

# Stop Loss Administration Manual

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# Thank you for your trust in Great American Employer Health Solutions.

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Your expertise and support are essential to helping employers and their teams thrive. We appreciate all the **great** work you do. If you ever have questions or need assistance, please reach out to our team.

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Thank you for choosing Great American Employer Health Solutions as your stop loss provider. We value the opportunity to work alongside you and are committed to building strong, transparent relationships that support exceptional outcomes for employers and their employees. Our goal is to ensure alignment, reduce uncertainty and create a seamless working experience. We look forward to working with you!

All Third Party Administrator (TPA) and intermediary personnel should become familiar with the requirements and processes in this manual to gain approval by Great American Employer Health Solutions and facilitate efficient administration of the medical stop loss policy, including the premium and claims handling process for the benefit of our mutual client, the Employer.

**The purpose of this manual is to provide information and instructions for administering the medical stop loss policies we offer. This includes:**

1. The timely disbursement of premium payments.
2. Regularly scheduled reporting.
3. Notifications of potentially catastrophic claims.
4. Reimbursement requests for specific and aggregate stop loss claims, including Specific Advance Funding and Aggregate Monthly Accommodation.

Please refer to the Stop Loss Insurance Policy (“Policy”) when you have questions about coverage. This document is provided as a guide and in no way binds Great American Insurance Company or the Employer in any matter that differs from the coverage expressly stated within the Policy. In the event of a conflict between this document and the Policy, the language of the Policy will take precedence and control.

**Key Contacts Quick Reference**

Consolidated directory of contacts and submission addresses referenced throughout this manual.

Purpose	Contact	Notes
Claims submissions & reports	<a href="mailto:EHSclaims@gaig.com">EHSclaims@gaig.com</a>	Specific claim forms, monthly aggregate reports, large claim notifications, supplemental submissions, and claims appeals.
Finance & premium remittance	<a href="mailto:EHSfinance@gaig.com">EHSfinance@gaig.com</a>	Remittance Detail Reports for all invoiced and remitted premium payments from employers.
SPD & amendment submissions	<a href="mailto:EHSops@gaig.com">EHSops@gaig.com</a>	All program templates, signed SPDs, and amended or updated plan documents for employer accounts.
New business & sales	<a href="mailto:MSLsales@gaig.com">MSLsales@gaig.com</a>	General sales inquiries and questions not addressed by a designated account representative.

*This table is a summary reference only. Refer to the Stop Loss Insurance Policy for complete terms. In the event of any conflict, the Policy language controls.*

# TPA Approval Process

Before any policies can be issued, Great American Employer Health Solutions must approve TPAs that administer claims on behalf of Great American Employers.

**For a TPA to gain approval, the following items are required:**

1. Completed Great American Employer Health Solutions TPA Questionnaire, or similar. (Please include all required attachments)
2. Confirmation that the minimum reporting requirements can be met as outlined.
3. Confirmation that premium invoicing and payment remittance processes follow minimum requirements as outlined.
4. Great American Employer Health Solutions review of Summary Plan Descriptions for sign off.
5. Complete Underwriting Pricing Review.

Great American Employer Health Solutions will notify the TPA upon initial approval. The TPA will be responsible for providing updated E&O, Fidelity Bond and licensing and appointment information annually.

**NOTE:** Evidence of renewals (*E&O, Cyber Liability, Fidelity Bond, TPA & producer licenses*) will be required as appropriate. Failure to provide evidence of renewals may delay issuing policies or claim payments.

For any questions, please contact your designated account representative or [MSLsales@gaig.com](mailto:MSLsales@gaig.com).

# Administering the Policy

## Licensing and Appointment

All producers, agents/agencies and soliciting TPAs must be properly licensed and appointed (*as required by applicable law*) to solicit and market stop loss coverage. All producers who are signing the stop loss application must be properly licensed and appointed by Great American Insurance Company and sign a producer agreement.

### Procedures for Appointment Process

- Prior to signing the stop loss application, your account executive will notify Great American Insurance Company to send an Agency Onboarding Application to the producer email address.
- The producer must complete a background check. In addition the producer must complete the application online and provide all required information to complete the onboarding process.
- The producer agreement will be signed electronically as part of the onboarding process.

The stop loss carrier, Great American Insurance Company, will not pay commissions to producers.

## Premium and Eligibility

For Great American Insurance Company Medical Stop Loss Policies, the TPA will manage front-end monthly collection of the various plan costs. The TPA will remit the premium monthly to Great American Employer Health Solutions on the due date listed in the Policy. For level funded arrangements, the TPA must collect the Employer claims funds from the Employer monthly and deposit them in a bank account established for the benefit of (FBO) the Employer.

Through scheduled reporting, the TPA will provide Great American Employer Health Solutions with evidence that the Employer's monthly premiums and employer claims fund payments are current.

## Premium Remittance

Great American Employer Health Solutions will provide banking information upon a TPA's approval. Premium payments must be sent via ACH/Wire Transfer.

Great American Employer Health Solutions requires Remittance Detail Reports for all invoiced and remitted payments from Employers by the end of the grace period following the Premium Due Date. Premium is calculated for the complete month, and no prorating is allowed.

Remittance Detail Reports must include:

1. Employer Name, State, Policy Number, and Policy Effective Year;
2. Month for which Premium Remittance applies;
3. Number of covered units per tier (EE, ES, EC, EF);
4. Premium rates applicable to each tier;
5. Documentation on any retroactive adjustments, including number of units per tier and number of retroactive months (*Please note that retroactive adjustments are limited to 3 months without written exception*); and
6. Calculation of total monthly premium remitted.

Please send all reports to [EHSfinance@gaig.com](mailto:EHSfinance@gaig.com).

## Late Premium Procedures

Timely payment of the full initial premium is required for the Policy to take effect and timely payment of premium for each subsequent month during the Contract Period is required for the Policy to remain in force. The TPA should collect premium by the due date each month and submit the premium owed to Great American Insurance Company by the end of the grace period. If premium is not received by the 15th day following the end of the grace period, the Policy will be terminated as of the Premium Due Date and a notice of termination will be sent to the Employer.

Claims will not be paid until the full premium amount is paid and received each month. To avoid delays in claim processing, please remit premium as soon as possible. If a Policy terminates for any reason, premiums must be paid up to the date of termination.

Any reminder notifications Great American Employer Health Solutions sends are sent as a courtesy and are not required under the Policy. Acceptance of premium beyond the grace period is at the sole discretion of Great American Insurance Company and does not establish precedent for acceptance of future premiums received beyond the grace period.

## Retroactive Member Terminations

Adjustments can be applied retroactively for up to 90 days from the date Great American Employer Health Solutions is notified, provided the following conditions are met:

- 1. Claim Restrictions:** No claims can be processed or paid during this period.
- 2. Employer Deductible Requirements:** The group's calculated aggregate deductible must still meet the minimum requirement after terminations and refunds.
- 3. Enrollment Limits:** The retroactive termination does not result in a 15% reduction in enrollment from initial enrollment, or a 10% month-over-month decrease.

## Member Additions

The Employer or their designated TPA is responsible for determining eligibility and Qualifying Life Event verification (*if applicable*) within a standard 30-day enrollment period. If a member is added outside of the 30 day enrollment period, an Individual Health Questionnaire should be submitted. If this is not provided, it can result in delayed or denied claim payments. All retroactive additions are subject to underwriting approval.

Retroactive terminations or additions which do not meet the above criteria but have extenuating circumstances, may be referred to Great American Employer Health Solutions for consideration of exceptions with Great American Insurance Company's approval. Please send any exception requests to your designated account representative.

Claims will not be paid until the full premium amount is paid and received each month. To avoid delays in claim processing, please remit premium as soon as possible.

# Scheduled Reporting

Great American Employer Health Solutions requires the following reporting within thirty (30) days of the first Policy inception date to support the Policy administration.

## Monthly Reporting

Great American Employer Health Solutions requires monthly submission of detailed Aggregate Stop Loss Reports submitted no later than the 15th of the month following the month for which the report is being submitted (the “Reporting Month”). Monthly aggregate reporting assists in documenting and monitoring potential aggregate claims and supports an expeditious aggregate accommodation process.

### Monthly Aggregate Reporting must include all of the following:

- The number of Covered Units for each Covered Unit Tier, for each month of the Contract Period.
- The Monthly Aggregate Factors stated in the Policy for each Covered Unit Plan and Tier.
- Monthly Calculated aggregate and Year-to-Date Calculated aggregate.
- For each month of the Contract Period, Monthly and Year-to-Date Total Medical and Rx Claims Paid for each Covered Unit Tier Type.
- Monthly and Year-to-Date Aggregate Accommodations.
- Monthly and Year-to-Date Loss Ratios.

### Example: [Sample Monthly Aggregate Report](#)

Reports and any related questions must be submitted to [EHSclaims@gaig.com](mailto:EHSclaims@gaig.com).



## Potential Large Claim Notification

The TPA and/or Employer must notify Great American Employer Health Solutions of any incurred, pending, or paid claims expected to exceed the Specific Deductible or trigger the large claim notification requirements described below.

Great American Employer Health Solutions must be notified of potential large claims within 10 days of the Employer or its TPA receiving any information that a claim is potentially catastrophic. Initial notification must be provided in writing to Great American Employer Health Solutions in accordance with the Policy. Failure to give prompt notice, as defined by the Policy, may result in an adjustment of the reimbursement to the Employer to reflect any savings that could have been obtained if we had been given prompt notification.

Notifications must be sent via email to [EHSclaims@gaig.com](mailto:EHSclaims@gaig.com).

### Notification Requirements:

There are two ways to identify potentially large claims:

#### a) Trigger Diagnosis

The TPA must give immediate notification to Great American Employer Health Solutions as soon as a claimant is diagnosed with any of the trigger diagnoses listed in the Appendix to this manual.

Identification of a potential large claim could be made through:

1. A request for eligibility or benefit verification for a serious diagnosis;
2. The pre-admission certification process;
3. Utilization review; or
4. Large case management.

Such potential claims can also be identified by review of the claim and diagnosis when the claim is submitted for adjudication.

If pre-admission certification, utilization review or large case management is performed by a third-party, the TPA is responsible for advising the contracted medical management firm of the importance of receiving immediate notification of an admission, outpatient procedure or request for sub-acute care.

We adhere to the Self-Insurance Institute of American (SIIA) Endorsed ICD-10 Code List for identifying catastrophic diagnoses (*ICD-10 Trigger Diagnosis Codes*). In addition to the ICD-10 Code List, the following conditions are considered to be catastrophic losses and should be referred immediately to Great American Employer Health Solutions:

1. Transplants – liver, kidney, heart, lung, pancreas, bone marrow or any combinations.
2. Hospitalization request of fourteen (14) days or greater.
3. Trauma/Multiple Injuries.
4. Request for transfer to a rehabilitation facility.
5. Hyperalimentation (TPN).
6. Home IV antibiotic therapy.
7. High Risk Pregnancy, including multiple births.
8. Initiation of hemodialysis.
9. Home Health Care request of twenty (20) days or greater.

## b) Amount Paid

Written notice is required when a claim reaches 50% of the specific deductible or \$25,000, whichever is lesser, and within 10 days of the date of loss for which a claim is made (*or as soon as is reasonably possible as required for specific diagnoses*). Written proof of loss must be given to Great American Employer Health Solutions within ninety (90) days of such a loss. These benefits must have been paid both within the terms of the approved SPD and the excess loss insurance coverage in force.

Notification can be made using the Specific Notification Form. If this notification form is not used, an approved written or electronic notification must include the following information:

- Type of notification (*i.e., Trigger Diagnosis, 50% Notice, etc.*);
- The Employer name, Policy number, and contract period;
- The effective date of the Policy;
- The employee's name, date of birth, effective date for coverage, Member ID or other unique identification number;
- If the claimant is a dependent: their name, date of birth, and relationship to employee;
- Any other potentially applicable insurance;
- Primary diagnosis;
- Case Management notes including Prognosis and estimated additional Cost;
- Any pertinent information regarding claimant's condition (*pending transplant, hospital confinement, etc.*);
- Name and phone numbers for any nurse case manager(s);
- Claims amounts; paid, pending or denied;
- Specific deductible; and
- Total amount of self-funded claims paid to date.

The [Specific Notification Form](#) will help ensure all required information and attachments are submitted.

Great American Employer Health Solutions requires this information to properly reserve for future potential cost during the applicable Policy period.

We appreciate any additional details available, such as secondary diagnosis, prognosis, accident details, clinical information, or case management reports.

If, during our review, we believe we can assist in cost containment, we will contact you to discuss.

## Renewal Reporting

In addition to the reporting above, at month nine (9) of the Policy term, the TPA must submit the following to Great American Employer Health Solutions for each Policy.

- Updated Member level census (*plans, tiers, relationships and dependents included*);
- IBNR/Pended claim report (*including pended/denied or claims in process; must include person, paid amount, DOS, DOP, ICD, CPT, and drug name or NDC*);
- Medical and Rx transactional claims (*must include member name, paid amount, DOS, DOP, ICD, CPT, and drug name or NDC*). Must be inclusive of all claims for the current plan year, but ideally inception to date;
- Case Management/Medical Management notes (*if available*);
- Updates to program, including plan designs, TPA, PBM, or cost containment program, if applicable. Changes must be approved ahead of time;
- Savings analysis for any new program/vendor that is being considered; and
- All monthly and large claim notices should also be up to date at this time to ensure timely reissue proposal release.

This information will provide our underwriting teams with the necessary documentation to submit a timely reissue proposal for the renewal period.

If all required data is received on time, you can expect a reissue offer within 60 days prior to the annual effective date. There is no guarantee of renewal, as outlined in the Policy.

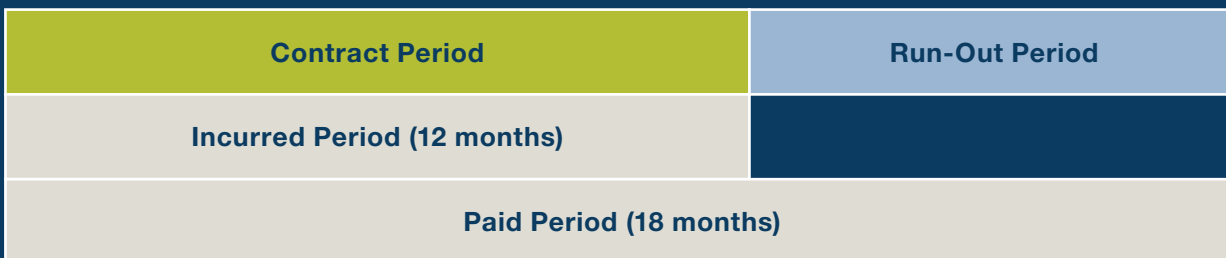
# Requests for Reimbursement

## Managing Within Contract Terms and Filing Timelines

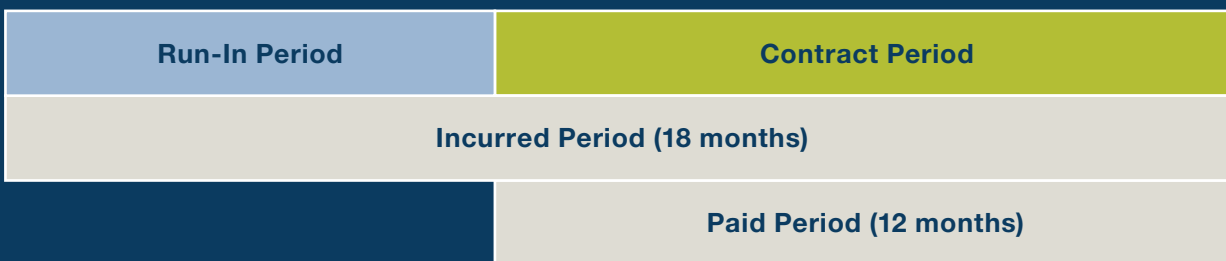
Claims must be **Incurred** and **Paid** within the terms of the Contract Basis in the Policy. Advance Reimbursement requests may be submitted throughout the Policy year according to the Advance Funding and Accommodation endorsements.

All claims must be submitted for reimbursement within 90 days of the **Paid** timeframe in the Policy. Any claims submitted after that period will be denied reimbursement.

**12/18:** Claims must be incurred in 12 month period, paid during the 18 month period (6 months of run-out)



**18/12:** Claims must be incurred in 18 month period, paid during the 12 month period (6 months of run-in)



*These are examples of contract terms for illustrative purposes only.*

## Specific Stop Loss Claims

Specific Stop Loss Coverage provides reimbursement to the Employer for claims paid in excess of the Specific Stop Loss Deductible per the Incurred and Paid Contract Bases in the Policy.

On a Traditional Stop Loss Policy, a Specific Stop Loss claim is eligible for submission as soon as the paid claims for a single Claimant exceeds the Specific Stop Loss Deductible.

Specific Claims must be submitted to Great American Employer Health Solutions within 90 days of the end of the coverage period. Any requests for reimbursement received after the last date for which a claim can be reimbursed under the terms of the Policy will be denied.

The [Specific Claim Form](#) is the preferred method to report a Specific Stop Loss Claim. All information on this form must be included in the submission. Once all required claim information has been received, determination will be made within thirty (30) calendar days.

**Initial Claim Submission** – The first claim submitted during the coverage period for an eligible individual whose incurred and paid charges have exceeded the specific deductible in the Policy.

**Subsequent Submission** – Also referred to as a Supplemental Submission. Any submission for the same claimant for the same Policy year submitted after the initial submission.

## Specific Claim Filing Guidelines

Please submit the [Specific Claim Form](#) completed, signed, and dated along with all required supporting documents via secure email to: [EHSclaims@gaig.com](mailto:EHSclaims@gaig.com).

## Subsequent Claim Filing Guidelines

The requirements for Subsequent Claims are the same as those of the Initial Claim Submission. If there have been no changes since the Initial or last Subsequent Claim submission, requirements related to proof of eligibility, continuation of coverage and coordination of benefits are waived.

## Advanced Funding for Specific Stop Loss Claims

Expedited reimbursement is available for Specific Stop Loss Claims. This option is available when the Advance Funding Endorsement is attached to the Policy, permitting the Employer to apply for specific stop loss reimbursement once the specific stop loss deductible is met.

Great American Employer Health Solutions must receive complete written notice requesting any advanced funding for a specific stop loss claim prior to thirty (30) days before the end of the contract period. Upon prior approval, level funded programs may submit requests for Advance Funding during the run-out period.

The following conditions must be satisfied when filing an advance funding request:

1. The Employer's premium payments must be current through the month in which the claim is submitted.
2. After the specific deductible for a covered person has been satisfied, the Employer must make additional claim payments of up to \$1,000.
3. Great American Employer Health Solutions will make subsequent reimbursements only after additional claim payments reach \$1,000 or every three months, whichever occurs first.
4. Claims submitted for advance funding must be fully processed according to the terms of the plan document and must be ready for payment.
5. Great American Employer Health Solutions will use normal audit procedures for all advance funding specific stop loss claims prior to making any payments.
6. You must release claim payment to the providers of care within five (5) business days of receiving our advance payment to you. Your payment will be considered a paid claim within the contract period provided the payments to providers are released within five (5) business days of receipt of the advance payment. If you do not pay the claims within five (5) business days, you must return the advance payment to Great American Employer Health Solutions.
7. Any portion of the advance funding not used to pay the claim, whether due to additional discounts or any other reason, must be returned to Great American Employer Health Solutions within five (5) business days of identification of the overpayment.
8. To be eligible for advance funding, the request must be received by Great American Employer Health Solutions prior to thirty (30) days before the end of the contract period, or run-out period, if later.

Failure to provide the requested information may impact the amount of reimbursement available.

The Plan is responsible for paying all eligible claim expenses prior to filing any reimbursement request.

## Aggregate Claims Reimbursement Request

An Aggregate Excess Loss Coverage provides for reimbursement to the Employer for Claims paid in Excess of the Calculated aggregate per the Contract Basis of the Policy.

Aggregate claims are filed after the Contract Period has expired and following any Run-Out Period when the total eligible claim expenses can be determined.

## Monthly Deductible Advance Reimbursement

The Monthly Deductible Advance Reimbursement Endorsement added to a Policy allows the Employer to receive interim Aggregate reimbursements during the Policy term rather than waiting until the end of the Contract Term. This provision is also called “Advance Aggregate Reimbursement” or “Monthly Aggregate Accommodation.”

For Policies including the Monthly Deductible Advance Reimbursement Endorsement, a request may be submitted during the Contract Period when the total eligible expenses to date exceed the Minimum Aggregate Deductible to date, or the actual calculated Aggregate, whichever is greater.

For Advance Aggregate Reimbursements to be made, all of the following conditions must be met:

1. The Minimum Monthly Aggregate (*calculated as 1/12th the Minimum Aggregate Deductible listed in the Policy*), **MUST** be reached prior to accommodations being made.
2. Great American Employer Health Solutions will make a monthly deductible advance reimbursement during the contract period when the covered expenses paid by the Employer during all prior contract months of the contract period exceed the sum of the monthly aggregate deductibles for the same contract months.
3. The TPA will calculate the monthly employer claims funds by multiplying the monthly census by tier by the Monthly Aggregate Factor set forth in the Policy. If the Employer claim fund amounts contributed by the Employer to date are less than the Minimum Annual Aggregate Deductible to date, the TPA must immediately notify the designated account executive.
4. Great American Employer Health Solutions will reimburse the Plan only after we receive a request for a Monthly Deductible Advance Reimbursement using the [Monthly Accommodation Claim Form](#).
5. We will not advance a monthly deductible advance reimbursement if the amount for which the Employer is eligible is less than \$1,000 in any given contract period.
6. If, at the end of the contract period, the sum of the monthly aggregate deductibles for all contract months in the contract period exceeds the total payments made by the Employer for covered expenses during the same contract months, you must repay any Monthly Deductible Advance Reimbursements requested within fifteen (15) days.
7. At the end of the contract period, Great American Employer Health Solutions reserves the right to review and audit TPA records for the purpose of making a final settlement of the account. If such an audit establishes that additional payments are due to the Employer, such payments will be made within five (5) days of completion of the audit. If such audit establishes that additional repayments are due to Great American Employer Health Solutions, such repayments must be made within fifteen (15) days of our request for repayment.
8. At any time during the Contract Period, when the cumulative advance reimbursement amount exceeds \$50,000, we reserve the right to request additional information, to review and to audit TPA records prior to releasing any additional monthly deductible advance reimbursements.

After the Contract Period has ended, the Employer must submit a full and complete aggregate claim submission to Great American Employer Health Solutions for a reconciliation to be completed. It is the TPA's responsibility to file Final Aggregate Claims for those Employers who have received Advance Reimbursement. Year End Aggregate Claims must be filed with Great American Employer Health Solutions within 90 days after the end of the time specified for payment of claims under the Policy per the Contract Basis. When filing a Year End Aggregate Claim, please refer to the [Year End Aggregate Claim Form](#) for required reports and documentation.

## Covered Expenses and Fees

Effective cost containment is a critical component of managing healthcare claims. Below is a summary of the types of fees that are eligible for reimbursement under the Policy.

### Savings Fees

Cost containment savings fees are reimbursable up to 25% of the savings, with a maximum reimbursement of \$50,000 per claimant per Policy year, provided the total claim exceeds the Specific Deductible. Cost containment vendors charging a savings fee should be approved in advance. Appropriate and complete backup is required for reimbursement.

### Large Case Management (LCM) Fees

Please note that fees associated with large case management may be eligible for reimbursement, limited to \$150 per hour. This is applicable when the total of claim payments plus the LCM fees exceeds the Specific Deductible, and provided that these fees are incurred and paid according to the Policy's terms. To facilitate the reimbursement process for LCM fees, kindly include copies of the LCM reports with your submission. Vendors charging case management fees should be approved in advance. Appropriate and complete backup, including case management notes and the invoice, is required for reimbursement.

### Reference-Based Pricing (RBP) Fees

As RBP programs can differ across vendors, it is important to inform us of the RBP vendor your plan is utilizing. We will then verify if the vendor is on our approved list and advise you on the eligibility of any related fees for reimbursement. Repricing fees are based on the difference between the billed amount and allowed amount of eligible charges. RBP fees are limited to no higher than 10% of total charge or actual charge, whichever is lower. Vendors should be approved in advance. Appropriate and complete claim submission backup, including the invoice, is required for reimbursement.

### State Surcharges

Certain states impose surcharges on inpatient and outpatient hospital services to fund various programs. Some of these claim related surcharges may be eligible for reimbursement under the Policy. Other capitated fees or PEPM assessments are not covered under the Policy.

### Subrogation

Vendors and subrogation fees should be approved in advance. See General Provisions Section and Policy for more information.



## Non-Reimbursable Fees

For clarity, the following fees are considered administrative or operational in nature and are not eligible for reimbursement under either the Specific or Aggregate stop loss coverage:

### Administrative Fees

This category includes fees for standard claims administrator responsibilities such as:

- Claims administrator-initiated peer to peer medical reviews;
- Medical record retrieval;
- Reasonable and customary (R&C) reviews;
- Experimental or investigational reviews;
- Administration of discount fees;
- PPO access fees;
- PBM access fees;
- Pay-for-Performance (P4P) fees; or
- Custodial care determinations.

### Capitated Rates

Fees billed on a flat per-member basis, such as capitated medical or provider arrangements, are not reimbursable under the Policy.

### Administrative Fees Related to Large Case Management (LCM)

Certain operational fees associated with Large Case Management are also not eligible for reimbursement. These include costs for:

- Routine communications (*emails, faxes*);
- Eligibility checks;
- Clerical support; or
- PEPM charges tied to LCM services.

Please be aware that only fees directly related to the management of a catastrophic claim, as mentioned in the Covered Expenses and Fees section above, may be considered eligible for reimbursement.

### Drug Card Administrative Fees

Administrative costs linked to drug card programs are considered routine plan administration and are therefore not reimbursable under the Policy.

### Recoveries

Any amounts recovered — such as through subrogation, settlements, or prescription drug or manufacturer rebates — do not apply toward the deductible and are not eligible for reimbursement under the Policy. In the event Great American Employer Health Solutions has reimbursed or advanced payment for an Eligible Plan Expense and a recovery is later identified or received, the Plan is responsible for promptly notifying and reimbursing Great American Employer Health Solutions up to the amount paid or advanced, even if the Policy is no longer in effect. Consistent with the terms of the Policy, Great American Employer Health Solutions retains the first right of recovery for any amounts reimbursed.

# General Provisions

## Contract Terms

Stop Loss claims are reimbursed based on the incurred and paid dates for eligible charges. The incurred and paid dates represent the essence of the Stop Loss coverage. It is critical that the Employer and their TPA understands what incurred and paid mean.

Great American Employer Health Solutions offers Specific and Aggregate Stop Loss Contract Terms based on the Employer's Incurred and Paid date parameters, subject to state requirements.

## Summary Plan Description (SPD) and its Amendments

Great American Employer Health Solutions relies on the SPD to determine eligible expenses as it is the basis on which claims are paid. Great American Employer Health Solutions must receive the latest version of the SPD for approval in accordance with the provisions of the Policy.

Any changes, amendments or modifications to the SPD should be submitted to Great American Employer Health Solutions for prior approval and will be in effect on the first day of the month following Great American Employer Health Solutions' approval of the proposed amendment. All program template, signed, and amended or updated SPD for Employers must be sent to [EHSops@gaig.com](mailto:EHSops@gaig.com).

In the absence of Great American Employer Health Solutions' prior written consent of the amendment, benefits will be payable under the Policy as though the Plan had not been amended.

## Eligibility

Great American Employer Health Solutions strictly adheres to the Eligibility requirements as defined under the Plan Document or Summary Plan Description (SPD).

It is extremely important that all parties understand the Plan benefits and that Great American Employer Health Solutions be provided with information that clearly and precisely indicates how a person has been determined to be eligible under the Plan. When completing the [Specific Claim Form](#) and [Employee Work Status Form](#) please include detailed information on how a claimant has been and continues to be eligible under the Plan.

In order to perform a complete and thorough review of any claim, these questions must be answered, and the required documents listed on the forms be submitted in their entirety. Failure to do so may delay the review process or impact the amount reimbursed.

## Third Party Liability and Subrogation Procedures

Third Party Liability or Subrogation involves situations where another (*third*) party is responsible for payment of health care expenses incurred by an individual covered under their employer's benefit plan because of some act or omission.

Subrogation provisions provide the Plan with an opportunity to recover some portion of the cost of the claimant's medical care from another responsible party. The other party may be an individual, insurance company or entity. The following documentation is required for us to review and issue reimbursement on cases involving Third Party Liability or Subrogation.

1. Liability (*Accident*) Questionnaire Form (*or similar TPA form*) completed by either the Employer or the claimant (*employee, dependent or the employee on behalf of a minor dependent*). Please include any appropriate supporting documentation; and
2. A Subrogation and Right to Recover Reimbursement Agreement signed by the Employer.

The Employer, via its TPA, is responsible for notifying Great American Employer Health Solutions if you believe a Third Party Liability or Subrogation opportunity is available.

All subrogation claims should go through our approved vendor. However, upon prior discussion and mutual agreement, we are willing to consider the use of vendors designated by the TPA. Any approval of an additional vendor must be in writing.

All Specific and Aggregate stop loss claim refunds should be forwarded to Great American Employer Health Solutions. Although refunds may not have been identified by the Employer immediately, once they are identified, such refunds should be sent to Great American Employer Health Solutions.

### **Claims Appeal**

Any claim that has been denied can be appealed within 90 days after the determination has been made by submitting supporting documentation or by providing additional evidence in writing (*hard copy or electronic*) to [EHSclaims@gaig.com](mailto:EHSclaims@gaig.com).

### **Right to Audit**

Great American Employer Health Solutions may require an on-site verification of a year-end aggregate claim or reconciliation. Upon receipt of the complete submission, we will perform a preliminary review of the request. We will then determine whether we will conduct a desk audit or an on-site audit, performed in the office of the TPA.

In the event of an on-site audit, an auditor will be assigned to the claim. The auditor will contact the TPA for any required additional information and to schedule an audit date. If a desk audit is conducted, the complete, fully documented aggregate stop loss claim will be reviewed, the audit process completed, and claim determination made within 30 to 60 calendar days of receipt of all required information.



## Key Timeframes Quick Reference

A consolidated summary of critical deadlines and timeframes referenced throughout this manual.

Item	Timeframe	Description
<b>Premium due</b>	Per policy due date	TPA must remit monthly premium by the due date listed in the policy.
<b>Grace period</b>	Per policy terms	TPA must submit premium owed to Great American Insurance Company by the end of the grace period.
<b>Late premium cutoff</b>	15 days after grace period	If premium is not received within 15 days after the grace period ends, the policy terminates.
<b>Retroactive adjustments</b>	Up to 90 days	Member terminations/additions may be applied retroactively up to 90 days from the notification date.
<b>Member enrollment window</b>	30 days	Standard enrollment period; additions outside this window require an Individual Health Questionnaire.
<b>Monthly aggregate reporting</b>	By the 15th of each month	Submitted no later than the 15th of the month following the reporting month.
<b>Large claim notice</b>	Within 10 days	Written notification required within 10 days of learning a claim may be potentially catastrophic.
<b>Claim submission deadline</b>	Within 90 days of paid period end	All claims must be submitted for reimbursement within 90 days of the paid timeframe in the policy.
<b>Renewal reporting</b>	Month 9 of policy term	TPA must submit census, claims data, case management notes, and program updates at month 9.
<b>Reissue offer</b>	Within 60 days prior to annual effective date	Renewal proposal issued if all required renewal data is submitted on time.

*This table is a summary reference only. Refer to the Stop Loss Insurance Policy for complete terms. In the event of any conflict, the Policy language controls.*



# Appendix

## ICD-10 Trigger Diagnosis Codes

The ICD-10 codes and diagnoses listed below are key indicators of potential catastrophic claims. Claims containing these codes should be referred to and disclosed to Great American Employer Health Solutions per the terms of the manual.

A00-B99	Certain Infectious & Parasitic Disease
A40	Streptococcal sepsis
A41	Other Sepsis
B15-B19	Viral hepatitis
B20	Human immunodeficiency virus (HIV) disease

C00-D49	Neoplasms
C00-C96	Malignant neoplasms
D46	Myelodysplastic syndromes

D50-D89	Diseases of Blood & Blood-Forming Organs & Disorders Involving Immune Mechanism
D57	Sickle-cell disorders
D59	Other Sepsis
D60-D64	Aplastic and other anemias
D65-D69	Coagulation defects, purpura & other hemorrhagic conditions
D70-D77	Other diseases of blood & blood-forming organs
D80-D89	Certain disorders involving immune Mechanism

E00-E89	Endocrine, Nutritional & Metabolic Diseases
E10-E13	Diabetes mellitus
E15-E16	Other disorders of glucose regulation and pancreatic internal secretion
E65-E68	Obesity and other hyper alimentation
E70-E89	Metabolic disorders

F01-F99	Mental, Behavioral & Neurodevelopmental
F10.1	Alcohol Abuse
F11.1	Opioid Abuse
F20	Schizophrenia
F31	Bipolar Disorder

F01-F99	Mental, Behavioral & Neurodevelopmental
F32.3	Major depressive disorder, single episode, severe with psychotic feature
F33.1-F33.3	Major Depressive Disorder, recurrent
F84.0	Autistic Disorder
F84.2	Rett's Syndrome
F84.5	Asperger's syndrome

G00-99	Diseases of the Nervous System
G00	Bacterial Meningitis
G04	Encephalitis Myelitis and Encephalomyelitis
G06-G07	Intracranial & intraspinal abscess & granuloma
G12.21	Amyotrophic Lateral Sclerosis
G35	Multiple Sclerosis
G36	Other Acute Disseminated Demyelination
G37	Other Demyelinating disease of central nervous system
G82.5	Quadriplegia
G83.4	Cauda Equina Syndrome
G92	Toxic Encephalopathy
G93.1	Anoxic Brain Injury

I00-I99	Diseases of Circulatory System
I20	Angina Pectoris
I21.09-I22	Acute myocardial infarction
I24	Acute and Subacute Ischemic Heart Disease
I25	Chronic ischemic heart disease
I26	Pulmonary embolism
I27	Other pulmonary heart disease
I28	Other diseases of pulmonary vessels
I33	Acute & Subacute Endocarditis
I34-I38	Heart Valve Disorders
I42-I43	Cardiomyopathy
I44-I45	Conduction Disorders
I46	Cardiac Arrest
I47-I49	Cardiac Dysrhythmias
I50	Heart Failure

<b>I00-I99</b>	<b>Diseases of Circulatory System</b>
I60-I61	Subarachnoid Hemorrhage/Intercerebral Hemorrhage
I63	Cerebral infarction
I65.8-I66	Occlusion of Precerebral /Cerebral Arteries
I67	Other cerebrovascular disease
I70	Atherosclerosis / Aortic Aneurysm

<b>J00-J99</b>	<b>Diseases of Respiratory System</b>
J40-J44	Chronic Obstructive Pulmonary Disease (COPD)
J84.10-J84.89	Postinflammatory Pulmonary Fibrosis
J98.11-J98.4	Pulmonary Collapse / Respiratory Failure

<b>K00-K95</b>	<b>Diseases of Digestive System</b>
K22	Esophageal obstruction
K25-K28	Ulcers
K31	Other diseases of stomach & duodenum
K50	Crohn's disease
K51	Ulcerative colitis
K55-K64	Diseases of intestine
K65-K68	Diseases of peritoneum & retroperitoneum
K70-K77	Diseases of liver
K83	Diseases of biliary tract
K85-K86	Diseases of pancreatitis
K90-K95	Other diseases of digestive system/ Complications of bariatric procedures

<b>M00-M99</b>	<b>Diseases of Musculoskeletal System &amp; Connective Tissue</b>
M15-M19	Osteoarthritis
M32	Systemic lupus erythematosus
M34	Systemic sclerosis
M41	Scoliosis
M43	Spondylolysis
M50	Cervical disc disorders
M51	Thoracic, thoracolumbar & lumbosacral intervertebral disc disorders
M72.6	Necrotizing Fasciitis
M86	Osteomyelitis

<b>N00-N99</b>	<b>Diseases of the Genitourinary System</b>
N00-N01	Acute & Rapidly Progressive Nephritic Syndrome
N03	Chronic Nephritic Syndrome
N04	Nephrotic Syndrome
N05-N07	Nephritis and Nephropathy
N08	Glomerular Disorders classified elsewhere
N17	Acute Kidney Failure
N18	Chronic Kidney Disease (CKD)
N19	Renal Failure, Unspecified

<b>O00-O9A</b>	<b>Pregnancy, Childbirth and the Puerperium</b>
O09	High Risk Pregnancy
O11	Pre-Existing Hypertension with Pre-Eclampsia
O14-O15	Pre-Eclampsia and Eclampsia
O30	Multiple Gestation
O31	Other complications specific to Multiple Gestations

<b>P00-P96</b>	<b>Certain Conditions Originating in Perinatal Period</b>
P07	Disorders of newborn related to short gestation & low birth weight
P10-P15	Birth Trauma
P19	Fetal distress
P23-P28	Other respiratory conditions of newborn
P29	Cardiovascular disorders originating in perinatal period
P36	Bacterial sepsis of newborn
P52-P53	Intracranial hemorrhage of newborn
P77	Necrotizing enterocolitis of newborn
P91	Other disturbances of cerebral status newborn

<b>Q00-Q99</b>	<b>Congenital Malformations, Deformations &amp; Chromosomal Abnormalities</b>
Q00-Q07	Congenital malformations of the nervous system
Q20-Q26	Congenital Cardiac malformations
Q41-Q45	Congenital Anomalies of Digestive system
Q85	Phakomatoses, not classified elsewhere
Q87	Congenital malformation syndromes affecting multiple systems
Q89	Other Congenital malformations

<b>R00-R99</b>	<b>Symptoms, Signs &amp; Abnormal Clinical &amp; Laboratory Findings, Not Elsewhere Classified</b>
R07.1- R07.9	Chest Pain
R40- R40.236	Coma
R57-R58	Shock, Hemorrhage
R65.2- R65.21	Severe sepsis

<b>T30-T32</b>	<b>Burns &amp; Corrosions of Multiple Body Regions</b>
T81.11- T81.12	Postprocedural cardiogenic & septic shock
T82	Complications of cardiac and vascular prosthetic devices, implants & grafts
T83-T85	Complications of prosthetic devices, implants and grafts
T86	Severe sepsis
T87	Complications to reattachment & amputation

<b>S00-T88</b>	<b>Injury, Poisoning &amp; Certain Other Consequences of External Causes</b>
S02	Fracture of skull and facial bones
S06	Intracranial injury
S07	Crush injury to head
S08	Avulsion & traumatic amputation of part of head
S12-S13	Fracture & injuries of cervical vertebra & other parts of neck
S14.0- S14.15	Injury of nerves & spinal cord at neck level
S22.0	Fracture of thoracic vertebra
S24	Injury of nerves & spinal cord at thorax level
S25	Injury of blood vessels of thorax
S26	Injury of heart
S32.0- S32.2	Fracture of lumbar vertebra
S34	Injury of lumbar & sacral spinal cord & nerves
S35	Injury of blood vessels at abdomen, lower back & pelvis
S36-S37	Injury of intra-abdominal organs
S48	Traumatic amputation of shoulder & upper arm
S58	Traumatic amputation of elbow and forearm
S68.4- S68.7	Traumatic amputation of hand at wrist level
S78	Traumatic amputation of hip and thigh
S88	Traumatic amputation of lower leg
S98	Traumatic amputation of ankle and foot

<b>Z00-Z99</b>	<b>Factors Influencing Health Status &amp; Contact w/Health Services</b>
Z37.5- Z37.6	Multiple births
Z38.3- Z38.8	Multiple births
Z48- Z48.298	Encounter for aftercare following organ transplant
Z49	Encounter for care involving renal dialysis
Z94	Transplanted organ and tissue status
Z95	Presence of cardiac & vascular implants & grafts
Z98.85	Transplanted organ removal status
Z99.1	Dependence on respirator
Z99.2	Dependence on dialysis



# THANK YOU FOR YOUR TRUST

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We appreciate the opportunity to work with you and value the trust you've placed in us. It's our privilege to support you and your organization, and we remain committed to delivering the high level of service and expertise you expect.



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