



Specific and Aggregate Medical Stop Loss Claims Procedures

Specific Stop Loss Claims Procedures

Monthly shocks/ISA reports are received for any and all claimants at 50% of the retention or claimants with a diagnosis that has the potential of exceeding the specific retention (see the Medical Management Case Profile and Quick check Referral Codes for required reporting). For each new claimant reported a detailed 50% notice and/or diagnosis is to be completed by the TPA.

If a claimant exceeds their specific retention, the following documentation is requested for review in order to issue reimbursement:

- Completed claim form
- Copy of enrollment card
- Copy of a claim detail report and/or bill
- Copy of the TPA's claim calculation work sheet
- Copy of COBRA election forms along with proof of cobra payments (if applicable)
- Copies of all correspondence regarding coordination of benefits
- Copies of all checks, EOB's or similar verification evidencing payment of claim
- Medical Case Management reports
- Utilization Review approval for in-patient hospital stays
- If an accident, need complete accident details (including ER reports/police reports) and subrogation documentation.

Once all required documentation is received, the specific claim will be processed in accordance with the Stop Loss Policy and Plan document.

Aggregate Stop Loss Claims Procedures

Monthly Paid claims and enrollment reports are received and entered into our system for monitoring. In the event of an aggregate claim an audit is performed at the end of the policy year and reimbursement issued accordingly. The standard documentation required is as follows:

- Year-end report of total paid claims inclusive of any and all retro's and adjustments
- Other documentation to support random individual claims selected for review

Aggregate Stop Loss Reporting Requirement

Monthly paid claims and enrollment, separate by covered benefit under the aggregate if enrollments differ.