the start of treatment is delayed by more than four weeks from the loss date
- Treatment is ended when the policy's monetary limits are reached
- Treatment is extended, without re-evaluation or outcome assessment
- Treatment is not consistent with usual standards of care
- Treatment plan exceeds 90 days with no evaluations during the 90-day period
- Treatment prescribed for the various injuries resulting from differing accidents is always the same in terms of duration and type of therapy
- Treatment provided is not usually associated with this type of injury
- Treatment requires specialized equipment, but the injured person cannot describe the equipment or procedure
- Treatment shows more than three therapy modalities in a single treatment session

Regarding Professional Issues

- Attorney/Medical provider is not located near the claimant/insured's residence
- Business/Contractors/Cleaning company are not licensed or are newly licensed
- Clinician has multiple locations and bills indicate regular or frequent treatment at one location
- Provider/Clinic doesn't allow a clinic inspection to be conducted or makes scheduling an inspection appointment very difficult

Regarding Slip & Falls or Food Products Liability

- Emergency medical responders were not called to the scene of the slip and fall
- The claimant did not receive medical treatment at an emergency room after the slip and fall

Regarding Specific CPT Codes

- Acupuncture, first 15 minutes (97810 or 97813) billed numerous times per visit
- Acupuncture, subsequent 15 minutes (97811 or 97814) billed more than twice per visit
- Biofeedback (90901) is performed on all of a provider's patients

- Chiropractic manipulation (98940-5) routinely billed in conjunction with an E&M visit without documentation of a separate office visit where treatment was required beyond normal pre and post manipulation assessment (should be billed with a -25 modifier)
- Community reintegration training (97537) billed repeatedly
- Consultation (99241-5) billed for own patient
- Davis series (72052) charge with fewer than seven images or reports
- Digital analysis of electroencephalogram (97957) routine appearance on bills
- E&M codes, complex/severe (992x4-5) billed for every visit until discharge
- E&M codes, complex/severe (992x4-5) billed for problem of relatively low severity
- E&M new patient (99201-5) billed every visit
- E&M, new patient (99201-5) billed for by provider in the same medical group where the patient has previously received treatment within the past three years
- E&M, prolonged services (99358), routine appearance on bills
- ESI (62310 or 62311) separate charge for drug and supplies (e.g. syringes, gloves, alcohol, etc.)
- ESI (62310 or 62311) billed more than three times in one calendar year
- Electric stim (97014) with modifier -50
- Interpretation hours (90887), billed with little detail in report
- MUA (22505) manipulation under anesthesia billed by a chiropractor (may also bill for assistant surgeons and standby assistant)
- MUA (22505) manipulation under anesthesia in conjunction with (23700 and 27194)
- MUA (22505) manipulation under anesthesia performed early in treatment
- Manual therapy (97140) routine appearance of charge
- Mechanized traction (97012), routine appearance of charge
- Modifier -51, routine appearance on bills
- Modifier -52, routine appearance on bills
- Modifiers - frequent use
- Muscle testing (95831) billed for each muscle rather than each extremity
- Muscle testing (95831) billed in conjunction with E&M codes (e.g. 99201-5)
- Needle EMG (95860 single extremity) multiple times per visit
- Needle EMG (95864) all four extremities (without justification documentation)
- Nerve conduction (95900 and 95903) on the same bill for the same nerve (95903 includes 95900)
- Nerve conduction tests (95900 and 95903) billed multiple times for the same nerve
- Nerve conduction tests (95900 and 95903) show the same results across patients
- Neuromuscular re-education (97112) billed in connection with a soft-tissue injury without nerve damage
- PDD (62287, Percutaneous disk decompression), routine appearance on bills
- Psychological test interpretation time (90887) is billed along with administration time (96101) without supporting documentation
- Psychological testing (96101) report is without detail
- Range of motion testing (95832) frequent
- Range of motion testing (95832) is billed for each muscle tested
- Range of motion testing (95832) is billed in conjunction with 95831
- Range of motion testing (95832) is billed in conjunction with E&M (e.g. 99201-5)
- Self-care/home management training (97535) billed repeatedly
- Subcortical/cortical mapping (95961 and 95962), routine appearance on bills
- Therapeutic activities (97530) billed in conjunction with 97112
- Therapeutic procedure with- 51modifier
- Unbundling of CPT Codes

- Unlisted codes (ending in 99)
- Unlisted modality (97039) routine appearance on bills
- Unlisted procedure (97139) routine appearance on bills
- Unlisted rehab (97799) routine appearance on bills

Durable Medical Equipment (DME) Fraud Indicators

Applicant/Claimant/Insured Indicators

- Patient denies ever receiving the DME or receiving less or different DME than the insurer is billed for
- Patient questions the amount of DME that is prescribed

Diagnosis Indicators

- Diagnosis in the bill is not supported by other documentation

Facility/Operation Indicators

- Bags of identical DME pre-labeled with patient names seen in the medical clinic
- Reminder notices in doctor's office to give out DME in pre-determined sets

Medical Bill Indicators

- Billing the insurer for DME component parts instead of as a complete unit as provided by the manufacturer
- Billing the insurer for defective medical equipment or for equipment that exceeds utilization or lifespan guidelines
- Billing the insurer for duplicate orders of DME or unnecessary amount of DME
- Billing the insurer for more expensive items than those actually shipped
- Billing the insurer for new DME when used and/or refurbished DME has been provided to the patient
- DME bill shows charges for equipment not in the doctor's order or patient's receipt
- DME bill shows excessive rental charges for equipment (e.g. rental of equipment cannot exceed 125% of the cost to purchase equipment)
- DME bill shows markups for equipment in excess of your state's standards for such markups
- DME billed for multiple patients is the same
- Invoice lists inexpensive products commonly available at local drugstores (e.g. over the counter – OTC) such as back massagers, heat lamps or neck braces, and billed under cryptic or fictitious model names and numbers or as customized equipment
- Mis-billing DME with multiple functions, such as hot/cold therapy units and billing as separate pieces of equipment
- Provider bills for medical supplies that were not used

Medical Treatment Indicators

- DME given to all injured persons is the same regardless of diagnosis
- DME is dispensed without instructions for use
- Inappropriate expensive medical equipment prescribed for minor injury

Professional Indicators

- Altering medical records to justify unnecessary DME
- DME prescriptions are written by DME suppliers rather than the patient's physicians
- Evidence exists of payments/commissions from a DME supplier to the ordering medical provider
- Evidence of patient lists being provided to the DME supplier
- Failing to credit the insurer for DME that is returned by the patient
- Improperly licensed/certified individual(s) prescribing/providing/administering DME
- Provider is a recent graduate with a high student loan debt
- Provider prescribes two types of DME items for patients at the same time

- Provider prescribing the DME may also be the owner or has an ownership interest in the DME company who manufactures and ships the DME
- Providing false or misleading information, such as offering of “free” equipment when they are actually billing the insurer
- Supplier ships DME to patients prior to obtaining a physician’s order, certificate of medical necessity, or prescription

Appendix 4 – Fraud Referral Checklist

Fraud Referral Checklist

A referral of an act of suspected insurance fraud shall contain the following information and data as applicable:

General Information
- ☐ Complete company name (The Union Labor Life Insurance Company)
- ☐ Complete company address
- ☐ Referrer's contact information
- ☐ Name and contact information of defense attorney

Insurance Policy or Claim Information
- ☐ Type of fraud (i.e. application, premium, producer)
- ☐ Type of policy (i.e. general liability, commercial auto, workers' compensation, disability)
- ☐ Policy or claim number
- ☐ Name and contact information of claimant or policyholder
- ☐ Date of loss or injury
- ☐ Description of loss or injury
- ☐ Policy state or state where loss or injury occurred
- ☐ Synopsis of all the facts

Documentation
- ☐ Red Flags, clearly identified in the referral
- ☐ Copies of suspected fraudulent documents (i.e. cashed checks, policy documents, declarations pages, correspondence)
- ☐ Pertinent documentation from claims files (i.e. deposition transcripts, medical records, accident reports, video surveillance)
- ☐ Contact information of parties of interest
- ☐ Timeline of events
- ☐ List of payments made and/or collected

Submitting Fraud Referrals

The Client Representative may refer an assignment by any of the following methods:

4. **Allied Universal PartnerLink® (preferred) - https://partnerlink.cni-aus.com**
5. **Phone 800-927-0456, and report to a SIU Manager (immediate/rush cases)**
6. **E-mail request to cases@aus.com**

The SIU will maintain a secure Internet Website and 1-800 toll free telephone and fax numbers for the receipt of our client's surveillance, claim investigation, and SIU assignments. This service is available, at minimum, from 8 a.m. EST to 9 p.m. EST.

These numbers are:

- **Voice – [800] 927-0456**
- **Fax – [800] 927-2239**

Appendix C. STATE-RELATED NOTICES

i. California Code of Regulations: Fair Claims Settlement Practices Regulations, (Title 10, Chapter 5, Subchapter 7.5, Article 1)

1. T. 10 s 2695.5 - Duties upon receipt of communications

California - Insurance Regulations

Duties upon receipt of communications

(a) Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer's premises.

(b) Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

(c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and the effective date of the revocation.

(d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer.

(e) Upon receiving notice of claim, every insurer shall immediately, but in no event more than fifteen (15) calendar days later, do the following unless the notice of claim received is a notice of legal action:

(1) acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.

(2) provide to the claimant necessary forms, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

(3) begin any necessary investigation of the claim.

(f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

Authority - §§ 790.04, 790.10, 12340-12417, inclusive, 12921, 12926, Insurance Code; and §§ 11342.2 and 11152, Government Code.

2. CALIFORNIA CODE OF REGULATIONS...TITLE 10. -- INVESTMENT...Chapter 5. -- Insurance Commissioner...Subchapter 7.5 -- UNFAIR OR DECEPTIVE ACTS OR PRACTICES IN THE BUSINESS OF INSURANCE...Article 1. Fair Claims Settlement Practices Regulations

T. 10 s 2695.7 - Standards for prompt, fair and equitable settlements

California - Insurance Regulations

Standards for prompt, fair and equitable settlements

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant's age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety.

(1) Where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages shall do so in writing.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

(3) Written notification pursuant to this subsection shall include a statement that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.

(4) The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code or mortgage guaranty

insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the California Insurance Code. All other provisions of subsections 2695.7(b)(1), (2), and (3) are applicable.

(c)(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, every insurer shall provide the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

(d) Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

(e) No insurer shall delay or deny settlement of a first party claim on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions, statutes or regulations, including those pertaining to coordination of benefits.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

(3) the extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;

(4) the extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;

(5) the procedures used by the insurer in determining the dollar amount of property damage;

(6) the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;

(7) any other credible evidence presented to the Commissioner that demonstrates that (i) any amount offered by the insurer in settlement of a first-party claim to an insured not represented by counsel, or (ii) the final amount offered in settlement of a first-party claim to an insured who is represented by counsel or (iii) the final amount offered in settlement of a third party claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

(h) Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment or otherwise take action to perform its claim obligation. The amount of the claim to be tendered is the amount that has been accepted by the insurer as specified in subsection 2695.7(b). In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more than thirty (30) calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. The time frames specified in this subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

(1) The time frame specified in subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code, or of mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills subject to Section 560 of the California Insurance Code. All other provisions of Section 2695.7(h) are applicable.

(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.

(k) Subject to the provisions of subsection 2695.7(c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claim as specified in

California Penal Code Section 550 or California Insurance Code Section 1871.4(a), the number of calendar days specified in subsection 2695.7(b) shall be:

(1) increased to eighty (80) calendar days; or,

(2) suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

(l) No insurer shall deny a claim based upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision shall do so only when the insurer has a good faith belief that such an examination is reasonably necessary.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim.

(p) Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation, or discontinues pursuit of subrogation, it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant. This subsection does not require notification if the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the loss sustained does not exceed the applicable deductible, or there is no legal basis for subrogation.

(q) Every insurer that makes a subrogation demand shall include in every demand the first party claimant's deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense. This subsection shall not apply when multiple policies have been issued to the insured(s) covering the same loss and the language of these contracts prescribe alternative subrogation rights. Further, this subsection shall not apply to disability and health insurance as defined in California Insurance Code Section 106.

Authority - §§ 553, 554, 790.03(h)(5), 790.03(h)(12), 790.10, 1861.03(a), 10350.10, 10111.2, 11580.2(k), 12340-12417, inclusive, 12921 and 12926, Insurance Code; §§ Sections 11152 and 11342.2, Government Code; Egan v. Mutual of Omaha Insurance Company (1979) 24 Cal.3d 809 [169 Cal.Rptr. 691]; KPFF, Inc. v. California Union Insurance Company (1997) 56 Cal.App.4th 963 [66 Cal.Rptr.2d 36] (certified for partial publication); and Betts v. Allstate Ins. Co. (1984) 154 Cal.App.3d 688 201 Cal.Rptr. 528]. Reference: Section 790.03(h)(2), (3), (4),

3. CALIFORNIA CODE OF REGULATIONS...TITLE 10. -- INVESTMENT...Chapter 5. -- Insurance .Commissioner...Subchapter 7.5 -- UNFAIR OR DECEPTIVE ACTS OR PRACTICES IN THE BUSINESS OF INSURANCE...Article 1. Fair Claims Settlement Practices Regulations

T. 10 s 2695.11 - Additional standards applicable to life and disability insurance claims

California - Insurance Regulations

Additional Standards Applicable to Life and Disability Insurance Claims

(a) No insurer shall seek reimbursement of an overpayment or withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld or reimbursement sought is an adjustment or correction for an overpayment made under the same policy unless:

(1) the insurer's files contain clear, documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting the reimbursement or withholding procedure, or

(2) the insurer's files contain clear, documented evidence pursuant to section 2695.3 of all of the following:

(A) The overpayment was erroneous under the provisions of the policy.

(B) The error which resulted in the payment is not a mistake of the law.

(C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date of discovery of such error. For the purpose of this subsection, the date of the error shall be the day on which the draft for benefits is issued.

(D) Such notice states clearly the cause of the error and states the amount of the overpayment.

(E) The procedure set forth above in (a)(2)(A) through (D) above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits unless such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance.

(d) An insurer that contests a claim under California Insurance Code Section 10123.13 shall subsequently affirm or deny the claim within thirty (30) calendar days from the original notification. In the event an insurer requires additional time to affirm or deny the claim, it shall notify the claimant and assignee in writing. This written notice shall specify any additional information the insurer requires in order to make a determination and shall state any continuing reasons for the insurer's inability to make a determination. This notice shall be given within thirty (30) calendar days of the notice (required under Insurance Code Section 10123.13) that the claim

is being contested and every thirty (30) calendar days thereafter until a determination is made or legal action is served. If the determination cannot be made until some future event occurs, the insurer shall comply with this continuing notice requirement by advising the claimant and assignee of the situation and providing an estimate as to when the determination can be made.

(e) When a policy requires preauthorization of non-emergency medical services, the preauthorization must be given immediately but in no event more than five (5) calendar days after the request for preauthorization. The preauthorization shall be communicated or confirmed in writing to the insured and the medical service provider, and shall explain the scope of the preauthorization and whether the preauthorization is or is not a guarantee of acceptance of the claim. In the event the preauthorization is denied, the reason(s) for the denial shall be communicated in writing to the insured and the medical service provider.

(f) No preauthorization shall be required by an insurer for emergency medical services.

(g) An insurer shall reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer.

Authority - §§ 790.10, 12921 and 12926, Insurance Code; and §§ 11342.2 and 11152, Government Code.

8403 Colesville Rd.
Silver Spring, MD 20910
202.682.0900
www.ullico.com

The Ullico Family of Companies:
The Union Labor Life Insurance Company
Ullico Casualty Group, Inc.
Ullico Investment Advisors, Inc.
Ullico Investment Company, Inc. *Member of FINRA/SIPC*

Like us on Facebook
www.facebook.com/UllicoInc