

SLG BENEFITS AND INSURANCE, LLC

ADMINISTRATION GUIDE

GENERAL POLICY ADMINISTRATION

SLG Benefits' Policy Administration function is integrated with each producer's underwriting team. Applications for coverage will be initiated upon notification to your underwriter that the group has accepted our stop loss proposal. The Application and Schedule of Insurance, once reviewed and completed to the producer's satisfaction, must be signed by the employer and then returned to your underwriter along with all other required documents. These documents will initiate coverage and become part of the employer group's Excess Loss Insurance Policy.

It is important to note that the policies and procedures outlined in this section are meant to be used as a guide and are stated in general terms. The specific terms and conditions found in the Policyholder's Application, Schedule of Insurance and Policy shall be considered the binding terms. Please contact your SLG underwriter at any time with questions or to request a specimen Policy and/or sample application. A careful review of these documents should help prevent any misunderstandings between the Plan Sponsor and insurance carrier as to the nature of coverage in effect during the Policy Period.

DOCUMENTS INITIATING COVERAGE

When the SLG Underwriter is informed that a client has accepted our proposal we will prepare a formal Application and Schedule of Insurance for presentation to the client. The Application contains important terms of the Policy being offered and applied for, tentative rates and coverage levels and the information necessary to complete final underwriting. The information included in the Application is used to complete the Schedule of Insurance.

The Application, Schedule of Insurance and Disclosure Statement must be signed and returned to SLG Benefits within 15 days after the effective date along with binder premium and corresponding Premium and Enrollment Statement. We cannot complete final underwriting or issue the Policy unless all outstanding items are received in a timely manner. We cannot release claim payments until a Policy has been issued. In addition, we cannot release commissions to the producer until the Policy has been issued and the Agent of Record has provided all necessary licensing information to SLG Benefits and is appointed by the insurance carrier.

To follow please find a brief description of the key documents necessary to bind coverage and fully issue the Excess Loss Insurance Policy:

APPLICATION

SLG Benefits will prepare this form and send it to the Producer for presentation to the client. The Application must be signed by a duly authorized official of the Plan Sponsor, as well as by the licensed agent. It is then returned to SLG Benefits. All information should be reviewed carefully and completed on the Application and signed by all appropriate parties prior to returning the document to SLG Benefits. We request that you carefully review the provisions for each type of coverage offered with the client. Be sure that they specifically understand which benefits are included in the Aggregate coverage. Typically, Medical and Prescription

Drug benefits are included under the Aggregate coverage. It is also important that you explain the maximums, limits, rate, factors, excess loss coverage basis (Paid, Incurred and Paid, etc.) and the function of the Aggregate Deductible.

Please find a more detailed description of some of the key Application items below:

Specific Lifetime Maximum Reimbursement per Covered Person:

Unless otherwise specified, this amount is \$1,000,000 less the Specific Attachment Point amount. The Lifetime Maximum will not exceed the lesser of (1) the amount shown in the Schedule; or (2) the lifetime amount set forth in the Plan.

Specific Reimbursement Percentage:

Unless otherwise specified, 100%

Maximum Aggregate Reimbursement (per Policy Period):

Unless otherwise specified, this amount is typically \$1,000,000

Aggregate Reimbursement Percentage:

Unless otherwise specified, 100%

Individual Claim Limit (Aggregate Loss Limit):

The maximum amount of Payments for Eligible Expenses counted for any one Covered Person under the Aggregate Excess Loss coverage (Typically equal to the Specific Attachment Point).

Please do not modify any coverage descriptions, factors, rates or limits without first calling SLG Benefits to see if a new application needs to be prepared. If a new application is necessary, SLG Benefits will promptly supply a revised copy.

The Application must be signed by an officer of the Plan Sponsor and clearly show the name and title of the person signing. This is the client contact SLG Benefits will use, if necessary, to communicate with during the Policy Period.

Finally, the Application must be signed (witnessed) by the Licensed Agent representing the Plan Sponsor and appointed by the insurance carrier.

Please contact your underwriter for assistance or questions regarding the completion of the Application.

A sample Application can be found in the Forms Section of this Guide.

SCHEDULE OF INSURANCE

The Schedule of Insurance is completed using the information detailed in the Application. SLG practices a paperwork reduction policy. This means your SLG underwriter will typically gather more information in an attempt to send out a Schedule of Insurance that is correct the first time. In doing this, we feel it makes sound business sense to issue the Schedule of Insurance along with the Application so our producers need not make multiple trips to the Policyholder delivering singular documents for signature.

Please do not modify any coverage descriptions, factors, rates or limits without first calling SLG Benefits to see if a new Schedule of Insurance needs to be prepared. If a new Schedule of Insurance is necessary, SLG Benefits will promptly supply a revised copy.

The Schedule of Insurance must be signed by an officer of the Plan Sponsor and clearly show the name and title of the person signing. This is the client contact SLG Benefits will use, if necessary, to communicate with during the Policy Period.

Finally, the Schedule of Insurance must be signed (witnessed) by the Licensed Agent representing the Plan Sponsor and appointed by the insurance carrier.

A sample Schedule of Insurance can be found in the Forms Section of this Guide.

DISCLOSURE STATEMENT

A Plan Sponsor Disclosure Statement must be completed for all new business accounts with SLG, even if the group is currently with the producer. It's purpose is to provide your underwriter with a complete list of plan participants, including employees, dependents, retirees and COBRA beneficiaries who are not at work or "at life" due to illness or injury on the proposed effective date or who incurred (or have the potential to incur) charges in excess of \$10,000 (or 50% of the Specific Deductible) in the last twelve months. This statement should be completed and submitted to us within the 15 day period immediately prior to the effective date. The Disclosure Statement is issued with detailed instructions to assist in completion by the Plan Sponsor. However, if there are any questions, please contact your underwriter immediately for assistance with this important document.

A sample Disclosure Statement can be found in the Forms Section of this Guide.

PREMIUM AND ENROLLMENT STATEMENT

All premium payments should be made payable to SLG Benefits and Insurance, LLC and sent to:

SLG Benefits and Insurance, LLC
9 Atlantic Avenue
Marblehead, MA 01945

The deposit premium is referenced on the Application and should be equal to the first month's Specific and Aggregate Premium (or the estimated annual Aggregate Premium amount, if being paid annually). The premium will be deposited in an escrow account until final underwriting is completed and coverage is bound.

A sample Premium and Enrollment Statement can be found in the Forms Section of this Guide.

MASTER PLAN DOCUMENT

The Master Plan Document forms an important part of the Excess Loss Insurance Policy. We require a fully executed copy signed by an official of the Plan Sponsor. The Plan Sponsor's signature on the copy forwarded to SLG Benefits acknowledges that Eligible Expenses will be reimbursed within the provisions of the plan document in our possession. This document will be used by SLG Benefits when reviewing specific and aggregate claims submitted for reimbursement under the Excess Loss Insurance Policy. SLG Benefits will review and verify that the plan document benefits match those understood by your SLG Benefits Underwriter at the time the proposal was prepared. Any changes from the originally submitted benefit plan quoted by the underwriter must be approved prior to acceptance and issuance of the Policy. Furthermore, all amendments considered during the Plan Year must be submitted to SLG Benefits for review prior to acceptance under the Excess Loss Insurance Policy.

Please be aware that SLG Benefits and Insurance, LLC, on behalf of our insurance company partners, is prohibited from considering any claim for reimbursement without receipt and acceptance of the signed Master Plan Document.

FINAL UNDERWRITING REQUIREMENTS

Before the Excess Loss Insurance Policy can be issued, the following must be received and reviewed by SLG Benefits:

- * Signed Application for Excess Loss Insurance Policy
- * Signed Schedule for Excess Loss Insurance Policy
- * Signed Plan Sponsor Disclosure Statement
- * Binder Premium including Premium & Enrollment Statement
- * Plan Document
- * Any other underwriting requirements or requested documentation

Final rates and factors are subject to possible revision based upon receipt and review of the following additional items as requested by your SLG Underwriter:

- * The full census which should include a date of birth, sex and dependent status for all participants covered under the health plan as of the Policy effective date. Please be sure to include all COBRA participants, as well as potential COBRA beneficiaries. If retirees are to be covered, they must be clearly identified on the census. If the final enrollment is significantly different (+/-10%) from the census used to quote the group, please be aware that this may affect the quoted rates and/or factors.
- * Claims experience for all included benefits up to the effective date, including month by month enrollment.
- * Information on any Participant who has (1) incurred claims at 50% or more of the selected specific deductible; (2) had a Potentially Catastrophic Loss (PCL) diagnosis during the past 12 months; or (3) is reasonably expected to generate claims greater than 50% of the selected Specific Deductible. On any Participant that meets the above criteria, please submit the following to SLG Benefits: age, sex, employee or dependent status, diagnosis, prognosis, original date of onset, date last claim was received, total claims received to date and current employment status. The above information is required on all claims paid, processed and unpaid, pending or denied for any reason.

* Detailed information should also be provided to SLG Benefits on any disabled employee, dependent, COBRA participant or retiree. In addition to the standard information described above, we also require the following on these Participants: the date and nature of disability and the current medical/employment status (diagnosis, prognosis and expected date of return to work).

* The final executed Plan Document for the group. We must review and approve the plan document to verify that benefits correspond with those assumed when we prepared our quote. Any non-standard plan provisions or changes in benefits may result in adjustments to quoted rates and/or factors. Please be aware that our approval of the Plan Document shall not supercede any exclusions or provisions established in the Policy.

* Any other information that may be requested by the underwriter.

If any of the required information cannot be supplied for any reason in a timely manner, please contact your underwriter immediately to request additional time or guidance in satisfying the requirements to issue the Policy.

OTHER IMPORTANT DOCUMENTATION

LICENSING REQUIREMENTS

In order to be approved as a producer for SLG Benefits and Insurance, LLC and to be appointed by the insurance company, the following required information must be received and approved by both SLG and the carrier. These documents are required for any producer or administrator that markets, services, collects commissions and/or requests claim reimbursement's on business in which SLG Benefits & Insurance is the Stop Loss Program Manager. These documents are generally one time only requirements. If the Approved and Appointed entity changes their name or the appointed individual leaves the entity, new documents will be required.

APPOINTMENT INFORMATION SHEET

Please complete the carrier Appointment Information Sheet for the agent or agency for which you are requesting appointment. If you need appointments in multiple states, please list each of the states on the appropriate line of this form. It is not necessary to complete multiple forms.

Whether you complete electronically or in paper format, please be sure that all information is complete and legible and that you have provided copies of licenses in all states for which you are requesting appointments. Please note that we will accept either copies or scanned images of the individual state licenses. For faster appointment processing we will accept electronic signatures on the Appointment Form in addition to scanned images of licenses.

Please be sure to specify a contact person who regularly submits requests for appointments and copies of licenses. This is the person that SLG will contact with questions, requests for any additional documents and information and notifications of all state responses.

Please note that commissions will be payable to the entity that the Appointment is requested for; an Individual Insurance Producer or a Business Entity Producer. In addition, all Policy service notices and new or renewal proposals will be directed to the entity approved for appointment.

If the Appointment is being completed as a Business Entity (Agency), please include a separate listing of all licensed employees that may produce and renew business with SLG. This listing should include the licensed employee name, license type, license number, effective date and expiration date. This information will be valuable in our compliance record maintenance for the primary producers that work with SLG.

PRODUCER AND COMPENSATION AGREEMENT

This document addresses the nature of the relationship between the Program Manager, SLG Benefits & Insurance, LLC and the Producer. The Producer may be an individual or business entity receiving commission or being compensated on a fee basis directly from the employer group. The Producer initiates the proposal process with SLG and maintains Policyholder service responsibilities.

A fully completed, endorsed and approved Producer and Compensation Agreement is required for Producer Approval by SLG Benefits and Insurance, LLC.

IRS FORM W-9

The Request for Taxpayer Identification Number and Certification is required for Approval and Appointment.

Business Entity Producers will reference a Federal Tax Identification Number and Individual Producer will reference a Social Security Number.

It is the responsibility of the TPA or Producer to notify SLG Benefits when an appointed Producer leaves their employment so we may terminate the agent's appointment with the insurance carrier. In addition, Approval and Appointment documents will need to be submitted for any individuals replacing terminated agents or new employees involved in the placement of Excess Loss Insurance with SLG Benefits are hired. If notification is not received, SLG reserves the ability to bill the TPA or Producer for any state mandated fees incurred for the terminated Producer.

ISSUING THE EXCESS LOSS INSURANCE POLICY

After rates and factors have been finalized and all the required documents and binder premium are received and approved by SLG Benefits, we will issue the Policy. SLG Benefits will send the executed Policy to the Producer for delivery to the Policyholder. We will include two copies of the Excess Loss Insurance Policy issued on behalf of the insurance carrier and three copies of the following:

- Fully executed signed Application
- Fully executed signed Schedule of Insurance, accepted by SLG Benefits and Insurance, LLC on behalf of the insurance company.

The Entire Excess Loss Insurance Policy consists of: 1) the Policy, including any endorsements; 2) the Application and Schedule and any attachments thereto; and 3) a copy of the Plan Document. If additional endorsements or changes are necessary after we have issued the Policy, the Policyholder will be required to resubmit signed paperwork to SLG so we may make the appropriate modifications to the Policy.

PREMIUM ACCOUNTING

SLG Benefits provides a Premium and Enrollment Statement to each Policyholder for the purpose of calculating all premium payments.

PREMIUM PAYMENTS

Premium payments are due on the first of the month. Payment should be submitted along with the Premium and Enrollment Worksheet. Customized worksheets are permitted, as long as the worksheet includes the following information:

1. Month for which payment being made is applicable
2. Group name and Policy number
3. Listing of rates being remitted (must document whether or not rates are on a gross or net basis)
4. Enrollment counts for the month being remitted (adjustments must be documented)
5. Calculation of total monthly premium

All premium payments should be made payable to SLG Benefits and Insurance, LLC & sent care of:

SLG Benefits and Insurance, LLC
9 Atlantic Avenue
Marblehead, MA 01945

LATE PREMIUM

A premium is considered past due if not received by the end of the Grace Period established in the Policy (normally 31 days) and may result in SLG Benefits making appropriate contact to determine the delay. SLG Benefits intends to notify all Producers of Policyholders whose premiums have not been received by the 10th of the following month. Our notice informs the Producer, which is also deemed to be notice to the Policyholder, that premium has not been received and that termination or a voiding of the Policy may take place without further notice.

Premiums received after the 10th are considered late payments. Any extensions for receipt of payment are granted at the sole discretion of SLG Benefits. We reserve the right to cease extensions past the grace period at anytime and without prior written notice.

It is the Policyholder's responsibility to make certain that premiums are paid. We request that you do not rely upon the expectation of receiving premium late notices in order to trigger payment of premiums. Coverage may be rescinded or terminated whether or not the late premium notice mentioned above is sent or received. Prior premium payment delay shall not constitute waiver by the insurance company and may not be used to create any release of responsibility for timely submission of current and future premium payments.

If any of these procedures are in conflict with any state law or regulation, we will adjust our procedures to conform with the state requirement accordingly.

PREMIUM VARIANCE

All policies are on a self-bill basis. We do not send billing statements and it is the Policyholder's responsibility to pay the monthly premium in a timely manner. If the premium paid does not match the actual amount due, we will send a notice of variance. We will allow the variance to be credited or the additional payment be made in the following month's billing statement.

Since the premium received by SLG Benefits for the first month of coverage is estimated, please allow for premium reconciliation between the estimate and the actual earned first month's premium. This can be adjusted when submitting the second month's payment. If final rates are not established by the time the second month's premium is due, an estimated amount is still required to be paid on time, with reconciliation occurring in the third month.

ENROLLMENT STANDARDS

Under certain circumstances, at the discretion of SLG Benefits, a given monthly premium total may be revised due to enrollment fluctuations. Premium revisions shall not be permitted that are based on enrollment adjustments in excess of ninety-days (90) from the first of the month in which SLG Benefits receives a request for premium revision.

Back charges or credits of more than 90 days for any employee must have supporting documentation that explains the delay in change notification. SLG Benefits will approve or disapprove these adjustments on a case-by-case basis. Please note that timely reporting is

important for you and the client's protection.

Enrollment changes of more than 10% from the effective date of coverage must be reported to SLG Benefits immediately. SLG Benefits has the right to change rates and/or factors in order to adjust for significant changes in plan participation. No action will be taken without notifying the TPA or Producer.

We will accept a no loss/no gain procedure on additions and terminations for a month. This means, if a group is completing their billing on the 15th of the month for the following month:

1. We will count all additions made between the 1st and the 15th of the month. Any additions made from the 16th to the end of the month will not be accounted for in that month and will be reflected in the following month's remittance.
2. We will count all deletions made between the 1st and 15th of the month. Any deletions made from the 16th to the end of the month will not be accounted for in that month and will be reflected in the following month's remittance.

This does not mean that the Plan Sponsor will not add or delete the individuals from the plan if it occurs after the 15th. It should list these individuals on the census for the next month, but a pro-rating for the short period is not necessary.

This philosophy mirrors running a census on the 15th of the month and reporting based off that census. It relies on the fact that most groups have a normal ebb and flow to additions and terminations and they will generally balance out. We do not pro-rate any premiums, so this is our recommended procedure.

TERMINATIONS

There are occasions that warrant termination of an employer's Policy. The following includes some, but not all conditions that will result in termination of coverage.

NON-PAYMENT OF PREMIUM

Premium is due on the first day of the month with a grace period as defined in the Policy. If it is not received within the grace period, the Policyholder will be considered terminated without further notice. This type of termination may also take place if premium is not paid according to the Policy terms. Examples of the latter would be the non-payment of an annual advance premium or when there is only partial payment of premiums due.

In the event that a check is returned unpaid and termination results, the TPA and/or Producer will be notified immediately of the problem. The overdue premium must be express mailed in the form of a certified check or money order to SLG within three (3) business days in order to prevent termination for non-payment of premium. If during any Policy Period, a second payment is returned unpaid, termination is automatic. If we accept the Reinstatement Application, all future premiums must be submitted by certified check or money order. No exceptions will be made to these procedures unless required by law.

In the event premium is not paid within the grace period and a Policy has not been issued, SLG Benefits will automatically rescind coverage.

TERMINATION AT THE POLICYHOLDER'S REQUEST

The Policyholder may effect termination by providing at least 31 days advance written notice. If the Policyholder cancels within 30 days of the effective date, they may request a full refund of the premium and the Policy will terminate on the Effective Date. If the Policyholder cancels the Policy at a later date, the Carrier will keep the premium earned to the date of termination. Additionally, upon termination, all minimum Annual Premiums shall be due unless prohibited by law.

CHANGE OF THIRD PARTY ADMINISTRATOR

If a Plan Sponsor is terminating its administrative agreement with its claims administrator, SLG Benefits may terminate the excess loss coverage as of that date. This means that a change in administration by the Plan Sponsor does not automatically transfer coverage under the Excess Loss Insurance Policy. SLG Benefits must receive a letter on the Plan Sponsor's letterhead communicating the new administrator. SLG Benefits must recognize the administrator as "Approved" or the Excess Loss Insurance Policy will not transfer. Changes in administration are only considered at the time of renewal or Policy anniversary, unless written approval is granted by SLG Benefits in advance of the mid-Policy Year change.

PLAN PARTICIPATION OR ENROLLMENT

The Schedule of Insurance defines the minimum expected levels of participation or enrollment in a covered plan. Failure by the Employer to maintain these requirements for three consecutive months may result in termination unless we agree in writing to continue coverage.

REINSTATEMENT

Once a Plan Sponsor has been terminated for non-payment of premium, the producer and/or Policyholder can request a Policy reinstatement. Request for reinstatement must be made within 30 days of the termination date of the Policy. SLG Benefits only allows one reinstatement per Policy Period. Additional reinstatement requests will be granted at the sole discretion of SLG Benefits.

When a Producer submits a request for reinstatement, it should be directed to the producer's SLG Underwriter.

In the reinstatement package, we will require the following items be submitted:

1. The Reinstatement Application to be completed and signed by an officer of the Plan Sponsor.

2. Our standard Disclosure Statement, to be completed and signed using the most current claims information.
3. The submission of a current monthly aggregate paid claims report (if aggregate coverage is to be reinstated).
4. Premium through the current month of the request for reinstatement.

The reinstatement package must be returned to SLG Benefits within 15 days of receipt by the Producer for consideration of reinstatement. Failure to return the reinstatement package within 15 days will result in forfeiture of the Policyholder's ability to apply for reinstatement. After complete review of the reinstatement package, SLG will issue their decision with 15 days which may include:

- a. Reinstatement with no changes to the Policy
- b. Reinstatement with revised Policy terms
- c. Denial of reinstatement request

A sample Request for Reinstatement Form can be found in the Forms Section of this Guide.

RESCINDED OR VOIDED COVERAGE

There are occasions when the Excess Loss Insurance Policy may be rescinded or considered null and void. If the Policy is considered null and void, the Policyholder would need to reapply for coverage and have the case re-underwritten prior to reinstatement of coverage. If the Excess Loss Insurance Policy is voided, all premiums received by SLG Benefits will be refunded directly to the Policyholder along with a rescission notice. The following are some, but not necessarily all, conditions that may cause the coverage to be null and voided:

Failure To Return All Documents

If SLG Benefits does not receive all of the documents required to issue the Policy within ninety (90) days after the proposed Effective Date, then SLG Benefits, on behalf of the insurance company, will void coverage back to the proposed Effective Date.

Misrepresentations

All statements made by the Policyholder or a representative of the Policyholder are, in the absence of fraud, understood to be representations and not warranties. Such statements will not be used to contest coverage unless contained in the Application and Schedule or any attachments to the Application and Schedule.

In case of a conflict between the Plan and the Policy, the Policy will prevail. We rely on the information provided to us to issue the Policy. The Policyholder represents this information is accurate. Should subsequent information become known which, if known prior to issuance of

this Policy, would affect the premium rates, factors, terms or conditions of coverage, we reserve

the right to revise the premium rates, factors, terms or conditions as of the Effective Date by providing written notice to the Policyholder. Any fraudulent statement will render this Policy null and void and claims, if any, will be forfeited.

COMMISSIONS

The Third Party Administrator, prior to submission of premium, may deduct commissions. Alternatively, the Third Party Administrator may choose to submit the gross premium to SLG Benefits and receive the commission from SLG Benefits. All producers, regardless of whether the premiums are remitted gross or net, must be approved by SLG Benefits and appointed by the insurance carrier.

Commissions are paid monthly for premium received and processed prior to the end of business day prior to commission payments.

MEDICAL CONVERSION

In certain cases the Producer may arrange for a Medical Conversion Policy from Celtic Life Insurance Company through their SLG underwriter. Eligibility for conversion is determined as follows:

1. The person must have been covered under the employer's medical plan as described in the plan document for at least six months.
2. The person's coverage must have ended prior to termination of the Excess Loss Insurance Policy.
3. The person is eligible to convert only once, even if he/she becomes covered under the employer's plan for a second time.
4. Only those who are under age 65 and residents of the United States are eligible.

It is important to note that Medical Conversions themselves are not handled by SLG Benefits. In the event that an eligible person requests medical conversion, a Medical Conversion Form is used to request Conversion from the Celtic Life and should be sent to SLG Benefits for forwarding to Celtic Life. The Conversion privilege must be exercised within 31 days, or the maximum number of days allowed within the state, whichever is less, after medical coverage terminates. No evidence of insurability will be required. The individual premium assessed for each conversion will be determined by Celtic Life and is based on the employee's state of residence, age, sex and the desired medical plan. Celtic Life can provide information on other medical plans as well.

REVISING OR AMENDING THE MASTER PLAN DOCUMENT

If a Plan Sponsor wishes to implement a plan change, written consent from SLG Benefits must be received before the changes can be covered under the Excess Loss Insurance Policy. Rates and factors will be subject to change as defined by the Policy. All plan change requests should be directed to your SLG Benefits Underwriter 31 days prior to implementation and should include

the proposed effective date of the changes. If the plan changes are approved, SLG Benefits will expect to receive a revised Plan Document or an amendment to the existing Plan Document, signed by the Plan Sponsor. Any amendments or plan changes implemented by the Plan Sponsor and TPA prior to review and approval by SLG Benefits shall not be considered covered expenses for the purposes of the Excess Loss Insurance Policy and will not be used in calculating claim reimbursements.

CHANGES IN ENROLLMENT

Enrollment changes of more than 10% from the enrollment on the effective date of coverage compared to the enrollment on any premium due date, must be reported to your SLG Benefits underwriter immediately. SLG Benefits has the right to change rates and/or factors to adjust for the change in plan participation.

SLG BENEFITS AND INSURANCE, LLC

CLAIMS GUIDE

INTRODUCTION

This document serves as a reference guide for Third Party Administrators working with SLG Benefits. It contains information about submitting Specific and Aggregate Excess Loss reimbursement requests, as well as information on how to access our value-added risk management services. We request that TPA claims staff review this information carefully to promote a more efficient claim review process. Delivering prompt and accurate claim reimbursement service is a tenet of SLG Benefits and directly benefits our mutual clientele.

It is important to note that the policies and procedures outlined in this section are meant to be used as a guide and are stated in general terms. The specific terms and conditions found in the Policyholder's Application, Schedule of Insurance and Policy shall be considered the binding terms. Please contact your SLG underwriter at any time with questions or to request a specimen Policy and/or sample Application and Schedule of Insurance from the insurance carrier. A careful review of these documents should help prevent any misunderstandings between the Plan Sponsor and the insurance carrier as to the nature of coverage in effect during the Policy Period.

All notifications, reimbursement requests and claims information should be directed to the following address:

SLG Benefits and Insurance, LLC
9 Atlantic Avenue
Marblehead, MA 01945

Phone: (800) 742-9279

Fax: (978) 740-9485

Email: riskmanagement@slgbenefits.com

IMPORTANT CONTRACT DEFINITIONS

The following are several important Policy definitions typically referenced by a TPA's claim staff. These do not represent all Policy definitions. We remind our TPAs to always carefully review the Policy if there are any questions regarding coverage or terms.

Covered Person:

This means an individual covered under the Plan

Covered Unit:

This means an employee, an employee with dependents or such other defined unit as agreed upon and as shown on the Application.

Benefit Period:

This means the period of time during which Eligible Expenses must be Incurred by a Covered Person and Paid by the Policyholder to be eligible for reimbursement under the Policy. This period does not alter the Policy Effective Date or Policy Period. It does not waive the Policy's eligibility requirements.

Eligible Expenses:

The eligible charges payable under the Plan and for which the Covered Person 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.

Incurred:

This means:

1. With respect to medical services or supplies, the date on which the services are rendered or supplies are received by the Covered Person; and
2. With respect to disability income benefits, the date each periodic benefit payment becomes payable to the Covered Person (not the date the disability commences).

Paid (Payment):

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

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

Plan Benefits:

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

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

Plan Benefits will also include those health benefits covered by the Plan during the Policy Period which are Paid during any Run-Out period or Incurred during any Run-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 or arrangement or excess loss coverage, whether issued by SLG Benefits, on behalf of the insurance company or another entity.

Policy Period:

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

Run-in Limit:

This means the maximum benefit amount Paid by the Policyholder under the Plan for Eligible Expenses Incurred by a Covered Person during the Run-in Period which will be applied toward payment under the Policy.

Run-in-Period:

This means the period of time shown in the Schedule of Insurance immediately prior to the first day of a Policy Period during which Eligible Expenses Incurred by a Covered Person, which are Paid by the Policyholder during the Policy Period, will be considered when determining benefit payments under this Policy.

Run-out-Period:

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

Individual Claim Limit:

This means the maximum amount of Payments for Eligible Expenses that will be counted for any one Covered Person under the Aggregate Excess Loss. The Individual Claim limit is shown in the Schedule of Insurance. It is also commonly referred to in the industry as a Loss Limit.

Large Claim:

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

Potentially Catastrophic Loss:

This means a Paid or pending claim that has the potential to be catastrophic. Potentially Catastrophic Losses include, but are not limited to the list of conditions found in the forms section of this guide.

Usual and Customary Charges:

This means the common charge for the same or comparable service or supply in the geographic area in which the service or supply is furnished. Usual and Customary Charges are determined based upon:

1. the amount of resources expended to deliver the treatment;
2. the complexity of the treatment rendered; and
3. charging protocols and billing practices generally accepted by the medical community

Experimental or Investigational:

Experimental or Investigational means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The covered service will also be considered Experimental/Investigational if the Covered Person is required to sign a consent form which indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, which is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or

any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental/Investigational. Treatment is also considered Experimental/Investigational if such treatment has not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services, Food and Drug Administration (FDA) or any other comparable state governmental agency and the Federal Health Care Finance Administration as approved for reimbursement under Medicare Title XVIII. A drug, device or biological product is considered Experimental/Investigational if it does not have FDA approval or it has FDA approval only under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption.

CONTRACT TERMS (CLAIMS BASIS)

Eligible Specific and Aggregate claims are reimbursed based on the Policyholder's Incurred and Paid date parameters (claim basis). It is extremely important that employers understand these terms and how they impact their overall Excess Loss reimbursement.

Incurred and Paid (12/12)

- a. Incurred during the Policy Period and
- b. Paid during the Policy Period

Incurred and Paid with a three month run-in provision (15/12)

- a. Incurred during the Policy Period or within three months prior to the beginning of the Policy Period and
- b. Paid during the Policy Period

Incurred and Paid with a six month run-in provision (18/12)

- a. Incurred during the Policy Period or within six months prior to the beginning of the Policy Period and
- b. Paid during the Policy Period

Incurred and Paid with a twelve month run-in provision (24/12)

- a. Incurred during the Policy Period or within twelve months prior to the beginning of the Policy Period and
- b. Paid during the Policy Period

Paid

- a. Incurred during the Policy Period or within 12 months prior to the group's original effective date with SLG Benefits and
- b. Paid during the Policy Period

Incurred in the Policy Period and Paid in the Policy Period plus three months (12/15)

- a. Incurred during the Policy Period and

- b. Paid during the Policy Period or within three months thereafter

Incurred in the Policy Period and Paid in the Policy Period plus six months (12/18)

- a. Incurred during the Policy Period and
- b. Paid during the Policy Period or within six months thereafter

Incurred in the Policy Period and Paid in the Policy Period plus three months (12/24)

- a. Incurred during the Policy Period and
- b. Paid during the Policy Period or within twelve months thereafter

SPECIFIC CLAIM GUIDE

NOTIFICATION REQUIREMENTS

SLG Benefits should be notified of potential catastrophic losses or other large claims as soon as reasonably possible. The procedures for notifying SLG Benefits are as follows:

Catastrophic Claims (using the Potential Catastrophic Loss List)

Utilization Review (UR) vendors, Large Case Management (LCM) vendors and TPAs should submit information regarding a catastrophic claim to the SLG Benefits Risk Management Department as follows:

Phone: (800)-742-9779
Fax: (978)-740-9485
E-mail: riskmanagement@slgbenefits.com

The information submitted will be carefully reviewed by our Risk Management Staff. We may provide suggestions, if warranted, to manage the claim effectively based on positive outcomes for the patient at the most reasonable cost for the Plan Sponsor.

The Potential Catastrophic Loss List can be found in the Forms Section of this Guide.

Standard Large Claim Notice (50% of the Specific Attachment Point)

If a claimant has reached 50% of the Specific Attachment Point, notification can be made using the Specific Claim Notification Form. Upon completion, this form should be mailed to the address above or may be sent via fax or e-mail as follows:

Fax: (978)-740-9485
E-mail: riskmanagement@slgbenefits.com

Specific Excess Loss written notification is required by the Excess Loss Insurance Policy with 30 days of the date the Plan Sponsor becomes aware or as soon as practically possible. Timely notification is required to assist us in establishing reserves and to carefully track each claimant's prognosis and disease state.

A sample Specific Claim Notification Form (Specific Claim Form A- Claim Notification or Initial Claim Filing Form) can be found in the Forms Section of this Guide.

SPECIFIC CLAIM FILING PROCESS

Specific claims are filed in one of two formats, Traditional or Rapid File.

The *Traditional File* format consists of the basic claim data, including the following:

- Enrollment and eligibility information;
- All itemized bills;
- Explanations of benefit (EOB's)
- All other supporting documentation

The *Rapid File* format is designed for pre-qualified TPA's and is based on reducing the voluminous paperwork. This format consists of the following claim submission:

- Enrollment and eligibility information;
- A computerized report in lieu of the individual bills and corresponding EOB's;
- All other supporting documentation

The computerized report referenced above provides information in a format that typically captures the EOB and itemized bill information. **Please note, however, that even with the Rapid File format we still require itemized bills and explanations for any individual charge over \$10,000.**

SLG Benefits has an approval process that TPA's must satisfy in order to file claims in a Rapid File format. If approved, the TPA will be subject to ongoing review to ensure acceptable claim accuracy standards are continuously met. If we determine after any review that there are serious concerns regarding claim adjudication, we will reserve the right to suspend the TPA's use of the Rapid File Format.

Unless the TPA has been pre-authorized to file claims using the Rapid File format, your Specific claims must be filed using the Traditional format.

I. FILING AN INITIAL SPECIFIC CLAIM

Once a claimant's paid eligible expenses under the Plan exceed their Specific Attachment Point, a request for reimbursement should be sent to SLG Benefits. A completed Specific Initial Claim Filing Form along with the following documentation should be submitted to SLG Benefits:

Traditional Claim Submission

- a. Specific Claim Form A (Initial Claim Filing)
- b. Copy of employee's Enrollment Card, including the date of hire and original effective date under the Plan
- c. Copy of the TPA's claim form if the claim is for a dependent
- d. Complete details regarding eligibility and if applicable, information regarding:
 - work status
 - pre-existing / HIPAA documentation
 - Subrogation
 - Coordination of Benefits
 - COBRA (including a copy of the election form and COBRA payment verification for all months)
- e. Copies of Explanations of Benefit (EOB's) attached to the corresponding itemized bills (Note: All itemized bills should be date-stamped indicating receipt date by the TPA.)
- f. Check copies, if not attached to the Explanation of Benefit copy

- g. Completion of the Specific Advance Reimbursement Form, if applicable
- h. Miscellaneous information as applicable
 - Complete accident details including how, when and where the accident occurred
 - Police Report for Motor Vehicle Accidents or for services for which a Law Enforcement agency is involved
 - Subrogation and Right of Recovery Reimbursement Agreement if charges were incurred as a result of third party liability
 - Coordination of Benefits (COB) documentation
 - PPO discount calculations / Re-pricing sheets
 - Large Case Management reports if applicable
 - Student Verification information if the claim is for a dependent over age 19

A Liability Questionnaire, Subrogation and Right of Recovery Agreement and Higher Education Verification Form and can be found in the Forms Section of this guide.

Rapid File Claim Submission (Pre-approval required)

- a. Specific Claim Initial Filing Form
- b. Copy of Enrollment Card including date of hire and the original effective date under the Plan
- c. Itemized provider bills for individual bills exceeding \$10,000 (a UB-92 summary bill will satisfy this requirement for hospital charges)
- d. Copy of the TPA's Claim Form if the claim is for a dependent
- e. Complete details regarding eligibility and if applicable, information regarding:
 - work status
 - pre-existing / HIPAA documentation
 - subrogation
 - Coordination of Benefits
 - COBRA (including a copy of the election form and COBRA payment verification for all months)
- f. Completion of the Specific Advance Reimbursement section if applicable
- g. System generated report containing the following information:
 - Employer/Group name
 - Employee name
 - Claimant name
 - Provider name
 - Date of Service and Payment Date
 - Types of service
 - Diagnosis or ICD-9 Code
 - Deductibles and coinsurance application
 - Ineligible or denied benefits with explanation code
 - Check numbers
 - Charge amount and Payment amount
 - PPO discounts
 - Total payment line calculation
 - Entries of voids and refunds when applicable
- h. Miscellaneous information as applicable
 - Complete accident details including how, when and where the accident occurred.
 - Police Report for Motor Vehicle Accidents or for services for which a Law Enforcement agency is involved

- Subrogation and Right of Recovery Reimbursement Agreement if charges were incurred as a result of third party liability
- Coordination of Benefits (COB) documentation
- PPO discount calculations / Re-pricing sheets
- Large Case Management reports if applicable
- Student Verification information if the claim is for a dependent over age 19

A Liability Questionnaire & Higher Education Verification Form can be found in the Forms Section of this guide.

II. FILING A SUPPLEMENTAL CLAIM

The Specific Claim Form B (Supplemental Specific Claim Filing) should be used with each subsequent claim filing after the initial claim has been processed. This form was designed to reduce the amount of time and paperwork necessary to file a claim after the TPA had already established key items such as eligibility and claimant information. Eligibility information, accident or Third Party Liability information and claimant information may be omitted provided there have been no changes since the initial or most recent supplemental claim filing.

1. Traditional Claim Submission
Supplemental claims should be submitted with items c-h listed in the Traditional Claim Submission section above.
2. Rapid File Claim Submission
Supplemental claims should be submitted with items c-h listed in the Rapid File Claim Submission section above.

A sample Specific Claim Form B (Supplemental Specific Claim Filing) can be found in the Forms Section of this Guide.

Filing Timelines

The following timelines are established in the Insurance Company Excess Loss Insurance Policy and we encourage each TPA and Plan Sponsor to become familiar with these requirements in order to avoid delay or forfeiture of a reimbursement.

Notice of Claim

SLG Benefits on behalf of the insurance carrier must be provided with a written notice of claim within 30 days of the date that the Plan Sponsor (or TPA) becomes aware of claims, with respect to a Covered Person, that have reached 50% of the Specific Attachment Point. Failure to furnish written notice within the time required by the Policy will not invalidate or reduce any claim if it was not reasonably possible to provide written notice within such time frame. However, written notice must be furnished as soon as possible, but in no event later than one year after the date written notice is first required. **Large Claims and Potentially Catastrophic Losses should be reported (regardless of whether charges have been Paid or are Pending Payment) as soon as practically possible.**

Proof of Loss

SLG Benefits on behalf of the insurance carrier must receive written Proof of Loss within 60 days after the date of loss. Late proof will be accepted only if it is shown to have been furnished as soon as reasonably possible and within one year of the date of loss.

Payment of Claims under the Excess Loss Insurance Policy

Amounts payable under the Policy will be paid upon receipt and acceptance by SLG Benefits of all the required material. Required material shall include proof of loss and proof of Payment for Eligible Expenses under the Plan and any reasonable requested supporting documentation. SLG Benefits on behalf of the insurance company will have sole authority to reimburse or deny claims under the Policy.

Benefit Determinations

Determination of benefits under the Plan is the sole responsibility of the Policyholder. SLG Benefits on behalf of the insurance company has no duty to settle or adjust claims filed under the Plan. We reserve the right to review each claim submitted for reimbursement to determine if the Policyholder is entitled to reimbursement under the Excess Loss Insurance Policy. SLG Benefits on behalf of the carrier will have sole authority to reimburse losses covered by the Policy.

III. FILING A SPECIFIC ADVANCE REIMBURSEMENT REQUEST

SLG Benefits, on behalf of the carrier, realizes that occasionally groups may have difficulty paying large provider bills, particularly when a prompt pay or time sensitive PPO discount may be involved. In an effort to assist our clients in meeting their financial needs, SLG offers access to our Specific Advance Reimbursement program. This value-added service provides tremendous cash-flow peace of mind in these financially stressful situations.

SLG Benefits must receive written notice of Specific Advance Reimbursement requests no more than (7) seven calendar days after the expiration date of the Excess Loss Insurance Policy, in order for the Plan Sponsor to be excused from actual payment according to the terms of the Policy. Any special exceptions must be submitted in writing to SLG Benefits prior to the end of the (7) seven day period after the expiration date of the Policy.

A fully completed and signed Specific Initial or Supplemental Claim Filing Form, along with the Specific Advance Reimbursement Form (or Combination Form) is required with each Advance Reimbursement request. As this is a specialized service program designed as a cash flow tool for the Plan Sponsor, we respectfully request that requested Specific Advance Reimbursement amounts be equal to or greater than \$1,000.

The following conditions must be satisfied in order for us to consider a Specific Advance Reimbursement Request. *These items are also outlined on the form which can be found in the Forms Section of this Guide:*

- 1) The form must be completed and submitted with each Specific Claim Advance Reimbursement request.
- 2) The Claim Administrator, prior to the expiration of the Specific Excess Policy, must process all eligible bills relating to this Advance Reimbursement request.
- 3) Checks totaling at least the amount of the Specific Attachment Point must be processed, paid and released to the indicated providers prior to the expiration of the Specific Policy or prior to this request, whichever is earlier.
- 4) Premium must be paid through the month in which the claim is submitted.
- 5) Advance Reimbursement requests will not be accepted if received more than (30) thirty days after the date of the Policy's cancellation or premature termination.
- 6) All eligible Expenses must be immediately released to providers upon our payment of the claim.
- 7) The claim request for Specific Advance Reimbursement must be greater than \$1,000.

SPECIAL NOTE

The Excess Loss Insurance Policy is written on reimbursement basis only. This means the Plan Sponsor is responsible for paying all eligible claim expenses prior to filing a reimbursement request. Specific Advance 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 Reimbursement, 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. This could lead to delays in receiving reimbursement or potential claim denials if claims have not been Paid within the terms of the Policy Period.

SPECIFIC TERMINAL LIABILITY OPTION

This product provides three months run-out protection for those claims incurred during the current Policy Period. It may be utilized in adherence with the following parameters:

- Available on the following contracts: 12/12, 15/12, 18/12, 24/12 and Paid
- Coverage is not applicable upon early termination of the group's Excess Loss Policy
- Product is intended for expiring Policyholders who are returning to a fully insured arrangement
- Not available at renewal unless elected on the group's original effective date

A sample Terminal Liability Endorsement can be found in the Forms Section of this Guide.

AGGREGATE CLAIM GUIDE

TPA MONTHLY REPORTING REQUIREMENTS

SLG Benefits on behalf of the insurance carrier requests that all TPAs report on or before the 15th day of each Policy Month, the following data for the preceding Policy Month:

1. Number of Covered Persons and/or Covered Units; and
2. A total of claims Paid

Most TPA's have an automated Aggregate Claim Report that summarizes the information listed above. Please feel free to submit your report.

A sample Aggregate Reporting Form can be found in the Forms section of this Guide.

FILING A YEAR END AGGREGATE CLAIM

In order to file a Year End Aggregate Claim for reimbursement under the Policy, we ask that the TPA gather the following required documentation:

- Completed Year End Aggregate Claim Form
- Paid Claims Analysis Report showing claimant name, date of service, type of service, amount charged and amount, date and Payee for each Payment made
- Eligibility listing which identifies date of birth, effective date, termination date and coverage type
- Proof of funding, including bank statements and/or deposit slips *
- Void & Refunded Claim Report *
- Benefit/Service Code report
- Aggregate Report (Monthly Loss Summary Report)
- Specific Claim Report showing claimants that have exceeded the Individual Attachment Point / Individual Claim Limit
- Listing of payments made outside the Aggregate Policy (i.e. Dental, Weekly Income, Vision, PPO Fees, Medical Records Fees, Capitated Fees, PCS (RX) Administrative Fees)
- Check Register
- Outstanding overpayment and subrogation log *
- Rx Card invoices if Rx Card is covered under the Aggregate Policy

- * SLG may also request this information for the month or two following expiration of your excess-loss Policy to review for retroactive adjustments.

Once the TPA has completed the Claim Form and compiled all of the information above, we request that this package of information be sent immediately to SLG Benefits at the following address:

SLG Benefits and Insurance, LLC
9 Atlantic Avenue
Marblehead, MA 01945

Phone: (800) 742-9279
Fax: (978) 740-9485

A Sample Year End Aggregate Claim Form can be found in the Forms Section of this Guide.

AGGREGATE ACCOMMODATION OPTION

Aggregate Accommodation is offered as an option to our smaller group clients to provide greater cash flow and financial protection for the largest dollar segment of their health plan. Any Accommodation is at all times, to be considered funds of the Carrier for which the use by the Policyholder of such funds is provided by Endorsement to the Policy. The Aggregate Accommodation should not be construed as a loan or cash advance.

If in any month during the Policy Period, the total Plan Benefits Paid by the Policyholder, for which reimbursement is provided under the Policy, 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) \$1000;

Then the Policyholder may request an advance of the aggregate excess benefit.

Accommodation Filing Requirements

In order to file an Aggregate Accommodation request we require the submission of the following documentation:

- a) Completed Monthly Aggregate Accommodation Form
- b) Monthly Loss Summary Reports showing the Policyholder's monthly paid claims data and aggregate census information
- c) Paid Claims Analysis Report showing claimant name, date of service, type of service, amount charged, and amount, date and Payee for each Payment made

Accommodation Filing Procedures

- All claims must be Paid by the Plan Sponsor prior to applying for an Aggregate Accommodation.
- Aggregate Accommodation requests must be received by SLG Benefits within 20 days following the end of the month for which the accommodation is requested.

(For example, if you are filing for the month of July, then we must receive your request no later than August 20th.)

- Aggregate Accommodation must be greater than our service minimum requirement of \$1,000.
- Aggregate Accommodation is not available in the final month of the Policy or during a run-out provision.
- The initial request for Aggregate Accommodation cannot be made prior to the end of the 90 day period following the first day of the Policy Period.

Reconciliation Procedures

If the Policyholder has not incurred an aggregate claim at the end of the Policy year, then the Policyholder must refund all Aggregate Accommodations. If the year-to-date claims fall below the accumulated aggregate deductible in any given month, all Accommodation advances must be refunded in the following month.

Failure to repay any overpayment within 60 days after written notice is provided shall result in either a 10% penalty per annum or a reduction of subsequent reimbursements under the Aggregate or Specific Excess Loss benefits by the amount of the overpayment.

SLG Benefits reserves the right to audit all records affecting our liability under this Policy.

A Sample Aggregate Accommodation Endorsement and Aggregate Accommodation Form can be found in the Forms Section of this Guide.

AGGREGATE TERMINAL LIABILITY OPTION

This product provides three months run-out protection for those claims incurred during the current Policy Period. It may be utilized in adherence with the following parameters:

- Available on the following contracts: 12/12, 15/12, 18/12, 24/12 and Paid
- Coverage is not applicable upon early termination of the group's Excess Loss Policy
- Product is intended for expiring policyholders who are returning to a fully insured arrangement
- Not available at renewal unless elected on the case's original effective date
- Coverage cost is commissionable and varies depending on the commission level selected

In conjunction with the extended coverage, the Monthly Aggregate Factors are increased by a factor of 1.25. Coverage is triggered upon expiration of the Excess Loss Insurance Policy. SLG Benefits will issue a Terminal Liability Policy Endorsement illustrating the modified Monthly Aggregate Factors and Minimum Annual Aggregate Attachment Point.

A Sample Terminal Liability Endorsement is included in the Forms Section of this guide.

GENERAL CLAIM HANDLING INFORMATION

Dental, Vision, Weekly Income and Prescription Drug Card Expenses

The Insurance Carrier's Policy is written to suit the individual needs of the Policyholder. Not all Policy's include the same types of coverage. In order to verify the exact Benefits included in the Policy we suggest you carefully review the Policyholder's Application.

Specific Coverage: Eligible Medical expenses are covered

Prescription Drug Card expenses (excluding administration fees) may be included under the specific coverage if elected by Policyholder and listed as a covered benefit on the signed Application.

Dental, Vision, and Weekly Income are typically not covered

Aggregate Coverage: Eligible Medical expenses are covered

Prescription Drug Card expenses (excluding administration fees), Dental, Vision, and Weekly Income are covered if the Policyholder elects any of these options and they are listed as a covered benefit on the signed Application.

Claim Settlement and Cost Containment Expenses

In recent years there has been a general consensus in the stop loss industry to allow non-traditional cost containment expenses under the specific and aggregate excess loss coverage. We are therefore including guidance on some of the more common expenses that may or may not be considered eligible charges under the Insurance Carrier's Policy. Our philosophy in general terms is that charges directly resulting in cost savings beneficial to the Plan and Excess Loss Carrier will be considered eligible towards satisfaction of the Individual and Aggregate Attachment Points. The following identifies and outlines our position on some of the more common claim settlement and cost containment charges:

PPO/Repricing Fees

% Of Savings: PPO/Re-pricing fees (from an outside vendor not related to the TPA) structured as a % of savings (to a 25% maximum) are eligible under the *Specific* coverage provided:

- a) Claim payments plus PPO fees exceed the Specific Attachment Point, or
- b) SLG Benefits has negotiated a discount which requires payment to a PPO network. In this case, reimbursement of these fees would be made even if the claimant had not exceeded the Specific Attachment Point.

PPO/Re-pricing fees (from an outside vendor not related to the TPA) structured

as a % of savings (25% maximum) are eligible under the *Aggregate* coverage provided:

- a) SLG Benefits has documentation these fees were included in the previous claims experience at the time of initial Underwriting, and
- b) The Underwriter acknowledged inclusion of this coverage in the Policyholder's Application/Schedule of Insurance.

Capitated Rate: PPO fees billed at a flat rate per employee per month (capitated) are not eligible under the Specific or Aggregate coverage.

Large Case Management (LCM) Fees

Large Case Management fees are payable under the *Specific* coverage provided:

- 1) Claim payments plus LCM fees exceed the Specific Attachment Point, or
- 2) SLG Benefits requested LCM implementation. If requested by SLG Benefits, reimbursement of these fees would be made even if the claimant had not exceeded the Specific Attachment Point. (Note: If SLG Benefits on behalf of the Carrier pays these fees, we must receive copies of the reports.)

Large Case Management fees (only those not previously paid as outlined in number 1 & 2 above) are payable under the *Aggregate* coverage.

Drug Card Administrative Fees

Administrative fees for Drug Card programs (similar to PCS) are not eligible for reimbursement under the Specific or Aggregate coverage.

State Surcharges

Certain states levy surcharges on in-patient and outpatient hospital bills for uncompensated care pools, training, etc. SLG Benefits on behalf of the insurance carrier will allow certain state surcharges (i.e. NY, MA) where the courts have ruled that ERISA does not prevent the imposition of the state surcharge. Please consult your SLG Benefits Underwriter for more updated information.

Legal Matters/Complaints

SLG Benefits should be advised immediately of any legal matter in which QBE the insurance carrier and/or SLG Benefits is named. The summons and complaint, along with the complete file and any supplemental documentation, should be forwarded immediately to our office.

SLG Benefits should be advised immediately of any lawsuit in which the insurance carrier or SLG Benefits is not named, but could become involved because of Specific or Aggregate Excess Loss

Insurance. The complete file and any supplemental documentation should be forwarded to us for review.

SLG Benefits should be advised of all Insurance Department Complaints in which our coverage is involved. The original complaint and complete claim file should be forwarded to us for review.

Hospital Audits

Very recently, there has been a resurgence of the hospital audit within the cost containment arena in part as a result of hospital over billing, particularly in the area of pharmacy charges. Accordingly, guidelines involving hospital audits have been revised.

When charges are believed to be excessive, the results of a hospital audit can be utilized as a benchmark for provider negotiation. 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 to not balance bill the patient. Reimbursement of audit fees is limited to 25% of savings.

SPLIT-FUNDED OR AGGREGATING SPECIFIC OPTION

Healthcare costs for employers continue to climb in double-digit increments as a result of medical trend and market fluctuation. SLG Benefits feels it is important to offer pricing alternatives designed to help Policyholders manage premium increases. These innovative products offer the Policyholder the ability to take a limited risk position on their specific premium. The Policyholder remits a discounted monthly premium rate during the course of the Policy period. If there is an individual(s) that exceeds the Specific Attachment Point, the Policyholder forgoes reimbursement until a predetermined risk corridor has been satisfied. 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.

Producers interested in presenting this alternative funding arrangement should notify their SLG Benefits underwriter. SLG Benefits offers discounts from 5% to 35% off of the traditional stop-loss premium. Variables contributing to the discount level selected are premium and deductible minimums, along with the Policyholder's risk tolerance.

If there is a specific claim(s) the Policyholder is responsible for claims over the Specific Attachment Point until the pre-determined corridor amount has been satisfied. Once the corridor amount has been satisfied, all eligible claims become the responsibility of the carrier for reimbursement to the Policyholder. It is important that the Policyholder submit all specific claims during the Policy Period to SLG Benefits even if they are still within the corridor for record keeping purposes.

A sample Split-Funded Agreement can be found in the Forms Section of this Guide.

Overpayments and Claim Refunds

All refunds should be forwarded to our office if the overpayment pertains to a specific or aggregate claim payment. Often, refunds are not received until after a Plan Sponsor's Policy year has expired. If the overpayments apply to the incurred and paid dates of the specific and/or aggregate coverage, please forward the refund checks to SLG Benefits for proper disposition to the Carrier.

IMPORTANT PLAN DOCUMENT PROVISIONS

The following are several important Plan provisions closely reviewed by SLG Benefits' claim staff when analyzing a claim reimbursement request. We ask our TPA's to assist us in our prompt review by carefully reviewing these Plan provisions and submitting explanations and supporting documentation with each reimbursement request if applicable.

Eligibility Review

Perhaps the single most important part of our claim review is to determine if an employee or a dependent was covered under the Plan at the time they incurred their expenses. We will rely on the Plan Sponsor's Plan Document for the definitions of Eligible Employees, Eligible Dependents, waiting periods for new hires and termination provisions.

The Excess Loss Insurance Policy reinsures the Policyholder's Plan Document and provides for reimbursement based on the exact wording contained therein. Therefore, it is extremely important that all parties fully understand the Plan benefits and that SLG Benefits be provided with information that clearly and precisely indicates how a person has been determined to be eligible under the Plan. For this reason, our Specific Claim Filing Forms request detailed information regarding how a claimant has been and continues to be covered under the Plan. In order for SLG Benefits to properly review a claim reimbursement request, our questions must be answered in their entirety. If this is not possible, we request that the TPA provide as much information as they have available along with an explanation as to why certain items cannot be obtained and/or submitted. Failure to do so may delay the review process.

When determining if an individual is covered under the Plan, please consider the following important items:

Employees:

What is his/her current employment status?

Is the employee actively working the minimum required number of hours to be covered under the Plan? (The standard is generally 30 hours, but each Plan varies)

Is the employee retired? If so, are retirees covered under the Plan and when did the employee retire? Are retirees covered under the Excess Loss Insurance Policy?

Is the employee disabled? If so, when was his/her last day actively at work and how has coverage been continued? (i.e. sick time, vacation, FMLA, Leave of Absence or COBRA)

Is the employee currently on a temporary Leave of Absence? If yes, please outline the Plan's provisions regarding the length of time such an individual would be allowed to remain on the Plan. Should he/she have been offered COBRA? If yes, what was the date?

Has the employee been temporarily or permanently laid off? If yes, what is the Plan's time-frame for allowing such an individual coverage under the Plan?

Dependents:

Does the dependent meet the Plan's definition of a covered Dependent?

If a child, what is the Plan Document's age limitation?

If over the Plan's age limit, (many Plans use age 19) does the child have to be a full-time student? If so, please provide full-time student verification from the school.

Has the dependent elected COBRA? If so, please submit copies of the COBRA Election form with verification that all COBRA premiums have been paid to date.

Sample Higher Education and Plan Eligibility/Work Status Forms can be found in the Forms Section of this Guide.

Leave of Active Service / Extension of Active Service

Another important aspect of our claim review will be the guidelines regarding continuation of benefits when an employee stops working for reasons other than termination of employment. Generally, benefits cease when active service ceases. Active service is considered to cease on the last day worked unless the result of a temporary layoff, a temporary disability or any other bona fide leave of absence.

The eligibility section of the Plan Sponsor's Plan Document will be reviewed to determine if an employee meets the requirements of an active full-time employee. If an employee is no longer considered active, the extension of active service provision of the Employer's Plan Document will be reviewed to determine if coverage can be extended. The extension of active service provision typically defines sick time, Family Medical Leave Act (FMLA), leave of absence, etc.

If the employee does not return to work after the extension of active service period, benefits may be continued under COBRA.

Once an employee exhausts the extension of active service period, active Plan benefits should be considered terminated and the person has had a qualifying event under COBRA. The employer can choose to continue benefits for the applicable COBRA period or the remainder of the COBRA period if the employer chooses to have the extension of active service provision run concurrent with the COBRA period.

Third Party Liability and Subrogation Procedures

An important part of any claim management strategy is the identification of potential Third Party

Liability situations where a claimant has incurred medical expenses caused by a negligent third

party. Careful review of the details of the claim may provide the Plan and the Policyholder with an opportunity to shift the costs of care onto the responsible third party.

Preparing Claim Documentation

When the TPA submits claims for reimbursement on cases involving third party liability, we must receive the following important documentation:

- a) SLG Liability Questionnaire Form (or similar TPA form) completed by either the TPA or the Policyholder. Please include any appropriate attachments.
- b) A Subrogation and Right of Recovery Reimbursement Agreement signed by the Policyholder.

These forms can be found in the Forms Section of this Guide.

Identifying Potential Third Party Liability Claims

Below are examples of potential third party claims that merit further investigation by the TPA.

Trauma cases

1. Prior to payment of the claims the TPA should send the SLG Liability Questionnaire (or their own form that requests the same information) to request exact details regarding the accident.
2. Claims should not be paid by the Plan until the questionnaire and applicable attachments have been completed and returned.
3. It can be advantageous to use a legal firm that specializes in the area of subrogation to review the information and if necessary to handle the subrogation related issues on behalf of the Plan.

Potential Medical Malpractice Claims

Medical malpractice claims are often very difficult to identify. Below are some indicators of potential medical malpractice situations.

1. Medical billings which are inconsistent with the initial diagnosis
2. Treatment for infections after surgery
3. Unusually large medication charges
4. Second surgical procedures within 24 hours of initial surgical procedures
5. Any surgery where a repair of an organ not related to the initial surgery is involved (nicks/lacerations of bladders, liver, colon, etc.)
6. Any complication related to the delivery of a child
7. Any re-admission to the hospital within two weeks after a surgical procedure
8. Any hospital stay that is more than five days beyond the usual and customary stay for the condition for which the individual was originally admitted
9. Any course of treatment where the total charges exceed the reasonably expected charges by

- more than 15%
10. Any cases involving infection such as sepsis
 11. Any disease that could have resulted from a blood transfusion
 12. Presence of billings for multiple surgeons when such bills are not indicated given the original procedure

If medical malpractice is suspected, we suggest that you order the patient's medical records (records and charts including the nursing notes and operating room notes) in addition to obtaining the Liability Questionnaire. Keep in mind that the Claimant is often unaware that malpractice has occurred. With this in mind, it may be up to the Plan or the Carrier to investigate the malpractice case.

Slip and Fall Cases:

This category of cases is typically the least likely to result in a substantial subrogation recovery. Trauma claims may be involved, therefore, these cases should be treated the same as any other trauma cases. Liability is often strongly contested by the property owner. The Plan and/or the Carrier should be prepared to negotiate the subrogation lien in these cases.

Dog Bites:

This category of claim involves trauma and these cases often make good candidates for subrogation, especially when the victim is a child. It is important to remember in cases involving young children (less than age 9) it is typically believed that they are not capable of being negligent. If they are not capable of being negligent then they can not be responsible under the doctrine of contributory negligence. Therefore, if any other party involved in the injury is negligent in any fashion and there is a source for recovery, a recovery should occur.

Injuries Involving Children:

In addition to dog bites, there are several types of injuries involving children where an argument might be made that the child was potentially at fault. It is important to note that young children (less than 9 years old) are generally not capable of negligence. Examples of this may be: children "darting out" in front of another motorist; children playing with dangerous instruments like fire or firearms; children falling into pools and ponds or other bodies of water. These cases are often successful subrogation cases. Again the procedures relative to trauma will apply.

Poisoning Cases:

This category of cases can encompass everything from food poisoning at a restaurant to chemical ingestion. An admission to the emergency room is generally involved with these cases. The TPA should flag ICD-9 and CPT codes that reflect food poisoning issues as well as claims for pumping the stomach, usage of antitoxins, charcoal and claims for anaphylactic shock.

Sports Activities:

Each sports injury should be reviewed on the basis of the sponsor of the event, the equipment used, supervision issues and individuals involved.

NOTE: There are multiple other categories of third party liability cases that we could mention. We are committed to assisting TPA's as needed in these areas. Please keep in mind that in subrogation cases where the Carrier has made reimbursements to the Policyholder, we will expect to take the lead in the process.

Medical Records

Medical records are not typically required as a part of a claim submission. However, we reserve the right to request this information as it is often invaluable in providing key information such as: diagnosis, accident details and the full nature of the treatment received by the claimant.

SLG will typically ask the TPA to request medical records (including hospital admission and discharge summaries) in the following situations:

1. Claims that may involve potentially pre-existing conditions.
2. Claims involving any accidents. This will help clarify if:
 - a. Alcohol and/or illegal drugs were involved
 - b. A crime or felony was committed
 - c. A third party was at fault (possible subrogation)
3. Claims involving alcohol treatment. This will help clarify if treatment was also for drug abuse.
4. Claims involving mental and nervous conditions. This will help clarify if the treatment was also rendered for alcohol and/or drug abuse in addition to a mental and nervous condition such as depression. Also, it will help determine if there was a suicide attempt.
5. Claims involving experimental or investigational treatment.

SLG BENEFITS AND INSURANCE, LLC
RISK MANAGEMENT GUIDE

SLG BENEFITS RISK MANAGEMENT PHILOSOPHY

Risk Management is an important component of the SLG Benefit's business model. The founding principals of SLG Benefits have spent a large portion of their careers refining a process that is seamless and intuitive to our producer and claim paying partners, financially rewarding to Employer Groups and outcome-oriented for the Claimant. Our process is quite simple: 1) Employ healthcare professionals to support our underwriters with timely and accurate medical assessments on Potentially Catastrophic Losses; and 2) Support our claim staff through the utilization of "best in class" risk management vendors. Our goal is to form strong and ongoing relationships with the claim staff and UR firms employed by our policyholders. This open and timely dialogue will allow for early identification and notification of potential Large Claims.

CONFIDENTIALITY

SLG Benefits maintains the highest standard in protecting Private Healthcare Information as established by the Health and Insurance Portability and Accountability Act of 1996. As a legal agent of a stop loss carrier, SLG Benefits has no interest in using or disclosing PHI for purposes not related to our quoting or administration of excess loss coverage. We do, however, recognize the need to maintain the confidentiality of PHI that we receive from the employer, TPA or associated vendor. If requested, we will enter into a confidentiality agreement that specifically addresses the use or disclosure of PHI for purposes related to our quoting or administration of stop-loss coverage. Please do not hesitate to contact us with any questions regarding confidentiality or PHI.

A Sample Confidentiality Agreement can be found in the Forms Section of this guide.

THE SLG BENEFITS UNDERWRITING PROCESS

At SLG Benefits, our underwriters work closely with the medical staff throughout the various stages of the underwriting cycle. During the initial case screening process, the medical staff is available to provide a quick survey of the case and identify individuals that the underwriter should seek additional information on. Pre and Post-sale the medical staff is responsible for reviewing disclosure information and providing the underwriter with a final liability assessment. If there is not adequate information to make an accurate determination, the risk management nurse may refer the case to our MD consultant for a telephonic Attending Physician Statement. The MD consultant may review the information in the claimant's file to form an assessment or discuss the treatment plan and prognosis with the claimant's Primary Attending Physician.

It is important to note that liability assessments made by our medical staff are used only as an initial guide to the underwriter to help them make the final underwriting decision.

THE SLG RISK MANAGEMENT PROCESS

A cornerstone of the SLG Benefits & value proposition is to provide our producers and claim payers with risk management tools. Once a new case is sold or an existing account is renewed, our medical staff will monitor potential high dollar claims and offer medical services to supplement the TPA's medical expertise. These services include case management oversight and facilitation of referrals to outcome-based transplant networks, claims negotiators, re-pricing vendors and specialty risk management vendors such as Pharmacy Benefit Managers and Neonatal specialists. We have invested resources into vetting these vendors to find those we believe to be the best in their individual designation based on outcomes and cost management. Our goal is to ensure that the claimant always receives the highest quality of care at the most appropriate cost.

Communication between the TPA, the UR vendor and our medical staff is the most critical component of the claim management process. Early notification is extremely important to SLG Benefits and is typically reflected in our stop-loss pricing. The initial referral regularly comes from the Utilization Review vendor based on the Potentially Catastrophic Loss List. This list consists of specific diagnoses that are key indicators of potentially catastrophic losses and acute medical situations that warrant close review and may require case management consultation. The claims administrator is also expected to notify SLG Benefits as soon as a claimant is identified as high risk, based on the Potentially Catastrophic Loss List or they feel has the potential to reach 50% of the specific deductible.

The Potentially Catastrophic Loss List can be found in the Forms Section of this Guide.

Referrals may be sent to the SLG Benefits Risk Management Department as follows:

Phone: 800-742-9279
Fax: 978-740-9485
E-Mail: riskmanagement@slgbenefits.com

Mail: SLG Benefits and Insurance, LLC
9 Atlantic Avenue
Marblehead, MA 01945

When we receive notification of a potentially catastrophic case, our medical staff will do an initial assessment of the patient's medical condition and treatment plan. The case and treatment plan will typically be discussed with the TPA or existing case manager. After completing our assessment, we typically designate the claimant into 1 of 3 categories:

Our medical staff reviews the case and determines that the estimated costs of treatment will not be significant and case management intervention is not indicated. Patient eligibility issues are verified, specific provider network arrangements reviewed and initial claims are analyzed. Our medical staff may monitor the case at specific intervals and will ask to be notified if claim activity increases so that the situation can be re-assessed if necessary.

Our medical staff determines that the claimant may require case management intervention or be a candidate for a referral to a specialty risk management vendor. Patient eligibility issues are verified, specific provider network arrangements reviewed and initial claims are analyzed. The case will typically be followed by a case manager assigned by the UR vendor or TPA. SLG Benefits may also make a case management recommendation if needed. Our medical staff will monitor the case and act as a resource to assist with services such as claim negotiations and access to specialty networks. The case will be followed regularly during the remainder of the Policy Year.

Our medical staff determines that there is significant potential for a catastrophic claim. Patient eligibility issues are verified, specific provider network arrangements reviewed and initial claims are analyzed. The case is then assessed for the most appropriate case manager based on the specific diagnosis and treatment plan. Throughout the claimant's episode of care, we expect the case manager to maintain close communication with the SLG Benefits medical staff. Our medical staff will review all case management data, recommend additional interventions and remain available as a valuable resource.

SPECIALTY RISK MANAGEMENT VENDORS

SLG Benefits maintains valuable relationships with numerous specialty vendors with expertise in claim cost management. These include outcome-based transplant networks, dialysis cost containment networks, specialty pharmacy benefit managers and claims negotiation/hospital auditing firms.

Outcome-Based Centers of Excellence

Improving technology and increased awareness have contributed to the increased frequency of solid organ and tissue transplants in recent years. SLG Benefits is able to assist plan administrators with the complicated transplant process through our contracts with several Outcome-Based Transplant Networks. Within a Transplant Program, the hospitals and their respective transplant teams focus on limited and specific transplant procedures. Each Transplant Program is required to meet strict credentialing criteria with respect to length of stay, complication rates and number of re-transplants. In addition, the Transplant Program will typically offer case rate pricing for the entire transplant continuum of care.

SLG Benefits' goal throughout this process is to provide the claimant with the opportunity to choose the right facility for their procedure based on published medical documentation. In addition, the Plan Sponsor secures the entire procedure at a fair price, protecting them against inflated charges due to complication potential and cost-shifting. There are not many areas of healthcare that can have such a dramatic impact on both the Plan and Claimant. The Plan Sponsor typically benefits through more consistent stop loss premium increases due to fixed provider pricing and for a claimant with a \$1 million limit, their benefit dollars have the potential to go a lot farther.

If our medical staff determines that the proposed treatment may include organ or tissue transplantation, we will provide the TPA with information on transplant facilities that currently participate in an outcome-based Centers of Excellence network. Outcomes data

is a valuable tool for case management and can be provided to assist the claimant in the facility selection process, if requested. Our medical staff will work closely with the TPA and case manager throughout the entire transplant process and serve as a liaison between the transplant network and the TPA.

Dialysis Cost Containment

Renal dialysis treatment is another area in healthcare where self-funded plans bear the highest cost through provider cost-shifting. Roughly 80% of all renal dialysis costs are paid by Medicare, 10% by Medicaid and Veterans Programs and 10% by the commercial market. With Medicare, Medicaid and Veterans Programs price-controlled by the government and fully insured markets using their buying power to negotiate significant discounts, it's easy to understand why costs have risen so dramatically for the self-funded population. SLG Benefits can recommend several vendors who offer access to national dialysis networks, providing Plans that use them the buying power needed to control costs. The network is built through relationships with quality providers and contracted rates that offer unparalleled economic value for the Plan. Through the use of specialty case managers, our recommended networks also provide valuable education for both claimants and employer groups. Utilizing a dialysis network offers the self-funded plan the greatest opportunity to preserve benefits for employees and provide pricing parity for employers.

Specialty Pharmacy Benefit Managers

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. SLG Benefits maintains relationships with several Specialty Pharmacy Benefit Management companies who provide specialized patient management services. Employer groups today rely heavily on their Pharmacy Benefit Manager (PBM) to control their prescription drug costs. What many Plan Sponsors do not realize is that the most expensive drug therapies, those typically biotech in nature, cannot be delivered through the 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. Specialty PBM's are a necessity today for all self-funded plans seeking to control runaway pharmaceutical costs and preserve valuable plan benefits.

Claim Negotiation and Hospital Auditing Services

SLG Benefits' Risk Management department can assist TPA's in their effort to maximize claims saving's, ensure optimal discounts on all out-of-network claims and aggressively pursue all charges felt to represent cost shifting. SLG Benefits has relationships with several national vendors who offer a suite of claim negotiation and auditing services designed to control costs and preserve valuable plan benefits.

SLG BENEFITS AND INSURANCE, LLC
UNDERWRITING GUIDE

THE HISTORICAL PERSPECTIVE

SLG Benefits and Insurance, LLC is a medical stop loss insurance Program Management Company. The company was created to surpass the needs of Third Party Administrators (TPA's) and broker/consultants specializing in the self-funded employee benefits marketplace. In the challenging arena of catastrophic claim management and healthcare funding products, the TPA's and broker's need for delivery of ideas from stop loss providers has become inconsistent with the rigid operating structure of some of the larger carriers and MGU's. Out of this business opportunity, SLG Benefits was formed to provide expertise and timely solutions to the medical stop loss and claim administration community. We plan to leverage our collective years of experience and personal standing in the benefits marketplace to provide medical reinsurance & insurance products and services that are in great demand. The Benefits Community expects delivery of ideas, answers to questions, direct access to decision makers and timely producer support. SLG Benefits has the expertise to exceed those expectations.

REINSURANCE

Our medical stop loss reinsurance agreements are with highly rated and qualified insurance carriers. SLG Benefits serves as a stop loss underwriting, claims and risk manager on their behalf. SLG Benefits will market stop loss products to a select group of producers and administrators nationwide. We believe our strength and dedication to the employer stop loss market will offer contractual and financial security to our producers and prospective policyholders.

THE MISSION

Our mission is to offer a medical stop loss product that will help our TPA and broker partners grow their businesses and support the self-funding concept. With increases in medical inflation, Plan Sponsors will increasingly rely on their brokers and TPA's to provide funding solutions. Our goal is to provide unparalleled product and expertise to our business partners. Our priority is to exceed the needs of our clients and deliver superior results to our risk takers.

PHILOSOPHY

At SLG Benefits, we recognize that the most valuable asset we have is our people. We have complimented our staff with a fully integrated computer system that allows us to work intelligently and efficiently to deliver all of our services at an elite business level. Claims, Administration, Accounting and Risk Management are all carefully woven into the underwriting process in an effort to produce superior results. Our underwriters are trained to understand the vast resources available to them which truly provide them with the tools necessary to "think outside the box". The automated underwriting system backstops the entire process by flagging important underwriting and policy triggers. This intelligence serves to cut down on errors, elevate difficult risks to senior management and focus our efforts on risk selection and closing business.

PROCESS OVERVIEW

- ❖ Underwriting Staff is trained to seek counsel on difficult risks. We advocate a strict referral system that gets the most complex cases into the hands of the most experienced decision makers.
- ❖ Underwriting Staff is highly trained in Managed Care Principles in an effort to steer our producers toward the best managed care environment to offset medical trend.
- ❖ Underwriting System includes sophisticated management tools used to track quote turnaround, quoting ratios and closing ratios from a variety of parameters.
- ❖ Medical Underwriting is handled by trained medical professionals to provide current, critical data to assist the underwriter in selecting profitable risk.
- ❖ Administrative Staff is highly trained to recognize the important pieces of information necessary to bind a risk such as Disclosure, Application, Schedule of Insurance and Binder check. In addition, they understand the urgency associated with these items and the ramifications of taking immediate action upon receipt.
- ❖ Claim Staff shares critical information with Underwriting and Marketing such as trigger claim notifications within the renewal or new sale window.

PRODUCT OVERVIEW

Self-funding is an effective approach that employers can use to gain greater flexibility and control over their health plan costs. In order to provide an extra measure of financial protection against catastrophic claims, most self-funded employers purchase Medical Stop Loss coverage. The amount of risk to be reinsured is a function of the employer's size, nature of business and risk tolerance. Employers can take advantage of several benefits not necessarily available under a traditional fully insured program such as lower operating costs, increased cash flow, flexibility in plan design and better claim management. In addition, self funded employers often enjoy reduced premium taxes since most states tax only the stop loss premiums and not the self-funded claim fund.

PRODUCT HIGHLIGHTS

- ❖ Minimum group size of 35 lives
- ❖ PPO, UR and Large Case Management program credits
- ❖ Consultative pricing including “no laser” renewal guarantee
- ❖ Market competitive Excess Loss Contract

SPECIFIC COVERAGE *

Specific Stop Loss is provided to limit the employer's cost for eligible medical expenses for each covered individual. This coverage addresses the employer's exposure to high expenses on a given individual (as opposed to an accumulation of expenses on all individuals).

- ❖ Specific Deductibles from \$15,000 to \$500,000
- ❖ Lifetime Maximums available: \$1,000,000, \$2,000,000 & \$5,000,000
- ❖ Contract Basis: 12/12, 12/15, 12/18, 12/24, 14/12, 15/12, 18/12, 24/12 and PAID
- ❖ Coverage options available: Medical, RX

AGGREGATE COVERAGE *

Aggregate Stop Loss is provided to limit the employer's overall annual cost for a self-funded plan. This coverage addresses the accumulation of expenses on all individuals (as opposed to high expenses for particular individuals).

- ❖ Flexible Attachment Points with 125% standard
- ❖ Per Policy Period Maximum available: \$1,000,000
- ❖ Contract Basis: 12/12, 12/15, 12/18, 14/12, 15/12, 18/12, 24/12 and PAID
- ❖ Coverage options available: Medical, RX, Dental, Vision and WDI

* Variations and alternatives are available to tailor the product to each individual client's needs. Please contact your underwriter for details.

OPTIONAL COVERAGE

- ❖ Specific Advance Reimbursement
- ❖ Split-Funded or Aggregating Specific Options
- ❖ Specific Terminal Liability Option
- ❖ Aggregate Accommodation Option
- ❖ Aggregate Terminal Liability Option
- ❖ Medical Conversion Option

VALUE-ADDED SERVICES

- ❖ Consultative underwriting and marketing services
- ❖ Internal claims re-pricing services
- ❖ Risk Management Oversight programs
- ❖ On-site technical and clinical expertise

INDUSTRY CLASSIFICATIONS

Preferred

Engineering
Insurance Agents/Carriers/TPA'S
Equipment Manufacturing

Non-Preferred

MET's/MEWA's
Law Firms
Long-term Care Facilities

Wholesale Trade-Non-Durable Goods
Accounting/Auditing Firms
Textile Manufacturing
Instrument Manufacturing

Associations
Employee Leasing Companies
Non-Taft Hartley Unions
Long-Haul Trucking/Trucking
Companies with independent
contractor drivers

REQUEST FOR PROPOSAL SUBMISSION CHECKLIST

- ❖ Official name of the employer
- ❖ Location of the group (City, State, Zip)
- ❖ Desired effective date of coverage
- ❖ Quote due date
- ❖ Specific deductible (current and proposed)
- ❖ Contract type (current and proposed)
- ❖ Commission level requested
- ❖ Current census (including year of birth or age, sex and type of coverage- if Cobra, Retiree or Disabled please designate accordingly)
- ❖ If the employer has multiple locations, include the number of employees in each location with corresponding zip code.
- ❖ Nature of business and/or SIC code
- ❖ Schedule of current benefits and proposed benefits, if different. (Note which coverages are to be included under the specific and aggregate contracts.)
- ❖ Monthly paid claims and enrollment
(Month by month aggregate report for the most recent 24 month minimum)
- ❖ Current and/or renewal rates (whether self-funded or fully insured)
- ❖ If fully insured with no paid claims experience, provide current and renewal fully insured rates on groups up to 250 lives.
- ❖ Shock claims in excess of 50% of the current deductible and any serious ongoing condition including diagnosis/prognosis
- ❖ PPO network and UR facility being implemented (if multiple networks, please specify by location).
- ❖ Please note the current PPO network if different than the proposed.
- ❖ Ancillary coverages requested (i.e. Aggregate Accommodation, Terminal Liability or Split-Funded Specific)

SPECIFIC STOP LOSS

Specific Stop Loss coverage is designed to limit the employer's cost for eligible medical expenses per covered individual. It allows self-funded employers to protect themselves from catastrophic claims exceeding the deductible level. The specific deductible is selected based on the size of the group, the employer's capacity to assume risk, as well as the medical claims experience of the plan. Once the specific deductible is exceeded, the Carrier will reimburse the employer for all eligible expenses.

CONTRACT OPTIONS

I. Incurred and Paid (12/12)

Eligible Claims will be covered that are in excess of the group's Specific Attachment Point and are:

- a. Incurred during the contract Period, and
- b. Paid during the Contract Period

II. Incurred and Paid with a three month run-in provision (15/12)

Eligible Claims will be covered that are in excess of the group's Specific Attachment Point and are:

- a. Incurred during the Contract Period, or within three months prior to the beginning of the Contract Period, and
- b. Paid during the Contract Period

III. Incurred and Paid with a six month run-in provision (18/12)

Eligible Claims will be covered that are in excess of the group's Specific Attachment Point and are:

- a. Incurred during the Contract Period, or within six months prior to the beginning of the Contract Period, and
- b. Paid during the Contract Period

IV. Incurred and Paid with a twelve month run-in provision (24/12)

Eligible Claims will be covered that are in excess of the group's Specific Attachment Point and are:

- a. Incurred during the Contract Period, or within twelve months prior to the beginning of the Contract Period, and
- b. Paid during the Contract Period

V. Paid

Eligible Claims will be covered that are in excess of the group's Specific Attachment Point and are:

- a. Incurred during the Contract Period, or within 12 months prior to the group's original effective date with SLG Benefits.
- b. Paid during the Contract Period

VI.. Incurred in the Contract Period and Paid in the Contract Period plus three months (12/15)

Eligible Claims will be covered that are in excess of the group's Specific Attachment Point and are:

- a. Incurred during the Contract Period, and
- b. Paid during the Contract Period or within three months thereafter

VII. Incurred in the Contract Period and Paid in the Contract Period plus six months (12/18)

Eligible Claims will be covered that are in excess of the group's Specific Attachment Point and are:

- a. Incurred during the Contract Period, and
- b. Paid during the Contract Period or within six months thereafter

VIII. Incurred in the Contract Period and Paid in the Contract Period plus three months (12/24)

Eligible Claims will be covered that are in excess of the group's Specific Attachment Point and are:

- a. Incurred during the Contract Period, and
- b. Paid during the Contract Period or within twelve months thereafter

SPECIFIC ADVANCE REIMBURSEMENT

Specific Advance Reimbursement is a value-added feature that provides financial assistance, easing the burden to Plan Sponsors when there is a significant individual claimant in excess of the specific deductible. This protection is available once eligible claim payments for any one claimant have exceeded the Specific Deductible, subject to a minimum reimbursement submission request per claimant of \$1,000.

Specific Advance Reimbursement is provided on all written business at policy inception and need not be requested. A Specific Advance Reimbursement Form must be completed for each Specific Advance Reimbursement claim request. The deadline for submission of the Specific Advance Reimbursement Form is 7 days after the expiration of the contract period. Specific Advance Reimbursement requests received after this date

will not be honored. On continuing claims, the TPA must complete this form with each subsequent claim submission.

A sample Specific Advance Reimbursement Form can be found in the Forms Section of this Guide.

SPECIFIC TERMINAL LIABILITY OPTION

This product provides three months run-out protection for those claims incurred during the current Policy Period. It may be utilized in adherence with the following parameters.

- ❖ Available on the following contracts: 12/12, 15/12, 18/12, 24/12 and Paid
- ❖ Coverage is not applicable upon early termination of the group's Excess Loss Policy
- ❖ Product is intended for expiring Policyholders that are returning to a fully insured arrangement
- ❖ Not available at renewal unless elected on the case's original effective date

A sample Terminal Liability Endorsement can be found in the Form Section of this Guide.

SPLIT-FUNDED & AGGREGATING SPECIFIC PREMIUM PRODUCTS

Healthcare costs for employers continue to climb in double-digit increments as a result of medical trend and market fluctuation. SLG Benefits feels it is important to offer Split-Funding and Aggregating Specific alternatives which are designed to help Policyholders manage premium increases. These innovative products offer the Policyholder the ability

to take a limited risk position on their specific premium. The Policyholder remits a discounted monthly premium rate during the course of the Policy period. If there is an individual(s) that exceeds the Specific Attachment Point, the Policyholder forgoes reimbursement until a predetermined risk corridor has been satisfied. The minimum premium amount plus the corridor will match the traditional premium charged.

These premium options can be valuable tools 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.

Producers interested in presenting these alternatives should notify their SLG Benefits underwriter. SLG Benefits offers discounts from 5% to 35% off of the traditional stop-loss premium. Variables contributing to the discount level selected are premium and deductible minimums, along with the Policyholder's risk tolerance.

Should a specific claim(s) occur, the Policyholder will be responsible for claims until the corridor dollar amount is satisfied. The amount will not exceed the total maximum traditional premium. Once the corridor amount has been satisfied, all eligible claims become the responsibility of the carrier for reimbursement to the Policyholder. It is important that the Policyholder submit all specific claims, even if they are still within the corridor to SLG Benefits for record keeping purposes.

DEFINITIONS

1. **Discounted Monthly Premium Rates:** These rates represent a pre-determined percentage of the Traditional Premium Rates. The level of discount is based on the deductible size and Annual Traditional Premium. Under the Specific Split-Funded Premium Arrangement, the discounted premium is remitted monthly by the Policyholder.
2. **Annual Policyholder Corridor Amount:** This amount represents the difference between the Traditional Annual Premium Costs and the Discounted Annual Premium Cost. Specific claims eligible for reimbursement under the policy would be subtracted from the Annual Corridor Amount until exhausted.
3. **Traditional Annual Premium Cost:** This cost is calculated by multiplying the Monthly Premium Rate (s) (prior to the split funded discount) by the first month's enrollment, by 12 months.
4. **Discounted Annual Premium Cost:** This cost is calculated by multiplying the Discounted Monthly Premium Rates by the first month's enrollment, by 12 months.
5. **Final Settlement:** A year-end final settlement will be calculated after the policy period based on the actual monthly enrollment. If the annual premium, based on the actual enrollment, fluctuates by 10% or greater than the initial premium, the Estimated Corridor Amount will be re-calculated. If the Estimated Corridor Amount increases due to enrollment change, claims have exceeded the Corridor and

subsequently have been reimbursed by the Carrier, the Policyholder must reimburse the Carrier for the difference between the Initial Corridor and the Final Calculated Corridor Amount.

6. **Maximum Policyholder Specific Claims Liability Cost:** This is the sum of the Discounted Payable Annual Premium Cost and the Annual Policyholder Corridor Amount, providing assumed annual premium based on the enrollment does not vary by 10% or greater during the policy period.
7. **Minimum Annual Policyholder Corridor Amount:** This amount shall not be less than 85% of the Annual Policyholder Corridor Amount at contract inception.
8. **Specific Claims:** These are eligible claims paid on behalf of a plan participant in excess of the employer's Specific Attachment Point which qualify for reimbursement under the excess loss insurance policy.
9. **Standard Monthly Premium Rates:** These rates represent the premium cost for the Specific excess loss coverage which would be payable by the Policyholder in the absence of the Specific Split-Funded Premium Arrangement.

SPLIT-FUNDED PREMIUM PRODUCT EXAMPLES

- Assumptions:
1. 12 month policy period
 2. \$75,000 Specific deductible
 3. Actual Avg. Monthly Enrollment- S 500, F 1,000: T 1,500
 4. 30% discount on standard monthly premium rates

Situation 1: Best case: No Specific claims paid during policy period

| <u>Traditional Premium Arrangement</u> | <u>Split-Funded Premium Arrangement</u> |
|--|---|
| Standard Monthly Premium Rates: | Discounted Monthly Premium Rates: |
| \$12.00 x 500 x 12 = \$72,000 | \$8.40 x 500 x 12 = \$50,400 |
| \$25.00 x 1,000 x 12 = \$300,000 | \$17.50 x 1,000 x 12 = \$210,000 |
| Traditional Annual Premium Cost: | \$372,000 |
| Discounted Annual Premium Cost: | \$260,000 |
| Annual Policyholder Additional Liability: | \$112,000 |
| Traditional Annual Premium Cost to the Policyholder: | \$372,000 |
| Discounted Annual Premium Cost to the Policyholder: | \$260,000 |
| Actual Policyholder Corridor Amount: | \$ 0 |
| Total Annual Cost to the Policyholder: | \$260,000 |
| SAVINGS: | \$112,000 |

Situation 2: Probable case: 2 claims: \$105,000 & \$95,000 = \$50,000 in excess of Specific

Traditional Premium Arrangement

Standard Monthly Premium Rates:

\$12.00 x 500 x 12 = \$72,000

\$25.00 x 1,000 x 12 = \$300,000

Split-Funded Premium Arrangement

Discounted Monthly Premium Rates:

\$8.40 x 500 x 12 = \$50,400

\$17.50 x 1,000 x 12 = \$210,000

Traditional Annual Premium Cost: \$372,000

Discounted Annual Premium Cost: \$260,000

Annual Policyholder Additional Liability: \$112,000

Traditional Annual Premium Cost to the Policyholder: \$372,000

Discounted Annual Premium Cost to the Policyholder: \$260,000

Actual Policyholder Corridor Amount: \$50,000

Total Annual Cost to the Policyholder: \$260,000

SAVINGS: \$ 62,000

Situation 3: Worst case: 5 claims: \$125,000 each = \$250,000 in excess of Specific

Traditional Premium Arrangement

Standard Monthly Premium Rates:

\$12.00 x 500 x 12 = \$72,000

\$25.00 x 1,000 x 12 = \$300,000

Split-Funded Premium Arrangement

Discounted Monthly Premium Rates:

\$8.40 x 500 x 12 = \$50,400

\$17.50 x 1,000 x 12 = \$210,000

Traditional Annual Premium Cost: \$372,000

Discounted Annual Premium Cost: \$260,000

Annual Policyholder Additional Liability: \$112,000

Traditional Annual Premium Cost to the Policyholder: \$372,000

Discounted Annual Premium Cost to the Policyholder: \$260,000

Actual Policyholder Corridor Amount: \$112,000

Total Annual Cost to the Policyholder: \$372,000

Carrier Reimbursement: \$138,000

SAVINGS: \$ 0

AGGREGATE COVERAGE

Aggregate excess loss coverage is provided to limit the employer's overall annual liability for a self funded plan. This coverage addresses the accumulation of expenses on all individuals (as opposed to high expenses for particular individuals) covered under the plan. When eligible expenses paid during a contract period exceed the annual aggregate deductible, the group is reimbursed as specified in the contract, typically after the close of the contract period.

In addition to medical benefits, most health benefits can be included in the Aggregate coverage with proper underwriting such as Prescription Drug, Dental, Vision and Short-Term Disability. Except for Prescription Drug Coverage, these ancillary charges cannot be included for coverage if they are a first time benefit offering to plan participants. See the "General Claim Handling Information" section of the SLG Benefit's Claims Guide for more detailed information regarding eligibility of non-standard expenses under the Aggregate.

The premium charged for this coverage is expressed as a rate per covered unit per month or as an amount due annually in advance. New monthly deductible factors, a new Minimum Aggregate Attachment Point and new rates are established at each contract renewal.

The Annual Aggregate Attachment Point is the greater of 1) the sum of Monthly Aggregate Factor amounts for each month of the Policy Period, determined by multiplying the total number of Covered Units by the Monthly Aggregate Factor amounts or 2) the Minimum Annual Aggregate Attachment Point.

The Minimum Annual Aggregate Attachment Point is the lowest amount of total Payments you must make under your Plan before you are eligible for reimbursement under the Aggregate Excess Loss coverage. The Minimum Annual Aggregate Attachment Point is established based on the first months enrollment multiplied by the

Monthly Aggregate Factor multiplied by the total number of months and is shown in the Schedule.

The maximum per Covered Person which may be applied annually to the Annual Aggregate Attachment Point (i.e. Individual Claim Limit) is also shown in the Schedule.

CONTRACT OPTIONS

I. Incurred and Paid (12/12)

Eligible Claims will be covered that are in excess of the group's Aggregate Attachment Point and are:

- a. Incurred during the contract Period, and
- b. Paid during the Contract Period

II. Incurred and Paid with a three month run-in provision (15/12)

Eligible Claims will be covered that are in excess of the group's Aggregate Attachment Point and are:

- a. Incurred during the Contract Period, or within three months prior to the beginning of the Contract Period, and
- b. Paid during the Contract Period

III. Incurred and Paid with a six month run-in provision (18/12)

Eligible Claims will be covered that are in excess of the group's Aggregate Attachment Point and are:

- a. Incurred during the Contract Period, or within six months prior to the beginning of the Contract Period, and
- b. Paid during the Contract Period

IV. Incurred and Paid with a twelve month run-in provision (24/12)

Eligible Claims will be covered that are in excess of the group's Aggregate Attachment Point and are:

- a. Incurred during the Contract Period, or within twelve months prior to the beginning of the Contract Period, and
- b. Paid during the Contract Period

V. Paid

Eligible Claims will be covered that are in excess of the group's Aggregate Attachment Point and are:

- a. Incurred during the Contract Period, or within 12 months prior to the group's original effective date with SLG Benefits.
- b. Paid during the Contract Period

VI. Incurred in the Contract Period and Paid in the Contract Period plus three months (12/15)

Eligible Claims will be covered that are in excess of the group's Aggregate Attachment Point and are:

- a. Incurred during the Contract Period, and
- b. Paid during the Contract Period or within three months thereafter

VII. Incurred in the Contract Period and Paid in the Contract Period plus six months (12/18)

Eligible Claims will be covered that are in excess of the group's Aggregate Attachment Point and are:

- a. Incurred during the Contract Period, and
- b. Paid during the Contract Period or within six months thereafter

VIII. Incurred in the Contract Period and Paid in the Contract Period plus three months (12/24)

Eligible Claims will be covered that are in excess of the group's Aggregate Attachment Point and are:

- a. Incurred during the Contract Period, and
- b. Paid during the Contract Period or within twelve months thereafter

AGGREGATE ACCOMMODATION OPTION

Aggregate Accommodation is offered as an option to our smaller group clients to provide greater cash flow and financial protection for the largest dollar segment of their health plan. Any Accommodation is at all times, to be considered funds of the Carrier for which the use by the Policyholder of such funds is provided by Endorsement to the Policy. The Aggregate Accommodation should not be construed as a loan or cash advance.

If in any month during the Policy Period, the total Plan Benefits Paid by the Policyholder, for which reimbursement is provided under the Policy, 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) \$1000;

Then the Policyholder may request an advance of the aggregate excess benefit.

Accommodation Filing Requirements

In order to file an Aggregate Accommodation request we require the submission of the following documentation:

- a) Completed Aggregate Accommodation Form
- b) Monthly Loss Summary Reports showing the Policyholder's monthly paid claims data and aggregate census information
- c) Paid Claims Analysis Report showing claimant name, date of service, type of service, amount charged, and amount, date and Payee for each Payment made

Accommodation Filing Procedures

- All claims must be Paid by the Plan Sponsor prior to applying for an Aggregate Accommodation.
- Aggregate Accommodation requests must be received by SLG Benefits within 20 days following the end of the month for which the accommodation is requested. (For example, if you are filing for the month of July, then we must receive your request no later than August 20th.)
- Aggregate Accommodation must be greater than our service minimum requirement of \$1,000.
- Aggregate Accommodation is not available in the final month of the Policy or during a run-out provision.
- The initial request for Aggregate Accommodation cannot be made prior to the end of the 90 day period following the first day of the Policy Period.

Reconciliation Procedures

If the Policyholder has not incurred an aggregate claim at the end of the Policy year, then the Policyholder must refund all Aggregate Accommodations. If the year-to-date claims fall below the accumulated aggregate deductible in any given month, all Accommodation advances must be refunded in the following month.

Failure to repay any overpayment within 60 days after written notice is provided shall result in either a 10% penalty per annum or a reduction of subsequent reimbursements under the Aggregate or Specific Excess Loss benefits by the amount of the overpayment.

SLG Benefits reserves the right to audit all records affecting our liability under this Policy.

A sample Aggregate Accommodation Endorsement and Aggregate Accommodation Form can be found in the Forms Section of this Guide.

AGGREGATE TERMINAL LIABILITY

This product provides three months run-out protection for those claims incurred during the current Policy Period. It may be utilized in adherence with the following parameters:

- ❖ Available on the following contracts: 12/12, 15/12, 18/12, 24/12 and Paid
- ❖ Coverage is not applicable upon early termination of the group's Excess Loss Policy
- ❖ Product is intended for expiring policyholders who are returning to a fully insured arrangement
- ❖ Not available at renewal unless elected on the case's original effective date

In conjunction with the extended coverage, the Monthly Aggregate Factors are increased by a factor of 1.25. Coverage is triggered upon expiration of the Excess Loss Insurance Policy. SLG Benefits will issue a Terminal Liability Policy Endorsement illustrating the modified Monthly Aggregate Factors and Minimum Annual Aggregate Attachment Point.

A sample Terminal Liability Endorsement can be found in the Forms Section of this Guide.

MEDICAL CONVERSION OPTION

SLG Benefits offers Medical Conversion through Celtic Life Insurance Company. This product allows eligible employees to convert their medical coverage and that of eligible dependents, if employment is terminated or if they become a member of an ineligible class of employees. In the case of a dependent, conversion is an option in the event of a legal divorce or employee death. A dependent child may also elect Conversion upon reaching an ineligible age as defined by the group plan. The medical benefits will be converted from the employer's plan to a group benefit plan provided by the conversion carrier. Contact your SLG Benefits Underwriter for more details.