Flow of Self-Funded Claims

-
- Plan Participant Receives HealthCare Services
  → Services Posted to Provider's Billing System
  → HealthCare Provider Submits Claim to 3PA
  → Claims Distributed to Plan Sponsor's Assigned 3PA Analyst
  → Claims Verified Through Adjudication Process
  → In-Network Payable Claims Priced Based on Provider Contracted Rates
  → Out-of-Network Claims Sent for Re-pricing
  → 3PA Processes Payments and Explanation of Benefits
  → 3PA Notifies Plan Sponsor Weekly of Total Claims Payable
  → Plan Sponsor Funds Claims and Payment is Released to
  → HealthCare Provider
  → Plan Participant

3PAdministrators
your benefits partner

Life of a Claim

After a plan participant receives medical services, the healthcare provider submits a claim following instructions on the member's insurance identification card. Our procedures dictate that mail is opened and distributed daily and claims are adjudicated within five business days. Electronic claim files are downloaded and processed daily. A check run is done weekly for each plan and payments and explanations of benefits (EOB) are printed during that process. The plan sponsor is notified of the total claim payments and as soon as funding is received, the checks and EOBs are released for mailing.

There are several options for funding of claim payments and the plan sponsor can decide which manner is most convenient for them. In our weekly check run process, claim payments are printed from checking accounts programmed into our claims system. The plan sponsor can send one check for the total claim payments and the actual claim checks are drawn off a 3PAdministrators (3PA) account. Funding can also be directed to 3PA through an automatic transfer from the employer's bank, or the employer's checking account information can be programmed and claim checks printed directly from that account. System security assures that no withdrawals can be made from programmed accounts except through the adjudication of a claim. Additionally, payments can only be issued to a plan participant or healthcare provider based on verified social security numbers or tax identification numbers.

A claim entered into the system, either manually or electronically, is applied to programmed plan parameters, adjudication logic and a benefit code cross reference table to determine how it adjudicates. Edit files within the system check for billing issues such as bundling or unbundling, duplicates or inappropriate coding. Usual and customary files are updated every six months. Discounts on in-network claims are applied either through re-pricing documentation from the PPO or are built into the plan. We forward out-of-network claims to a re-pricing vendor that can apply discounts from their affiliated networks or who negotiates directly with a provider for charge reductions. Services are billed at a percentage of savings so the plan is not paying per employee per month fees for wrap network access.

Technology

Our claims adjudication software is one of the top systems available. Healthpac was developed by Eldorado Computing, Inc. in the 1980's and has been subject to continuous development in response to industry changes and client needs. There are quarterly releases with updates to enhance capabilities and to offer continued compliance with applicable legislation.

Healthpac's flexibility allows for set-up of a vast array of benefit designs that are tailor-made for each group. The system's eligibility files allow for tracking eligibility by effective and termination dates and by age, as well as flagging coordination of benefits. The plan build monitors timely filing limitations and checks for duplicate charges.

3PAdministrators also offers administration of Health Reimbursement Accounts (HRA), Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA). The software utilized for these types of plans comes from P+W Software who is a leader in this area of the industry. This system interfaces with Healthpac and can sweep claims processed first through the medical plan.

Personalized Service

Each plan is assigned a dedicated claims analyst who will handle all aspects of the claims process, including customer service. Our phones are answered in person and calls directed to the appropriate analyst based on group assignment. We feel this provides a superior level of personalized service to the plan sponsors, the plan participants and healthcare providers.

1113 Riders Club Road Onalaska, WI 54650 608-779-3000