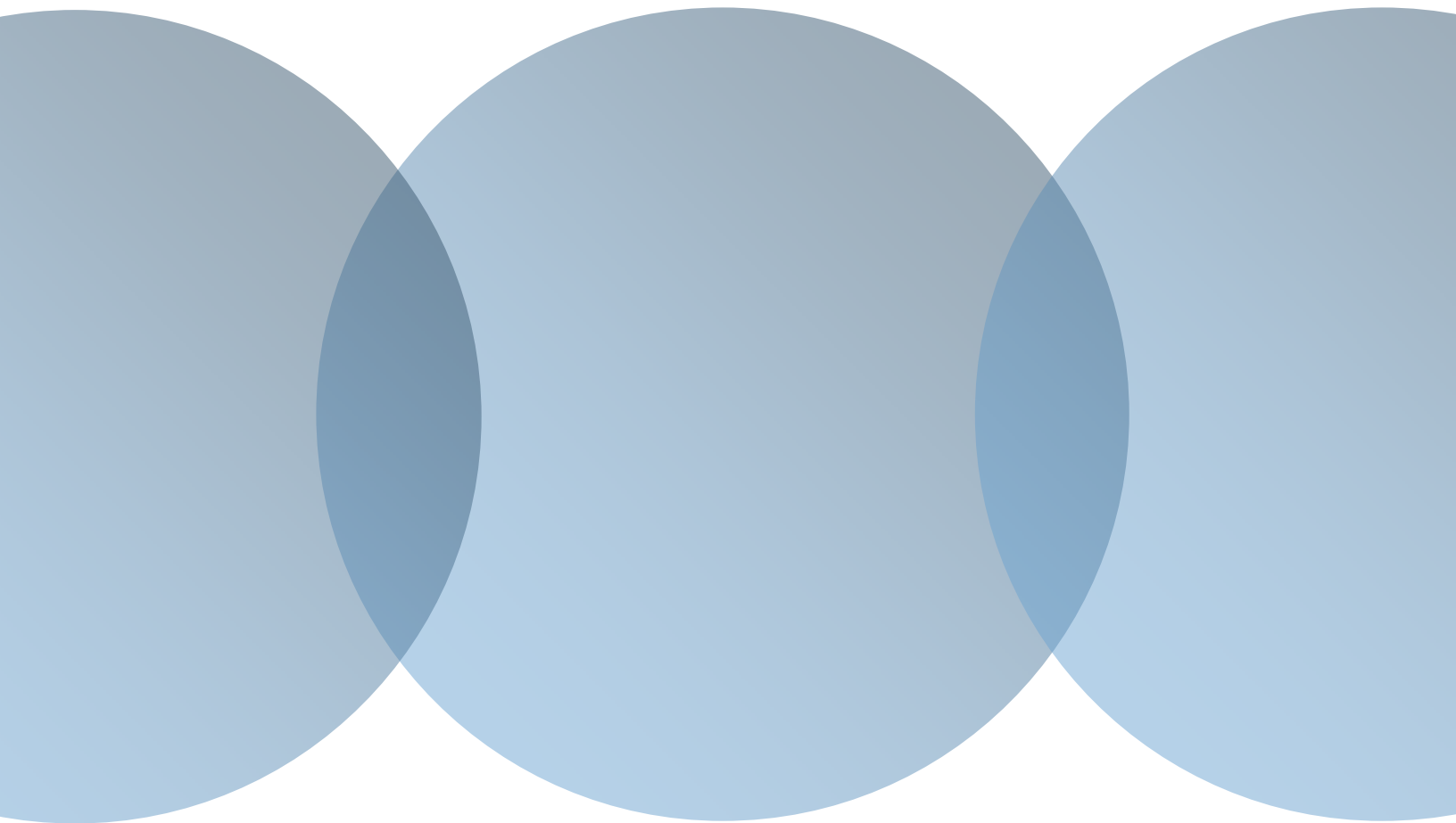




# Medical Stop Loss

## Administrative Guide



# ZURICH AT A GLANCE

## Who We Are

Zurich in North America is a member of Zurich Financial Services Group (Zurich), an insurance-based financial services provider with a global network of subsidiaries and offices in North America and Europe as well as in Asia Pacific, Latin America and other markets. Founded in 1872, Zurich is headquartered in Zurich, Switzerland and employs about 58,000 people serving customers in more than 170 countries.

In 1912, Zurich became the first foreign insurer to enter the U.S. market. Today in the U.S., through Zurich in North America, Zurich is a leading commercial property and casualty insurer, serving a wide range of commercial customers such as small and mid-sized business, large domestic corporations and global multinationals.

## Financial Strength Ratings

A financial strength rating is a third-party assessment of an insurance company's financial security, based on its ability to meet policyholder claims. As of December 11, 2008, Zurich had the following ratings:

Rating Agency	Financial Strength Rating	Rating Outlook
A.M. Best	A	Stable
Fitch Ratings	A+	Positive
Moody's	A1	Stable
Standard & Poor's	AA-	Stable

# INTRODUCTION

Zurich in North America's medical stop loss insurance programs are designed to assist you in managing complex health risks and protecting bottom-line results for customers. Our products are specifically designed to protect a self-insured employer from catastrophic loss. Through a platform of outcome-driven services, Zurich's medical stop loss coverage reduces the financial impact of large medical claims while ensuring effective patient outcomes.

We also recognize the need for a financially steadfast medical stop loss provider with broad experience to create solutions for our partners and customers. Our resources are unsurpassed in the industry and include:

- Financial strength and stability to assume risk as a direct writer
- Direct access to quality underwriting and claims expertise
- Responsive claims management with no reliance on third-party reinsurance
- Access to a comprehensive national organ transplant network
- Access to medical case management relationships and expertise
- Direct access to regional Business Development Managers for product expertise and customer service
- Rate differentiation for use of the most cost-effective PPO networks

We pride ourselves on our capabilities and resources to address an array of specialty health issues and our specialists, with an in-depth knowledge and intimate understanding of complexities in the healthcare arena, are recognized as experts in the industry. Please feel free to call upon our professionals at any time.

**Our innovative medical stop loss insurance programs have been designed and developed exclusively for you, our partner. Thank you for choosing Zurich in North America as your premier medical stop loss insurance carrier and we look forward to working with you.**

As a partner of Zurich in North America this Medical Stop Loss Administrative Guide has been prepared for your use exclusively. This Guide has been designed for ease and efficiency and is not intended to alter the terms of any Stop Loss Insurance Policy issued by Zurich American Insurance Company. If there is any conflict between the terms of this Guide and the terms of the actual Stop Loss Insurance Policy issued, the terms of the Policy will govern.

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# MEDICAL STOP LOSS CONTACTS BY DEPARTMENT

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## CLAIMS

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### MELVILLE, NEW YORK

Zurich North America - Specialty Health  
Medical Stop Loss Claims  
58 South Service Road, Suite 300  
Melville, New York 11747-2342

**Toll Free:** 866.841.9305

**General Claims Email Address:** [sl\\_claims@zurichna.com](mailto:sl_claims@zurichna.com)

Name	Title	Telephone	Facsimile	Email
Kathy Kelsch	Claims Manager	631.845.2314	631.845.2310	<a href="mailto:kathy.kelsch@zurichna.com">kathy.kelsch@zurichna.com</a>
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Maritza Murtha	Benefit Analyst	631.845.2309	631.845.2310	<a href="mailto:maritza.murtha@zurichna.com">maritza.murtha@zurichna.com</a>
Joyce Bonanza	Claims Associate	631.845.2305	631.845.2310	<a href="mailto:joyce.bonanza@zurichna.com">joyce.bonanza@zurichna.com</a>

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## CASE MANAGEMENT

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### FRAMINGHAM, MASSACHUSETTS

Zurich North America - Specialty Health  
175 Crossing Boulevard, Suite 100  
Framingham, Massachusetts 01702

Name	Title	Telephone	Facsimile	Email
Bruce Gilman, RN, CCM	Program Development Manager	508.808.6516	505.808.6525	<a href="mailto:bruce.gilman@zurichna.com">bruce.gilman@zurichna.com</a>

### MELVILLE, NEW YORK

Zurich North America - Specialty Health  
58 South Service Road, Suite 300  
Melville, New York 11747-2342

**Toll Free:** 866.841.9305

Name	Title	Telephone	Facsimile	Email
Cathy Ruggero, RN, CCM	Case Manager	631.845.2315	631.845.2326	<a href="mailto:catherine.ruggero@zurichna.com">catherine.ruggero@zurichna.com</a>

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## PREMIUM & ACCOUNTING

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### MELVILLE, NEW YORK

Zurich North America - Specialty Health  
Medical Stop Loss Premium & Accounting  
58 South Service Road, Suite 300  
Melville, New York 11747-2342

**Toll Free:** 866.841.9305

Name	Title	Telephone	Facsimile	Email
Tracey Brennan	AVP Premium & Statistical Reporting	631.845.2313	631.845.2310	<a href="mailto:tracey.brennan@zurichna.com">tracey.brennan@zurichna.com</a>
Michelle Puglia	Manager, Premium & Statistical Reporting	631.845.2301	631.845.2310	<a href="mailto:michelle.puglia@zurichna.com">michelle.puglia@zurichna.com</a>
Donna Falcetta	Account Representative	631.845.2303	631.845.2310	<a href="mailto:donna.falcetta@zurichna.com">donna.falcetta@zurichna.com</a>

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## UNDERWRITING

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### CHICAGO, ILLINOIS

Zurich North America - Specialty Health  
Medical Stop Loss Underwriting  
10 South Riverside Plaza  
Chicago, Illinois 60606

**Request for Proposal Email Address:** [sl\\_rfp@zurichna.com](mailto:sl_rfp@zurichna.com)

<b>Name</b>	<b>Title</b>	<b>Telephone</b>	<b>Facsimile</b>	<b>Email</b>
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Michael Griffin	AVP & Regional Underwriting Manager	312.496.9526		<a href="mailto:michael.griffin@zurichna.com">michael.griffin@zurichna.com</a>
Erin Rich	Underwriting Manager	585.359.2030	866.708.4954	<a href="mailto:erin.rich@zurichna.com">erin.rich@zurichna.com</a>
Carrie Lorenz	Senior Underwriter	708.418.1590	708.418.1613	<a href="mailto:carrie.lorenz@zurichna.com">carrie.lorenz@zurichna.com</a>
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### FRAMINGHAM, MASSACHUSETTS

Zurich North America - Specialty Health  
Medical Stop Loss Underwriting  
175 Crossing Boulevard, Suite 100  
Framingham, Massachusetts 01702

**Request for Proposal Email Address:** [sl\\_rfp@zurichna.com](mailto:sl_rfp@zurichna.com)

<b>Name</b>	<b>Title</b>	<b>Telephone</b>	<b>Facsimile</b>	<b>Email</b>
Tony D'Orazio, CLU	AVP & Regional Underwriting Manager	508.808.6511	508.808.6525	<a href="mailto:tony.d'orazio@zurichna.com">tony.d'orazio@zurichna.com</a>
Todd Hayes	Senior Underwriter	508.808.6512	508.808.6525	<a href="mailto:todd.hayes@zurichna.com">todd.hayes@zurichna.com</a>
Mark Woodward	Senior Underwriter	508.808.6514	508.808.6525	<a href="mailto:mark.woodward@zurichna.com">mark.woodward@zurichna.com</a>

### MELVILLE, NEW YORK

Zurich North America - Specialty Health  
Medical Stop Loss Underwriting  
58 South Service Road, Suite 300  
Melville, New York 11747-2342

**Toll Free:** 866.841.9305

**Request for Proposal Email Address:** [sl\\_rfp@zurichna.com](mailto:sl_rfp@zurichna.com)

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Sharon Rudolph	Underwriting Technician	631.845.2322	631.845.2326	<a href="mailto:sharon.rudolph@zurichna.com">sharon.rudolph@zurichna.com</a>
Margaret Brennan	Contract Administrator	631.845.2323	631.845.2326	<a href="mailto:margaret.brennan@zurichna.com">margaret.brennan@zurichna.com</a>

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## SALES & MARKETING

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### HOME OFFICE:

Zurich North America - Specialty Health  
One Liberty Plaza, 31<sup>st</sup> Floor  
New York, New York 10006

<b>Name</b>	<b>Title</b>	<b>Telephone</b>	<b>Facsimile</b>	<b>Email</b>
Dan Fenton	Senior Vice President, Specialty Health	212.553.5565	212.225.7041	<a href="mailto:dan.fenton@zurichna.com">dan.fenton@zurichna.com</a>

## MID ATLANTIC REGIONAL SALES OFFICES:

Zurich North America - Specialty Health  
5005 Rockside Road, Suite 940  
Independence, Ohio 44131

<b>Name</b>	<b>Title</b>	<b>Telephone</b>	<b>Facsimile</b>	<b>Email</b>
Ed Tyburski	Senior Vice President, Sales	216.447.4035	216.447.4055	<a href="mailto:ed.tyburski@zurichna.com">ed.tyburski@zurichna.com</a>
Amy Szalay	National Account Manager	216.447.4058	216.447.4055	<a href="mailto:amy.szalay@zurichna.com">amy.szalay@zurichna.com</a>

Zurich North America - Specialty Health  
26935 Northwestern Highway, Suite 520  
Southfield, Michigan 48033

<b>Name</b>	<b>Title</b>	<b>Telephone</b>	<b>Facsimile</b>	<b>Email</b>
Vince Lewis	Business Development Manager	248.263.2408	248.350.9310	<a href="mailto:vince.l.lewis@zurichna.com">vince.l.lewis@zurichna.com</a>

## NORTH CENTRAL REGIONAL SALES OFFICE:

Zurich North America - Specialty Health  
1400 American Lane  
Tower 2, Floor 19  
Schaumburg, Illinois 60196

<b>Name</b>	<b>Title</b>	<b>Telephone</b>	<b>Facsimile</b>	<b>Email</b>
Jeffrey Anderson	Business Development Manager	847.605.8850	847.605.7633	<a href="mailto:jeffrey.anderson@zurichna.com">jeffrey.anderson@zurichna.com</a>

## NORTHEAST REGIONAL SALES OFFICE:

Zurich North America - Specialty Health  
680 Andersen Drive  
Foster Plaza, Building 10 – 6<sup>th</sup> Floor  
Pittsburgh, Pennsylvania 15220

<b>Name</b>	<b>Title</b>	<b>Telephone</b>	<b>Facsimile</b>	<b>Email</b>
Joe Byers	Regional Sales Director	412.937.5113	412.937.5451	<a href="mailto:joseph.byers@zurichna.com">joseph.byers@zurichna.com</a>

## NORTHWEST & SOUTHWEST REGIONAL SALES OFFICE:

Zurich North America - Specialty Health

<b>Name</b>	<b>Title</b>	<b>Telephone</b>	<b>Facsimile</b>	<b>Email</b>
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## SOUTH CENTRAL PLUS CO, KS, NM & WY REGIONAL SALES OFFICE:

Zurich North America - Specialty Health  
12222 Merit Drive, Suite 700  
Dallas, Texas 75251

<b>Name</b>	<b>Title</b>	<b>Telephone</b>	<b>Facsimile</b>	<b>Email</b>
Courtney Davis	Regional Sales Director	214.866.1012	214.866.1025	<a href="mailto:courtney.davis@zurichna.com">courtney.davis@zurichna.com</a>

## SOUTHEAST REGIONAL SALES OFFICE:

Zurich North America - Specialty Health  
3003 Summit Boulevard, Suite 1800  
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<b>Name</b>	<b>Title</b>	<b>Telephone</b>	<b>Facsimile</b>	<b>Email</b>
Johnny Banks	Business Development Manager	404.851.3431	404.851.3681	<a href="mailto:john.banks@zurichna.com">john.banks@zurichna.com</a>

# CLAIMS MANAGEMENT AND ADJUDICATION SERVICES

## SPECIFIC STOP LOSS

### Notification of Specific Claim

Early identification and notification of potentially catastrophic claims is essential to providing quality claims management services and Zurich North America needs your help in identifying these claims. Timely notification ensures the implementation of large case management and other cost containment strategies, which can be mutually beneficial to all parties by preserving Plan Benefits and saving claims dollars.

Zurich requires notice of any claim with potential of reaching or exceeding 50% of the Specific Deductible, whether or not bills have been received or payments made. Many Third Party Administrators are notified of serious claims through the pre-certification and/or utilization review process. Once you have been alerted of a serious claim or when you have referred a claimant to large case management, please take the next step and notify Zurich by submitting a Specific Claim Notification/Claim Reimbursement Request Form, yours or ours.

Please notify us when any Covered Person has been diagnosed with or treated for any of the codes listed under the following categories during the current Benefit Period:

<b>001 - 139</b>	<b>Infectious and Parasitic Diseases</b>
038 - 038.9	Septicemia
042	AIDS / HIV
070 - 070.9	Viral Hepatitis
<b>140 - 239</b>	<b>Neoplasms</b>
140 - 149.9	Malignant Neoplasm of Lip, Major Salivary Glands, Gum, Mouth, Oropharynx, Nasopharynx, and/or Hypopharynx
150 - 150.9	Malignant Neoplasm of Esophagus
151 - 151.9	Malignant Neoplasm of Stomach
153 - 153.9	Malignant Neoplasm of Colon
154 - 154.8	Malignant Neoplasm of Rectum
155 - 155.2	Malignant Neoplasm of Liver
157 - 157.9	Malignant Neoplasm of Pancreas
161 - 161.9	Malignant Neoplasm of Larynx
162 - 162.9	Malignant Neoplasm of Lung
170 - 170.9	Malignant Neoplasm of Bone
174 - 174.9	Malignant Neoplasm of Female Breast
179 - 182.8	Malignant Neoplasm of Uterus or Cervix
183 - 183.9	Malignant Neoplasm of Ovary
185	Malignant Neoplasm of Prostate
186 - 186.9	Malignant Neoplasm of Testis
188 - 189.9	Malignant Neoplasm of Bladder, Kidney, Urinary
191 - 191.9	Malignant Neoplasm of Brain
192 - 192.9	Malignant Neoplasm of Nervous System
194 - 194.9	Malignant Neoplasm of Endocrine Glands
195 - 195.8	Malignant Neoplasm of Other Ill-Defined Sites
196 - 196.9	Secondary Malignant Neoplasm Lymph Nodes
197 - 197.8	Secondary Malignant Neoplasm Respty and Digestive Systems
198 - 198.89	Secondary Malignant Neoplasm Other Specified Sites
200 - 208.9	Lymphoma and/or Leukemia
235	Neoplasm Uncertain Behavior
239.2	Neoplasm Unspecified Nature – Bone, Skin
<b>240 - 279</b>	<b>Endocrine, Nutritional, Metabolic, Immunity</b>

250 - 250.9	Diabetes
277.0	Cystic Fibrosis
278.0	Obesity/Hyperalimant

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**280 - 289 Diseases of the Blood and Blood-Forming Organs**

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282.6	Sickle-Cell Anemia
284.9	Aplastic Anemia NOS
286 - 286.9	Coagulation Defects and/or Hemophilia

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**320 - 389 Diseases of the Nervous System and Sense Organs**

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330	Cerebral degenerations
344.0 - 344.09	Quadriplegia and Quadripareis
331.0 - 331.9	Reye's Syndrome
344.1	Paraplegia
348.0 - 348.9	Encephalopathy
357 & 358	Neuropathy / Myasthenia Gravis

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**390 - 459 Diseases of the Circulatory System**

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410 - 410.9	Acute Myocardial Infarction
411 - 411.89	Acute and Subacute Ischemic Heart Disease
414 - 414.05	Coronary Atherosclerosis (ASHD)
415 - 415.19	Acute Pulmonary Heart Disease
416 - 416.9	Chronic Pulmonary Heart Disease
417.1	Aneurysm of Pulmonary Artery
421 - 421.9	Acute and Subacute Endocarditis
424 - 424.9	Valve Disorders
425 - 425.9	Cardiomyopathy
426 - 426.9	Conduction Disorders
427 - 427.9	Cardiac Dysrhythmias
428 - 428.9	Heart Failure
430 & 431	Subarachnoid / Intracerebral Hemorrhage
434.9	Occlusion of Cerebral Arteries
436	Acute Cerebrovascular Accident (CVA)
440 - 441.9	Atherosclerosis / Aortic Aneurysm

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**460 - 519 Diseases of the Respiratory System**

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480 - 486	Pneumonia
490 - 496	Chronic Obstructive Pulmonary Disease (COPD), etc.
515	Postinflammatory Pulmonary Fibrosis
518 - 518.89	Pulmonary Collapse and/or Respiratory Failure

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**520 - 579 Diseases of the Digestive System**

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555 - 555.9	Regional Enteritis (Crohn's Disease)
560.0 - 560.9	Intestinal Obstruction
562.1	Diverticulitis of Colon
567 - 567.9	Peritonitis
569.0 - 569.9	Other Disorders of Intestine
570 - 571.9	Liver Diseases and Cirrhosis
572.8	Other Sequela of Chronic Liver Disease
573 - 573.9	Other Liver Disorders
577 - 577.9	Pancreas Diseases
578 - 578.9	Gastrointestinal Hemorrhage

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**580 - 629 Diseases of the Genitourinary System**

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584 - 584.9	Acute Renal Failure
585	Chronic Renal Failure
586	Renal Failure, Unspecified

588 Disorders resulting from impaired renal function  
592 Calculus of Kidney & Ureter

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**630 - 677 Complications of Pregnancy, Childbirth**

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641.1 Placenta Previa  
642.5 - 642.7 Eclampsia, pre-eclampsia  
644.0 - 644.2 Premature Labor  
648.0 Gestational Diabetes  
651 Multiple Gestation  
654.5 Cervical Incompetence

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**710 - 739 Diseases of the Musculoskeletal System and Connective Tissue**

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715.0 - 715.9 Osteoarthritis  
721.3 Lumbosacral Spondylosis  
722.0 - 722.9 Intervertebral Disc Disorders  
730 - 730.09 Osteomyelitis and/or Periostitis  
737.3 Kyphoscoliosis and scoliosis

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**740 - 759 Congenital Anomalies**

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747.2 Aortic Atresia / Stenosis  
751.6 Biliary Atresia  
759 - 759.9 Other and Unspecified Congenital Anomalies

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**760 - 779 Conditions Originating in the Perinatal Period**

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765 - 765.1 Prematurity  
769 Respiratory Distress Syndrome  
770.0 - 770.9 Other Respiratory Conditions of Newborn

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**780 - 799 Symptoms, Signs, and Ill-Defined Conditions**

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785 - 785.9 Symptoms Involving Cardiovascular System  
786.5 - 786.59 Chest Pain

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**800 - 999 Injury and Poisoning**

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800 - 804.9 Fracture of Skull  
805 - 805.9 Fracture of Vertebral Column  
806 - 806.9 Fracture of Vertebral Column with Spinal Cord Injury  
828 - 828.1 Multiple Fractures  
853 - 854.1 Intracranial Injury  
869 - 869.1 Internal Injury  
887 - 887.7 Traumatic Amputation of Arm and Hand  
897 - 897.7 Traumatic Amputation of Leg  
949 - 949.5 Burns  
952 - 952.9 Spinal Cord Injury  
996 - 997.0 Complications peculiar to certain specified conditions

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**V01 – V82 Supplementary Classification of Factors Influencing Health Status**

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V23 Supervision of High-Risk Pregnancy  
V42 - V58.9 Transplants, etc.

## **Initial Specific Claim Filing**

A Specific claim occurs when Plan Benefits, Paid on behalf of a Covered Person, exceed the Specific Deductible. To request reimbursement, please complete a Specific Claim Notification/Claim Reimbursement Request Form, yours or ours, and submit it along with the supporting documentation to us.

Initial Specific claim submissions require the following documentation:

- A completed **SPECIFIC CLAIM NOTIFICATION/SPECIFIC CLAIM REIMBURSEMENT REQUEST FORM**, yours or ours.
- An **ENROLLMENT FORM**, which indicates the employee's original effective date of coverage under the employer's group health plan, types of coverage elected, and names of covered dependents.
- A **CERTIFICATE OF CREDITABLE COVERAGE** or verification of a pre-existing condition investigation, if applicable.
- **COBRA** documentation: the COBRA notification, which includes the qualifying event and date of the qualifying event, the COBRA Election Form, and verification of COBRA premium payments, if applicable.
- Verification of no **OTHER INSURANCE COVERAGE**, for a spouse or dependent: a medical claim form completed, signed and dated by the claimant within the last twelve (12) months, which indicates whether or not other insurance coverage is or was available.
- **SUBROGATION** documentation, for accident related claims: a police and/or accident report, a signed subrogation agreement and any attorney correspondence, if applicable.
- Itemized **PROVIDER BILLS** attached to each corresponding **EOB** and **BENEFIT CHECK**.
- Large case management reports, operative reports, and medical reports.
- Prognosis, future treatment plan, and estimation of projected expenses, as well as paid and pending amounts.

## **Supplemental Specific Claim Filing**

Supplemental Specific claim submissions only require the following:

- A completed **SPECIFIC CLAIM NOTIFICATION/SPECIFIC CLAIM REIMBURSEMENT REQUEST FORM**, yours or ours.
- Itemized **PROVIDER BILLS** attached to each corresponding **EOB** and **BENEFIT CHECK**.
- Large case management reports, operative reports, and medical reports.
- Prognosis, future treatment plan, and estimation of projected expenses, as well as paid and pending amounts.

***All Specific claim notifications and reimbursement requests should be directed to our Medical Stop Loss Claims Department.***



# SPECIFIC CLAIM NOTIFICATION/CLAIM REIMBURSEMENT REQUEST FORM

Please check appropriate box:

50% Notification    Diagnosis Notification    Initial Claim    Supplemental Claim    Final Claim    Specific Advance Funding  
\_\_\_\_\_ - Date by which the Policyholder must receive funding in order to avoid lost discount(s)

Policyholder: \_\_\_\_\_ Policy Period: \_\_\_\_\_  
Employee Name: \_\_\_\_\_ Employee's SSN: \_\_\_\_\_  
Claimant Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
Prognosis: \_\_\_\_\_

### If Accident, Please Include Accident Details

Attending Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
First Date of Service: \_\_\_\_\_ Last Date of Service: \_\_\_\_\_  
Total Claims Paid to Date: \$ \_\_\_\_\_ Total Claims Pending In-house: \$ \_\_\_\_\_

### Comments about Pre-Screening, Auditing, Bill Negotiation and/or Large Case Management:

\_\_\_\_\_  
\_\_\_\_\_

### REQUEST FOR REIMBURSEMENT

Total Plan Benefits Paid: \$ \_\_\_\_\_  
Less Specific Deductible Amount: ( \$ \_\_\_\_\_ )  
Reimbursement Requested: \$ \_\_\_\_\_  
Estimated Future Expenses: \$ \_\_\_\_\_

Please include legible copies of the following:

1) Original Enrollment Form with Effective Date of Coverage, Proof of Creditable Coverage and COBRA Documentation. 2) Verification of no Other Insurance Coverage, if claimant is a dependent. 3) Itemized Provider Bills Attached to each corresponding EOB and Benefit check. 4) Detailed Itemized Inpatient Hospital Bills in Excess of \$25,000.00.

Submitted by: \_\_\_\_\_ Title: \_\_\_\_\_  
TPA Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_ Facsimile: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Prepared Date: \_\_\_\_\_ Notes: \_\_\_\_\_

# AGGREGATE STOP LOSS

## Monthly Aggregate Reporting

Zurich requires Monthly Aggregate Reporting, by the fifteenth (15<sup>th</sup>) of each month of the Policy Period, for any Policyholder who has purchased Aggregate coverage. Monthly Aggregate Reporting assists Zurich in documenting and monitoring potential Aggregate claims.

Please include the following with your Monthly Aggregate Reporting:

- A completed **MONTHLY AGGREGATE REPORTING AND CLAIM REIMBURSEMENT REQUEST FORM**, yours or ours, which includes the number of Covered Units by coverage type for each month of the Policy Period, as well as deductions for ineligible claim expenses, such as Specific claims, voids and/or refunds and extra-contractual benefit payments.

## Aggregate Claim Filing

An Aggregate claim occurs when Plan Benefits, Paid on behalf of all Covered Persons, exceed the Minimum Annual Aggregate Deductible. Aggregate claims are typically filed after the Aggregate Benefit Period has expired and the total Eligible Claim Expenses can be determined. To request reimbursement, please complete a Monthly Aggregate Reporting and Claim Reimbursement Request Form, yours or ours, and submit it along with the supporting documentation to us.

Aggregate claim submissions require the following documentation:

- A completed **MONTHLY AGGREGATE REPORTING AND CLAIM REIMBURSEMENT REQUEST FORM**, yours or ours.
- A **DETAILED PAID CLAIMS REPORT** run based on the Benefit Period of the Aggregate coverage, which provides year to date totals by claimant and grand total. If the Benefit Period for the Specific coverage is different than the Aggregate, please include a detailed claims report run based on the Benefit Period of the Specific coverage as well.
- A census or **ELIGIBILITY LISTING** of all employees covered at any time during the Policy Period, including COBRA participants, which includes effective dates, termination dates and types of coverage.
- A report of **CLAIMS PAID BY BENEFIT CODE**.

Depending upon our review of the above documentation, the Aggregate claim audit will be conducted at our facility. If the Aggregate claim exceeds the Minimum Annual Aggregate Deductible by more than \$50,000.00 an onsite audit at your facility may be required.

In order to reduce the amount of onsite time required to complete an audit, the following items may also be attached to your Aggregate claim reimbursement request:

- Itemized **PREMIUM BILLING STATEMENTS** for each month of the Policy Period, including the three months prior and three months after.
- Copies of the **MONTHLY PREMIUM REPORTING AND REMITTANCE FORMS**, yours or ours.
- **CHECK REGISTERS** for the Policy Period.
- A list of **VOIDS, REFUNDS, CREDITS AND/OR REVERSALS** for the Policy Period, including all months after.

- Copies of the itemized **PRESCRIPTION DRUG CARD INVOICES** and **PROOF OF FUNDING**, if the Aggregate Coverage includes free-standing prescription drug program expenses.

*Please note, any of the reports requested above may be provided in hard copy or on diskette in print, spool, TXT, SDF, or formatted text files form.*

### **Monthly Aggregate Accommodation Claim Filing**

Monthly Aggregate Accommodation claim filing is available to any Policyholder who has purchased the Monthly Aggregate Accommodation option.

A request for reimbursement of a Monthly Aggregate Accommodation claim may be made after the end of the fourth (4<sup>th</sup>) month that the Policy has been in force and through the eleventh (11<sup>th</sup>) month of coverage, if cumulative Plan Benefits exceed the cumulative Aggregate Deductible. Zurich will advance to the Policyholder, as a loan, Monthly Aggregate claims of \$1,000.00 or more. Any advances must be repaid during any subsequent months to the extent that Plan Benefits are less than the Monthly Aggregate Deductible.

The Monthly Aggregate Deductible is calculated by using the greater of:

- A. The total number of Covered Units for each month of the Policy Period multiplied by the corresponding Covered Unit's Monthly Aggregate Deductible Factor; or
- B. The amount equal to one twelfth of the Minimum Annual Aggregate Deductible Amount shown in the Schedule of Stop Loss Insurance.

Please include the following with your Monthly Aggregate Accommodation claim reimbursement request:

- A completed **MONTHLY AGGREGATE REPORTING AND CLAIM REIMBURSEMENT REQUEST FORM**, yours or ours, which includes deductions for ineligible claim payments, such as Specific claims, voids and/or refunds and extra-contractual benefit payments.
- A **DETAILED PAID CLAIMS REPORT** run based on the Benefit Period of the Aggregate coverage, which provides year to date totals by claimant and grand total. If the Benefit Period for the Specific coverage is different than the Aggregate, please include a detailed claims report run based on the Benefit Period of the Specific coverage as well.

***All Aggregate claim reports and reimbursement requests should be directed to our Medical Stop Loss Claims Department.***



## VALUE ADDED PROGRAMS

### **Specific Advance Funding**

Specific Advance Funding is an option, which protects the Policyholder's cash flow in the event of a large Specific claim. Zurich offers this option at no additional charge to our clients.

The Third Party Administrator can request Specific Advance Funding for Plan Benefits in excess of \$1,000.00 by following this process:

- The Third Party Administrator adjudicates the claim and forwards all of the usual Proof of Loss documentation required to request reimbursement prior to actually releasing the check(s) to the provider(s).
- The Third Party Administrator must clearly identify the request for Specific Advance Funding at the time of the claim submission.
- Zurich's Claims Department will evaluate the documentation and if complete, Zurich will issue a reimbursement check within 5-10 business days.
- Upon receipt of Zurich's reimbursement, the Third Party Administrator should immediately release all Plan Benefit check(s) and fax copies to Zurich's Medical Stop Loss Claims Department as confirmation that the check(s) have been released to the corresponding provider(s).
- Zurich must receive Proof of Loss for Specific Advance Funding requests on or before the last day of the Specific Benefit Period. Any claim reimbursement requests submitted after that date must be Paid and fully funded by the Policyholder.

In order to be eligible for Specific Advance Funding, the following will apply:

- The Specific claim must be in compliance with all other terms and conditions of the Stop Loss Insurance Policy issued.
- The Policyholder must have Paid and fully funded all Plan Benefits up to the Specific Deductible Amount.
- The Policyholder's premium payments must be current.
- The Stop Loss Insurance Policy must be in force. Requests made after the Policy has terminated will be deemed not Paid and will not be eligible for reimbursement.

### **EZ Claims - Specific Claim Submission Guidelines And Criteria**

Zurich is pleased to offer EZ Claims, also known as "low documentation," Specific claim submission to our Partner TPAs. EZ Claims, or "low doc," is Zurich's innovative program for saving time, money and effort in submitting Specific claims for reimbursement. With the EZ Claims program, you need only submit a detailed paid claims report and claim eligibility documentation. There is no need to send Provider Bills and EOBs.

Approval for submitting EZ Claims is granted when certain standards and criteria are met and are determined on an individual basis with our Partner TPAs. Basic criteria are:

- Satisfactory onsite TPA audit has been performed by Zurich granting approval for the EZ Claims program.
- Timely submission of Notification of potential catastrophic claims, or claims at 50% of the Specific Deductible.
- Desk audit of Specific claims submitted over a period of time has shown an error rate of less than 5%.

- Corrections of any errors can be made easily without reference to provider bills.
- Automated claims adjudication system, which can determine; covered benefits, benefits payable, calculate reasonable and customary fees, verify eligibility, check for duplicate claims, flag for Pre-Ex and COB, is able to sort by incurred and paid dates and is adjusted for voids/refunds/adjustments.
- Ability to produce a single report, which contains the following information:
 

✓ Employee Name	✓ Total Billed Amount(s)
✓ Claimant Name	✓ Ineligible Amount(s)
✓ Incurred Date(s)	✓ Deductible(s) and Co-Pay(s)
✓ Provider Name(s)	✓ Benefit(s) Paid
✓ Service Code(s)	✓ Date(s) Paid
✓ Diagnosis Code(s)	✓ Check Number(s)

With Zurich's EZ Claims program, we perform periodic onsite audits to verify a continuing accuracy rate of 95% or higher for Specific claim submissions. This efficient way of submitting Specific claims can dramatically reduce costs and simplify work for our Partner TPAs.

### **Electronic Claim Filing**

In conjunction with the EZ Claims program, Zurich is prepared to accept electronic claim filing from our Partner TPAs. Zurich is flexible in accepting your EZ Claims Specific claim submissions electronically and will work with you to custom tailor an electronic claim transaction that best suits your needs.

***For more information on Zurich's Value Added programs, please contact our Medical Stop Loss Claims Department.***

# ZURICH ADVANCED MEDICAL MANAGEMENT

## Case Management

Case management (CM) services provide ongoing management of serious illness or injury by coordinating appropriate cost-effective treatment. The Case Management Society of America (CMSA) defines case management as, “a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.”

Zurich encourages the utilization of CM services. All notifications of claim are reviewed to assess the need for implementation of case management services and a registered nurse (RN) and certified case manager (CCM) is available to discuss whether a claimant meets the criteria for referral to CM. Zurich will either work with your case manager(s), or refer the case to a Zurich preferred CM vendor for specialized management, when an individual has the potential to or has exceeded the Specific Deductible. Zurich’s preferred vendors have been chosen for their quality services and clinical specialties.

Zurich will pay for the cost of CM services when the case has been referred by us to one of our preferred vendors, or will consider CM costs as part of the Specific claim. In order to be eligible for reimbursement, Zurich requires ongoing communication, both verbal and written, with the case manager(s). The case management reports should include; claimant status, treatment plan, expected outcome, and results of negotiations, as well as case management short and long term goals. CM fees will not be reimbursed unless reports are included with the Specific claim submission.

## Hospital Bill Review

There was a time when significant savings could be achieved through preferred provider organization (PPO) network discounts. However, it seems, some participating providers have discovered and are taking advantage of loop holes in their PPO contracts, especially when the contract includes provisions which exempt participating providers from standard bill reviews for inappropriate coding combinations, also known as “unbundling” and “upcoding,” or reasonable and customary (R&C) allowances.

We have found that these questionable billing practices seem to be most prevalent under revenue codes 636 (drugs/detail code) and 275 (med/surg supplies and devices) and for illustrative purposes, here are two examples:

*An inpatient confinement of three (3) days and total charges billed in the amount of \$75,767.25 with a 20% PPO discount. Since the provider was participating in the PPO network, the claim was repriced and \$60,613.80 was paid to the provider. Based on the UB-92 and detailed itemized bill, the provider billed \$70,956.00, of the total charges, under revenue code 636 (drugs/detail code) for 36 units of Gammar IV at 5 grams per unit. The Average Wholesale Price (AWP), at the time, per 5 gram unit of Gammar IV was \$625.00 or \$22,500.00 for the 180 grams administered.*

*An inpatient confinement of thirteen (13) days and total charges billed in the amount of \$222,614.93 with a 35% PPO discount. Not a bad discount at all, but read on. Upon review of the UB-92, it was found that \$132,166.00 of the total charges was billed under revenue code 275 (med/surg supplies and devices), which represented 60% of the total charges billed. Upon contacting the third party administrator, it was discovered that not only did the provider accidentally double bill for the dual chamber pacemaker, the provider also unbundled the charges into three separate line items, even though they paid a single price of \$23,941.00 for the all-inclusive three piece system.*

Zurich encourages you to pre-screen all hospital bills, whether in or out-of-network, and refer them to us, or your preferred vendor, for further review and/or audit when:

- Ancillary charges represent 60% or more of the total charges billed, and/or

- One line item or revenue code represents 40% or more of the total charges billed.

Fees for hospital bill audits will be included as part of the Specific claim and in order to be eligible for reimbursement, Plan Benefits must exceed the Specific Deductible. If it is not possible to complete the audit within the Specific Benefit Period, we will consider providing an extension for the charges under review. You should request written acknowledgement from Zurich, which indicates we are aware of the outstanding audit and have agreed to provide an extension.

## **Dialysis Claims**

Dialysis is the process of cleaning the blood and removing excess fluid artificially with special equipment when the kidneys cease to function. There are two methods of dialysis: peritoneal and hemo. Both treatments eliminate toxic substances that would otherwise accumulate in the body and it also helps control blood pressure. Dialysis is not a cure for permanent kidney failure but for people with chronic or end stage renal disease (ESRD) it is a lifesaving treatment and often an interim step before kidney transplant.

Billed charges for dialysis claims can total anywhere from \$5,000 to \$40,000 per month, with some charges exceeding \$70,000 per month. Managing dialysis claims remains a challenge since dialysis providers rarely participate in PPO networks. While most dialysis providers are willing to give a 5% to 15% discount off billed charges, rarely will the self-funded group health plan achieve any real savings, since the billed charges most often exceed the reasonable and customary (R&C) allowance for the services rendered.

Although most Plans include language to support reimbursement of dialysis claims at the R&C allowable rate, many do not use this option. Additionally, there are a growing number of patients in need of dialysis and all signs indicate continued growth in this area of healthcare. Dialysis claims can be devastating to a self-funded group health plan without proper cost containment. Managing these claims, while providing quality cost effective care to the patient, remains a challenge. Zurich is committed to establishing a program that will assist in this challenge.

Since individuals receiving dialysis for the treatment of end stage renal disease (ESRD) are eligible for both Medicare Parts A and B, it is imperative to this discussion to review the basics of this federally funded program, highlights of which are included here:

- Medicare coverage usually starts the fourth (4<sup>th</sup>) month of dialysis treatments. For instance, if a patient started dialysis treatments anytime in July, Medicare Part A coverage would start on October 1. The same holds true if the patient enrolls in Medicare Part B, which is optional.
- Medicare coverage is secondary to the employer group health plan, when the employer has 100 or more employees, for a 30-month coordination period, which usually begins the fourth (4<sup>th</sup>) month of dialysis treatments. This means that if the self-funded group health plan does not pay 100% of the health care bills during the 30-month coordination period, Medicare may pay for the remaining expenses.
- Medicare coverage can start as early as the first (1<sup>st</sup>) month of dialysis, if the patient chooses home dialysis and receives training in a Medicare approved training facility. Medicare would still be secondary to the self-funded group health plan but the coordination period begins earlier.
- Medicare coverage includes Part A and Part B benefits:
  - **Medicare Part A** covers:
    - ◆ **Inpatient dialysis treatments** (if you are admitted to a hospital for special care)
  - **Medicare Part B** covers:
    - ◆ **Outpatient dialysis treatments** (when you get treatments in any Medicare-approved dialysis facility)
    - ◆ **Self-dialysis training** (includes instruction for you and for the person helping you with your home dialysis treatments)
    - ◆ **Home dialysis equipment and supplies** (like alcohol, wipes, sterile drapes, rubber gloves, and scissors)

- ◆ **Certain home support services** (may include visits by trained hospital or dialysis facility workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply)
  - ◆ **Certain drugs for home dialysis**, such as:
    - heparin,
    - the antidote for heparin when medically necessary,
    - topical anesthetics, and
    - Epogen or Epoetin alfa.
  - ◆ **Outpatient doctors' services**
  - ◆ **Most other services and supplies that are a part of dialysis, e.g., laboratory tests**
- ESRD patients can enroll in Medicare Part A & B at their local Social Security Administration office.

*Zurich encourages the claims administrator or case manager(s) to provide information regarding Medicare benefits to any patient with ESRD so they are well informed about these benefits. It is particularly important to explain the benefit of adopting Part B coverage. The insured will need to pay a nominal monthly premium to Medicare in order to maintain Part B coverage.*

- If the claims administrator pays dialysis claims according to R&C allowances and the patient has Medicare Part B coverage, the dialysis provider should bill Medicare for the balance, not the patient.

Zurich will assist and act as a resource in the management of dialysis claims. We can refer dialysis claims to quality independent vendors who will either negotiate directly with out-of-network providers to obtain deeper discounts, or apply R&C allowances based on a thorough review of the actual billed charges.

**For more information about Medicare Coverage of Kidney Dialysis and Kidney Transplant Services, please visit [www.medicare.gov](http://www.medicare.gov).**

## **Oncology Claims**

Cancer treatment is becoming more and more difficult to manage. New protocols are being developed and the United States Food and Drug Administration (FDA) is frequently approving new drugs for different types and stages of cancer. In addition, doctors are often prescribing drugs "off label" for treatment with drugs not approved for the particular cancer diagnosis. Many of the new chemotherapeutic drugs and biologics are very expensive and in many cases, the length of treatment is prolonged to maintain remission. Initial treatment protocols may achieve remission for a patient but there may be second and third line treatments to offer patients that extend the length of treatment as well as increasing the overall cost of treatment. The good news is that many cancer patients are achieving remission and extension of life not possible prior to these advancements in treatment. Cancer treatment is often given in the outpatient setting and pre-certification of outpatient care is not required by many Plans. As a result, Claims Administrators may be unaware of a cancer patient until the large claims are submitted. All of these factors lend to the difficulty in managing complex oncology claims.

The key to effective management of complex oncology claims is in early identification and implementation of appropriate care management. We encourage self-funded group health plans to review their Plan Documents and/or Summary Plan Descriptions and consider adding a pre-certification or pre-authorization requirement for outpatient cancer care. This will then allow for earlier identification of the cancer patient and earlier intervention by case management to assist in coordinating appropriate services. Patients with an oncology diagnosis who are referred to specialized oncology care management programs, which may include physician oversight, will benefit from improved quality of care. The Plan will also benefit as it realizes an increase in cost containment.

Zurich will assist and act as a resource in the management of oncology claims. We can refer oncology claims to quality independent vendors who may provide Specialized Cancer Case Management, peer review of treatment protocols, access to Oncology Centers of Excellence Network, claims audits, and/or negotiate discounts.

## **Neonates**

Premature or severely ill neonates present a challenge because of the complex care needs and their associated costs. According to the Self-Insurance Institute of America, Inc. (SIIA) neonatal claims represent one-third (1/3) of all reinsurance dollars paid. Treatment of high-risk newborns is a lengthy process that may take months to years and requires large amounts of family and monetary resources. For this reason, it is of utmost importance that cost containment efforts used to manage these complex cases be performed in a professional and compassionate manner.

To meet the challenge of managing these cases, Zurich has contracted with a preferred vendor who specializes in care management solutions for medically complex newborns. Zurich's Neonatal Care Management program offers access to a team of experts who are specialists in the care of premature babies and who will oversee and coordinate the unique care needs of this population

To implement Zurich's Neonatal Care Management program, please contact us as soon as you learn of a premature or ill newborn. Here are referral guidelines to consider:

- Infants born at less than 34 weeks gestation
- Infants weighing less than 1500 Gms (3.3lbs)
- Infants requiring ventilation (premature or full-term)
- Infants with complex congenital anomalies, including:
  - Congenital heart disease
  - Defects of gastrointestinal tract
  - Neurological defects
  - Severe respiratory distress
  - Other potential complications of newborns
  - Requiring continued treatment in a post-acute facility

Zurich will coordinate referral to our preferred vendor to implement Zurich's Neonatal Care Management program and their specialized care management staff will either provide primary case management or act in consultation with your case manager(s). As an added value, these services are provided at no additional cost when initiated by Zurich.

## **Enhanced Transplant Coverage**

Organ transplants are lifesaving procedures for individuals with end stage disease. Peripheral stem cell or bone marrow transplants are performed to treat individuals with cancer, inherited blood diseases, or diseases of the immune system. Recognizing the importance of promoting and assisting in the delivery of quality cost-effective treatment, Zurich has developed a unique Enhanced Transplant Coverage (ETC) program, which offers access to a renowned transplant network developed and administered by INTERLINK Health Services (INTERLINK). The ETC program affords each transplant candidate with the best possible treatment option by making available a national "transplant centers of excellence." Each transplant center of excellence is chosen based upon the types of transplants performed, patient outcomes, and the quality of the transplant surgical teams. Each transplant center of excellence within INTERLINK's network is subject to stringent credentialing and annual quality reviews to ensure continued excellence.

Transplant candidates should be referred to a transplant case manager with the specific expertise and experience to manage these complex cases. As an added resource, INTERLINK has case managers available to assist your case manager(s) in efficiently and effectively managing the transplant candidate's needs from the initial evaluation through post-transplant care.

As a value-added benefit to the Plan, Zurich will reduce the Specific Deductible by \$10,000.00, when an individual receives a transplant at an INTERLINK network transplant center of excellence and the eligible Plan Benefits exceed the Policyholder's Specific Deductible. Access to the ETC program is available at no additional cost.

It is important to notify Zurich of potential transplant candidates so that we can assist in coordinating access to the INTERLINK network, as well as ensure that the Plan and the transplant candidate receive the additional benefits available as a result of their participation in the Enhanced Transplant Coverage program.

**For a complete listing of each transplant center of excellence participating in the ETC program, please visit [www.interlinkhealth.com](http://www.interlinkhealth.com).**

## **Trauma**

Trauma is defined as bodily injury or shock caused by an accident, an unanticipated event leading to injury. By its very nature, injury or trauma caused by an accident is treated as an emergency. The trauma patient's management frequently begins at the accident site, continues with acute care in the hospital, and is often followed by a period of rehabilitation, either inpatient or outpatient.

There are many factors of concern when an individual sustains a traumatic injury. First and foremost is the importance of receiving quality care for the physical injury. Equally important is having the patient assessed for any psychological trauma resulting from such injuries.

Zurich believes that managing care involves not only managing cost but is also about helping to ensure the injured person is receiving quality care and assisting them in their rehabilitation to achieve the best possible outcomes. With this goal in mind, Zurich can provide specialized case management services by nurses experienced in managing complex trauma cases or can act as a resource to your existing case management program.

Please notify Zurich of any individuals with traumatic injuries so that case management needs can be assessed and implemented appropriately. As an added value, access to specialized case management is provided at no additional cost.

## **Prompt Payment Discounts**

Since PPO discounts do not always result in the level of savings previously achieved, another alternative is to try and negotiate a prompt pay discount in addition to the PPO discount. Providers may be willing to negotiate further in order to ensure timely recovery of their receivables. Negotiating prompt payment discounts has demonstrated Plan savings equal to or greater than those found through the standard PPO contract. We encourage you to pursue these negotiations as actively as possible.

## **Out-of-Network Provider Negotiation**

Prospective and retrospective bill reviews by a vendor can be an effective way to negotiate fees with out-of-network providers. Significant savings can be achieved through the negotiation of hospital fees, physician fees, home care, pharmacy, and durable medical equipment. Vendors of these services normally charge a percentage of savings averaging 30% or less. We recommend negotiating a maximum fee or "cap", which is reasonable to the service being provided, i.e., 25% to 30% of savings up to a maximum fee of \$5,000.00. Vendors do not normally charge if they are unsuccessful in negotiations.

## **Subrogation**

All efforts should be made to investigate possible third party recovery for injuries or illnesses caused by accidents. Any Plan Benefits exceeding the Specific Deductible with potential for recovery will be referred to our vendor for subrogation management to represent Zurich's and the Policyholder's interest. We will work with the Plan Administrator and coordinate with their subrogation recovery efforts.

## **Contractual Changes**

Zurich is aware that at times, consideration should be given to certain claim situations where a service not covered under the Plan would provide Medically Necessary and Appropriate treatment while replacing a more expensive covered service. For example, confinement in a rehabilitation facility may not be covered by the Plan but may provide quality, medically approved care, at less cost than continued acute care. This type of contractual change

would make good sense, as it would not only be a cost effective alternative for both the Plan and Zurich, but the Plan Participant would continue to receive the quality health care they deserve.

When requesting a contractual change, the plan administrator must verify that the service is medically necessary, not for custodial care or assistance in activities of daily living and is for active medical treatment provided by clinically licensed professionals. A specific treatment plan should be obtained from the treating physician and should include: recommended treatment plan; expected length of treatment; expected outcome; provide cost comparison of requested services vs. alternative options; and confirm Medical Necessity and Appropriateness of the proposed service. Since various options and resources are available for continued treatment, comparing options helps to determine appropriateness and cost effectiveness. The plan administrator, in conjunction with a case manager, should obtain and compare options from various resources, inpatient and outpatient, to aid in the review and/or approval of the request for a contractual change in the Plan and medical stop loss insurance Policy.

Our goal is to help ensure the most appropriate care for the patient, while keeping in mind that the plan administrator, as the fiduciary, must make all benefit decisions in the interest of all Plan participants.

*In today's competitive medical market, it is important to utilize all cost containment strategies available to us and our objective is to work cooperatively with you to achieve the most cost effective outcome without sacrificing the quality of care.*

*Our goal is to encourage, promote, and make every effort possible to provide access to quality cost-effective health care. Please join us in our efforts to ensure that each Plan participant receives the quality healthcare they deserve, while preserving the Plan's assets, simply by notifying us of all potentially catastrophic claims so that we can implement the most appropriate Zurich Advanced Medical Management program.*

*For more information on any of the above Zurich Advanced Medical Management programs, please contact one of our Case Managers at 508.808.6516 or 631.845.2315.*

# **PREMIUM REPORTING AND REMITTANCE**

## **Monthly Premium Reporting**

Premium reporting forms are provided for your convenience to report monthly enrollment and calculate premium payments due. These forms are pre-printed with the name of the Policyholder, Third Party Administrator, Policy Period, coverage types, and rates by which premium due should be calculated.

The initial premium is due on the effective date of each policy at Zurich's office, or to our designated representative. Subsequent premium payments are due in advance on the first (1<sup>st</sup>) day of each month at Zurich's office, or to our designated representative. A grace period of thirty-one (31) days shall be allowed for the payment of each premium after the first premium payment. If payments are not received by the thirty-first (31<sup>st</sup>) of the month, all coverage automatically terminates as of the premium due date. All payments received by our representative (TPA/Broker) are due and payable at Zurich's office within ten (10) days of the payment due date. If payment is not received within this period, a late fee will be assessed in accordance with the terms in section 2D of the producer agreement.

Stop Loss premium due is calculated by multiplying the rate shown by the number of enrollees for the current month. Combine the total amount due for the current month and the amount due or the amount to be credited for adjustments. Commissions may be calculated and deducted and net premium submitted, or gross premium may be paid and commission checks will be paid monthly to the broker of record.

All premium payments should be made payable to Zurich North America. The payment and corresponding premium report should be submitted to the following address:

**Zurich North America  
3061 Paysphere Circle  
Chicago, Illinois 60674**

*If you have any questions concerning coverage, rates, premium to be paid, or to request a supply of pre-printed forms, please contact our Premium & Accounting Department.*

# MONTHLY PREMIUM REPORTING AND REMITTANCE FORM

Policyholder: \_\_\_\_\_

Policy Number: \_\_\_\_\_

TPA: \_\_\_\_\_

Policy Period: \_\_\_\_\_ For the Month of: \_\_\_\_\_

Coverage	CURRENT MONTH			ADJUSTMENTS			Gross Due	COMMISSION		Amount Remitted
	Rate	Lives	Amount Due	Rate	Lives	Amount Due		%	Amount	
Single Rate	\$00.00							00.00%		
Family Rate	\$00.00							00.00%		
Other Specific	\$00.00							00.00%		
Other Specific	\$00.00							00.00%		
Aggregate	\$00.00							00.00%		
Other	\$00.00							00.00%		
Sub Total:										
Other Adjustment(s), please explain:										
TOTAL										

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Telephone: \_\_\_\_\_

Mail this Form with Premium to: **Zurich North America**  
**3061 Paysphere Circle**  
**Chicago, Illinois 60674**

Premium Payments: Premiums are due in advance on the first (1<sup>st</sup>) of each month. If premium payments are not received by the thirtieth (30<sup>th</sup>) of the month, all coverage automatically terminates as of the premium due date.

**THIS FORM MUST BE RETURNED WITH THE MONTHLY PREMIUM PAYMENT**

## STOP LOSS POLICY DEFINITIONS

**ANNUAL AGGREGATE DEDUCTIBLE** as shown in the SCHEDULE OF STOP LOSS INSURANCE for any one **Policy Period** means the greater of:

1. The cumulative monthly total of **Covered Units** multiplied by the Monthly Aggregate **Deductible** Factors; or
2. The Minimum **Annual Aggregate Deductible**.

**BENEFIT PERIOD** means the period of time in which **Plan Benefits** must be **Incurred** by the **Covered Person** and **Paid** by the **Plan** to be eligible for reimbursement under this **Policy**. This period does not alter the **Policy** effective date and **Policy Period**, nor does it waive the eligibility requirements of this **Policy**.

**COMPANY** means the Zurich Company issuing this **Policy**.

**COVERED BENEFITS** means the benefits provided for **Covered Persons** by the **Plan** as defined in the **Policy**.

**COVERED PERSON** means any eligible individual entitled to benefits under the **Policyholder's Plan**.

**COVERED UNIT(S)** for the purposes of determining the premiums payable or the **Annual Aggregate Deductible** means the following:

1. Employee; or
2. Employee with dependents; or
3. Such other defined unit as agreed between the **Company** and the **Policyholder**.

**DEDUCTIBLE(S)** means the Specific **Deductible(s)**, or Aggregate **Deductible(s)**, as shown in the SCHEDULE OF STOP LOSS INSURANCE.

**ELIGIBLE CLAIM EXPENSE(S)** means **Plan Benefits** which are **Incurred** by a **Covered Person** under the **Plan(s)** and for which benefits have been **Paid** by the **Policyholder** in accordance with the terms of the **Plan(s)** on the Claims Basis shown in the SCHEDULE OF STOP LOSS INSURANCE. **Eligible Claim Expenses** which are covered under the terms of the **Plan(s)**, **Paid** by the **Policyholder** and not excluded under the terms of this **Policy** shall be included in the calculation of the reimbursements payable under this **Policy** after the **Deductible(s)** of this **Policy** has been satisfied.

**EXPERIMENTAL OR INVESTIGATIONAL TREATMENT** means a treatment, procedure, service, device, or drug (treatment) which will be considered to be experimental or investigational if:

1. The treatment has not been approved by the United States Food and Drug Administration (FDA) at the time the treatment is provided; or
2. The treatment is identified as a Phase I, II, III, or IV clinical trial or under study to determine its maximum tolerated dose, its safety, its efficacy, or its toxicity as compared with the standard means of treatment or diagnosis; or
3. The treatment is governed by a written protocol that references determinations of safety, toxicity and/or efficacy in comparison to conventional alternatives and/or has been approved or is subject to the approval by an Institutional Review Board (IRB) or the appropriate committee of the provider institution; or
4. The treatment is being provided subject to the **Covered Person's** execution of an informed consent that references determinations of safety, toxicity or efficacy in comparison to conventional alternatives; or
5. The predominant opinion of medical experts as expressed in published peer-reviewed literature is that further research is necessary in order to determine safety, toxicity, or efficacy in comparison to conventional alternatives.

**Experimental or Investigational Treatment** will be considered an **Eligible Claim Expense** under this **Policy** when the following criteria are met:

1. Treatment protocol identified as a Phase II, III, or IV clinical trial, or the equivalent, will be considered an **Eligible Claim Expense** when all of the following criteria are met:
  - (a) There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative; and
  - (b) The clinical trial is subject to review by an IRB and has been approved by the governing local IRB; and

- (c) The **Covered Person** has executed an informed consent, which has been approved by the IRB; and
- (d) The treatment protocol has been approved by one or more of the following organizations, the treatment is being provided within one of the centers designated by the clinical trial sponsor as a participating center and is being provided under the direction of the principal investigator at that center:
  - i. National Institutes of Health (NIH).
  - ii. NIH cooperative group or center.
  - iii. United States Department of Health and Human Services (HHS), which includes the Center for Medicare and Medicaid Services (CMS).
  - iv. FDA.
  - v. United States Department of Defense.
  - vi. United States Department of Veterans Affairs; or
- 2. Treatment utilizing drugs previously approved by the FDA for non-approved indications when all of the following criteria are met:
  - (a) There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative.
  - (b) The provider has complied with all of the IRB's requirements for providing the treatment; or
- 3. Treatment utilizing Investigator sponsored trials which are done in accordance with IRB approved protocols in an academic medical center that is a recipient of NIH grants and which meets all of the criteria in 1.(a) through 1.(d) above. Investigator sponsored trials will be considered on a case-by-case basis. Investigator or drug company sponsored trials in which there is no academic medical center involvement and where the principal investigator is not affiliated with an academic medical center will not be considered for coverage except by recommendation of an independent third party reviewer.

To determine if any treatment meets the standards for coverage, the **Company** reserves the right to obtain an independent third party review.

**INCURRED** means as follows:

- 1. with respect to services, the date on which the services are rendered to the **Covered Person**; or
- 2. with respect to supplies, the date on which the supplies are given to the **Covered Person**.

**LIFETIME LIMIT OF LIABILITY** means the amount shown in the SCHEDULE OF STOP LOSS INSURANCE and is the maximum amount the **Company** will reimburse the **Policyholder** with respect to any **Covered Person(s)** under this **Policy** issued by the **Company** but not more than the Lifetime Maximum specified in the **Plan**.

**MEDICALLY NECESSARY AND APPROPRIATE** means that a service, supply or drug is provided by a recognized provider, is accepted by the United States Food and Drug Administration and is generally accepted as the standard of care for the control or cure of the illness or injury being treated by physicians practicing in the same or related specialty field.

**PAID** means:

- 1. the draft or check for payment of **Plan Benefits** is issued and released by the **Policyholder** by mail or other means or funds are transmitted electronically by the plan supervisor to the payee; and
- 2. sufficient funds are available:
  - a. in the account from which the draft or check is issued for a non-zero balance account or from the account from which the funds are electronically transmitted; or
  - b. to permit the draft or check to be honored in a zero-balance account.

**PERCENTAGE REIMBURSABLE** means the percentage at which the **Company** will consider **Plan Benefits** under this **Policy**.

**PLAN(S)** means the **Policyholder's** self-funded benefit plan(s) as described in its **Plan(s)** document as required by either Federal or state law. A copy of the **Plan(s)** document is attached to this **Policy** for the purpose of determining the **Company's** liability under this **Policy**.

**PLAN BENEFITS** means **Eligible Claim Expenses** which are **Incurred** by a **Covered Person** under the **Plan(s)** and for which benefits have been **Paid** by the **Policyholder** in accordance with the terms of the **Plan(s)** on the Claim Basis shown in the SCHEDULE OF STOP LOSS INSURANCE. **Plan Benefits** which are covered under the terms of the **Plan(s)**, **Paid** by the **Policyholder** and not excluded under the terms of this **Policy** shall be included in the calculation of the reimbursements payable under this **Policy** after the **Deductible(s)** of this **Policy** has been satisfied.

**POLICY** means this Stop Loss Policy.

**POLICYHOLDER** means the applicant named in the [Renewal] Application for Stop Loss Insurance Coverage.

**POLICY PERIOD** means the dates shown in the SCHEDULE OF STOP LOSS INSURANCE.

**PROOF OF LOSS** means receipt of a complete claim form, satisfactory to the **Company**, and other supporting documentation required by the **Company**.

**PROVIDER NETWORK(S)** means a network(s) or similar organization consisting of selected health care providers (e.g., physicians and hospitals) that provide services or supplies to a **Covered Person** at a discounted or pre-determined price.

**THIRD PARTY ADMINISTRATOR** means a firm or person which has been retained by the **Policyholder** to pay claims and/or provide other administrative services on behalf of the **Policyholder**.

**WAR** means expenses resulting from war or any act of war declared or undeclared, whether civil or international, and any substantial armed conflict between organized government forces of a military nature.