This workbook has been to designed to provide you with the necessary tools to enable you to properly submit an Aggregate claim. It has been designed to allow you to tab to the cells requiring information.

Key elements needed for the filing process include:

1. Demonstrating the total amount of "eligible" Paid Claims meeting the terms of the Stop Loss policy.

2. Identifying and deducting the non-eligible claim amounts included in the filed Paid Claim total.

3. Confirming those net claim payments meet the terms of the Stop Loss Policy (Incurred/Paid dates; "Paid" as defined therein, etc.).

4. Confirming the headcounts of membership 'eligible' during the term of the stop loss coverage period to determine the proper attachment point (deductible) to be met before claims totals in excess of the deductible would be considered for reimbursement under the Aggregate cover.

Complete the Aggregate claim form as per Page 2 contained herein.

Data should be sent direct to our aggregate team at aggclaims@getcba.com. Please CC Prodigy's claims department at claims@prodigystoploss.com

You can also upload the data to us. Contact our administration office at 916-226-2010 for details.

If you are uncertain as to what is needed or how to proceed, please contact our claims office, CBA, directly:

Corporate Benefit Audits: 978-794-3900.

PRODIGY
HEALTH INSURANCE SERVICES

Aggregate Claim Submission

PRODIGY
HEALTH INSURANCE SERVICES

Policy Holder Group Name: _____
Policy Period: _____ to _____
Contract type: (eg 12/12, 12/15, etc.)_____ Today's Date: _____

$ _____ **- Total Claims Paid Year-To-Date**
$ _____ **- Less claims excess of Specific Deductible (including Lasers)**
$ _____ **- Less Ineligible or Extra Contractual Claims**
$ _____ **- Less Rebates / Recoveries / Void**
$ _____ **- Total Eligible towards Aggregate**
$ _____ **- Less Attachment Point***
$ _____ **- Total Amount Requested**

NOTE: Enter numbers as debit or credit amount.

* attachment point is the greater of the Year to Date based on Census, as per monthly aggregate reports, or the Minimum Attachment Point, as per the policy.

The following documentation may be needed to verify your request for reimbursement:
Excel formatted reports are preferred (mark all items included with submission)

_____ Annual summary report of monthly participation, including retroactive adjustments, claim paid by type line of coverage; and monthly & cumulative aggregate attachment point
_____ Contract year-to-date monthly check register showing all payments, voids, reissues and refunds. Check register should include check number, payment date, name of provider and name of claimant.
_____ Bank statements showing all disbursements and deposits made during the policy year plus one month after policy period.
_____ Voids and refunds not accounted for in paid claim report
_____ Overpayment letters for pending recoveries
_____ Copies of monthly policyholder stop loss billing statements
_____ Detailed eligibility report including all active, terminated and COBRA claimants covered during the policy year.
_____ Contract year-to-date itemized detailed paid claims report including claimant, date of service, date paid, check number, amount charged, diagnosis, amount paid, deductible, coinsurance, name of provider and type of service.
_____ Summary service code report. This report should summarize claim payments made by service code (ie: hospital, surgical, lab, drug, etc.)
_____ Benefit analysis report in summary format for the policy period showing out-of-contract or extra-contractual claims, PPO, or Cost Containment fees, medical records payments and any other administrative fees.
_____ Summary of claims processed during the plan year but not yet released and/or funded
_____ Listing in the subrogation claims

If prescription drug coverage is included in the Aggregate coverage, please also provide:

_____ Prescription drug invoices for the policy period, itemized by claimant
_____ Documentation of drug rebates

Other Items Included here with:

_____

Administrator's Name: _____
Street Address: _____
Contact Name: _____
Email Address: _____

Aggregate Accomodation Claim Submission

PRODIGY
HEALTH INSURANCE SERVICES

Policy Holder Group Name: _____
Policy Period: _____ to _____
Contract type: (eg 12/12, 12/15, etc) _____ Today's Date: _____

$ _____ **- Total Claims Paid Year-To-Date**
$ _____ **- Less claims excess of Specific Deductible (including Lasers)**
$ _____ **- Less Ineligible or Extra Contractual Claims**
$ _____ **- Less Rebates / Recoveries / Void**
$ _____ **- Total Eligible towards Aggregate**
$ _____ **- Less Attachment Point***
$ _____ **- Total Amount Requested**

NOTE: Enter numbers as debit or credit amount.

* attachment point is greater of the Year to Date based on Census, as per monthly aggregate reports, or the Minimum Attachment Point, as per the policy.

The following documentation may be needed to verify your request for reimbursement:
Excel formatted reports are preferred (mark all items included with submission)

_____ Annual summary report of monthly participation, including retroactive adjustments, claim paid by type line of coverage; and monthly & cumulative aggregate attachment point.
_____ Contract year-to-date monthly check register showing all payments, voids, reissues and refunds. Check register should include check number, payment date, name of provider and name of claimant.
_____ Bank statements showing all disbursements and deposits made during the policy year plus one month after policy period.
_____ Voids and refunds not accounted for in paid claim report.
_____ Overpayment letters for pending recoveries.
_____ Copies of monthly policyholder stop loss billing statements.
_____ Detailed eligibility report including all active, terminated and COBRA claimants covered during the policy year.
_____ Contract year-to-date itemized detailed paid claims report including claimant, date of service, date paid, check number, amount charged, diagnosis, amount paid, deductible, coinsurance, name of provider and type of service.
_____ Summary service code report. This report should summarize claim payments made by service code (ie: hospital, surgical, lab, drug, etc.).
_____ Benefit analysis report in summary format for the policy period showing out-of-contract or extra-contractual claims, PPO, or Cost Containment fees, medical records payments and any other administrative fees.
_____ Summary of claims processed during the plan year but not yet released and/or funded
_____ Listing in the subrogation claims

If prescription drug coverage is included in the Aggregate coverage, please also provide:

_____ Prescription drug invoices for the policy period, itemized by claimant
_____ Documentation of drug rebates

Other Items Included here with:

_____

Administrator's Name: _____
Street Address: _____
Contact Name: _____
Email Address: _____