ALLIED™ NATIONAL
A 90 Degree Benefits Company

FUNDING®
A Level-Funding Solution for Small Groups
ADVANTAGE

15+ Plan Sponsor (Employer) Disclosure With Statement

INSTRUCTIONS FOR COMPLETION

"Plan Sponsor" refers to the employer; "Plan" refers to the employer's health plan for its employees; "Plan Benefits" refers to the self-funded benefits selected by the employer. If the Plan Sponsor permits independent contractors to participate in its Plan, references to "employee" and "employment" include independent contractors and their relationship with the Plan Sponsor. Use of such terms is solely for convenience and does not establish an employment relationship nor alter or waive the independent contractor status.

Section 1 – Provide Plan Sponsor contact information

Section 2 – Provide all requested information for Plan Sponsor and its Plan

Section 3 – Plan Sponsor must read and sign

Section 4 – Agent of Record Information – complete & sign

Case submission checklist - The following required items must be enclosed:

- **This completed Plan Sponsor Statement (all items must be fully completed).**
- **Level-Funded Health Plan employee IHQ Form for each FT employee that is enrolling for coverage. Applicable for groups of 1-14 Full time employees.**
- **Copy of Plan Sponsor's most recent state quarterly unemployment tax report for groups of less than 15 employees.**
- **Copy of Plan Sponsor's most recent billing (for its current health plan coverage if applicable).**
- **Copy of Plan Sponsor's renewal Package (for its current health plan coverage).**
- **Copy of signed and dated Proposal with selected benefits, rates, and total monthly premium cost.**
- **Freedom Disclosure Form (if applicable).**
- **A business check for the estimated total cost of the Plan Benefits for the first month made payable to: Allied National, LLC. Or ACH Authorization and Voided check copy if electing monthly Auto Bank Draft.**

SECTION 1 – PLAN SPONSOR CONTACT INFORMATION

Company Legal Name (not DBA) _____

DBA Name if Applicable _____ Tax ID# _____

Primary Contact _____ Primary Contact Email _____

Physical Address _____

Mailing Address (if different) _____

City _____ County _____ State _____ Zip _____

Main Phone # _____ Contact's Phone # _____

SECTION 2 – PLAN & PLAN SPONSOR INFORMATION

(All questions must be answered in full)

1. Plan Sponsor is a: ❑ Sole Proprietorship ❑ Partnership or L.L.C. ❑ Corporation ❑ C or S Corp ❑ Other: _____
2. Specific nature of Plan Sponsor's business: _____ SIC Code: _____
3. Does Plan Sponsor have an affiliate, subsidiary or parent company **whose employees are also participating in the Plan Sponsor's Health Plan**?.....❑ Yes ❑ No
   If yes please provide name and address of each company including Tax ID# for each: _____
   _____
   _____
   For related companies to jointly sponsor an ERISA health plan, the companies must be part of a Control Group (as defined by IRS, check with your accountant if uncertain of your Control Group status). By enrolling employees of affiliates, Plan Sponsor affirms the Control Group status of all participating companies. (If the affiliates do not meet the definition of a Control Group they may still be underwritten and renewed together as if a single group, but each company will be a Plan Sponsor with their own plan documents and separate claim fund accounts. Please contact sales for assistance with such a submission.)
4. Name of person at Plan Sponsor handling health plan details: _____
5. Does Plan Sponsor currently have health plan coverage in-force (or within the past 90 days)?.....❑ Yes ❑ No
   If "Yes", please provide the: 1) Name of Insurance Company _____ start date of coverage _____
   2) end date of coverage (if applicable) _____ and
   3) # of former employees and/or family members currently on COBRA (or state) continuation coverage _____
   4) Does the plan sponsor use a COBRA Administration Company.....❑ Yes ❑ No
   5) Does the plan sponsor wish to have their COBRA employees billed on your group invoice or billed directly _____
6. Does Plan Sponsor classify full time employment as working at least 30 hours per week?.....❑ Yes ❑ No
   Will only full-time employees be eligible to participate in Plan Sponsor's health plan? ..... ❑ Yes ❑ No
   (If "No" to either or both, please provide details on another sheet. Approval is subject to additional review.)
7. Please certify the following ("full-time" is working at least 30 hours per week):
   A. Plan Sponsor currently employs _____ **full-time** employees [including owner(s), partners, and officers].
   B. Plan Sponsor currently employs _____ part-time employees (including owner(s), partners, and officers)
   C. Plan Sponsor currently employs _____ temporary, seasonal, and/or union employees.
   Please note if these employees are considered as part of the eligible class.....❑ Yes ❑ No
   D. Plan Sponsor was established (or first conducted business) on (month & year) _____
   E. Within the past 90 days, _____ **full-time** employees terminated employment with Plan Sponsor (voluntarily or not).
8. Does Plan Sponsor's health plan exclude any class of employee from eligibility? .....❑ Yes ❑ No
   If "Yes", please describe the class(es) (any class exclusion must be non-discriminatory and approved in advance):
   _____
9. Plan Sponsor consents to periodic reviews of its employment records, for purposes of verifying the number and names of all employees eligible to participate in Plan Sponsor's health plan, and agrees to furnish, upon request, a current employee census and state unemployment tax report. .....❑ Yes ❑ No
10. Plan Sponsor selects the following waiting periods for its health plan:
    A. If hired on/before the effective date of the Plan being established, an employee becomes eligible upon completion of: ❑ 0 months ❑ 1 month ❑ 2 months
    B. If hired after said effective date, an employee becomes eligible on the first day of the month coinciding with or next following the completion of: ❑ 1 month ❑ 2 months
    A fully completed enrollment form must be received by Allied National prior to the employee effective date.
11. Will any HRA or GAP plan, insured or self-funded, be used to supplement this self-funded Plan? ……❑ Yes ❑ No
    (If Yes, please describe or provide a copy of the HRA/GAP benefit schedule):
    _____
12. For the Plan Benefits selected below, Plan Sponsor requests an effective date of _____. Plan Sponsor acknowledges that approval of the Stop-Loss Insurance is dependent upon all required paperwork being fully and properly

completed, signed on or before the requested effective date, submitted to Allied National within five (5) business days thereafter, and then approved in writing.

13. To defray the costs of employee coverage under Plan Sponsor's health plan, Plan Sponsor agrees to contribute: _____% or $_____ to Employee Coverage (must be at least 25%); and _____%, or $_____to Dependent Coverage (optional - dependent contributions are not required).
14. Plan Sponsor acknowledges and understands that the following minimum participation requirements will apply to the Plan Benefits selected below: For major medical and Cost Saver plans at least 75% of eligible employees must participate. Plan Failure to maintain this requirement for three (3) consecutive months will result in termination of the Plan Benefits, **including the Stop-Loss Insurance**. If that occurs, Plan Sponsor will be liable for 100% of the cost of all claim payments under its Plan.
15. Plan Sponsor further acknowledges and understands that: Stop-Loss Insurance is an annual insurance contract and not guaranteed renewable; access to all available benefits under the Stop-Loss Insurance is subject to the Stop-Loss Insurance policy remaining in effect for the entire policy year and meeting the minimum specific and annual aggregate deductibles (as described in the Stop-Loss Insurance policy); and early termination of said Stop-Loss Insurance may result in reduction of benefits and/or increased claim exposure.
16. Plan Sponsor further acknowledges and understands that the only employees and dependents eligible for coverage under the Stop-Loss Insurance at the time of issue are those whose exact names and dates of birth were presented in the final submission and the final proposal signed by the Plan Sponsor. An incorrect name or date of birth will render that employee or dependent ineligible for Stop Loss Insurance coverage. I have reviewed and confirmed all names and dates of birth in the final proposal are correct.

SECTION 3 – CERTIFICATION & SIGNATURE

Plan Sponsor, by its authorized representative named below, acknowledges, agrees, accepts and/or consents to the following:

The Plan Benefits selected above represent a program of services designed for Plan Sponsor's health plan ("Plan") and includes the provision of a summary plan description for the Plan ("Plan SPD"), administrative services ("Delegated Services") and Stop-Loss insurance coverage ("Stop-Loss Insurance"). Plan Sponsor consulted with the agent of record and reviewed the Plan Benefits brochure and guide before making its selection. The specific benefits selected by Plan Sponsor for its health plan are stated in the signed proposal attached to the Stop-Loss Insurance application.

Plan Sponsor's health plan is a self-funded Employee Welfare Benefit Plan established for its employees. Certain rights granted by the “Employee Retirement Income Security Act of 1974” (ERISA), the “Consolidated Omnibus Budget Reconciliation Act of 1985” (COBRA), the “Health Insurance Portability and Accountability Act of 1996” (HIPAA), the Patient Protection and Affordable Care Act of 2010 (PPACA), and other federal and state benefit laws apply to the participating employees. Plan Sponsor retains all plan sponsor, plan administrator and plan fiduciary responsibilities under said benefit laws. Plan Sponsor remains responsible for compliance with said benefit laws, including all mandatory notices to participants and all regulatory reports and filings. HIPAA guaranteed availability and renewability do not apply to the self-funded Plan Benefits or the Stop-Loss Insurance.

No liability is created or assumed by the insurance company under the Stop-Loss Insurance until the Stop-Loss Insurance application has been approved in writing. If for any reason the application is not approved, the sole obligation of the insurance company will be, and Plan Sponsor shall be entitled to only, a refund of any premiums paid. A claim incurred by a Plan Sponsor employee is eligible for benefits under the Stop-Loss Insurance only if that employee was covered under the Plan at the time the claim was incurred. Coverage under the Stop-Loss Insurance is based on the Plan SPD. Any change to the Plan SPD, or any benefit payment inconsistent with the Plan SPD, may not be covered under the Stop-Loss Insurance. Plan Sponsor shall reimburse the Stop-Loss Insurance for any ineligible benefits, including expenses incurred under the Plan's Outpatient Prescription Drug Card Benefit, and any advances issued pursuant to the accommodation provision in the Stop-Loss Insurance.

Plan Sponsor has engaged the agent of record shown below as its Plan consultant, to assist in establishing and/or maintaining the Plan and in securing the Plan Benefits (including the Plan SPD and Stop-Loss Insurance) and the Delegated Services. The agent of record will receive a portion of the fees charged for the Plan Benefits as compensation for those consulting services. The agent of record has no authority to bind the Stop-Loss Insurance or alter its terms.

Plan Sponsor has also engaged Allied National to act as the third-party administrator for the Plan, which includes the delegation to Allied National of certain non-fiduciary, ministerial administrative acts, duties or responsibilities on behalf of the Plan. The Delegated Services have been negotiated via a separate administrative services agreement, between the Plan Sponsor and Allied National, and are not part of the Stop-Loss Insurance. None of the premium charged for the Stop-Loss Insurance will pay for (or be allocated to) the Delegated Services, and none of the fees charged for the Delegated Services will pay for (or be allocated to) the Stop-Loss Insurance. If the Stop-Loss Insurance is not approved, Allied National will have no obligation to provide the Delegated Services to Plan Sponsor. Delegated Services include, but are not limited to:

- Tracking employee and dependent enrollment in the Plan;
- Billing, collecting, holding and disbursing Plan funds, from which to pay claims and Stop-Loss Insurance premiums;
- Providing utilization management services for inpatient admissions, maternities and certain outpatient services;

- Processing provider claims to determine and pay Plan benefits, as provided under the terms of the Plan;
- Billing, collecting and remitting agent of record consulting fees; and
- Arranging access to, and billing and remitting fees for, discounted fee arrangements (including managed care and pharmacy networks) and wellness programs (or similar employee support programs).

Employer and employee Plan contributions provided by Plan Sponsor (to pay benefits and loss adjustment expenses under the Plan) will be held in trust with similar funds provided by sponsoring employers of other plans, in an interest-bearing bank account administered by Allied National. All earned and accrued interest shall be retained by Allied National (as part of its reasonable compensation for the Delegated Services). If eligible benefit payments exceed Plan contributions, funds may be advanced to the employer by the Stop-Loss Insurance company (under the Stop-Loss Insurance accommodation provision). If eligible benefit payments exceed the agreed to specific or aggregate maximums, coverage becomes available under the Stop-Loss Insurance.

I have authority to represent and act on behalf of Plan Sponsor in submitting this Plan Sponsor Statement, the answers and information provided in this Plan Sponsor Statement are complete and true to the best of my knowledge and belief, and I understand that any material misrepresentation or omission in this Plan Sponsor Statement may nullify coverage under the Stop-Loss Insurance coverage.

List Owners:_____ Email Addresses: _____

Who is authorized to sign stop loss documents? _____

Signed at_____ Signature _____
City & State

Name (Print)_____

Date_____ Title_____
Must be signed by Firm Owner, Partner or Officer

Final monthly costs and eligibility are determined at the time of underwriting. DO NOT cancel current coverage until written notice of approval of Stop-Loss coverage has been received from Allied National.

SECTION 4 – AGENT OF RECORD INFORMATION

Producer's Name _____ Allied Agent #_____

Agency or Company _____

Address _____

City _____ State_____Zip _____

Telephone ( ) _____ Fax ( )_____

Social Security Number or TIN _____ Email Address _____

Pay consulting fees to: ❑ Agent _____ ❑ Agency _____

DELIVERY OF PLAN MATERIALS

Plan materials, including ID cards, are mailed directly to the employees home address on file.

PRODUCER'S STATEMENT

I am now appointed with the Stop-Loss carrier in the state where this employer is located. ❑ Yes ❑ No

I hereby certify that all of the information contained in this Plan Sponsor Statement and in the employee enrollment forms is correct to the best of my knowledge, and I know of no adverse information concerning this employer or any individual's health status other than as disclosed. I have complied with the underwriting rules and regulations and have explained in detail the self-funded plan and Stop-Loss coverage to the employer.

I hereby acknowledge the consulting fees paid to me by the employer will be billed and collected on my behalf by Allied National and that those fees are based on the actual enrollment in any month.

Date Completed _____ Signature of Agent _____

General Agent name and number: _____

RETURN TO: UNDERWRITING • ALLIED NATIONAL • P.O. BOX 29187 • SHAWNEE MISSION, KS 66201-9187

Electronic copies of this form submitted via facsimile, email or other electronic means shall be deemed an original.

PLAN SPONSOR (EMPLOYER) DISCLOSURE STATEMENT

HIPAA Privacy permits the release of Protected health information (PHI) to evaluate and accept the risk associated with the Plan Sponsor as a part of "health care operations". The Company/MGU ("Allied") shall use the information provided solely to evaluate the risk's acceptability and shall not disclose any PHI collected except in performing the risk evaluation.

The Company will rely upon the attached disclosure form's information, which will become part of the Plan Sponsors (Employer) Statement. The purpose of this document is to allow the Company to take underwriting action on all known risks in the categories listed below. The Plan Sponsor's responsibility, either directly or through their designated representative, is to accurately report all claims known as of the date of this disclosure by making a thorough review of all applicable records. Such records shall include historical claims reports, disability reports, current information from administrators, insurers, utilization management companies, managed care companies, and any Agent/Broker of the Plan Sponsor. In exchange, the Company will accept the liability for any truly unknown risks. The attached disclosure form must be completed and signed by the appropriate parties no more than thirty (30) days before the proposed Effective date of Stop Loss coverage and received by the Company within five (5) days of completion.

List on the Disclosure Form all Participants with risks that are known to be:

1. Currently disabled, confined to a Medical Facility, or have been precertified or prior authorized for care within the last three months.
2. Have received medical services during the current plan year, the cost of which exceeds the lesser of 50% of the lowest Specific Retention Amount applied for or $50,000.
3. Have been identified as a candidate for Case Management and will exceed during the policy period, the lesser of 50% of the lowest Specific Retention Amount applied for, or $50,000.
4. Have been diagnosed or have an active diagnosis during the current plan year, with a condition represented by any of the ICD-9 and ICD-10 codes or high-cost drugs contained on the attached list and have also received medical services constituting $5,000 during the same period.

If the Plan Sponsor fails to disclose any risks known to fall into the one of the above categories, either intentionally or because a thorough review of the records was not conducted, neither the Company, nor the Stop Loss Policy will have any liability for claims on the risk not disclosed.

As of _____(date), the Plan Sponsor verifies, to the best of its knowledge, that the information herein is accurate and complete.

Verified by the Plan Sponsor:

Authorized Signature _____ Date _____

Title _____

Disclosure Form

Full Legal Name of Company _____

THIS FORM MUST BE COMPLETED IN ACCORDANCE WITH INSTRUCTIONS ON THE PREVIOUS PAGE. THESE INSTRUCTIONS CLEARLY DEFINE THE TIME FRAMES REQUIRED FOR SUBMISSION OF THE DISCLOSURE STATEMENT.

Each question below must be completed. If the answer is "yes" to any part, please provide details in the space provided or, if necessary, attach another sheet. "Participant" refers to any of the following eligible persons: employee, COBRA participant, retiree or dependent or any person eligible under the Plan.

1. Have claims on any Participant during the last 12 months been incurred and/or paid in excess of 50% of the Specific deductible or $50,000 (whichever is less)?..... ☐ Yes ☐ No
2. Are any Participants currently, or have they been in the past 60 days, confined to a hospital or other medical facility on multiple occasions or for three (3) or more consecutive days or have any Participants been precertified or prior authorized for inpatient care within the last three months?..... ☐ Yes ☐ No
3. Other than the individuals already listed, are there other known potential Shock Loss Claims? Potential Shock Loss Claims are defined on the Potentially Catastrophic Diagnosis and High-Cost Drug listing pages below and include any high-cost drug or condition that may reasonably be assumed to cost $50,000 or more in the last 9 months. The example diagnosis and high-cost drug lists are intended to help the Plan Sponsor identify potential catastrophic claims and may not be a comprehensive list. ..... ☐ Yes ☐ No
4. Are there currently any dependent children over the normal termination age covered by the plan under a disabled or handicapped child extension provision? ..... ☐ Yes ☐ No
5. Are there any Participants who are expected to be absent from work due to disability on the effective date of the Stop Loss Policy coverage? ..... ☐ Yes ☐ No
6. Have any Participants been absent from work or unable to perform the normal functions of a person of like age and gender due to disability during the past 60 days; this includes employee sick time, Family Medical Leave or scheduled Leave of Absence? ..... ☐ Yes ☐ No

Full Name (Last, First, MI)	Date of Birth	Diagnosis/ Prognosis/ High-Cost Drug	Beginning Date of Treatment	Amount of Paid Claims (last 12 months)	Amount of Pended Claims

7. Are any Participants covered under COBRA, or COBRA eligible? ..... ☐ Yes ☐ No

   Please provide the following information for all eligible COBRA Participants (this includes Participants that are eligible but have not yet made an election). Please include those Participants listed above if applicable.

COBRA Participant	Relationship to Insured	Qualifying Event	Beginning Date	Ending Date

8. If this policy is currently fully insured, are extended benefits available from the prior insurer for presently disabled employees and/or dependents? ..... ☐ Yes ☐ No
9. Are any Participants covered as a Special Enrollee, or eligible as a Special Enrollee? ..... ☐ Yes ☐ No

   Please provide the following information for all Special Enrollees and all eligible Special Enrollees (this includes Participants that are eligible but have not yet made an election). Please include those Participants listed above if applicable.

Special Enrollee	Date of Birth	Re-enrolled (Yes/No)	If "Yes," Date Re-enrolled	If "No," Date Eligible

EXAMPLES OF POTENTIALLY HIGH-COST DRUGS

The following list, provide examples of some high-cost drugs that could potentially result in a Shock Claim. Please refer to the instructions on the Disclosure Statement to determine if claimants with the following high-cost drugs are required to be disclosed. Shock loses are injuries, illnesses, diseases, diagnoses, or high-cost drugs that are reasonably likely to result in a significant medical expense claim or disability.

A high-cost drug is defined as a drug for which monthly costs exceed $10,000.

Examples (this list is not meant to viewed as an exhaustive list identifying every potential high-cost drug):

Avastin	Imatinib	Taltz
Berinert	Kalbitor	Technivie
Cinryze	Kalydeco	Tyvaso
Daklinza	Keytruda	Uptravi
Epclusa	Kynamro	Ventavis
Firazyr	Lumizyme	Viekira
H.P. Acthar	Opdivo	Xyrem
Harvoni	Orkambi	Yervoy
Humira	Soliris	Zaltrap
Ibrance	Sovaldi	Zepatier
Iclusig	Stelara	

Conditions leading to use of high-cost drugs may include: enzyme deficiencies (genetic mutations, Hereditary Angio- Edema, Hunter's Syndrome and other), various cancers, Cystic Fibrosis, Multiple Sclerosis, Nephrotic Syndrome, Psoriasis and other inflammatory conditions, Hepatitis C, Hemophilia A, B & C, Hemolytic Uremia Syndrome, MDS, Narcolepsy and Pulmonary Arterial Hypertension.

EXAMPLES OF POTENTIALLY CATASTROPHIC DIAGNOSES

The following ICD-9 and ICD-10 diagnosis codes list, provide examples of some diagnoses that could potentially result in a Shock Claim. Please refer to the instructions on the Disclosure Statement to determine if claimants with the following conditions/high-cost drugs are required to be disclosed. Shock loses are injuries, illnesses, diseases, diagnoses, or high-cost drugs that are reasonably likely to result in a significant medical expense claim or disability.

ICD-10	**ICD-9**			ICD-10	ICD-9	
A00–B99		**Infectious Disease**		**O00–O9A**		**Pregnancy, Childbirth & Puerperium**
B17.1–B17.11	70	Hepatitis C		O30.10–O30.109	651.1	Triplet Pregnancy
C00–D49		**Neoplasms**		O30.20–O30.209	651.2	Quadruplet Pregnancy
C00-C14	141-148	Malignancies of oral cavity and pharynx		060.00-060.14	644.2	Preterm Labor
C15-C26	150-159	Malignant Neoplasm of digestive organs				
C30–C39	160-165	Malignant neoplasm of respiratory organs		**P00-P96**		**Perinatal Conditions**
C43–C44	172.3	Melanoma		P07.00–P07.36	765-765.1	Preterm Infant

C50-C50	174-189	Breast Malignancies		P22.0	769	Respiratory Distress Syndrome of Newborn
C51-C68	174-189	Genitourinary Malignancies				
C69–C72	191-199	Malignancies of the Nervous System		**Q00-Q99**		**Congenital Malformations**
C81–C96	200-208	Leukemias, Lymphomas and Myelomas		Q20–Q28	745-746	Congenital Heart Diseases
				Q39.0–Q39.4	750.3	Tracheoesophageal Fistula
D50–D89		**Hematologic Disorders**			765.7	Abdominal Wall Anomalies
D57.1	282.6	Sickle Cell Anemia				
D61.01	284	Aplastic Anemia		Q89.7	759.7	Multiple Anomalies
D66	286	Hemophilia/Hereditary Factor VIII Deficiency				
D81.0	279.2	Severe Combined Immune Deficiency (SCID)		**S00–T88**		**Injury, Poisoning and Trauma**
D82.1	279.11	DiGeorge Syndrome		S06.0–S06.9	852-854	Brain Injuries
D83.1	279.1	Immune Deficiency T Cells (AIDS)		S12–S14	952.9	Spinal Cord Injuries
D84.1	277.6	Alpha 1-Antitrypsin		S88	897	Amputations
E70–E88		**Metabolic Disorders**		T07	959.8	Multiple Trauma Injuries
E75.22	272.7	Gaucher's Disease		T20–T32	945-948	Burns
E84.0	277	Cystic Fibrosis		T79		Early Complications of Trauma Graft vs. Host Disease
G00–G99		**Diseases of the Nervous System**		T86.00–T86.02 T86.00–T86.09	279.52	Graft vs. Host Disease
G12.21	355.2	Lou Gehrig's disease (ALS)		Z94.84	41.01, 41.04, 41.047, 41.09	Stem Cell Transplant
G61.0	357	Guillain-Barre Syndrome		Z94.2	33.5	Lung Transplant
G91.1	331.4	Obstructive Hydrocephalus		Z94.0	55.69	Kidney Transplant
				Z94.4	50.5	Liver Transplant
I00–I99		**Diseases of the Circulatory System**		Z94.1	37.51	Heart Transplant
I27.0	416	Primary Pulmonary Hypertension		Z94.6	41	Bone Marrow Transplant
I42.0–I42.9	425	Cardiomyopathy				
I46.9	427.5	Cardiac Arrest		T86.90–T86.92	996.8	Complications of Transplants
I60.9	430	Subarachnoid Hemorrhage		T86.90–T86.99	996-8	Complications of Transplants
J00–J99		Disease of the Respiratory System				
J96.00–J96.92	518.81	Respiratory Failure				
J84.10	515	Post inflammatory Pulmonary Fibrosis				
K00–K95		**Diseases of the Digestive System**				
K70.0-K74.69	571	Chronic Liver disease/Cirrhosis				
K72.00-K72.91	572.8	Liver Failure				
N00-N99		**Diseases of the Genitourinary System**				
N18.1-N189	585	Chronic Renal Failure				