

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.