



MEDICAL STOP LOSS INSURANCE MANUAL

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MSL-MAN-17

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SECTION 1: INTRODUCTION AND CONTACT INFORMATION

We welcome you as a valuable client of our company. This manual is provided by Amalgamated Life Insurance Company (“Amalgamated Life” or the “Company”) to assist you in getting the most out of your Medical Stop Loss (stop loss) insurance coverage. This manual contains a product overview, ongoing disclosure requirements, claim and premium submission information, and forms.

All stop loss inquiries, claim notifications, and payment requests should be submitted to the Amalgamated Life people shown below.

Please note that your Policy is the final document for all coverage issues. The Policy is the final word if any information in this manual differs from the coverage expressly stated within the Policy. The term stop loss and/or excess loss are considered the same in this manual.

SUBMISSION OF PREMIUM AND DISCLOSURE/ONGOING DISCLOSURE

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UNDERWRITING DEPARTMENT

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REQUEST FOR PROPOSAL SUBMISSION

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SECTION 2: STOP LOSS PRODUCT REVIEW

Specific Stop Loss Deductible

Under Specific stop loss insurance, a specific deductible and basis is established for each Contract Period for each covered individual. Once a covered individual's paid claims exceed the specific deductible, Amalgamated Life will pay the eligible amount paid that exceeds the specific deductible limited by the Individual Maximum Lifetime Benefit.

Since Amalgamated Life provides advance reimbursement (see "Specific Advancement" below), you need only show claim payments up to the specific deductible when filing a claim with us.

An option available on Specific Stop Loss is an Aggregating Specific Deductible sometimes known as a Corridor Deductible. Under an aggregating specific, the deductible shown is an agreed to amount that the group pays for all claims above the Specific Individual Deductible, i.e., the amount is paid before Amalgamated Life pays for any claims above the Specific Individual Deductible. An Aggregating Specific can save you significant administrative cost if you wish to take some of the specific risk.

Specific Stop Loss Contract Basis

Amalgamated Life offers any combination of incurred and paid periods as the basis for reimbursement. The most common basis is "Paid" which covers claims that are paid during the contract period and incurred any time before or during the contract period. The second most common basis is 12/15 which covers claims incurred during the contract period and paid either during the contract period or within the three months following the end of the contract period.

You may elect to include only medical benefits under stop loss or medical benefits plus other self-funded coverage such as Dental, Vision Care, Weekly Indemnity or Prescription Drug Benefits as eligible coverage. These elections will be stated in the policy.

Stop Loss Coinsurance

A Stop Loss Policy usually reimburses all eligible claims at 100%. However, you may choose a lower percent or a combination dollar amount and percent to lower your stop loss premium. The applicable percent is stated in the Policy.

Actively At Work Provision

Some health plans extend benefits for disabled employees. Stop Loss Policies usually require an employee be actively at work. However, Amalgamated Life allows you to waive our requirement (at an additional premium). The applicable provision is stated in the Policy.

In addition, in order to provide Amalgamated Life some protection, the Company uses a disclosure procedure that requires a fully completed disclosure statement. This statement must identify all participants known to be disabled, or not actively-at-work (employee) or actively-at-life (dependent), or to have had high claims in the recent past, or have the potential to incur high dollar claims based on the diagnosis and/or treatment. The disclosure form must be completed and signed by the appropriate parties no more than 30 days prior to the proposed effective date of coverage or of the renewal effective date, as applicable, and received by the Company within five days of completion. If disabled, or high risk participant is identified, Amalgamated Life has the option to decline or accept the risk, offer a Laser (an amount up to which we will not recognize for payment) for that participant, or increase the

cost of the stop loss coverage. It is important to note that if a participant is not disclosed, Amalgamated Life reserves the right to re-underwrite the group, and/or rescind or laser coverage for the undisclosed individual.

Specific Advancement – Advance Funding

Specific Advancement or Advance Funding is included in all our contracts at this time and covers Eligible Claim Payments. These claims should be fully processed according to the terms of the benefit plan and ready for payment. You are expected to use the advance funding within ten business days to pay the stop loss claim(s). Such claim payments made within the ten days (net of any amounts returned) will for purposes of this contract be considered made on the Amalgamated Life date of payment. If this does not happen, you are expected to return the funds within five more business days. If you do not return the unused funds within the five business days, interest at prime plus 4% will be charged.

Annual Aggregate Deductible/Attachment Point

The Annual Aggregate Deductible or Attachment Point is the amount of annual paid claims for all plan participants that must be paid by the policyholder/employer before the Aggregate stop loss coverage will reimburse claims.

The Annual Aggregate Deductible is calculated by multiplying the deductible factors by the number of covered employee and dependent units each month. If total claims paid in a plan year for eligible coverages under the employer's self-funded plan exceed the Annual Aggregate Deductible, Amalgamated Life will reimburse the agreed upon amount and/or percentage of eligible claims in excess of the deductible subject to any maximum payment stated in the Policy.

Claims reimbursed to the employer under specific Stop Loss coverage are excluded from the total of aggregate claims eligible for reimbursement under aggregate Stop Loss. Only those eligible expenses that accumulated towards the specific deductible are counted towards the aggregate; since anything over the specific deductible would have been reimbursed to the employer, and, therefore, they are not a liability incurred. Claims reimbursed under an Aggregating Specific Deductible (or Corridor Deductible) are also excluded from the total aggregate claims eligible for reimbursement. Claims paid up to any laser amount are also excluded from the total aggregate claims eligible for reimbursement.

You may elect to include only medical benefits under aggregate stop loss or medical benefits plus other self-funded coverage such as Dental, Vision Care, Weekly Indemnity or Prescription Drug Benefits as eligible coverage. These elections will be stated in the Policy.

Minimum Aggregate Deductible

The minimum aggregate deductible is usually 80% of the annual aggregate deductible and is stated in the Policy.

Aggregate Accommodation or Aggregate Conditional Reimbursement

This is an optional aggregate stop loss benefit. It means if aggregate claims for the contract period exceed the aggregate deductible at the end of any month, there will be conditional reimbursement of the aggregate excess insurance benefit before the end of the contract period. Normally, reimbursement for an aggregate stop loss claim is made at the end of the policy period (since that is when all aggregate factors are truly known). However, large fluctuations from month to month can occur. This option allows smoother cash flows.

If the accounting shows that no benefits were due under the Stop Loss Policy, or that the Aggregate Accommodation benefits paid exceed the annual benefit, the excess paid by the Company will be remitted back to the Company. The payment is to be made within 30 days after termination or the end of the contract period. If not, the company will subtract the amount from any Specific Stop Loss Claim payments due.

SECTION 3: PAYMENT OF PREMIUMS

If the effective date of this Contract is other than the first day of a calendar month, premiums payable under this Contract are due and payable on the first of each calendar month. The first payment should include the period from the effective date to the first of the following month and the first full month's premium. Please consult your Policy on the grace period and what happens for non-payment of premium. The Company will be entitled to offset claim reimbursements against any due and unpaid premiums.

You can remit premiums to us on your own form if it provides for the information shown on the enclosed Stop Loss Insurance Premium Statement.

SECTION 4: STOP LOSS CLAIM PRINCIPLES

Our stop loss claim commitment is to reimburse the policyholder accurately and quickly and to base our claim reimbursement exactly in accordance with the Stop Loss Insurance Policy.

Specific Stop Loss Claim Service Commitment

It is our goal to review and pay specific stop loss claims within 15 working days from receipt of all required claim information.

Aggregate Stop Loss Service Commitment

Upon receipt of the complete submission, we will perform a preliminary review of an aggregate claim request. We will then determine if we will do an "in-house" desk audit or an "on-site" audit, performed in the office of the Third Party Administrator (TPA). Our goal is to pay claims within 30 to 60 calendar days unless an "on-site" audit is required.

In the event of an "on-site" audit, an auditor will be assigned to the claim. The auditor will contact you and the TPA for any required additional information and to schedule an audit date.

SECTION 5: MONTHLY NOTIFICATION - CASE MANAGEMENT REQUIREMENTS SPECIFIC STOP LOSS

We are strong supporters of large case management and are willing to back our support with active help if requested. Amalgamated Life is here to work with your TPA or Case Management Contractor to reduce the cost of claims.

In some cases it will be apparent that claims may reach the specific deductible level. As a standard practice, we require the standard 50% threshold notification explained below. In addition, we require Trigger notification based on a list of potential high dollar claim diagnoses shown below in the Case Management and trigger notification Sections and shown in the modified Self-Insurance Institute of America (SIIA) disclosure form by diagnosis category codes.

If there is a potential or actual claim, we need to be contacted as soon as possible and large case management should be implemented as soon as possible. Please forward all case management information when you receive it. If you wish, we'll provide input on available courses of action.

If it is easier for you to send us a monthly claims computer extract, we will complete the reports below and send them to you.

Case Management

Please provide large case management for the following situations (and the diagnoses shown below). If you require our assistance, please let us know as soon as possible:

- A. Home Uterine Monitoring/Terbutaline Infusion Therapy
- B. Home IV/Infusion Therapy (i.e. antibiotics, TPN, chemotherapy, narcotics, enteral, etc.)
- C. Private duty nursing
- D. Extensive durable medical equipment
- E. Inpatient rehabilitation, psychiatric, chemical dependency and SNF confinements
- F. Home Health Care beyond 3 weeks
- G. Hospitalization beyond 7 days, ICU for over a week
- H. Any other situation the TPA feels large case management intervention would be helpful or the specific deductible may be reached

50% Threshold Notifications

Notification must be given to us when the total amount of Plan Benefits paid on a covered individual equals or exceeds 50% of the specific deductible. This allows us to set up our reserves and also allows us to review the cost saving procedures that are being used by the TPA. **Amalgamated Life is looking to build long lasting relationships with our groups. This cannot be achieved if we lack prompt claim notice (within 60 days). A cooperative spirit will provide you a secure renewal, assistance and cooperation especially when times get rough.** As a reminder, Amalgamated Life's goal is to work with you and your TPA, Case Manager and Utilization Review Firm to obtain information and process the claim as quickly as possible. Amalgamated Life is always available to assist in claim management and will provide in writing how we can assist you.

Trigger Notification - Catastrophic Diagnosis List

In order to better manage claims, we require notification be given to us when a catastrophic diagnosis on a covered individual has been identified, or when you expect a stop loss claim may result or a 50% notification may result. We use the SIIA list of diagnoses. You can submit these claims on the standard Proof of Loss Claim Form (check 50% notice) or use your own computer listing as long as the following information is included:

- Policyholder name
- Employee name, Social Security number, address and home phone number
- Claimant's name & relationship to employee
- Diagnosis Code(s) AND prognosis
- Specific deductible
- Amount of self-funded claim paid to date

- Any pertinent information regarding claimant's condition (pending transplant, hospital confinement, etc.) and name and phone numbers for any attending physicians.
- Case Management or patient management notes, pre-certification documents would be especially helpful.

Potential High Dollar Diagnoses

Please contact us immediately for any of the following diagnoses or diagnosis code(s) shown in the Modified SIIA form attached to this manual. Notification includes, but is not limited to, pre-certification, case management notes, benefits verification or provider bills.

Inpatient Hospital Stay Longer Than 7 days

Transplant - Dialysis

- Heart, Liver, Bone Marrow Transplant
- Organ Rejection
- Cardiomyopathy
- Biliary Aresia
- Renal Failure

Neonatal

- Premature Birth
- Hydrocephalus
- Respiratory Distress
- Meningiomyelocele
- Bronchopulmonary Dysplasia
- Major or Multiple Congenital Anomaly

Obstetrical

- High Risk Pregnancy
- Birth or expected birth of 3 or more
- Previous history of Neonatal ICU Confined Infant
- Toxemia (Hypertension) requiring hospitalization

Neurological

- Brain Tumor
- TIA (Transient Ischemic Attack)
- Closed Head Injury
- Unconsciousness (any cause)
- Cerebral Aneurysm or AV Malformation
- Meningitis or Encephalitis
- Reye's Syndrome
- Anoxic Encephalopathy
- Guillain-Barre
- Quadriplegia
- Paraplegia
- Chronic Stroke
- MS or ALS
- Alzheimer's Disease

Traumatically Injured

- Thermal Burns or Frostbite (>10% if child, >20% if adult)
- Crush Injuries
- Amputations
- Multiple Trauma or Fractures

Psycho-Neurotic

- Anorexia Nervosa
- Adolescent Adjustment
- Manic Depression (Bipolar Disorder)
- Schizophrenia
- Sexual Abuse
- Depression With or Without Attempted Suicide

Cardiovascular

- Ruptured Abdominal Aortic Aneurysm
- Coronary Atherosclerosis
- MI (Myocardial Infarction - Heart Attack)
- Cardiac Bypass
- Intractable Angina
- Peripheral Vascular Disease With Pending Amputation

Respiratory

- Respiratory Dependency
- Emphysema
- Chronic Bronchitis or Asthma

Malignancy

- Multiple Surgeries
- Radiation Treatments
- Cancer in Children
- Chemotherapy
- Acute Leukemia
- Aplastic Anemia
- Kaposi's Sarcoma

Other

- AIDS
- Cystic Fibrosis
- Muscular Dystrophy
- Cerebral Palsy
- Lupus
- Loss of Sight or Hearing
- Diabetes with Complications
- Chronic Gastro-Intestinal
- Hyperalimentation (TPN)
- Home IV Antibiotic Therapy
- Initiation of Hemodialysis
- Request for Transfer to a Rehabilitation Facility

See the attached modified SIIA Notification Form

SECTION 6: MONTHLY NOTIFICATION - CLAIMS MANAGEMENT AGGREGATE STOP LOSS

We require monthly notification of Aggregate Stop Loss Status Reports. The report should be sent to us within 20 days following the end of each month. As with Specific Stop Loss information, we will accept the format used by the TPA for this purpose as long as the following information is included. Please read the submission requirements in a subsequent section of this manual for a thorough discussion of Aggregate Stop Loss Claim payments.

- Employer Name
- Stop loss group policy number
- Contract period dates
- Contract basis, e.g., 15/12, Paid, etc.
- Census count by tier by eligible coverage, e.g., composite, single, family, Medical, Dental, etc. for all employees eligible for coverage, e.g., active employees, retired, etc. specified in the Policy
- Claims information:
 - Total paid claims for eligible employees and coverages
 - Claims covered by the Specific Stop Loss including pending/outstanding claims, if known
 - Claims covered by the Aggregate Stop Loss (applied to the attachment point)
 - Claims paid but not covered by neither the specific nor aggregate stop loss
 - Amounts should not include voids, refunds, extra-contractual payments, etc.
- Amount of reimbursement requested, if any, and the contract period for which the request is made
- Amount of conditional reimbursement requested, if applicable, including amount claimed, previous reimbursements made and any outstanding conditional reimbursements

If it appears that aggregate claims will exceed the attachment point, we will request that your TPA voluntarily work with us to manage claims using specialized vendors (i.e. professional fee negotiators and specialty networks).

SECTION 7: ANNUAL CENSUS NOTIFICATION

It is the responsibility of the Policyholder to submit an annual census report in EXCEL format. Amalgamated Life should receive this report 90 days prior to the renewal date of your Stop Loss Policy. This report must include employee's date of birth, gender, zip code and job classification.

SECTION 8: SPECIFIC STOP LOSS CLAIMS SUBMISSION REQUIREMENTS

File your claim when the total amount of eligible expenses (as described in your Plan Document subject to any terms, limitations and exclusions of the Stop Loss Policy) are paid on behalf of a covered individual exceed the stop loss specific deductible (a laser amount, if any, is considered a stop loss specific deductible). If your Policy does not state that you have Advance Funding, you need to have paid the claim (check actually issued and payment sent to the payee and funds on deposit to cover the check) before we will reimburse you for the claim.

Note: It is strictly the policyholder's (or TPA, on the policyholder's behalf) responsibility to adjudicate claims and make all claim decisions. Amalgamated Life cannot advise, recommend or otherwise direct the policyholder's course of action on a claim. If a claim payment decision is contrary to the Plan Document, Amalgamated Life will adjudicate the claim according to the Plan Document – see extra-contractual claims below. We cannot commit to claim reimbursement amounts prior to existence of a claim to us – to do so could possibly place Amalgamated Life in a plan fiduciary role and may expose Amalgamated Life to unwarranted legal action.

Specific Stop Loss Claims Submission Requirements – Eligibility Information

- A. Employee Proof of Eligibility/Enrollment Form showing:
 - 1. Enrollment form showing effective date, date of hire, employee signature, signature date
 - 2. If the enrollment form does not correspond with the plan's waiting period, please have the group's authorized representative explain the eligibility
 - 3. Proof showing any enrollment change such as termination of employment, last day actively at work if disabled and effective date of change, etc.
- B. Dependent Proof of Eligibility
 - 1. Enrollment form that shows beginning date, employee signature, signature date
 - 2. If the enrollment form does not correspond with the plan's waiting period, please have the group's authorized representative explain the eligibility
 - 3. Proof showing any enrollment change such as change in status, etc.
 - 4. If a spouse claim, verify spouse's employment status and whether spouse has other coverage (if other coverage verify effect on order of benefit determination)
 - 5. If a child claim, verify child qualifies and whether child has other coverage
 - 6. If a student claim, verify full-time student status (transcript or letter from the continuing education facility)
 - 7. This information may include:
 - a. Recent form signed and dated by the employee showing no other insurance on claimant
 - b. Complete name, address and phone number of other employer and copy of waiver
 - c. Divorce decree or court order stating who must cover the dependent(s)
- C. COBRA, if applicable
 - 1. Copy of the certified letter offering COBRA
 - 2. Date of qualifying event
 - 3. Date of election
 - 4. Effective date
 - 5. Documentation of premium payment checks
 - 6. Last day worked
- D. Leave of Absence – Family Medical Leave Act (FMLA)
 - 1. Copy of application for leave
 - 2. Copy of plan benefits if not included in the Plan Document
 - 3. Last day worked AND date returned to work
 - 4. If an employee is on leave but is/was eligible for COBRA coverage, we require that they must be/have been enrolled in the COBRA coverage to be covered under the Stop Loss Policy

- E. If the patient is not on the last census that was supplied to us, we may require additional verification (e.g., premium payments or list premium billings, HIPAA Certificate of Credible Coverage, etc.)

Specific Stop Loss Claims Submission Requirements – Claim Information

- A. Administrators request for reimbursement
 - 1. Copy of claim reimbursement form, fully completed and dated
 - 2. Copy of claim summary and calculation sheets
 - a. Include UCR (Usual Customary Reasonable) amounts
 - b. Include most common semi-private room rates if charges are being billed for private room and board
 - c. Identify COB amounts
- B. Claim detail
 - 1. Copies of detailed itemized bills
 - 2. Copies of EOB's
 - 3. Physician orders (length and duration) for therapy
 - 4. Physician orders (time frame) for extensive durable medical equipment
 - 5. Physician orders (length and duration) for home services
 - 6. Daily nursing notes for home services
 - 7. Operative reports
 - 8. Hospital pre-certification documentation if applicable
 - 9. Proof of any required hospital audit pre-screen
 - 10. Results of any hospital audits if applicable
 - 11. Copy of Hospital UB92 and itemization (if applicable, specify if DRG or per diem reimbursement)
 - 12. Prescription drug payments, if covered
 - 13. Documentation if the deductible and/or coinsurance was met prior to the stop loss effective date
- C. Proof of claim payment
 - 1. Proof of claim payments (e.g. check drafts, check numbers on EOBs)
 - 2. If specific advancement is used, copies of cancelled checks will need to eventually be submitted.
 - 3. Discount fee negotiations for non-PPO bills
- D. Case Management Reports (not necessary if you use *ALICARE Medical Management (AMM)*). *Case management includes patient management, assessment, monitoring reports, treatment plans, negotiated discounts, ongoing management and prognosis reporting.*
- E. Any claim investigation papers, phone conversation documentation, etc.
- F. If expenses are due to an accident, we will require:
 - 1. Written statement signed by the insured with the accident detail including when, where and how accident/injury occurred
 - 2. Copy of auto policy Declaration Page and EOB's showing payments made by the Auto Policy carrier if applicable (we will offset by auto carrier payments)
 - 3. Copy of third party auto policy Declaration Page, if applicable
 - 4. Police report if applicable
 - 5. Signed subrogation agreement (for each accident)
 - 6. Attorney correspondence
 - 7. Workers compensation
 - 8. All pertinent documentation regarding injury, and investigation phone calls

Specific Stop Loss Claims Submission Requirements – Plan Document

- A. Copy of most current document and all amendments
- B. Document should include
 - 1. ERISA language
 - 2. HIPAA language
 - 3. COBRA language
 - 4. Leave of Absence language
 - 5. Termination provisions
 - 6. Benefit descriptions and limitations and exclusions
 - 7. Definitions section which should include the definitions for the following:
 - a. Medical necessity
 - b. Active full time employee
 - c. Dependent
 - d. UCR (Usual Reasonable Customary)
 - e. Experimental and investigational
 - f. Totally disabled

Extra-contractual Claims

Extra-contractual claims (i.e., claims that are not eligible for reimbursement by Amalgamated Life) are not covered.

SECTION 9: AGGREGATE STOP LOSS CLAIM SUBMISSION REQUIREMENTS

When the attachment point is exceeded (either on an annual basis or, if a conditional reimbursement option is in effect, on a monthly basis – see the section that discusses the conditional reimbursement option), the TPA submits the following:

- A. Administrators request for reimbursement
 - 1. Copy of claim reimbursement form, fully completed and dated
 - 2. Copy of the most recent aggregate monthly claim report (specified in Section 6)
 - 3. Census reports for the period claimed, indicating all covered persons, original effective dates, termination dates and coverage status (if A.2. does not contain this information)
- B. Additional information may be required and will be requested once the initial claim submission is reviewed and audit requirements determined. This information can include, but is not limited to:
 - 1. Funding verification (monthly bank statements or other documentation of claims account funding)
 - 2. If prescription drug card charges are included, itemized monthly invoices and verification of payment (if not included on monthly check registers)
 - 3. COBRA documentation for COBRA participants
- C. Proof of Claim which includes the contract year-to-date monthly check register showing all payments, voids, reissues and refunds; identifying any non-claim payments (e.g. administration fees, etc.). The register should show the check number, date of check, name of claimant, incurred date and check amount. The claim must have been funded by you, i.e., checks actually issued, payment sent to the payee and funds on deposit to cover the claim.

- D. Contract year-to-date claim listing showing the claimant, coverage, date of payment, date of service (beginning and ending), procedure code, and amount billed, allowed and paid. Both Items B and C should closely reconcile to item A2.
- E. Reimbursement is limited to the aggregate stop loss policy maximum benefit and is subject to any minimum attachment point.
- F. An aggregate stop loss claim should ultimately be submitted the later of 60 days following the end of the contract period or the end of the basis period, e.g. basis 12/24 would need to be submitted within one year and 60 days following the end of the contract period.

Eligible claims exceeding the specific stop loss deductible and reimbursed under the specific stop loss coverage do not count as accumulated claims under aggregate stop loss coverage. *If a claimant is covered by a laser, the difference between the specific deductible and the lasered claimant's deductible is not attributable to the aggregate claims. If a "Run-in" limit applies, only amounts up to that limit will apply.*

SECTION 10: AGGREGATE ACCOMMODATION–CONDITIONAL REIMBURSEMENT

You have the option of including an aggregate accommodation benefit, i.e., a conditional reimbursement provision. The option must be included at the beginning of the contract period and may not be added at any other time. The benefit is neither a loan nor an advance on any payment due under the Aggregate Stop Loss Excess Loss Policy. The funds are considered Amalgamated Life funds and are to be held by you as "Funds Held on Deposit". Funds are transferred when the sum of eligible cumulative claims paid at the end of any month during the contract period exceeds the (cumulative) year-to-date attachment point. If an aggregate claim is filed at the end of the contract period, the amount of the claim is then considered a payment under the Aggregate Stop Loss Excess Loss Policy for the amount of the claim. Any excess (still recorded as Funds Held on Deposit) will be remitted to Amalgamated Life the earlier of 30 days after termination, or end of the contract period, or subtracted from any specific stop loss claim payments due.

In addition to TPA submission of the supporting documentation, The *Aggregate Claim/Conditional Reimbursement Request form* is required for each monthly request.

SECTION 11: CLAIM APPEAL PROCESS

If additional information is required to complete the processing of a stop loss claim, a letter pending the reimbursement will be sent to the TPA with an explanation and a listing of the items needed to complete the claim filing. If no response is received, a second letter will be sent to the TPA as a reminder. If still no response is received, a letter will be sent denying the claim. Any denied claim can be appealed by submitting supporting documentation or by providing other evidence in writing. Amalgamated Life may enlist the services of qualified experts to support denials based on medical necessity or experimental and investigational provisions or other provisions in the stop loss policy.

There are two appeal levels as follows:

Level I - First appeal - performed by Stop Loss Claims Department

Level II - Second and final appeal - performed by the Amalgamated Life Claim Appeal Board

All decisions made by the Amalgamated Life Claim Appeal Board are final. Additional requests for appeal will be denied. Submit all claim appeals to our Stop Loss Claims Department at the address shown previously in this Manual.

SECTION 12: COST SAVING VENDORS

Amalgamated Life expects the TPA has arrangements with cost saving vendors to manage claims. Upon receipt of your potential claim notification to us, if you have not already contracted with one or more of these types of vendors, we may contact you and suggest one or more cost saving vendors become involved. In the case of a large subrogation recovery, we reserve the right to have the claim managed by a vendor of our choice. All claims are still subject to the provisions and limitations set forth in the Stop Loss Policy and Plan Document Date.