LifeWise Assurance Company
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Claims Reimbursement and Reporting Instructions

Specific Stop Loss Claim Reimbursement

A reimbursement request is submitted when an eligible claimant exceeds the Specific deductible amount of the Stop Loss contract. As the plan administrator, it is your responsibility to provide LifeWise Assurance Company with an initial notice of claim and a request for reimbursement to receive payment for a claim that has reached the Specific deductible.

Initial notification must be given for an individual claimant at the earliest of:

- Attaining 50% of the Specific deductible (Form 024852)
- Incurring a claim with a potentially catastrophic diagnosis as specified in the ICD Codes or large claim identifiers on the Potential High Dollar Claim Notification (Form 024850)
- Pre-certifying a hospital confinement with a potentially catastrophic diagnosis

Requesting a reimbursement requires specific line item detailed information. Requesting a reimbursement requires specific line item detailed information. The Specific Stop Loss Claim Form (024851) should be used for both the initial notice and request for reimbursement.

A request for reimbursement must be made once an individual claimant's benefit payments exceed the Specific deductible during the contract period. Send a completed Specific Stop Loss Claim Form (024851) along with the following information:

1. The claimant's payment history that includes the following data (Excel format preferred):

- Employee Social Security Number
- Employee Name
- Claimant Name
- Claimant Date of Birth
- Claimant Relationship to Employee
- ICD Diagnosis Code(s)
- Incurred Dates (from and through)
- Type of Service (CPT/Revenue codes)
- Charged Amount
- Allowed Amount
- Coinsurance/Copay/Deductible Amounts
- Total Paid Amount and Payee Name
- Date Paid
- Check Number
- Provider of Service
- Place of Service

2. Proof of eligibility and enrollment verification

3. Supporting documentation verifying eligibility of the claim (continuation of coverage documentation, COBRA election form and proof of COBRA premium payments, Medicare information with effective dates, other insurance information, etc.)

The omission of any of the above information may result in a delay in processing your request for reimbursement. Reimbursement will be issued based upon the results of a detailed claim examination. Any claim or benefit questions will be identified and resolved as quickly as possible during the examination process.

Send claims and all supporting documents to LWACStopLossClaims@LifeWiseAC.com or via U.S. Mail to the address on the claim form.

Aggregate Stop Loss Claim Reimbursement

LifeWise Assurance Company requires an Aggregate Report at the end of each month for each group with Aggregate coverage. To help make this process easier, a report template has been developed that will auto calculate some of the required data. The completed report should be send to the Stop Loss Claims department indicated on the report template. The enrollment number of insured units on the report should match the number of inforce lives provided on the group's corresponding monthly premium statement.

Aggregate Report/Template Design

Maximum Aggregate Eligible Claim Expenses is the per participant amount as specified in the policy.

Minimum Aggregate Deductible as specified in the policy. This amount must be entered in the space provided for auto calculations

Month/Year as determined by the policy. Enter the month and year of the first month of the policy (acceptable formats: January 2011, Jan 2011, 01/2011). Subsequent months will automatically populate.

Tier Type is the definition of the insured unit. Enter the tier names/descriptions (Single, Single + Spouse, Family, etc.) for the first coverage month – subsequent months will populate automatically.

Number of Units is the number of insured units per tier. Enter the number of units per tier each month.

Factor Dollar Amount is the expected claim amount per covered unit. Enter the applicable Aggregate Monthly Deductible Amount per Covered Unit as shown in the policy.

Aggregate Deductible by Tier is the expected claim amount per tier (the number of covered units multiplied by the aggregate monthly deductible Factor). This amount is automatically calculated in the report template.

Cumulative Aggregate Deductible is the cumulative sum of current month's aggregate deductible amount (sum of the Aggregate Deductible by Tier) and the prior month(s) aggregate deductible amount(s). This amount is automatically calculated in the report template.

Pro-rated Minimum Aggregate Deductible is the year-to-date minimum attachment point (Minimum Aggregate Deductible divided by 12 and multiplied by the number of coverage months). This amount is automatically calculated in the report template.

Gross Claims Paid is the total claim payments covered by the Reimbursement Agreement. Enter the monthly total claim amount by coverage in the appropriate columns (column headers in the template can be changed to correspond with the Reimbursement Agreement).
Total Claims Paid is the total of all the covered claim payments. This amount is automatically calculated in the report template.

*At the end of the contract period, if the Claim Total exceeds the Cumulative Aggregate Deductible, an **Aggregate Claim Form** (024849) must be submitted along with all required proofs for reimbursement. An audit will be performed prior to any reimbursement.*

Amount Exceeding Maximum Aggregate Eligible Expense is the total sum of the amount(s) by which each claimant's claims exceeded the Maximum Aggregate Eligible Claim Expense. Amounts exceeding the Maximum Eligible Aggregate Claim Expense should be listed by claimant on the Max. Eligible Expense Worksheet" tab in the report template.

FRAUD NOTICE

Arizona: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation on or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a Class 2 misdemeanor.

California: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

All other states: Any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.