PROPOSAL TO:

Jefferson Parish
State of Louisiana

SOQ-22-043 Claims Management Third-Party Administration Jefferson Parish Government

PREPARED BY:

Jerry Armatis
Vice President, Sales

Phone: (504) 883-8404
jarmatis@ccmsi.com

3510 North Causeway Blvd., Suite 400
Metairie, LA 70002

August 2022

CCMSI®

www.ccmsi.com

Table of Contents

CCMSI

General Professional Services Questionnaire

SOQ-22-043 Claims Management Third-Party Administration
Jefferson Parish Government

General Professional Services Questionnaire Instructions

- The General Professional Services Questionnaire shall be used for all professional services except outside legal services and architecture, engineering, or survey projects.
- **The General Professional Services Questionnaire should be completely filled out. Complete and attach ALL sections. Insert "N/A" or "None" if a section does not apply or if there is no information to provide.**
- Questionnaire must be signed by an authorized representative of the Firm. Failure to sign the questionnaire shall result in disqualification of proposer pursuant to J.P. Code of Ordinances Sec. 2-928.
- All subcontractors must be listed in the appropriate section of the Questionnaire. Each subcontractor must provide a complete copy of the General Professional Services Questionnaire, applicable licenses, and any other information required by the advertisement. Failure to provide the subcontractors' complete questionnaire(s), applicable licenses, and any other information required by the advertisement shall result in disqualification of proposer pursuant to J.P. Code of Ordinances Sec. 2-928.
- If additional pages are needed, attach them to the questionnaire and include all applicable information that is required by the questionnaire.

General Professional Services Questionnaire

A. Project Name and Advertisement Resolution Number:

SOQ-22-043 Claims Management Third-Party Administration
Jefferson Parish Government

B. Firm Name & Address:

Cannon Cochran Management Services, Inc. (CCMSI)
3510 North Causeway Blvd., Suite 400
Metairie, LA 70002

C. Name, title, & contact information of Firm Representative, as defined in Section 2-926 of the Jefferson Parish Code of Ordinances, with at least five (5) years of experience in the applicable field required for this Project:

Jerry Armatis
Vice President, Sales
CCMSI
3510 North Causeway Blvd., Suite 400
Metairie, LA 70002
Phone: (504) 883-8404
jarmatis@ccmsi.com

D. Address of principal office where Project work will be performed:

CCMSI
3510 North Causeway Blvd., Suite 400
Metairie, LA 70002

E. Is this submittal by a JOINT-VENTURE? Please check:

YES _____ NO X_____

If marked "No" skip to Section H. If marked "Yes" complete Sections F-G.

F. If submittal is by JOINT-VENTURE, list the firms participating and outline specific areas of responsibility (including administrative, technical, and financial) for each firm. Please attach additional pages if necessary.

1. Not applicable.

General Professional Services Questionnaire

2. Not applicable.

G. Has this JOINT-VENTURE previously worked together? Please check: Not applicable. YES _____ NO _____

H. List all subcontractors anticipated for this Project. Please note that all subcontractors must submit a fully completed copy of this questionnaire, applicable licenses, and any other information required by the advertisement. See Jefferson Parish Code of Ordinances, Sec. 2-928(a)(3). Please attach additional pages if necessary.

Name & Address:	Specialty:	Worked with Firm Before (Yes or No):
1. Not applicable.		
2.		
3.		
4.		
5.		

General Professional Services Questionnaire

I. Please specify the total number of support personnel that may assist in the completion of this Project: _____
8 Team Members. See Exhibit 1 for Client Service Team Biographies.
J. List any professionals that may assist in the completion of this Project. If necessary, please attach additional documentation that demonstrates the employment history and experience of the Firm's professionals that may assist in the completion of this Project (i.e. resume). Please attach additional pages if necessary.
PROFESSIONAL NO. 1
Name & Title: See Exhibit 1 for Client Service Team Biographies.
Name of Firm with which associated: CCMSI
Description of job responsibilities:
CCMSI utilizes dedicated Client Service Teams, delivering exceptional personalized service to Jefferson Parish. Each claim adjuster on a team has access to every claim file. In the absence of your Liability team, Adjusters Bernard Deckelman and Rick Poyner, Karen Bonnet will be available for claim handling and questions. In the absence of your WC team, LT adjuster Lori Francis and MO adjuster Patricia Aperwhite, Donnell Langley will be available. In addition, your Account Manager, Karen Thurman as well as Executive Account Manager, Jerry Armatis are always available for inquiries and issues.
Years' experience with this Firm:
See Exhibit 1 for Client Service Team Biographies.
Education: Degree(s)/Year/Specialization:
See Exhibit 1 for Client Service Team Biographies.
Other experience and qualifications relevant to the proposed Project:
See Exhibit 1 for Client Service Team Biographies.

General Professional Services Questionnaire

K. List all prior projects that best illustrate the Firm's qualifications relevant to this Project. Please include any and all work performed for Jefferson Parish. Please attach additional pages if necessary.	
PROJECT NO. 1	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Veronica Guevara, Risk Management & Compliance Director ***Bexar County, Texas*** 101 W. Nueva St., Suite 901 San Antonio, TX 78205 Veronica.guevara@bexar.org 210-335-2559	Third Party Administration.
Length of Services Provided:	**Cost of Services Provided:**
8/1/2019 to current	Confidential to Client.

PROJECT NO. 2	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
John Petrelli, CPCU, AIC, ARM Director, Risk Management and Professional Standards ***Orange County, Florida*** (407)836-9636 John.Petrelli@ocfl.net	Third Party Administration.
Length of Services Provided:	**Cost of Services Provided:**
12/12/2017 to current	Confidential to Client.

General Professional Services Questionnaire

PROJECT NO. 3	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Cindy Bradshaw, State Insurance Administrator ***Mississippi State Agencies*** 1428 Lackland Dr. Jackson, MS 39216 (601) 359-5014 Cindy.bradshaw@dfa.ms.gov	Third Party Administration.
Length of Services Provided:	**Cost of Services Provided:**
7/1/2013 to current	Confidential to Client.

PROJECT NO. 4	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Guy Cormier, Executive Director ***Parish Government Risk Management Agency*** 707 North 7th Street Baton Rouge, LA 70802 (225) 343-2835 guy@lpgov.org	Third Party Administration.
Length of Services Provided:	**Cost of Services Provided:**
1/1/1997 to current	Confidential to Client.

General Professional Services Questionnaire

PROJECT NO. 5	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Alan Hurst, Acting Executive Director ***Commonwealth of Kentucky*** 200 Fair Oaks Lane 5th Floor, Suite 511 Frankfort, KY 40601 (502) 564-5943 Alanb.hurst@ky.gov	Third Party Administration.
Length of Services Provided:	**Cost of Services Provided:**
7/1/2005 to current	Confidential to Client.

PROJECT NO. 6	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Jeff Hale, M.A., SHRM-CP Human Resources Director ***Unified Government of Athens-Clarke County*** 375 Satula Avenue, Athens, GA 30601 jeff.hale@accgov.com Direct: (762) 400- 6361 Main HR: (706) 613-3090	Third Party Administration.
Length of Services Provided:	**Cost of Services Provided:**
This is a past client as was requested within the RFP. We served the County for 3+ years.	Confidential to Client.

General Professional Services Questionnaire

L. List all prior and/or on-going litigation between Firm and Jefferson Parish. Please attach additional pages if necessary.

Parties:		Status/Result of Case:
Plaintiff:	**Defendant:**	
1.Not applicable.		
2.		
3.		
4.		

M. Use this space to provide any additional information or description of resources supporting Firm's qualifications for the proposed project.

Please refer to our proposal response and exhibits.

CCMSI is a privately held, employee owned and leading third party administrator for property/casualty programs including workers compensation, liability, property and property claims management. Since 1978 we have provided claim services, loss control, managed care, internet claims analysis and reporting services for individual self-insureds and self-insured groups. We have over 87 Public administrative clients with many in Louisiana. Our experience with large governmental programs allows us to understand the unique nature and demands of claims administration for public entities.

Since 2006 we have provided claims administrative services for Jefferson Parish. During that time we have created a customized program, dedicated adjusters, unique best practices, designed reporting and claims analysis for the Parish. By creating flexible and customized solutions for the Parish the results have been outstanding.

A few highlights:

- Medical Only closed claims ratio of 116% with average incurred cost of $1041
- Indemnity closed claims ratio of 130% with average incurred cost of $39,605
- In 2021, $1,839,773.00 in medical bill savings
- Liability closed claim ratio of 108% with average incurred cost of $13,052

General Professional Services Questionnaire

We work hard to develop long-term partnerships with our clients….partnerships that add value to their risk management programs and a difference to their bottom line. We value and look forward to, hopefully, many more years working with Jefferson Parish.

N. To the best of my knowledge, the foregoing is an accurate statement of facts.

Signature: _____ **Print Name: Rodney J. Golden**_____

Title: Chief Operating Officer_____ **Date: 8/30/2022**_____

CCMSI

Minimum Requirements for Selection

Minimum Requirements for Selection

A. The Parish of Jefferson cordially invites SQQ from firms that have a minimum of ten (10) years' Experience in the field of adjusting and handling General Liability, Professional Liability, Employment Practices Liability, Public Officials and Employee's Liability, Automobile Liability, Workers' Compensation, and other claims.

Cannon Cochran Management Services, Inc. (CCMSI), a Delaware-registered S-Corporation, has led the way as the gold standard third-party administrator for property/casualty programs **since 1978**, providing unrivalled workers' compensation, liability, and property claims management. We bring together the best talent in the TPA industry and prioritize the needs, goals, and expectations of our clients by utilizing innovative solutions, cutting-edge technology, and tailored approaches to claim services, loss control, managed care, internet claims analysis, and reporting services.

CCMSI has provided these services to Jefferson Parish since 2006.

As a privately held, ***100% employee-owned*** company, CCMSI is beholden to our clients—not insurance carriers, brokers, or private equity funds. This empowers our team to make client-centric decisions and focus on long-term client value creation versus short-term financial performance. Our dedication to transparency and reputation for the highest quality client satisfaction, superior results, integrity, and promise fulfillment has earned us the respect of our clients and partners nationwide.

CCMSI does not believe in a one-size-fits-all approach and understands that each client comes to us with unique needs. We listen and collaborate with you to deliver strategic, efficient, and cost-saving solutions and pride ourselves in exceeding expectations. This client-focused approach has established CCMSI as the quality standard in our industry with a ***client retention rate of 98%***. We partner with self-insured groups and individual employers in a wide range of industries, including governmental, retail, manufacturing, healthcare, gaming, construction, transportation, and higher education.

CCMSI has consistently been certified as a great workplace by the analysts at Great Place to Work®. Ensuring we have a positive work environment is essential to CCMSI's success and future growth. Our culture allows us to attract and retain the highest quality staff and maintain the lowest turnover percentage in the industry, which provides continuity and consistent delivery of exceptional service for our clients. Without our greatest asset, our staff, we would not be able to successfully *deliver what matters most* to our clients. See all results here: http://reviews.greatplacetowork.com/ccmsi

CCMSI offers Jefferson Parish a wide range of risk management services designed for comprehensive coverage and administrative efficiencies. Services include:

- Client-specific third-party claims administration;
- Self-insured group administration services: accounting, underwriting, marketing, and excess placement;
- Loss control: industry-specific loss control programs;
- iCE: CCMSI's internet claims analysis and reporting tool;
- Comp MC: CCMSI's private label managed care program;
- FIRE: CCMSI's Special Investigation Unit program; and
- CLEAR: CCMSI's legal bill review program.

CCMSI has over 1,800 employees from thirty-five office locations for five hundred plus individual self-insured employers, ten plus captives, forty plus primary insurance companies, and fifty plus self-insurance groups.

B. Respondent Firm shall utilize & provide Jefferson Parish access to a comprehensive claims Management system with the ability to run customizable, scheduled and live reporting.

iCE (Internet Claims Edge), CCMSI's trailblazing Risk Management Information System software, was designed with your needs in mind. As with all CCMSI solutions, iCE is customizable and tailored to the requirements of our clients. Through this web-based, mobile-friendly system, you can view each claim in real time, 24/7; by user-defined filters (including type of claim and date of loss); at a high level or in detail; and include adjusters' notes and bill images. This powerful claim analysis and reporting tool provides:

- ***Initial Reporting*** Create initial report forms online in iCE or send us claims via web service or through a custom-built interface. Offers industry-specific custom reporting, such Accident Reports created specifically for our transportation clients.
- ***Executive Summary Dashboard*** View and customize a broad overview of your risk management analysis.
- ***Claims Analysis*** A powerful and flexible analysis tool enabling users to view claims in as little or as much detail as they wish.
- ***MyReports*** CCMSI's enterprise reporting engine offers countless possible combinations of data for analysis. Reports can be exported to PDF or Excel, scheduled for systematic delivery directly to an email inbox, or posted to iCE.
- ***Comp MC*** MyReports allows users to run managed care reports for Comp MC (CCMSI's managed care program) with the ability to choose any number of reports from our library, such as PPO penetration or savings by a specific location.
- ***OSHA Reporting*** Removes the need for duplicate data entry by compiling claims information recorded in the Initial Report to create OSHA 300 (Log), 300-A (Summary), and 301 (Incident Report) forms, which may be printed at any time for any location.
- ***Claim Risk Assessment*** Predictive modeling module identifying claims that have the potential to be higher risk, allowing for early intervention and better outcomes.
- ***ClaimView*** Mobile-friendly claimant portal for injured workers, allowing them to view their lost time payments and active drug cards, upload photos of documents, and communicate with their adjuster.
- ***Stewardship and Benchmarking*** Utilizing historical trends and other benchmarking sources (such as WCRI and IDS), we can perform regular and detailed analysis of our performance, providing clients extensive metrics to drive the success of the claims management program.

Additional features of iCE include:

- Flexible, user-friendly navigation;
- Capability to receive data from a multitude of data sources;
- Password protection with varying levels of security access;
- Allows hierarchy of up to twenty-five levels to track data by state, department, etc.;
- Ability to create customized user fields;
- Ability to view adjuster notes by category, including summary, medical, litigation, reserves, etc.;
- Ability to generate state-specific First Report of Injury and other state forms in PDF;
- Ability for clients to upload documents directly to the claim file/adjuster;

- Online medical bill and medical report viewing; and
- Predictive Analytics utilizing daily AI functionality to determine risk drivers, future treatments, and estimated financial incurred values.

Reporting Features:

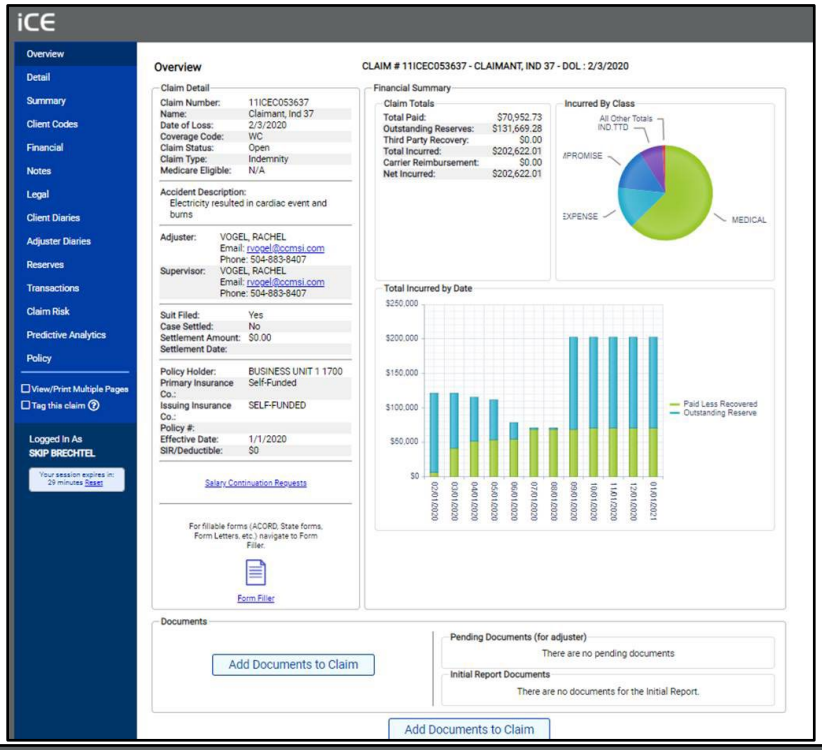
- Online access to monthly standard reports dating back twenty-four months;
- User-specific Executive Portal showing key data upon login;
- Dashboard functionality, customizable to the user's needs;
- Complete ad hoc reporting capabilities, including financial, claims detail, and loss control data;
- Summary and detail claim reporting with drill-down capabilities;
- Analytical tools, including historical and current period comparisons and various graphical presentation; and
- Cost containment savings and fee reporting.

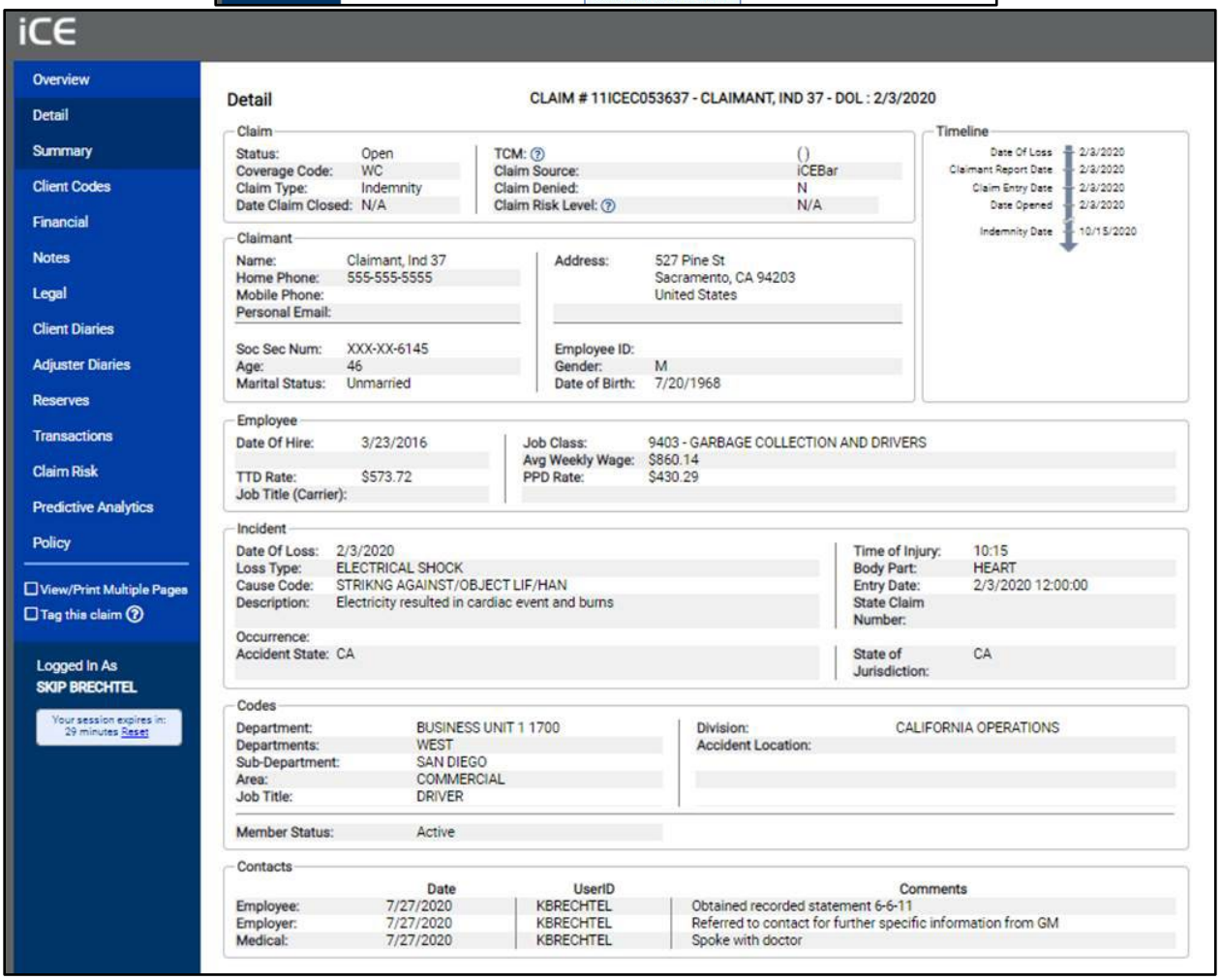
Overview of Access and Reporting

Levels of access are assigned to Jefferson Parish's designated employees, who are then able to review every aspect of the claim file from a selected group (e.g., department or division), a particular time period, or Jefferson Parish as a whole. Client-specific reports, including loss, financial, and summary reports; monthly check registers; and monthly vendor payments will be posted on Jefferson Parish's iCE report tab and maintained in PDF format for a rolling twelve-month period.

All payments made on a claim are listed on the financial transaction screens, which provide information on each individual payment and a link to scanned images of medical bills and reports, complete with commentary. In addition, we offer *as of date* financial information with a simple calendar selector, allowing information rollback to a previous date.

The following screenshots display claim file categories and a navigational sidebar containing other key elements available for Jefferson Parish review.

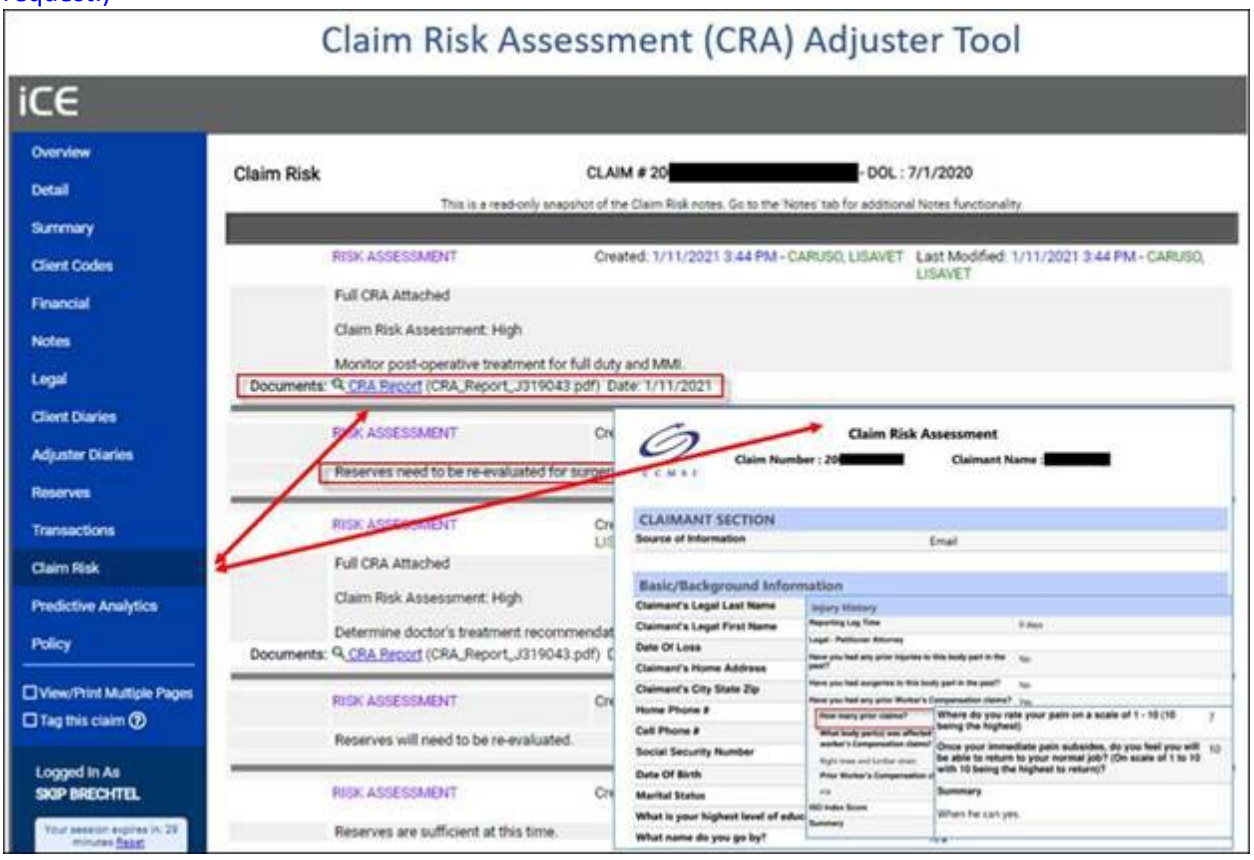

iCE
Overview
Detail
Summary
Client Codes
Financial
Notes
Legal
Client Diaries
Adjuster Diaries
Reserves
Transactions
Claim Risk
Predictive Analytics
Policy
View/Print Multiple Pages
Tag this claim
Logged In As
SKIP BRECHTEL
Your session expires in: 29 minutes Reset
Overview
CLAIM # 11ICEC053637 - CLAIMANT, IND 37 - DOL : 2/3/2020
Claim Detail
Claim Number: 11ICEC053637
Name: Claimant, Ind 37
Date of Loss: 2/3/2020
Coverage Code: WC
Claim Status: Open
Claim Type: Indemnity
Medicare Eligible: N/A
Accident Description:
Electricity resulted in cardiac event and burns
Adjuster: VOGEL, RACHEL
Email: rvogel@ccmsi.com
Phone: 504-883-8407
Supervisor: VOGEL, RACHEL
Email: rvogel@ccmsi.com
Phone: 504-883-8407
Suit Filed: Yes
Case Settled: No
Settlement Amount: $0.00
Settlement Date:
Policy Holder: BUSINESS UNIT 1 1700
Primary Insurance Co.: Self-Funded
Issuing Insurance Co.: SELF-FUNDED
Policy #:
Effective Date: 1/1/2020
SIR/Deductible: $0
Salary Continuation Requests
For fillable forms (ACORD, State forms, Form Letters, etc.) navigate to Form Filler.
Form Filler
Financial Summary
Claim Totals
Total Paid: $70,952.73
Outstanding Reserves: $131,669.28
Third Party Recovery: $0.00
Total Incurred: $202,622.01
Carrier Reimbursement: $0.00
Net Incurred: $202,622.01
Incurred By Class
All Other Totals IND.TTD
APROMISE
EXPENSE
MEDICAL
Total Incurred by Date
$250,000
$200,000
$150,000
$100,000
$50,000
$0
Paid Less Recovered
Outstanding Reserve
Documents
Add Documents to Claim
Pending Documents (for adjuster)
There are no pending documents
Initial Report Documents
There are no documents for the Initial Report.
Add Documents to Claim


iCE
Overview
Detail
Summary
Client Codes
Financial
Notes
Legal
Client Diaries
Adjuster Diaries
Reserves
Transactions
Claim Risk
Predictive Analytics
Policy
View/Print Multiple Pages
Tag this claim
Logged In As
SKIP BRECHTEL
Your session expires in: 29 minutes Reset
Detail
CLAIM # 11ICEC053637 - CLAIMANT, IND 37 - DOL : 2/3/2020
Claim
Status: Open
Coverage Code: WC
Claim Type: Indemnity
Date Claim Closed: N/A
TCM: ()
Claim Source: ICEBar
Claim Denied: N
Claim Risk Level: N/A
Timeline
Date Of Loss 2/3/2020
Claimant Report Date 2/3/2020
Claim Entry Date 2/3/2020
Date Opened 2/3/2020
Indemnity Date 10/15/2020
Claimant
Name: Claimant, Ind 37
Home Phone: 555-555-5555
Mobile Phone:
Personal Email:
Address: 527 Pine St
Sacramento, CA 94203
United States
Soc Sec Num: XXX-XX-6145
Age: 46
Marital Status: Unmarried
Employee ID:
Gender: M
Date of Birth: 7/20/1968
Employee
Date Of Hire: 3/23/2016
TTD Rate: $573.72
Job Title (Carrier):
Job Class: 9403 - GARBAGE COLLECTION AND DRIVERS
Avg Weekly Wage: $860.14
PPD Rate: $430.29
Incident
Date Of Loss: 2/3/2020
Loss Type: ELECTRICAL SHOCK
Cause Code: STRIKNG AGAINST/OBJECT LIF/HAN
Description: Electricity resulted in cardiac event and burns
Occurrence:
Accident State: CA
Time of Injury: 10:15
Body Part: HEART
Entry Date: 2/3/2020 12:00:00
State Claim Number:
State of Jurisdiction: CA
Codes
Department: BUSINESS UNIT 1 1700
Departments: WEST
Sub-Department: SAN DIEGO
Area: COMMERCIAL
Job Title: DRIVER
Division: CALIFORNIA OPERATIONS
Accident Location:
Member Status: Active
Contacts
Date
UserID
Comments
Employee: 7/27/2020 KBRECHTEL Obtained recorded statement 6-6-11
Employer: 7/27/2020 KBRECHTEL Referred to contact for further specific information from GM
Medical: 7/27/2020 KBRECHTEL Spoke with doctor

Jefferson Parish has the ability to filter claim information by a multitude of data fields, including date of loss, claimant name and/or Social Security Number, claims denied, and total incurred over a specific dollar amount. Once the desired claim has been located, Jefferson Parish can view and download information, such as claim status (open, closed, pending); detailed summary of claim facts and information; employment information (e.g., average weekly wage and PPD rate); as well as all adjustor log notes, including action plan/diary review, settlement evaluation, and summary of medical treatment and case management activity. In addition, clients can quickly view financial transactions and analysis, including detailed payments, medical invoices, and charts to provide a comprehensive and visual breakdown of claim reserves and reserve development.

CCMSI Claim Risk Assessment (CRA) and New Gradient AI Daily Claim Scorecard

CCMSI understands early identification and intervention of potential high-risk claims can deliver dramatic cost-savings benefits to our clients. Since 2015, we have utilized Claim Risk Assessment (CRA) Adjuster Tool, a customized in-house claim scoring system to classify indemnity claims as potential high, moderate, or low risk. The scoring system captures seventy-five data fields, such as comorbidities, distance to doctor, claimant's probability of returning to work, prior surgeries, etc. (Note: A complete list is available upon request.)

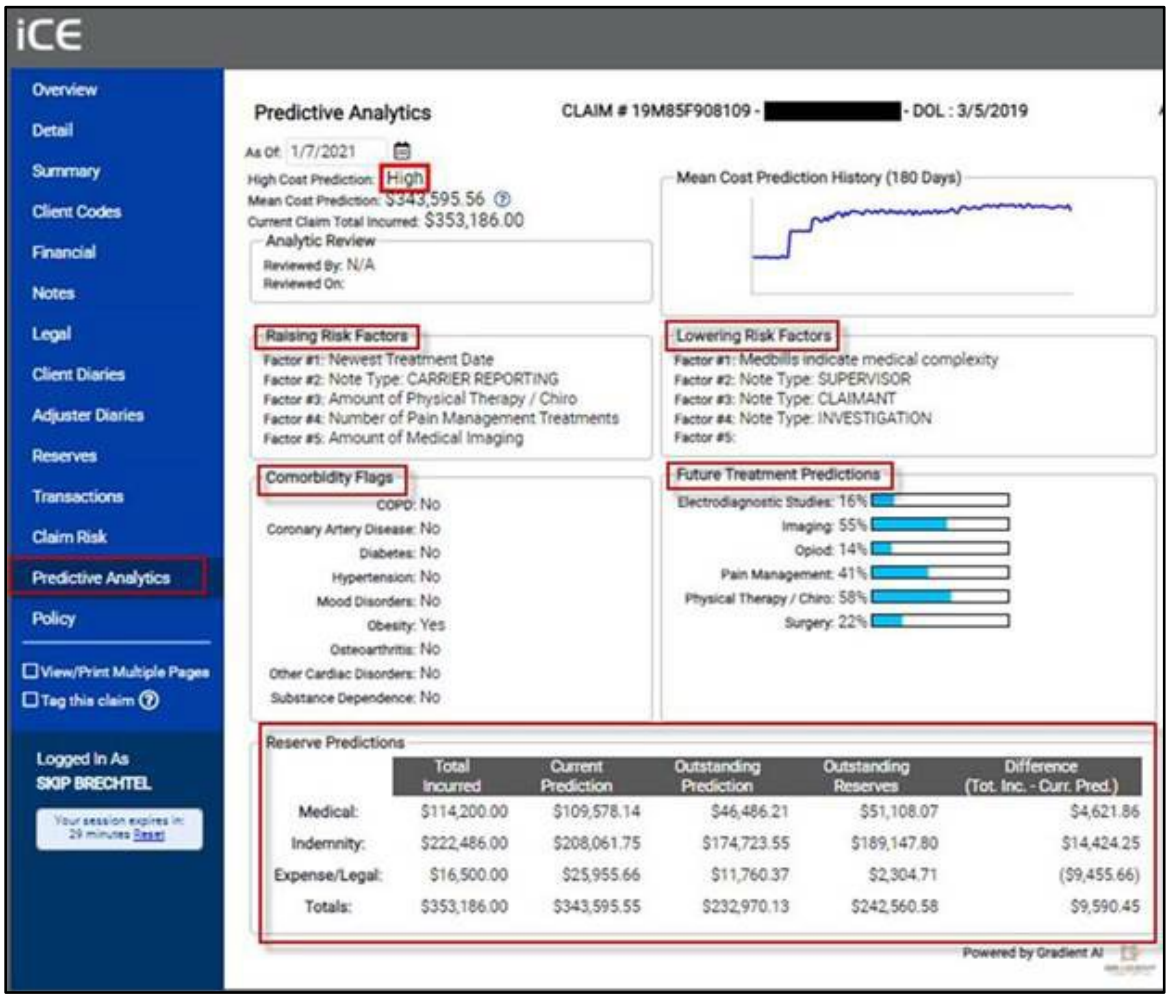


In First Quarter 2019, CCMSI completed its integration with Gradient AI, utilizing its artificial intelligence product to score all indemnity and medical-only claims nightly. Gradient now utilizes over forty-five million workers' compensation claims and additional third-party datasets to perform daily analysis, proving to be extremely successful in early identification of claim drivers and costs.

Each evening, CCMSI transmits all claims data fields captured in our system to Gradient AI, including transactions, adjuster notes, medical bills, prescriptions, and our claim risk assessment fields. Gradient then scores the claims and provides CCMSI with the following information:

- Risk classification of *High*, *Medium*, or *Low* of claim being high cost;
- Total incurred predication (starting thirty days after receipt by CCMSI);
- Treatment predictions (e.g., surgery, PT, electrodiagnostic, imaging, opioids, pain management);
- List of all comorbidities; and
- List of factors impacting cost of the claim (e.g., legal, return to work, future medical).

The screenshot below illustrates how this is depicted in our clients' iCE portals:



Jefferson Parish adjusters, supervisors, and account managers use this information as an additional tool in the assessment of the claim and in discussions with Jefferson Parish.

Phase Two of the Gradient AI product will provide our claims team and Jefferson Parish with additional claim intervention information, which can be utilized to assist with recommended interventions in six key areas: NCM, IME, Rx utilization, settlement, subrogation, and MSA.

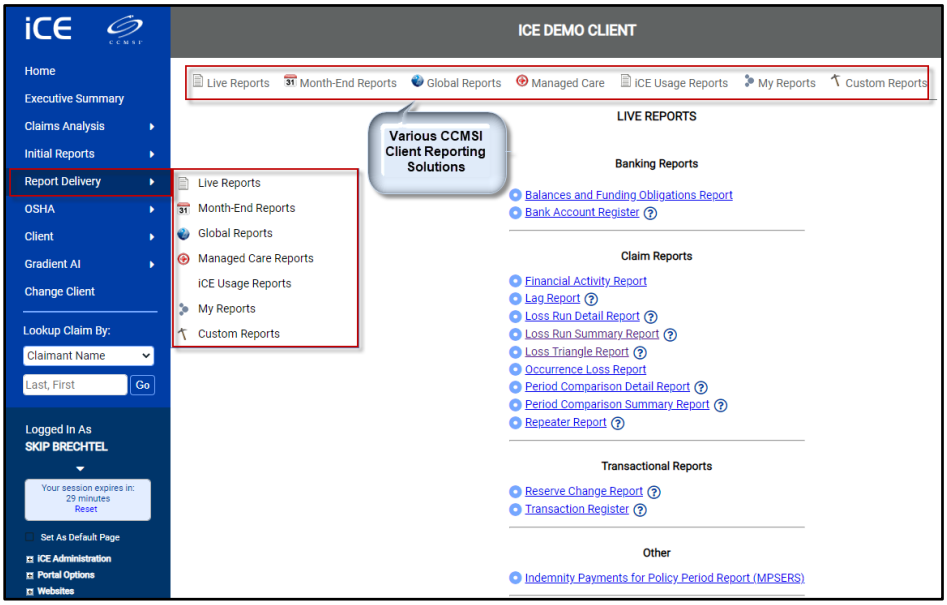
CCMSI is currently working with Gradient AI on the following additional predictive models:

- Evaluation of medical-only claims that will convert to indemnity claims;
- Evaluation of claims that will have attorney representation;
- Estimated average duration of lost days;
- Medical providers with best outcomes; and
- PT scorecard and analytic status of claimant physical therapy progress.

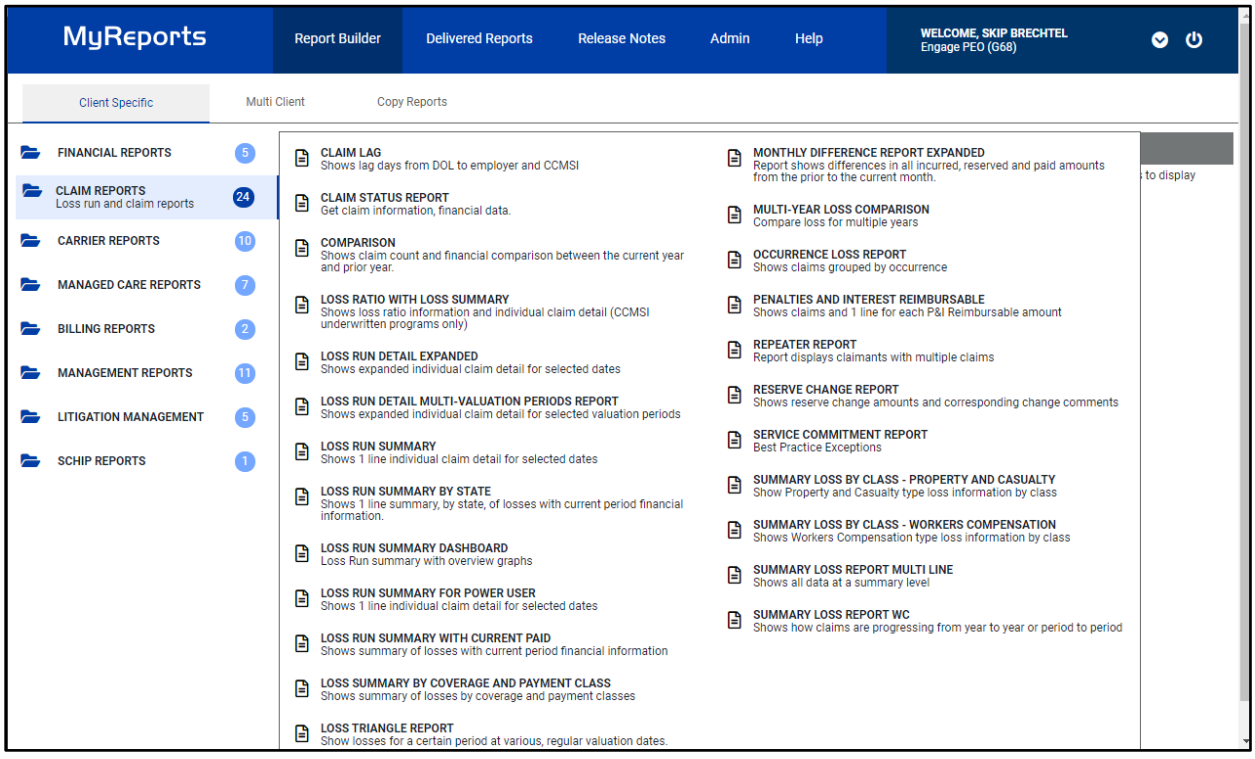
Reports

CCMSI's iCE (Internet Claims Edge) risk management system is designed to provide timely, accurate, and robust data for Jefferson Parish. Users can easily retrieve claims and loss control data via standard and ad hoc online reports as high level or as detailed as they choose.

- ***Standard Reports*** Over the years, CCMSI has developed a catalog of over four hundred reports based specifically on the requirements of our clients, including detailed claim information, summary (at various reporting levels), check and payment registers, and loss ratio (by desired operating levels). These static reports are posted online within five business days and available 24/7 within iCE.
- ***Ad hoc reporting*** Jefferson Parish can generate a wide array of useful ad hoc reports with the opportunity to sort and categorize by various fields and data. Robust analytics, such as valuable charts and graphs, are provided.
- ***Special Customized Reports*** On the rare occasion our clients' reporting needs cannot be met by our catalog of standard or ad hoc capabilities, we can custom design and develop reports to fit their precise needs. Our standard fee is $150/hour for development; however, if the custom report requests are minimal, this will most likely be free of charge.
- ***Live Reports*** This feature provides the thirteen most commonly used reports by our clients, including detail and summary loss runs, comparative period, loss triangles, and reserve change reports. These reports can be generated with user-selected periods and *as of* dates.



- ***MyReports*** MyReports allows Jefferson Parish to build a customized loss run with over three hundred fields from which to choose. This report can be scheduled to run automatically on a regular basis, then emailed in PDF or Excel or posted to iCE. Our customer service team is available to assist in creating these reports.



C. Respondent Firm shall staff and maintain an office within the Parish of Jefferson's Department of Risk Management offices in order to service its claims. Adjusters shall be dedicated to the Jefferson Parish account.

Jefferson Parish's account will continue to be managed in our Metairie, LA office location and we will continue to staff and maintain an office within the Parish of Jefferson's Department of Risk Management offices.

D. Respondents shall include within their SOQ a description of their firm's qualifications including the current territory(ies) that it services, coverage lines handled, a listing of memberships in local and national professional organizations, and a list of specific personnel who will be responsible for ensuring the efficiency and quality of service to the Parish of Jefferson and its employees. Resumes are required on each of the key personnel, such as office manager, supervisors and adjusters. These resumes should include any professional designations held by the individuals as well as listing of memberships in professional organizations. Direct experience of adjusting staff will be a determining factor in the Parish of Jefferson's selection process. Respondents must include a job description for each Classification of the service team.

CCMSI is a multi-line TPA with 1800 employees and offices in 35 states. We have long-term experience and understanding of the unique risks with Public Entity clients. With over 33% of our client base in the public sector, which includes Cities, States, Counties, Parish Governments, Utilities, School Boards, Louisiana Police Juries and Waste Disposal. **See Exhibit 1 for Client Service Team Biographies.**

Because of the pivotal positions of the team, the Parish of Jefferson shall retain the right to meet, review and approve of any potential assignee to the team at the inception of the service and throughout the term of the contract, which results from the SOQ.

CCMSI agrees.

E. Respondents shall supply a list describing similar previous work done, arranged by subject area, stating client's name (governmental agency or private business) and the names of contact persons for each client listed.

Veronica Guevara, Risk Management & Compliance Director
Bexar County, Texas
101 W. Nueva St., Suite 901
San Antonio, TX 78205
Veronica.guevara@bexar.org
210-335-2559

John Petrelli, CPCU, AIC, ARM
Director, Risk Management and Professional Standards
Orange County, Florida
(407)836-9636
John.Petrelli@ocfl.net

Cindy Bradshaw, State Insurance Administrator
Mississippi State Agencies
1428 Lackland Dr.
Jackson, MS 39216
(601) 359-5014
Cindy.bradshaw@dfa.ms.gov

Guy Cormier, Executive Director
Parish Government Risk Management Agency
707 North 7th Street
Baton Rouge, LA 70802
(225) 343-2835
guy@lpgov.org

Alan Hurst, Acting Executive Director
Commonwealth of Kentucky
200 Fair Oaks Lane
5th Floor, Suite 511
Frankfort, KY 40601
(502) 564-5943
Alanb.hurst@ky.gov

F. Respondents shall supply financial statements for the past three (3) years or other representation of financial solvency.

Please refer to Exhibit 2 for the past three years audited financial statements.

CCMSI

Scope of Services

Scope of Services

A. Claims Administration

The following items should be addressed in each SOQ, in the order they appear below, for the purpose of guiding the Parish of Jefferson in its evaluation process. A Respondent's failure to do so will result in the lowering of its rating or the disqualification of the Respondent.

1. Experience and Professional Qualifications:

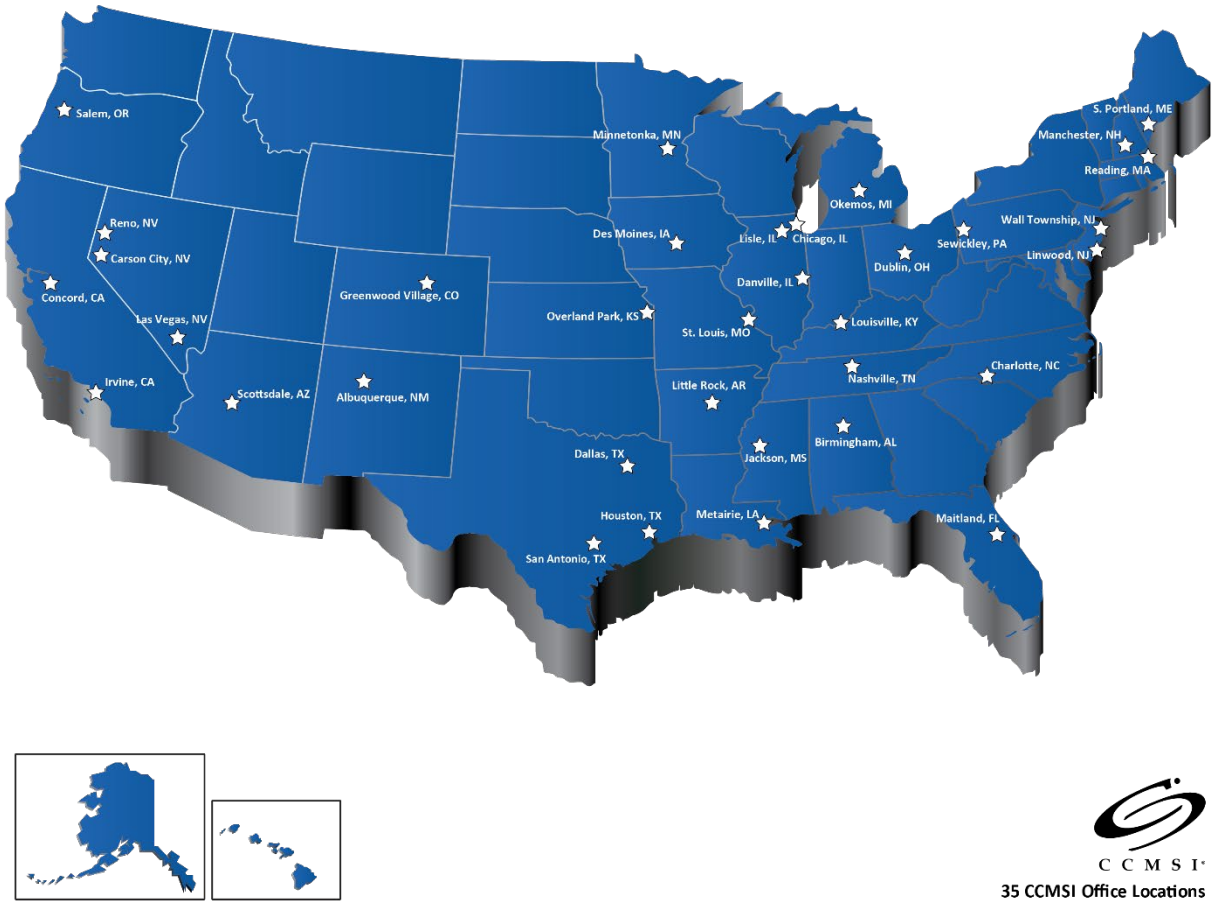
a. A general statement about the company, stating the length of time it has been in business as a Claims Administrator and has been adjusting General Liability, Professional Liability, Employment Practices Liability, Public Officials and Employee's Liability. Automobile Liability, Workers' Compensation, SELA/Property, and other claims. Please include the location of the company's principal office.

Cannon Cochran Management Services, Inc. (CCMSI), a Delaware-registered S-Corporation, has led the way as the gold standard third-party administrator for property/casualty programs since 1978, providing unrivalled workers' compensation, liability, and property claims management. We bring together the best talent in the TPA industry and prioritize the needs, goals, and expectations of our clients by utilizing innovative solutions, cutting-edge technology, and tailored approaches to claim services, loss control, managed care, internet claims analysis, and reporting services.

CCMSI has provided these services to Jefferson Parish since 2006.

As a privately held, ***100% employee-owned*** company, CCMSI is beholden to our clients—not insurance carriers, brokers, or private equity funds. This empowers our team to make client-centric decisions and focus on long-term client value creation versus short-term financial performance. Our dedication to transparency and reputation for the highest quality client satisfaction, superior results, integrity, and promise fulfillment has earned us the respect of our clients and partners nationwide.

CCMSI's Corporate Headquarters is located in Danville, Illinois.



C C M S I

35 CCMSI Office Locations

b. Experience including any professional designations, membership, in local and national professional organizations held by the individuals, and the number of staff members. The identity of the person assigned as the account executive for the administration of the Parish of Jefferson's claims, including a complete resume for this individual. The identities of supervisors and adjusters to provide claims administration, a complete resume for each, the resume should include the number of years of experience in each assigned area, and a description of whatever training is provided.
NQTE: The Parish of Jefferson reserves the right to accept/reject key personnel.

CCMSI is a multi-line TPA with 1800 employees and offices in 35 states. We have long-term experience and understanding of the unique risks with Public Entity clients. With over 33% of our client base in the public sector, which includes Cities, States, Counties, Parish Governments, Utilities, School Boards, Louisiana Police Juries and Waste Disposal. **See Exhibit 1 for Client Service Team Biographies.**

c. Indicate the location from which the account will be served, including answers to the following:

Jefferson Parish's account will continue to be managed from our Metairie, LA office location and will continue to staff personnel within the Parish of Jefferson's Department of Risk Management.

NOTE: The Parish of Jefferson will require the service company to staff and maintain an office within the Parish of Jefferson's Department of Risk Management offices in order to service its claims.

i. Is the Respondent, therefore, willing to set up a fully staffed, office within the Parish's building?

Yes.

ii. What is the Respondent's maximum capacity for its present operations and what modifications in equipment and staffing would be necessary if awarded this contract?

We have unlimited capacity in our current location and will need no modifications.

iii. Please provide information concerning backup personnel in the absence of the key personnel.

CCMSI utilizes dedicated Client Service Teams, delivering exceptional personalized service to Jefferson Parish. Each claim adjuster on a team has access to every claim file. In the absence of your Liability team, Adjusters Bernard Deckelman and Rick Poyner, Karen Bonnet will be available for claim handling and questions. In the absence of your WC team, LT adjuster Lori Francis and MO adjuster Patricia Aperwhite, Donnell Langley will be available. In addition, your Account Manager, Karen Thurman as well as Executive Account Manager, Jerry Armatis are always available for inquiries and issues.

2. Your administrative philosophy as it relates to:

Note: we have created customized Best Practices (BP) for Jefferson Parish using an integration of CCMSI Corporate Best Practices and Jefferson Parish Client Specific Instructions. **Please refer to Exhibit 3 – Corporate Claims Handling Best Practices and Exhibit 4 – Jefferson Parish Special Account Handling Guidelines.**

a. Payment or nonpayment of claims- Please refer to Jefferson Parish's Client Specific Instructions page 3 "Denials" & CCMSI Best Practices page 53.
b. Method of managing the reporting of claims- Please refer to Jefferson Parish's Client Specific Instructions page 1 "Initial Reports" & "Loss Notices/Initial Contact"
c. Injured employee's work status- See CCMSI Best Practices page 42.
d. Workers' Compensation Appeals Bond and Rehabilitation Unit appearances- CCMSI will have available a representative to attend as requested.
e. Fraud referrals- See CCMSI Best Practices page 71.
f. Notification of payment or nonpayment decisions to claimant and Parish of Jefferson- Please refer to Jefferson Parish's Client Specific Instructions page 3 "Denials"
g. Providing loss information- while loss information is available in real time in ICE, special reports have and can be created to meet clients' specific needs with the ability schedule reports for automatic delivery at desired times such as weekly, monthly, annually etc.
h. Approach to subrogation- Please refer to Jefferson Parish's Client Specific Instructions page 6 "Subrogation"
i. Settlements- Please refer to Jefferson Parish's Client Specific Instructions page 2 "Settlement Authority"
j. Reserving- Please refer to Jefferson Parish's Client Specific Instructions page 2 "Reserve Recommendations" & CCMSI Best Practices page 32.
k. Late payment policy- see CCMSI Best Practices, Claim Payments outlining expectations on time lines for payment. If a payment is issued late due to a CCMSI related error, CCMSI will be responsible for any penalties and/or attorney's fees if assessed.

I. Assignment, utilization and monitoring of vendors, e.g. surveillance, rehabilitation counselors, case management- Please refer to Jefferson Parish's Client Specific Instructions page 5-6 "Approved Vendors" & CCMSI's Best Practices page 76.

3. Your claims administrative system procedures:

a. Promptness of accident investigation including: procedures utilized by your firm to complete accident investigations and turnaround time from receipt of claim to investigation. Is the claimant contacted within twenty-four (24) hours?

*Initial contact with the claimant and Jefferson Parish within 24 hours
*Secure Jefferson Parish documents, incident reports, work orders and medical records
*Obtain any Police report
* Contact witnesses
* Finalize determination of liability and/or compensability

b. File review/diary calendar, frequency of the file review; as a general rule, the Parish of Jefferson requires all cases be reviewed at least every thirty (30) days. Can your firm provide this service? What is the frequency and criteria for supervisory or managerial diary review?

Diary

For medical only claims, the Jefferson Parish claim adjuster will complete the initial action plan/diary review within thirty days and maintain a recurring action plan/diary every thirty to ninety days until claim closure. All action plans/diary reviews will be documented in the claim log notes under the appropriate headings (Action Plan/Diary Review).

For indemnity/questionable claims, the Jefferson Parish claim adjuster will complete the initial action plan/diary review within thirty days and subsequent action plans/diary reviews every thirty to ninety days depending on severity and activity of the claim. All action plans/diary reviews will be documented in the claim log notes under appropriate headings (Action Plan/Diary Review).

Diaries will be maintained on an on-going basis, and are to be completed within ten days of the due date.

Your supervisor will review all claims upon intake to guarantee correct staff assignment based on complexity of the case and staff experience and skill level, and will identify any potential complexities and necessary actions in the file notes.

Per our Corporate Claim Standards, all files must have an initial supervisor diary review within the first thirty days of receipt of a new claim. Supervisors will then be responsible for maintaining subsequent diary reviews every thirty to ninety days, depending on severity and activity of a claim.

Our claim system has an automated diary system for adjusters and supervisors, in which an automated supervisory diary notification is sent to the supervisor of the designated claim upon setup and is recurring until claim closure.

Below is what a supervisor looks at when reviewing/evaluating a claim on diary:

- **Coverage**: Was coverage verified and/or were coverage issues clearly documented in the system and appropriate follow-up actions taken.
- **Contact**: Was it documented clearly and in the timeframe established by our Corporate Claim

Standards or Jefferson Parish. Was this contact meaningful and was there appropriate follow-up contact.

- **Investigation**: Was a full investigation completed or attempted within the timeframe established by our Corporate Claim Standards or by Jefferson Parish-specific handling guidelines. Was the investigation thorough enough to support the compensability decision on the claim. Was the compensability rationale clearly documented in the log notes. Was subrogation, recovery, salvage, or SIF investigated and documented. Was the Index Bureau utilized properly and documented in the log notes in accordance with our Corporate Claim Standards. Is additional investigation necessary.
- **Reserves**: Were the initial reserves established within Corporate Claim Standard guidelines. Were the reserves reviewed and updated timely as developments occurred. Was the reserve rationale from the adjuster clearly documented in the log notes. Are the reserves adequate based on known exposures.
- **Medical & Disability Management**: Were pertinent medical records requested, received, and documented timely in the log notes. Were medical bills properly adjudicated within state specifications or within thirty days. The supervisor will also evaluate the appropriate use of IMEs, Medical Case Management, and Vocational Rehab professionals. Did the adjuster make every effort to return the injured employee to work at the earliest possible time.
- **Litigation Management**: Were all pertinent legal information/requests handled in a timely manner. Was the litigation plan and/or settlement strategy of the claim managed and directed by the claim professional, as well as clearly documented in the claim log notes.
- **Excess/Reinsurance**: If the claim met the reporting requirements, was prompt notice given and documented clearly in the claim log notes. Were timely follow-up reports provided to the carrier/Jefferson Parish once the initial report was made.
- **File Documentation & Misc.**: Was a meaningful initial action plan developed/documented and updated timely to reflect important changes. Were log notes and the claim summary current, concise, and complete. Were Jefferson Parish instructions followed. Was the claim file concluded effectively and timely.

Following the file review, supervisors will document their findings and recommendations for future handling in the file notes and continue monitoring to ensure their recommendations were executed.

c. Expectation to subcontract any part of the contract with the Parish of Jefferson; Please explain in detail and identify any potential sub-contractor, including address, contact person and telephone number. Are these costs included in your fee or charged separately to the Parish of Jefferson? What is the method for determining when and if these services are warranted, and what is your firm's procedure for monitoring these services? This does not include allocated cost expense.

No expectation to subcontract any part of the contract.

d. It is the expectation of the Parish of Jefferson that the selected TPA make an aggressive effort to comply with the needs of the Parish. Such needs may require the TPA to provide various reports. The development and preparation of these reports should be included in the final cost of service. The Parish of Jefferson will not be responsible for any costs incurred by the selected TPA to have these reports prepared by subcontractor or outside service, including. The Parish of Jefferson will not be responsible for paying any costs or fees associated with any Parish of Jefferson/TPA meetings or mediations during the term of this contract.

We are currently providing custom reports that have been created specifically for Jefferson Parish at their requests. Those reports have been and will be provided at no charge.

e. Procedures and guidelines for handling claims (standard service).

Please refer to Exhibit 3 – Corporate Claims Handling Best Practices and Exhibit 4 – Jefferson Parish Client Specific Instructions.

f. Record keeping, correspondence.

All documents for record keeping and correspondence are attached to the occurrence.

g. The period of retention of a file that is closed or resolved; identify what constitutes a closed file.

Standard retention is 15 years. **Liability**: once a claim has been settled, a release is secured and payment is issued. If in litigation, the file will be closed when a release and dismissal are secured and final legal invoices are paid. **Workers Compensation**: claims are closed when the injured employee returns to work, is settled or resolved through litigation.

h. Number of employees to be assigned to the administration of the claims, including the maximum number of claims assigned to each adjuster. The Parish of Jefferson shall allow each General Liability, Automobile Liability and other claims adjuster to handle not more than 125 claims at any given time. A minimum of two (2) dedicated casualty claim adjusters will be required. These Adjusters will be housed on-site at The Parish's Department of Risk Management. The Parish of Jefferson shall require one (1) dedicated Workers' Compensation claim adjuster and one (1) person for Medical only and payment processing.

Agreed. We are currently providing 2 dedicated Liability adjusters onsite at the Dept. of Risk Management with each having no more than 125 open claims and 1 dedicated Workers Comp and one designated Med Only adjuster.

i. Type of disaster recovery system or plan in case of catastrophe or other disaster.

It should be noted that CCMSI's Louisiana offices in Metairie and New Orleans sustained substantial damage from Hurricane Katrina in the Fall of 2005 and were out of operation for over three and a half months. The day after the storm, CCMSI's Management Team immediately assigned a Disaster Team Unit to locate all employees and transfer all account services to other CCMSI offices. All necessary claim payments were handled either out of the CCMSI Jackson, MS or Danville, IL offices. Client services to all Louisiana and Mississippi accounts went uninterrupted and CCMSI also developed a debit card payment system for displaced claimants that were scattered throughout the country.

CCMSI maintains two data centers. The primary data center is located in Danville, IL. Secondary data center is located in Indianapolis, IN. All servers are backed up nightly and database servers are backed up hourly. All data at rest is encrypted. All data is replicated securely to our secondary data center in real-time. Both data centers are both physically and logically secured restricting access to authorized staff. Video surveillance with motion detection alerts management of access. Access logs are reviewed monthly. Both data centers have environmental controls and alerts for power, fire and temperature events.

Controls are in place for new hire and terminations to assure physical and logical access is addressed. Visitors must check in at the reception desk, identified with visitor badge and accompanied while visiting CCMSI.

CCMSI Network is protected by an enterprise firewall with intrusion prevention system protecting our infrastructure from potential threats. Enterprise Antivirus and Antimalware are installed on all endpoint devices and severs. Signatures are updated daily. All remote access requires approval and multi-factor authentication. All endpoints are encrypted using Microsoft BitLocker.

CCMSI websites are secure using HTTPS with Transport Layer Security (TLS 1.2). CCMSI also uses Secure FTP for any data transfer processes. Email is encrypted using opportunistic TLS and forced TLS for clients that request. Email that contains sensitive information uses strict encryption.

Quarterly penetration and vulnerability testing is performed by an independent security vendor to test our external facing infrastructure. Bi-annual intrusive testing is performed on our external facing applications to check for vulnerabilities. Internal vulnerability scans are performed quarterly as well.

CCMSI completes annual SOC 1 and SOC 2 audits to demonstrate that our financial, technology, and security controls are properly designed and operate effectively regarding the confidentiality, integrity and availability of customer information.

CCMSI has a formal Information Security Policy implemented that outlines our controls and policies. Employees are required to review and acknowledge the policy annually. CCMSI also has an extensive security awareness program requiring employees to complete quarterly training. Security newsletters and cyber tips/alerts are also communicated regularly.

CCMSI maintains a cybersecurity insurance policy which includes pre-approved services (Breach coaches, forensic and ransomware services, call center and notification services, etc.) to assist with any security event.

Please refer to Exhibit 5 - Data Disaster Recovery Plan and Exhibit 6 – Business Continuity Plan.

j. Subrogation and Second Injury Fund procedures; your firm's experience based upon percentage recovery and dollar amount over the past three (3) years.

CCMSI acknowledges Jefferson Parish's claim costs can be significantly reduced by identifying, pursuing, and achieving optimal recoveries, when applicable; therefore, when a third party is involved in a claim, it may be possible to recover significant funds directly from them or their insurance carrier.

CCMSI's claim representatives are well versed in the pursuit of subrogation and potential recovery of funds when available and accessible. Subrogation investigations are conducted on all claims showing potential subrogation involvement.

2019-2021 Second Injury Fund Summary:

- All states past 3 years totaled $47,235,603. Specifically for Louisiana the past 3 years totaled $18,814,270.

2019 Subrogation Summary:

- Total subrogation all clients = **$23,898,717.69**

2020 Subrogation Summary:

- Total subrogation all clients = **$26,222,806.10**

2021 Subrogation Summary:

- Total subrogation all clients = **$30,890,265.52**

Potential types of claims that may involve subrogation include, but are not limited to:

- Animal bites
- Slips and falls (on or off insured premises)
- Aircraft, train, or boat accidents
- Motor vehicle accidents
- Construction site accidents
- Machinery accidents
- Product-related claims
- Losses involving an explosion or fire
- Lifting/loading/unloading accidents
- Inhalation/exposure claims
- Criminal interaction claims

When a CCMSI claim representative becomes aware of a recovery potential, they will discuss the matter with a claim supervisor first and then Jefferson Parish, obtaining authority to pursue the opportunity further. Once authorized, the claim representative will place the third party on notice of our *rights of recovery*. Should there be viable recovery potential, a subrogation/recovery action plan is produced in the claim file notes, outlining the subrogation issues involved, potential for recovery, probable amount to be recovered, and steps to be taken to affect the recovery. As with general action plans, subrogation action plans are revised as the facts of the claim warrant.

Subsequent follow-ups are performed in order to keep the third party apprised of the nature and extent of damages and progression of the claim towards conclusion. If the third party disputes the accident facts and/or liability for the claimant's injuries, the claim representative attempts to negotiate a reasonable and timely settlement if it is financially prudent to do so. Should the third party continue to dispute liability or the extent of monies owed, then the claim representative will pursue the matter further through legal remedies (i.e., mediation, suit). Subrogation will be pursued until such time it is deemed imprudent, improbable, or until Jefferson Parish advises to discontinue.

k. Services provided to walk-in claimants.

Our offices are easily accessible for claimants with prior notice

l. Any claims adjustment standards that your firm believes are pertinent.

Over the years in partnership with Jefferson Parish we have incorporated Jefferson Parish unique claim handling best practices and reporting needs with our Corp Best Practices.

m. Jefferson Parish requires daily balance access to the Trust Funds and General Ledger. The Trust Fund accounts will be established by the Parish of Jefferson at its designated banking institution. The TPA will be responsible for the accuracy and information contained in this system. Jefferson Parish will require internet read only access as it relates to the Trust Fund and General Ledger.

CCMSI agrees.

n. The TPA will be responsible for the verification of the legitimacy of payments made to service providers and for the disbursal of the benefits through Jefferson Parish's check issuance process. Jefferson Parish therefore reserves the right for staff of its office or its designee to conduct audits of financial accountability procedures.

CCMSI agrees.

o. The TPA will be responsible for any and all NSF charges incurred for any reason.

CCMSI agrees.

p. The TPA will be responsible for producing and mailing 1099s, in accordance with Internal Revenue Service regulations, for all claims payments made.

CCMSI agrees.

q. The TPA will be responsible for producing any reports required by regulatory bodies, including but not limited to the LDOL 1000, Annual Report of Workers Compensation Costs and the Second Injury Fund Future Liability Worksheets.

CCMSI agrees.

r. Provide a description of your internal quality control program and the procedures utilized by management personnel to ensure the quality of services to be provided to the Parish of Jefferson.

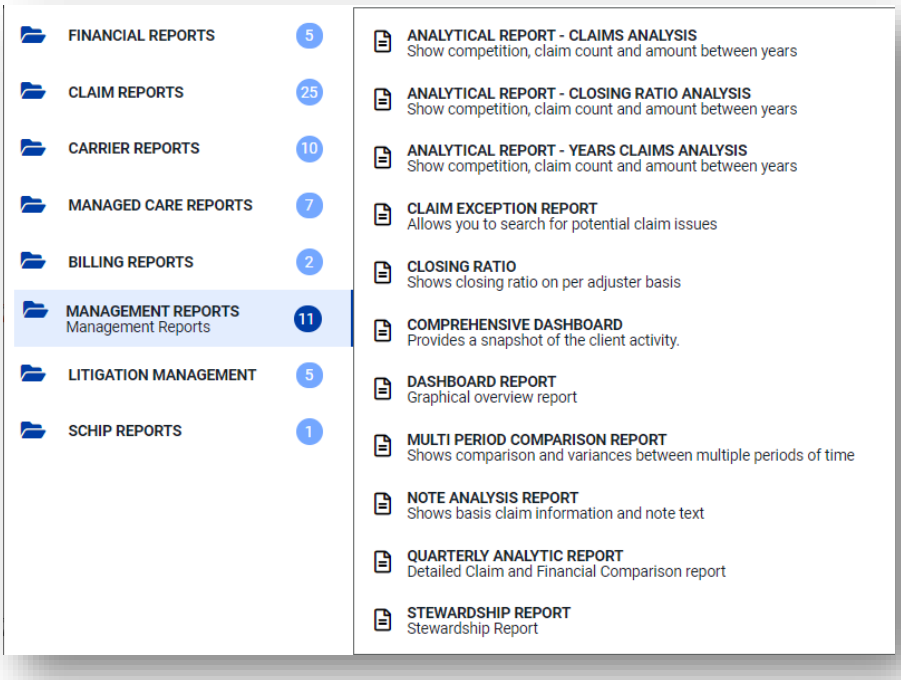
Our entire quality assurance program is driven to ensure our strict adherence to Best Practices, and even more importantly, to Jefferson Parish's definition of quality—the individualized Jefferson Parish Quality Service Plan.

CCMSI is guided by our commitment to continue to provide superior claims management for Jefferson Parish. As such, the Quality Assurance Team, with a wealth of experience from claims management, system training, auditing, and management training, has developed the resources that enable us to consistently provide quality, aggressive claims management.

Quality Service Plan In order to design the structure of the program to meet the exact specifications of Jefferson Parish, custom and detailed handling instructions have been created. We work diligently with the Parish to ensure continuous and consistent compliance with these instructions.

Jefferson Parish Scorecard At the outset of the relationship, a Jefferson Parish Scorecard will be developed in concert with Jefferson Parish to identify the specific criteria upon which CCMSI's performance will be evaluated. Your account manager will meet with you annually to complete the evaluation, producing a numeric rating of each aspect of CCMSI's claims handling and Jefferson Parish service. If we score less than 100%, a specific action list is developed and implemented to improve our results over the next year. **Jefferson Parish Scorecard results are one of our most important performance metrics, and thus used for employee performance evaluation and incentive purposes.**

Monthly Report Review Your account manager will run Management Reports from MyReports to review data and claims trends.



Annual Stewardship Meetings We hold annual performance evaluations and strategy meetings to review the prior year's performance, including service, claim causes, and loss cost trends and analysis. In addition, we collaborate with Jefferson Parish to develop and implement strategies for improving the results of the program in the next year.

Annual Corporate Audits CCMSI performs annual audits on a sample of claims handled by each adjuster through a standard method understood by all claims staff. After each review, discussion and feedback sessions take place with the individual office and claim personnel applicable to the audit. If needed, management of that office and the audit team (if requested) implement action plans to address any areas identified as needing improvement.

Goals of the Audit Team

- Ensure compliance with Best Practices, Jefferson Parish handling instructions, and carrier requirements;
- Provide an objective audit with constructive feedback;
- Help management and claims staff proactively identify areas for improvement;
- Work with our claims staff to provide solutions to any areas identified as needing improvement;
- Foster understanding of our Mission with all claims staff;
- Streamline processes to ensure timely delivery of services to Jefferson Parish; and
- Ensure quality service and value to Jefferson Parish.

Basic Process

- The audit will include eight to ten files for each adjuster, unless additional information is needed. If clear trends are evident after reviewing eight claims, the auditor may elect not to review further files.
- Four claims will be audited for staff who earned 93% or higher on their last two audits. If the new score is 93% or higher, the score on these four claims will be used as the final score. If the score

is below 93%, an additional four to six claims will be reviewed for a full audit.

- The claims selected will include those assigned to the adjuster during the time period since the last internal audit. Typically, this will be a date range of the prior eight to nine months in order to finalize the prior audit, and then not within the last one to two months.
- For indemnity adjusters, it is preferred they are assigned to the claim from the start or receive the transfer from a medical only adjuster; avoiding transfers from another indemnity adjuster, if at all possible.
- The audit will include a review of all adjusters handling files, including supervisors with significant caseloads, P&C adjusters, indemnity adjusters, and medical only adjusters.

If there are any serious issues identified, an earlier repeat audit may be recommended. This continuous evaluation of the claims staff, as well as the processes and systems, is communicated to senior management, fostering growth and development in the claims staff and local management, and encouraging continuous improvement in CCMSI's quality handling of claims.

See Exhibit 7 for Internal Auditing Guidelines & Worksheets.

External Audits and File Reviews CCMSI coordinates audits and file reviews with Jefferson Parish, brokers, and excess insurers. We welcome the opportunity to validate our quality procedures, gauge our performance, and address any improvements that are needed. The account manager facilitates the auditor's review and coordinates the company's written response and procedural action items.

Supervisor Reviews We perform reviews utilizing a detailed quality checklist to ensure compliance with internal best practices and Jefferson Parish's specific Quality Service Plan. Supervisor reviews are performed upon claim intake and no fewer than thirty to ninety days thereafter, based on claim complexity. Supervisors will not simply check off Best Practice compliance, but diligently push proactive and aggressive claims handling to drive rapid file closure.

Supervisor Audits File audits are conducted on a designated number of files for each adjuster and Jefferson Parish on a monthly basis.

s. Claims management system (Risk Management Information System); Describe your firm's claims management system.

iCE (Internet Claims Edge), CCMSI's trailblazing Risk Management Information System software, was designed with your needs in mind. As with all CCMSI solutions, iCE is customizable and tailored to the requirements of our clients. Through this web-based, mobile-friendly system, you can view each claim in real time, 24/7; by user-defined filters (including type of claim and date of loss); at a high level or in detail; and include adjusters' notes and bill images. This powerful claim analysis and reporting tool provides:

- ***Initial Reporting*** Create initial report forms online in iCE or send us claims via web service or through a custom-built interface. Offers industry-specific custom reporting, such Accident Reports created specifically for our transportation clients.
- ***Executive Summary Dashboard*** View and customize a broad overview of your risk management analysis.
- ***Claims Analysis*** A powerful and flexible analysis tool enabling users to view claims in as little or as much detail as they wish.

- ***MyReports*** CCMSI's enterprise reporting engine offers countless possible combinations of data for analysis. Reports can be exported to PDF or Excel, scheduled for systematic delivery directly to an email inbox, or posted to iCE.
- ***Comp MC*** MyReports allows users to run managed care reports for Comp MC (CCMSI's managed care program) with the ability to choose any number of reports from our library, such as PPO penetration or savings by a specific location.
- ***OSHA Reporting*** Removes the need for duplicate data entry by compiling claims information recorded in the Initial Report to create OSHA 300 (Log), 300-A (Summary), and 301 (Incident Report) forms, which may be printed at any time for any location.
- ***Claim Risk Assessment*** Predictive modeling module identifying claims that have the potential to be higher risk, allowing for early intervention and better outcomes.
- ***ClaimView*** Mobile-friendly claimant portal for injured workers, allowing them to view their lost time payments and active drug cards, upload photos of documents, and communicate with their adjuster.
- ***Stewardship and Benchmarking*** Utilizing historical trends and other benchmarking sources (such as WCRI and IDS), we can perform regular and detailed analysis of our performance, providing clients extensive metrics to drive the success of the claims management program.

Additional features of iCE include:

- Flexible, user-friendly navigation;
- Capability to receive data from a multitude of data sources;
- Password protection with varying levels of security access;
- Allows hierarchy of up to twenty-five levels to track data by state, department, etc.;
- Ability to create customized user fields;
- Ability to view adjuster notes by category, including summary, medical, litigation, reserves, etc.;
- Ability to generate state-specific First Report of Injury and other state forms in PDF;
- Ability for clients to upload documents directly to the claim file/adjuster;
- Online medical bill and medical report viewing; and
- Predictive Analytics utilizing daily AI functionality to determine risk drivers, future treatments, and estimated financial incurred values.

Reporting Features:

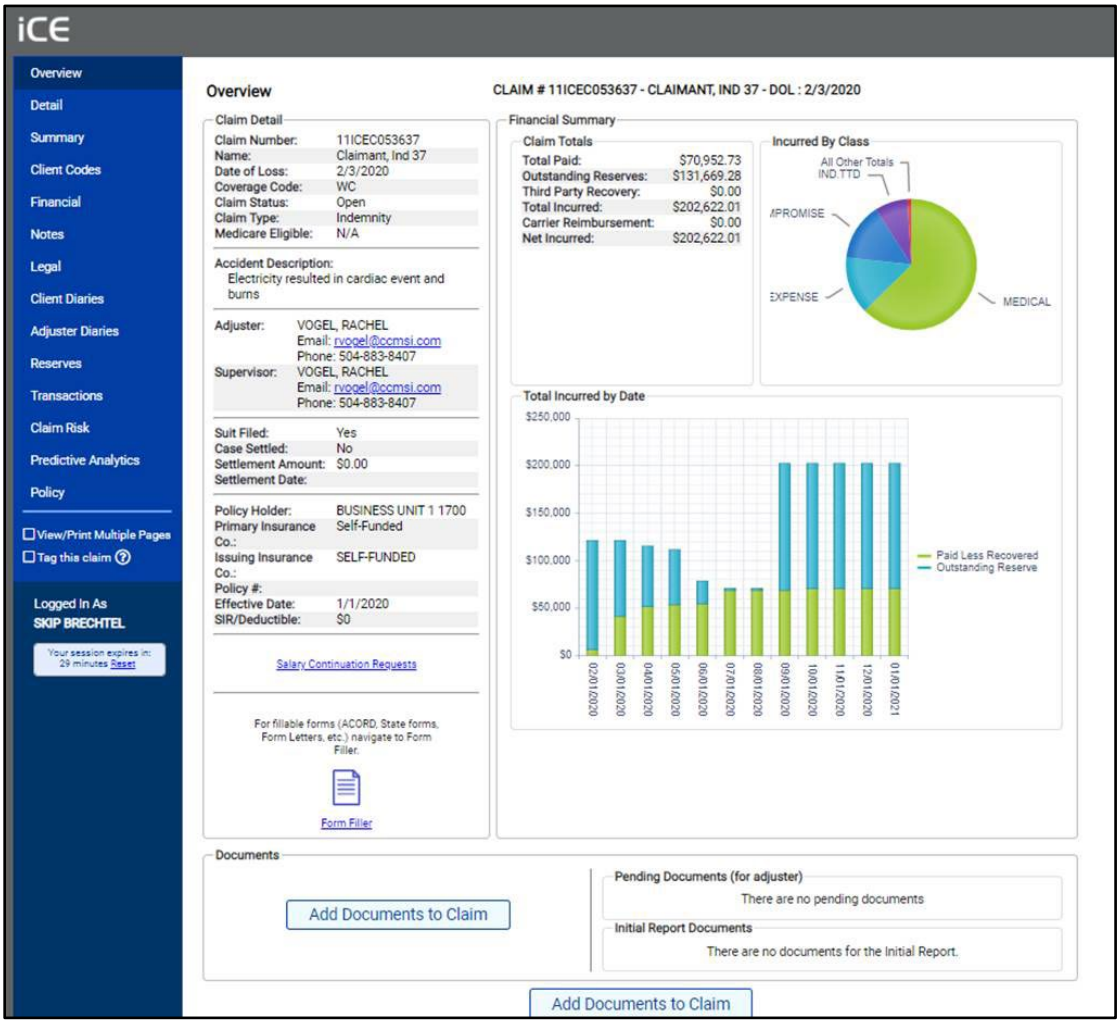
- Online access to monthly standard reports dating back twenty-four months;
- User-specific Executive Portal showing key data upon login;
- Dashboard functionality, customizable to the user's needs;
- Complete ad hoc reporting capabilities, including financial, claims detail, and loss control data;
- Summary and detail claim reporting with drill-down capabilities;
- Analytical tools, including historical and current period comparisons and various graphical presentation; and
- Cost containment savings and fee reporting.

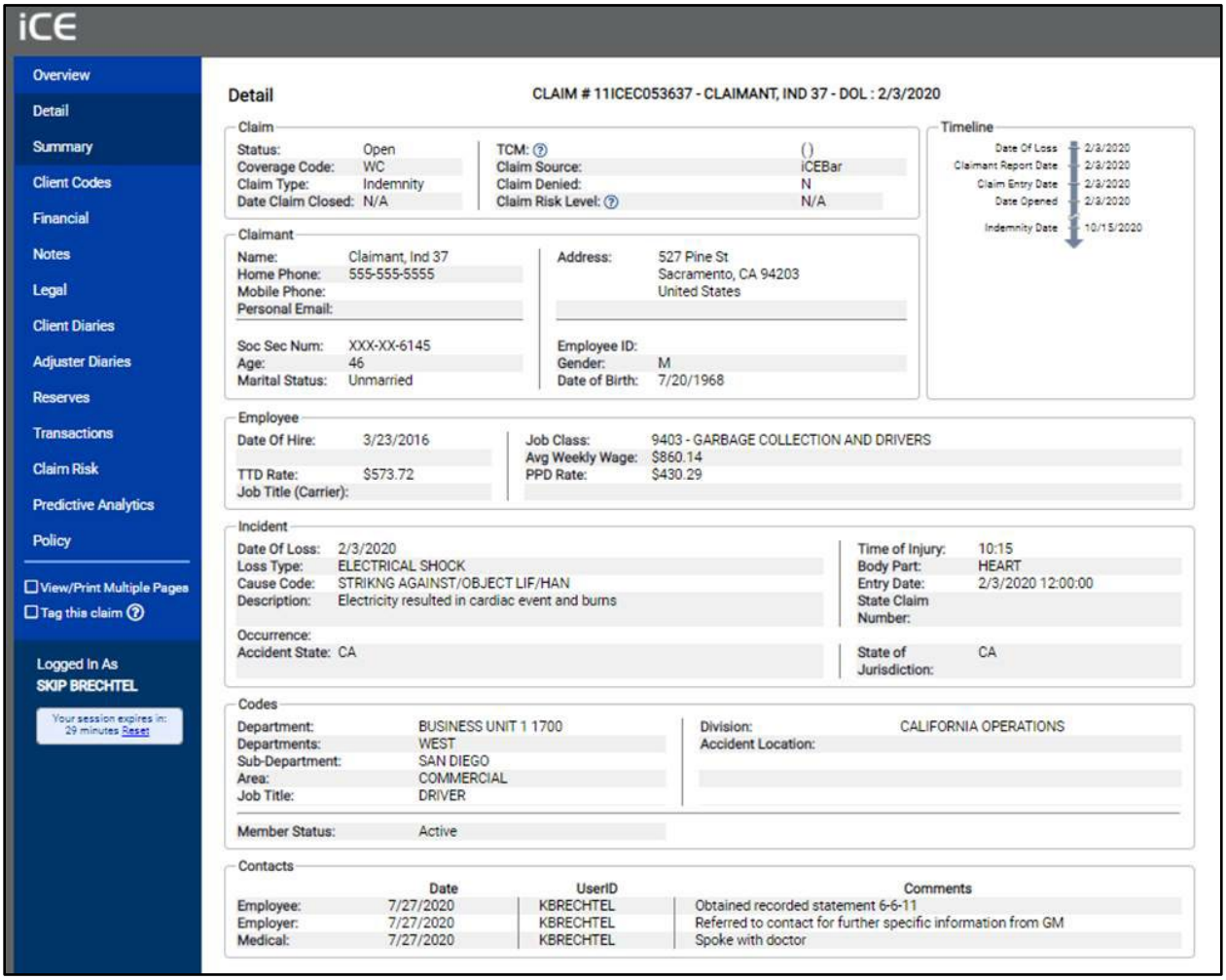
Overview of Access and Reporting

Levels of access are assigned to Jefferson Parish's designated employees, who are then able to review every aspect of the claim file from a selected group (e.g., department or division), a particular time period, or Jefferson Parish as a whole. Jefferson Parish-specific reports, including loss, financial, and summary reports; monthly check registers; and monthly vendor payments will be posted on Jefferson Parish's iCE report tab and maintained in PDF format for a rolling twelve-month period.

All payments made on a claim are listed on the financial transaction screens, which provide information on each individual payment and a link to scanned images of medical bills and reports, complete with commentary. In addition, we offer *as of date* financial information with a simple calendar selector, allowing information rollback to a previous date.

The following screenshots display claim file categories and a navigational sidebar containing other key elements available for Jefferson Parish review.

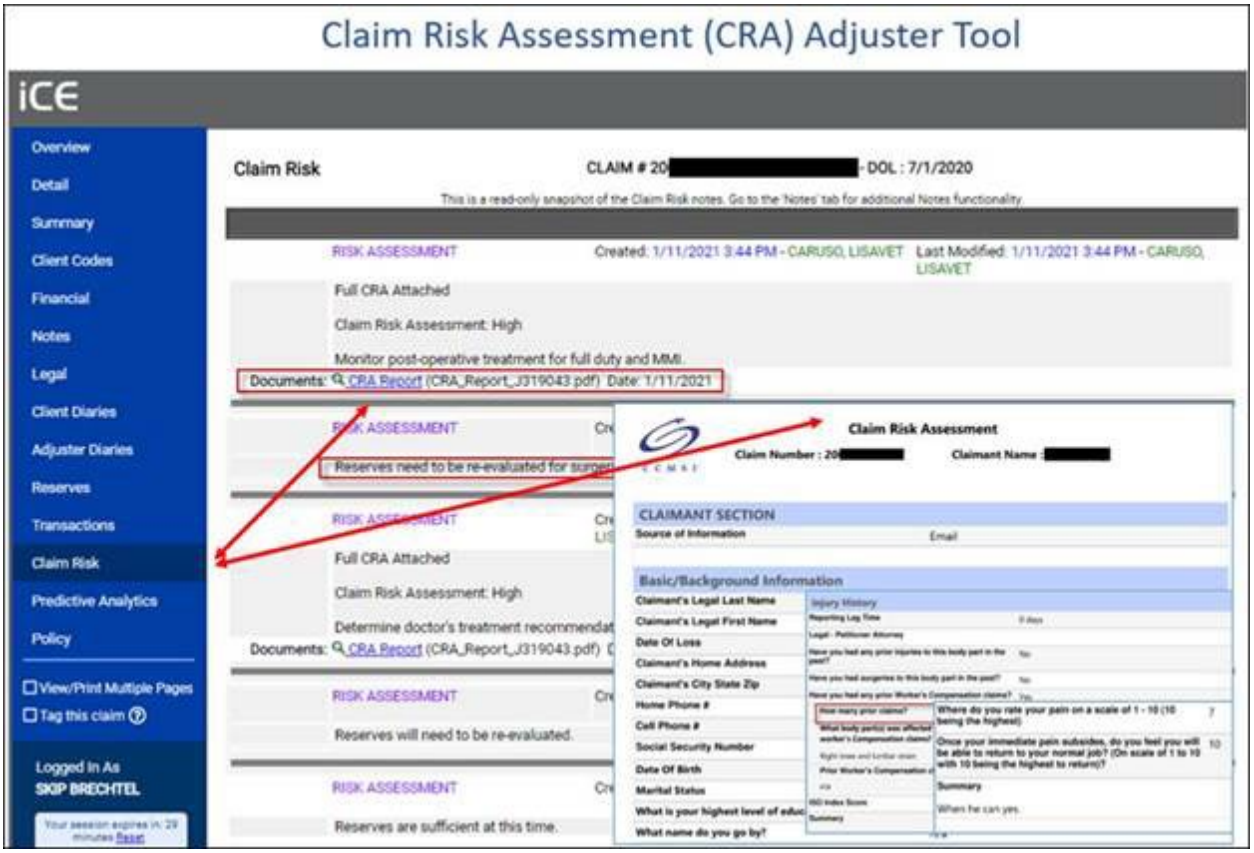




Jefferson Parish has the ability to filter claim information by a multitude of data fields, including date of loss, claimant name and/or Social Security Number, claims denied, and total incurred over a specific dollar amount. Once the desired claim has been located, Jefferson Parish can view and download information, such as claim status (open, closed, pending); detailed summary of claim facts and information; employment information (e.g., average weekly wage and PPD rate); as well as all adjustor log notes, including action plan/diary review, settlement evaluation, and summary of medical treatment and case management activity. In addition, Jefferson Parish can quickly view financial transactions and analysis, including detailed payments, medical invoices, and charts to provide a comprehensive and visual breakdown of claim reserves and reserve development.

CCMSI Claim Risk Assessment (CRA) and New Gradient AI Daily Claim Scorecard

CCMSI understands early identification and intervention of potential high-risk claims can deliver dramatic cost-savings benefits to our clients. Since 2015, we have utilized Claim Risk Assessment (CRA) Adjuster Tool, a customized in-house claim scoring system to classify indemnity claims as potential high, moderate, or low risk. The scoring system captures seventy-five data fields, such as comorbidities, distance to doctor, claimant's probability of returning to work, prior surgeries, etc. (Note: A complete list is available upon request.)

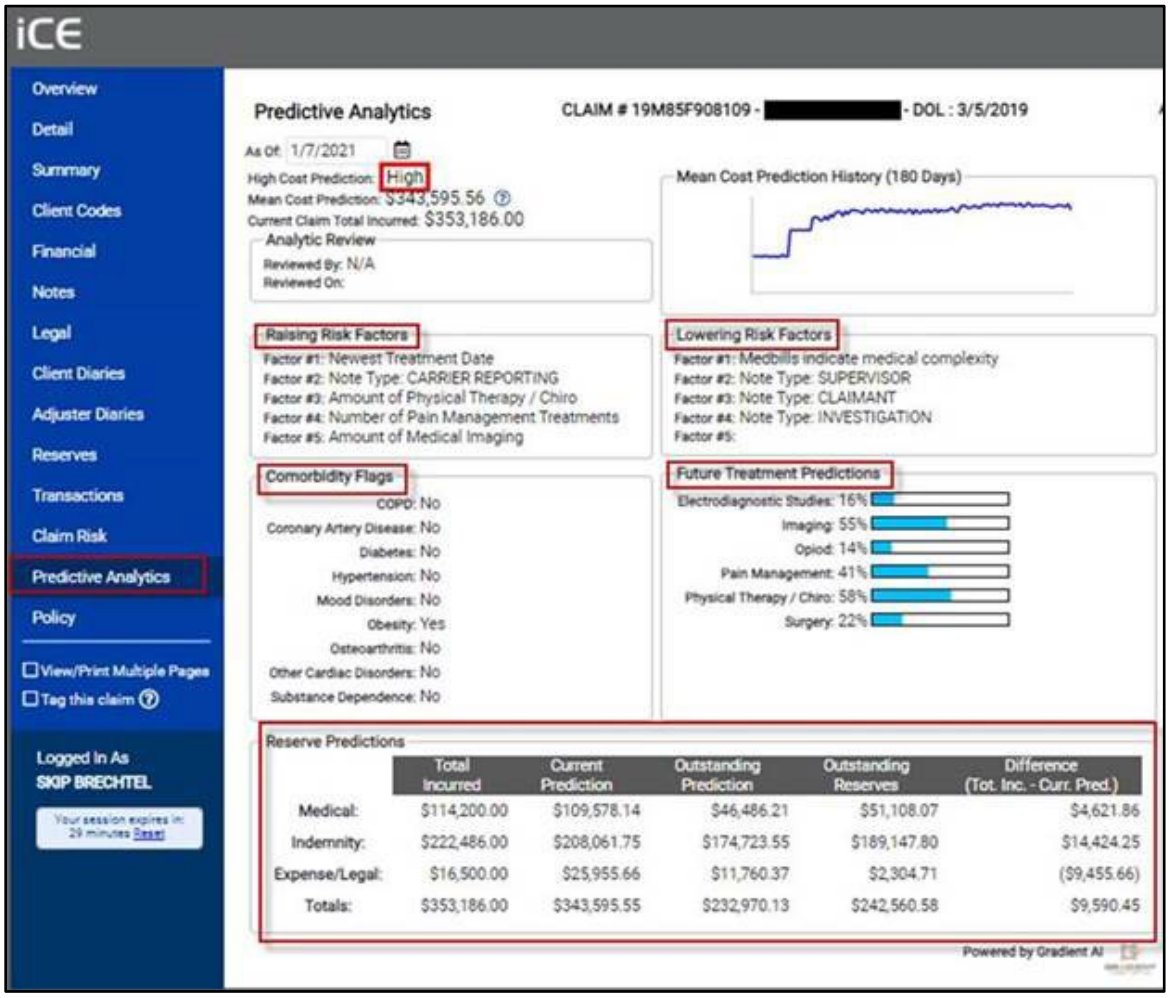


In First Quarter 2019, CCMSI completed its integration with Gradient AI, utilizing its artificial intelligence product to score all indemnity and medical-only claims nightly. Gradient now utilizes over forty-five million workers' compensation claims and additional third-party datasets to perform daily analysis, proving to be extremely successful in early identification of claim drivers and costs.

Each evening, CCMSI transmits all claims data fields captured in our system to Gradient AI, including transactions, adjuster notes, medical bills, prescriptions, and our claim risk assessment fields. Gradient then scores the claims and provides CCMSI with the following information:

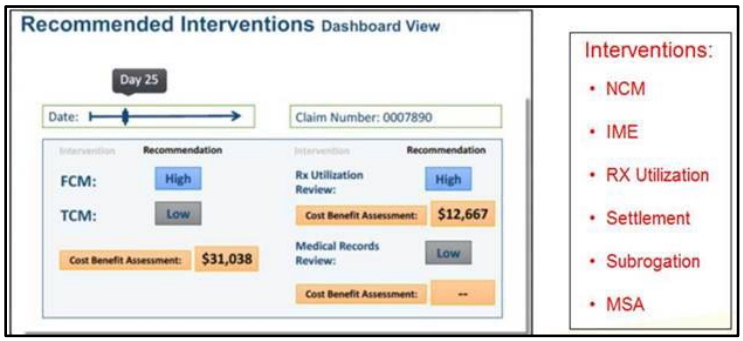
- Risk classification of *High*, *Medium*, or *Low* of claim being high cost;
- Total incurred predication (starting thirty days after receipt by CCMSI);
- Treatment predictions (e.g., surgery, PT, electrodiagnostic, imaging, opioids, pain management);
- List of all comorbidities; and
- List of factors impacting cost of the claim (e.g., legal, return to work, future medical).

The screenshot below illustrates how this is depicted in our clients' iCE portals:



CCMSI adjusters, supervisors, and account managers use this information as an additional tool in the assessment of the claim and in discussions with Jefferson Parish.

Phase Two of the Gradient AI product will provide our claims team and clients with additional claim intervention information, which can be utilized to assist with recommended interventions in six key areas: NCM, IME, Rx utilization, settlement, subrogation, and MSA.



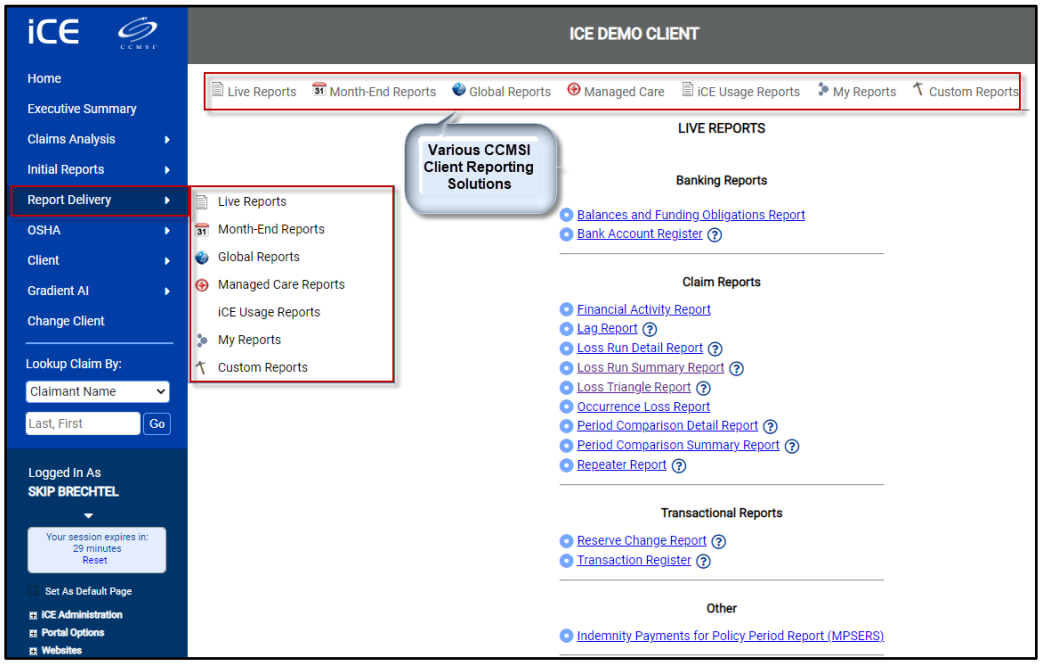
CCMSI is currently working with Gradient AI on the following additional predictive models:

- Evaluation of medical-only claims that will convert to indemnity claims;
- Evaluation of claims that will have attorney representation;
- Estimated average duration of lost days;
- Medical providers with best outcomes; and
- PT scorecard and analytic status of claimant physical therapy progress.

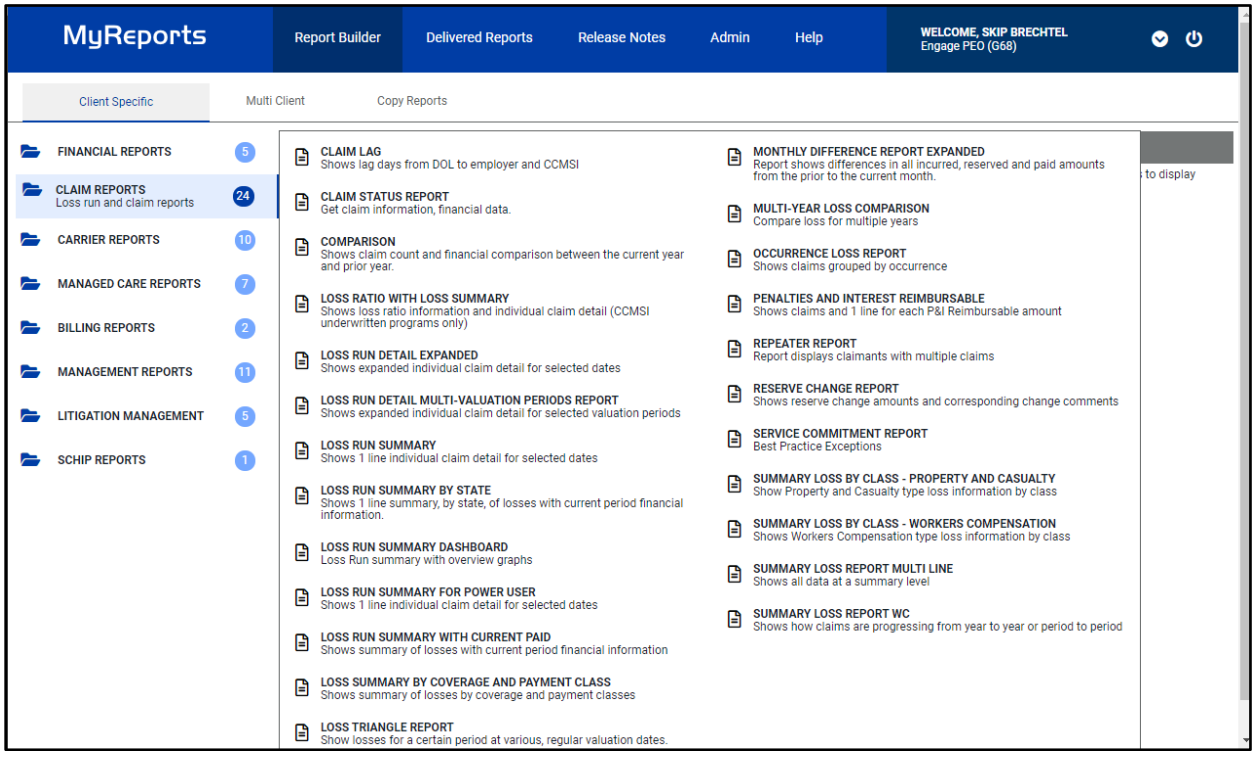
Reports

CCMSI's iCE (Internet Claims Edge) risk management system is designed to provide timely, accurate, and robust data for Jefferson Parish. Users can easily retrieve claims and loss control data via standard and ad hoc online reports as high level or as detailed as they choose.

- ***Standard Reports*** Over the years, CCMSI has developed a catalog of over four hundred reports based specifically on the requirements of our clients, including detailed claim information, summary (at various reporting levels), check and payment registers, and loss ratio (by desired operating levels). These static reports are posted online within five business days and available 24/7 within iCE.
- ***Ad hoc reporting*** Jefferson Parish can generate a wide array of useful ad hoc reports with the opportunity to sort and categorize by various fields and data. Robust analytics, such as valuable charts and graphs, are provided.
- ***Special Customized Reports*** On the rare occasion Jefferson Parish's reporting needs cannot be met by our catalog of standard or ad hoc capabilities, we can custom design and develop reports to fit their precise needs. Our standard fee is $150/hour for development; however, if the custom report requests are minimal, this will most likely be free of charge.
- ***Live Reports*** This feature provides the thirteen most commonly used reports by our clients, including detail and summary loss runs, comparative period, loss triangles, and reserve change reports. These reports can be generated with user-selected periods and *as of* dates.



- ***MyReports*** MyReports allows Jefferson Parish to build a customized loss run with over three hundred fields from which to choose. This report can be scheduled to run automatically on a regular basis, then emailed in PDF or Excel or posted to iCE. Our customer service team is available to assist in creating these reports.



B. Financial Statement

The Claims Administrator shall furnish, on an annual basis, a copy of the most recent financial report, if available, including all statement and footnote disclosures as required by generally accepted accounting principles. The audit report shall contain an unqualified opinion from a Certified Public Accounting firm, which is acceptable to the Parish of Jefferson. If the claims administrator does not have audited financial reports, the claims administrator shall provide a copy of the most recent internal financial report available.

Please refer to Exhibit 2 for CCMSI's audited financial statements.

C. References

1. For which major clients (3,000 or more employees) does your firm presently administer claims? Please provide names and telephone numbers of individuals who may be called as references. Please also indicate the types of claims administered.

Veronica Guevara, Risk Management & Compliance Director
Bexar County, Texas
101 W. Nueva St., Suite 901
San Antonio, TX 78205
Veronica.guevara@bexar.org
210-335-2559

John Petrelli, CPCU, AIC, ARM
Director, Risk Management and Professional Standards
Orange County, Florida
(407)836-9636
John.Petrelli@ocfl.net

Cindy Bradshaw, State Insurance Administrator
Mississippi State Agencies
1428 Lackland Dr.
Jackson, MS 39216
(601) 359-5014
Cindy.bradshaw@dfa.ms.gov

Guy Cormier, Executive Director
Parish Government Risk Management Agency
707 North 7th Street
Baton Rouge, LA 70802
(225) 343-2835
guy@lpgov.org

Alan Hurst, Acting Executive Director
Commonwealth of Kentucky
200 Fair Oaks Lane
5th Floor, Suite 511
Frankfort, KY 40601
(502) 564-5943
Alanb.hurst@ky.gov

2. Have any clients terminated your firm's services as a Claims Administrator within the past three (3) years? If so, please identify the client, a contact person and provide a brief description of any reason or background for the termination.

Past Client:

Jeff Hale, M.A., SHRM-CP
Human Resources Director
Unified Government of Athens-Clarke County
375 Satula Avenue, Athens, GA 30601
jeff.hale@accgov.com
Direct: (762) 400- 6361
Main HR: (706) 613-3090

D. General

1. In a brief statement, please describe the principle reason or reasons your organization should be selected as the Claims Administrator for the Parish of Jefferson.

CCMSI is a privately held, employee owned and leading third party administrator for property/casualty programs including workers compensation, liability, property and property claims management. Since 1978 we have provided claim services, loss control, managed care, internet claims analysis and reporting services for individual self-insureds and self-insured groups. We have over 87 Public administrative clients with many in Louisiana. Our experience with large governmental programs allows us to understand the unique nature and demands of claims administration for public entities.

Since 2006 we have provided claims administrative services for Jefferson Parish. During that time we have created a customized program, dedicated adjusters, unique best practices, designed reporting and claims analysis for the Parish. By creating flexible and customized solutions for the Parish the results have been outstanding.

A few highlights:

- Medical Only closed claims ratio of 116% with average incurred cost of $1041
- Indemnity closed claims ratio of 130% with average incurred cost of $39,605
- In 2021, $1,839,773.00 in medical bill savings
- Liability closed claim ratio of 108% with average incurred cost of $13,052

We work hard to develop long-term partnerships with our clients….partnerships that add value to their risk management programs and a difference to their bottom line. We value and look forward to, hopefully, many more years working with Jefferson Parish.

2. Will your representatives attend meetings concerning claims administration whenever requested to do so by the Parish of Jefferson?

Yes.

3. Does your firm agree that all books, claims, files, records, including all electronic data, lists of names, journals and ledgers, tapes, cards and drawings always remain the property of the Parish of Jefferson and your firm uses such exclusively for the Parish of Jefferson, and at the direction of the Parish of Jefferson?

Yes.

4. Does your firm agree to cooperate fully with an outside audit of its claims administration processes and procedures?

Yes.

5. Does your firrn agree to adhere to generally accepted Workers' Compensation, Automobile and Liability claims administration processes and industry standard practices?

Yes.

6. Does your firm agree to provide security and safe keeping of the Parish of Jefferson's records and to return such records to the Parish of Jefferson if a new administrator is hired in the event your firm's contract is terminated?

Yes.

7. The Claims Administrator must carry insurance coverage that meets or exceeds the minimum insurance coverage requirements outlined in Attachment A

Yes. **Please refer to Exhibit 8 for CCMSI's insurance coverage certificates.**

CCMSI

Exhibits

CCMSI

Exhibit 1 – Client Service Team Biographies

Jerry R. Armatis

Executive Vice President – Metairie, LA

Biographical Information

Professional Experience

As a member of the Cannon Cochran Management Services, Inc. (CCMSI) Executive Committee and Executive Sales Team, Mr. Armatis is involved in defining the overall direction of the company and responsible for overseeing the sales, marketing, and account management efforts for the Southeast region. He serves as executive account manager to the Kentucky Retail Association SIF; Parish of Jefferson, Louisiana; Coca Cola Bottling Company United; Mississippi State Agencies; Rollins/Orkin; Acosta Sales and Marketing; Orange County, Florida; and several Louisiana governmental entities and multi-line national clients.

Following several years in the general sales force, Mr. Armatis began his career in the insurance industry with third-party administrator Creative Risk Controls, where he worked to maintain the current client base as well as solicit new business. In 1996, Mr. Armatis and five partners formed Management Services USA, Inc. to pursue claims administration business in the areas of Louisiana, Mississippi, and Nevada. Five years later, the company had expanded into nine states with eleven offices. In 2003, Management Services USA merged with CCMSI to create an organization with a national presence and regional focus.

Education and Professional Training

Mr. Armatis received a degree in Marketing and Transportation from the University of Arkansas in 1978 and attended The Aetna School of Insurance in 1995.

Karen Thurman, CWCP

State Director – Metairie, LA

Biographical Information

Professional Experience

Ms. Thurman is a proven leader in insurance and risk management endeavors, and is highly experienced in operations management, account management, claims, loss prevention, project management, implementation, and training. She joined Cannon Cochran Management Services, Inc. (CCMSI) in 2001 as claim manager in the New Orleans branch office, bringing over twenty years of significant claims management experience in property, casualty, and workers' compensation.

Serving as Louisiana state director since 2006, Ms. Thurman is responsible for day-to-day operations, as well as profit and loss accountability for our Louisiana operations. In addition, she serves/has served as account manager for Coca-Cola Bottling Company United, Caesars Entertainment, Jefferson Parish School Board, Jefferson Parish, and various municipality clients.

Prior to CCMSI, she handled general liability claims at Wausau Insurance Company and was offered the opportunity to broaden her areas of expertise into workers' compensation claims. Her strong customer focus to both external and internal customers afforded her significant success at Wausau, receiving several promotions to include workers' compensation supervisor.

Professional Training

Ms. Thurman holds a license in the state of Louisiana and the professional designation of Certified Workers' Compensation Professional (CWCP). She has completed numerous management development classes on topics including diversity, conflict resolution, human resources, and progressive discipline, and has participated in a variety of claims, technical, and legislative classes. She stays on top of current changes in the insurance industries by attending conferences and continuing educations course.

Professional Activities

Ms. Thurman is an active member of the Louisiana Association of Self Insured Employers (LASIE) and regional and local RIMS chapters.

Karen Bonnet

Liability Claims Manager – Metairie, LA

Biographical Information

Professional Experience

Ms. Bonnet joined Cannon Cochran Management Services, Inc.'s (CCMSI) Metairie, Louisiana office in 2004, was promoted to liability supervisor in 2008, and claim manager soon thereafter. She participates in claim reviews and client meetings and oversees a team that handles claims for both national and local accounts.

She began her career in the insurance industry in 1981 with Liberty Mutual Insurance Company and transitioned to assistant office manager in 1986. In 1991, she accepted a claims specialist position, handling business auto and general liability claims and worked in the specialty unit, handling claims for JC Penney Stores, United Parcel Service, Ford Rent-A-Car, and Sanderson Farms. She was promoted to senior claims specialist in 1997, managing personal auto claims for the State of Louisiana.

Prior to CCMSI, Ms. Bonnet handled business auto and general liability claims for contracting companies throughout Louisiana and Mississippi for Bituminous Insurance Company.

Professional Training

Ms. Bonnet is a licensed adjuster in Louisiana, Alabama, Alaska, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Maine, Michigan, Minnesota, Mississippi, Montana, Nevada, New Hampshire, Oregon, Rhode Island, South Carolina, Texas, Utah, Washington, West Virginia, and Wyoming.

Donnell Langley, RPA, CWCP

Workers' Compensation Claim Manager – Metairie, LA

Biographical Information

Professional Experience

With more than forty years of experience in claim handling, Ms. Langley serves as workers' compensation claim manager of the Cannon Cochran Management Services, Inc. (CCMSI) Metairie office, overseeing a team of three claim supervisors and twelve workers' compensation adjusters. Throughout her time with CCMSI, she has held the positions of workers' compensation supervisor, overseeing nine adjusters, and liability litigation supervisor for Harrah's Entertainment's Central region.

Ms. Langley began her claims career in 1980 with New Orleans-based Rosenbush Claims Service, handling claims for the State of Louisiana and later transitioning to longshore and harbor workers' and casualty claims. She additionally adjusted workers' compensation claims for the City of New Orleans account until 1988, at which time she handled USL&H claims at ITT Hartford.

She later joined Crawford & Company in 1990 as the designated Louisiana workers' compensation adjuster for Delta Beverage Group, Laitram Corporation, and Allwaste Environmental Management. She was the designated USL&H claim representative for Sea Land Service, Inc. and Elmwood Dry Dock, and later managed casualty claims for Sav-A-Center and Winn-Dixie. As a designated adjuster, she was responsible for preparing quarterly reports and attending client file reviews.

In 1996, Ms. Langley joined Travelers Property Casualty as a complex claim case manager to exclusively manage complex USL&H claims. Her inventory consisted entirely of worldwide cases with values in excess of $100,000 and catastrophic/severe injuries. She then moved to FA Richard & Associates, managing claims statewide for the Louisiana Employers Mutual Insurance Company.

Professional Training and Activities

Ms. Langley is licensed in the states of Louisiana, Mississippi, and Texas; completed the Certified Workers' Compensation Professional Program to obtain her CWCP designation; and is a member of the National Registry of Registered Professional Adjusters.

She continuously strives to better serve clients by keeping abreast of changes in the claim environment by regularly attending seminars in casualty, workers' compensation, Medicare Set-Asides, and liability settlement allocations.

Bernard E. Deckelman, Jr.

Multi-Line Claim Specialist – Metairie, LA

Biographical Information

Professional Experience

Mr. Deckelman possesses over thirty years of multi-line claims management, litigation, personnel management, and risk management experience. He began his insurance career as the internal auditor/insurance manager of Tangipahoa Parish School Board, for whom he wrote the school system safety manual and was involved in issues concerning general liability, workers' compensation, auto, errors and omissions, and discrimination claims against the school board. He continued working with large insurance companies, such as AIG, Continental, and CRC, in the roles of claim adjuster, special settlement adjuster, and senior negotiator.

His current duties as a multi-line claim specialist include handling general and auto liability claims, investigating, determining liability, and resolving claims for Jefferson Parish. In his handling of litigated files, he works closely with the Parish Legal Department and numerous outside defense attorneys. Mr. Deckelman's personal approach with both clients and claimants stands out as an invaluable asset to Cannon Cochran Management Services, Inc. (CCMSI).

Education and Professional Training

Mr. Deckelman is a graduate of Loyola University of the South and pursued graduate work in Business at Eastern Michigan University. He remains current on the industry through numerous courses and seminars relating to safety and multi-line claim handling.

Rick Poyner

Multi-Line Claim Consultant – Metairie, LA

Biographical Information

Professional Experience

Mr. Poyner joined Cannon Cochran Management Services, Inc. (CCMSI) in 2018, and presently manages all aspects of claim handling, including reviewing for coverage, managing non-litigated and litigated cases, and providing recommendations to his clients in his role as multi-line claim consultant.

He began his career in the insurance industry with Allstate Insurance Company, where he handled liability and casualty claims and served as a liaison for agents and agency staff, assisting with existing claim inquiries and coverage questions for twenty years. He also participated as an arbitration forum panelist, hearing liability and damages disputes.

Education and Professional Training

Mr. Poyner earned a Bachelor of Arts (BA) in Economics from the University of Oklahoma, a Bachelor of Science (BS) in Information System Security from ITT-Technical Institute, and holds a resident Louisiana Comprehensive Adjuster license.

Lori Francis

Senior Workers' Compensation Claim Specialist – Metairie, LA

Biographical Information

Professional Experience

Ms. Francis joined Cannon Cochran Management Services, Inc. (CCMSI) in 2011 and serves as a senior workers' compensation claim specialist, handling state workers' compensation claims and lost-time claims for Jefferson Parish.

She began her career in the insurance industry more than thirty years ago as a claim assistant, medical only adjuster, and assistant to the claims manager, updating claims procedures, correcting processing errors, and general supervision of claim assistants.

Ms. Francis was employed with Self Insurors Service Bureau, Inc. in 1990, and began on-the-job training as a lost-time claims adjuster, handling state workers' compensation claims for the Louisiana Restaurant Association and Louisiana Nursing Home Association. Additionally, she held the position of lost-time workers' compensation claims adjuster with Napoleon Services and Management Services USA, handling claims for the Louisiana Timberman's Association and PGRMA accounts.

She managed Louisiana State workers' compensation claims for eight years with Creative Risk Controls, Inc. for the City of Kenner, Plaquemines Parish Government, Plaquemines Parish School Board, and St. Mary Parish School Board, handling settlement negotiations and litigated, subrogation, and Second Injury Fund (SIF) claims.

Patricia A. Aperwhite

Medical Only Adjuster - Metairie, LA

Biographical Information

Professional Experience

Ms. Aperwhite has worked in the medical claims industry for several well-known companies in the New Orleans area since 1998, and was as an office manager at management consultant firm TSG Solutions. She joined Cannon Cochran Management Services, Inc.'s (CCMSI) Metairie, Louisiana office as a senior medical only claim representative in 2008, and currently serves as a medical only adjuster.

Her current responsibilities include setting up and managing medical-only files; establishing reserves; reviewing and approving medical treatment; maintaining her diary; and communicating with providers, claimants, employers, and attorneys. Additionally, she provides support to claim staff, handling more sophisticated accounts with different or stringent claim-handling service instructions.

Education and Professional Training

Mrs. Aperwhite holds a bachelor's degree in Business from the University of New Orleans and continues to improve her professional knowledge through in-house training activities and educational seminars.

CCMSI

Exhibit 2 – Past 3 Years Audited Financial Statements

CCMSI HOLDINGS, INC.

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED JUNE 30, 2021 AND 2020

CCMSI HOLDINGS, INC.
TABLE OF CONTENTS
YEARS ENDED JUNE 30, 2021 AND 2020

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
CCMSI Holdings, Inc.
Danville, Illinois

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of CCMSI Holdings, Inc. and its subsidiary, which comprise the consolidated balance sheets as of June 30, 2021 and 2020, and the related consolidated statements of comprehensive income, stockholders' equity, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Board of Directors
CCMSI Holdings, Inc.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CCMSI Holdings, Inc. and its subsidiary as of June 30, 2021 and 2020, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information which includes the consolidating balance sheet, consolidating statement of comprehensive income, and the consolidating statement of cash flows is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Danville, Illinois
October 5, 2021

CCMSI HOLDINGS, INC.
CONSOLIDATED BALANCE SHEETS
JUNE 30, 2021 AND 2020

	2021	2020
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents:		
Operating	$ 15,999,040	$ 11,809,308
Premium Trust	94,919	206,398
Debt Securities Available for Sale	7,085,309	-
Receivables:		
Management Fees, Net of Allowance for Doubtful Accounts of $200,000 and $250,000, Respectively	19,988,150	18,990,996
Premiums	1,616,675	635,722
Other	1,066,087	761,717
Prepaid Expenses and Other Assets	3,055,159	3,085,731
Total Current Assets	48,905,339	35,489,872
INVESTMENT IN LIMITED LIABILITY COMPANY	228,541	185,891
PROPERTY AND EQUIPMENT, NET	18,189,140	15,854,613
Total Assets	$ 67,323,020	$ 51,530,376
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable	$ 4,626,130	$ 4,397,955
Accrued Expenses	11,263,528	5,965,366
Premium Accounts Payable	1,474,715	704,142
Payroll Tax Deferral - FICA Tax	2,015,147	-
Deferred Revenue	11,100,025	11,848,345
Total Current Liabilities	30,479,545	22,915,808
LONG-TERM LIABILITIES		
Payroll Tax Deferral - FICA Tax	2,015,147	1,234,104
Deferred Lease Liability	1,251,073	1,080,683
Total Long-Term Liabilities	3,266,220	2,314,787
Total Liabilities	33,745,765	25,230,595
STOCKHOLDERS' EQUITY		
Common Stock - $0.01 Par Value, 1,000,000 Shares Authorized; 290,353 Issued and Outstanding	2,903	2,903
Additional Paid-In Capital	4,797,112	4,797,112
Retained Earnings	28,768,894	21,499,766
Accumulated Other Comprehensive Income	8,346	-
Total Stockholders' Equity	33,577,255	26,299,781
Total Liabilities and Stockholders' Equity	$ 67,323,020	$ 51,530,376

See accompanying Notes to Consolidated Financial Statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
YEARS ENDED JUNE 30, 2021 AND 2020

	2021	2020
OPERATING REVENUE	$ 179,778,444	$ 165,492,860
OPERATING EXPENSES		
Personnel Salaries and Benefits	131,830,196	120,881,823
Managed Care Services	14,103,870	12,488,306
Occupancy	11,060,183	11,211,614
Depreciation and Amortization	5,072,426	4,839,259
Supplies and Postage	1,967,776	2,101,195
Travel	1,816,111	2,938,607
Professional Fees	385,141	337,862
Consulting	958,630	979,659
Computer	2,856,448	2,200,936
Marketing and Sales	178,114	229,876
Miscellaneous	2,346,896	1,496,638
Total Operating Expenses	172,575,791	159,705,775
INCOME FROM OPERATIONS	7,202,653	5,787,085
OTHER INCOME (EXPENSE)		
Undistributed Equity in Income (Loss) of Limited Liability Company	42,649	(26,484)
Interest Income	23,826	238,323
Total Other Income (Expense)	66,475	211,839
NET INCOME	7,269,128	5,998,924
OTHER COMPREHENSIVE INCOME		
Unrealized Gains on Debt Securities Available for Sale	8,346	-
COMPREHENSIVE INCOME	$ 7,277,474	$ 5,998,924

See accompanying Notes to Consolidated Financial Statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
YEARS ENDED JUNE 30, 2021 AND 2020

	Total	Common Stock	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income
BALANCE – JUNE 30, 2019	$ 20,300,857	$ 2,903	$ 4,797,112	$ 15,500,842	$ -
Net Income	5,998,924	-	-	5,998,924	-
BALANCE – JUNE 30, 2020	26,299,781	2,903	4,797,112	21,499,766	-
Unrealized Gains on Debt Securities	8,346	-	-	-	8,346
Net Income	7,269,128	-	-	7,269,128	-
BALANCE – JUNE 30, 2021	$ 33,577,255	$ 2,903	$ 4,797,112	$ 28,768,894	$ 8,346

See accompanying Notes to Consolidated Financial Statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2021 AND 2020

	2021	2020
CASH FLOWS FROM OPERATING ACTIVITIES		
Net Income	$ 7,269,128	$ 5,998,924
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:		
Depreciation	5,072,426	4,839,259
Amortization on Debt Securities Available for Sale	89,671	-
Provision for Bad Debts	(50,000)	26,016
Noncash Compensation Expense	4,604,773	1,364,927
Undistributed Equity in (Income) Loss of Limited Liability Company	(42,650)	26,484
Effects of Changes in Operating Assets and Liabilities:		
Receivables	(2,232,477)	(2,005,227)
Prepaid Expenses and Other Assets	30,572	(810,130)
Accounts Payable	228,175	(636,304)
Accrued Expenses	1,463,962	(5,441,954)
Deferred Revenue	(748,320)	676,487
Payroll Tax Deferral - FICA Tax	2,796,190	1,234,104
Deferred Lease Liability	170,390	1,080,683
Net Cash Provided by Operating Activities	18,651,840	6,353,269
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of Equipment and Leasehold Improvements	(7,406,953)	(5,393,565)
Purchases of Debt Securities Available for Sale	(15,086,869)	-
Proceeds from Sales and Maturities of Debt Securities	7,920,235	-
Net Cash Used by Investing Activities	(14,573,587)	(5,393,565)
NET INCREASE IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH	4,078,253	959,704
Cash, Cash Equivalents, and Restricted Cash – Beginning of Year	12,015,706	11,056,002
CASH, CASH EQUIVALTENTS, AND RESTRICTED CASH – END OF YEAR	$ 16,093,959	$ 12,015,706
Supplementary Disclosures:		
Operating Cash	$ 15,999,040	$ 11,809,308
Premium Trust (Restricted Cash)	94,919	206,398
Total Cash, Cash Equivalents, and Restricted Cash	$ 16,093,959	$ 12,015,706

See accompanying Notes to Consolidated Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

CCMSI Holdings, Inc. (the Company) is a holding company whose subsidiary provides third-party administration services for workers' compensation, property/casualty, and professional liability self-insurance programs of various businesses, governments, and pooled associations. The Company is subject to regulations of certain regulatory agencies and undergoes periodic examinations by those regulatory agencies.

The significant accounting and reporting policies for CCMSI Holdings, Inc. follow:

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and its wholly owned subsidiaries, Cannon Cochran Management Services, Inc. (dba: CCMSI) and Comp MC, Inc. The accounts of Comp MC, Inc. are included with the accounts of CCMSI for financial statement presentation. All significant intercompany accounts and transactions have been eliminated in the consolidation.

The consolidated financial statements of the Company have been prepared in conformity with accounting principles generally accepted in the United States of America and conform to predominant practice within the industry.

Use of Estimates in Preparing Financial Statements

In preparing the accompanying consolidated financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements and the reported amounts of revenues and expenses for the reporting period. Actual results could differ from those estimates. Material estimates which are particularly susceptible to significant change in the near term include the fair value of the Company's shares of common stock outstanding determined by an independent appraisal of the Company. The fair value estimates of the Company's common stock are used to determine share-based compensation liabilities, ESOP compensation expenses, and stock repurchase commitments.

Fiduciary Assets and Liabilities

The Company collects funds used to pay claims for self-insurance programs administered by CCMSI. The funds are not assets of the Company and, accordingly, are not included in the accompanying consolidated financial statements.

Cash and Cash Equivalents

For purposes of the statements of cash flows, any highly liquid debt instruments with an original maturity of three months or less are considered to be cash equivalents, including investments in commercial paper. Amounts included in premium trust accounts represent restricted cash from insurance premiums collected from the insured and held by the Company. The restricted cash is required to be set aside by contractual agreement for the remittance of premiums collected on behalf of carriers.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Cash and Cash Equivalents (Continued)

The Company maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Company has not experienced any losses in such accounts. The Company believes it is not exposed to any significant credit risk on cash.

Debt Securities

Management determines the appropriate classification of the securities at the time they are acquired and evaluates the appropriateness of such classifications at each balance sheet date. At June 30, 2021, the Company's debt securities were classified as available for sale. Debt securities that are classified as available for sale are stated at fair value, and unrealized holding gains, and losses are reported as accumulated other comprehensive income within stockholder's equity.

Realized gains and losses are determined on the basis of the cost of the securities sold. The cost of securities sold is based on the specific-identification method. The amortization of premiums and accretion of discounts are recognized in interest income using methods approximating the interest method over the period to maturity. For callable debt securities purchased at a premium, the amortization period is shortened to the earliest call date.

Receivables

Receivables are uncollateralized customer obligations which generally require payment within 30 days from the invoice date. Payments of accounts receivable are applied to the specific invoices identified on the customer's remittance advice or, if unspecified, to the earliest unpaid invoices.

The carrying amounts of accounts receivable is reduced by a valuation allowance that reflects management's best estimate of amounts that will not be collected. The allowance for doubtful accounts is based on management's assessment of the collectibility of specific customer accounts and the aging of the accounts receivable. If there is a deterioration of a major customer's credit worthiness or actual defaults are higher than the historical experience, management's estimates of the recoverability of amounts due the Company could be adversely affected. All accounts or portions thereof deemed to be uncollectible or to require an excessive collection cost are written off to the allowance for doubtful accounts.

Adoption of New Accounting Standards

In 2021, the Company adopted Financial Accounting Standards Board's Accounting Standards Codification Top 606, *Revenue from Contracts with Customers*, which requires the recognition of revenue from promised goods or services are transferred to customers in an amount that reflects the consideration to which an entity expects to be entitled in exchange for those goods or services. There was no material impact on the Company's financial position and results of operations upon adoption of the new standard.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Adoption of New Accounting Standards

On January 1, 2020, the Company adopted ASU 2017-08, *Receivables – Nonrefundable Fees and Other Costs (Subtopic 310-20); Premium Amortization on Purchased Callable Debt Securities.* The standard required an entity to shorten the amortization period for certain purchased callable debt securities held at a premium to the earliest call date. The adoption of this ASU did not have a material impact on the Company's financial statements.

Revenue Recognition and Deferred Revenue

The Company recognizes revenues when control of the product or service has been delivered to the customer, in an amount that reflects the consideration that the Company expects to be entitled in the exchange. To determine revenue recognition arrangements that an entity determines to be in the scope of ASC 606, the Company performs the following five step evaluation: 1) identify the contract with a customer, 2) identify performance obligations in the contract, 3) determine the transaction price, 4) allocate the transaction price to the performance obligations, 5) recognize revenue when or as the entity satisfies a performance obligation.

The Company's principal revenue generating activities includes compensation for management services rendered in connection with the operation and management of self-insurance programs for stand-alone organizations and self-insured risk groups. The Company also receives compensation for certain medical bill review services (Comp MC). Fees for management services are recorded as earned over the period which the service is to be provided. Fees for medical bill review services are recognized in the period when the service is provided. The Company may bill and collect fees in advance for services to be performed over a period of time and those fees are deferred and recognized ratably over that same period or as the services are provided. The Company may also bill and collect fees subsequent to the performance of the services and those fees are recognized as earned in the period which the service is provided.

The Company uses independent brokers in connection with the marketing of certain self-insurance programs. Operating revenue is stated net of commissions paid to these brokers.

The timing of revenue recognition, billings, and cash collections results in receivables, contract assets, and contract liabilities. Accounts receivable are recorded when the right to consideration becomes unconditional and are presented separately in the consolidated balance sheets. When the Company's billing occurs subsequent to revenue recognition a contract asset is recognized and is recorded as unbilled receivables, which is included in management fees receivable in the consolidated balance sheets. When the Company is entitled to bill a customer in advance of the recognition of revenue, a contract liability is recognized and is recorded as deferred revenue in the consolidated balance sheets.

The Company may incur incremental costs to obtain a sales contract, which under ASC 606 should be capitalized and amortized over the life of the contract. The Company elected the practical expedient to allow the Company to expense these costs since the majority of the contracts are short term in nature with a life of one year or less.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Revenue Recognition and Deferred Revenue (Continued)

The Company disaggregates its revenue from contracts with customers as follows for the years ended June 30:

	2021	2020
Stand-Alone Organizations	$ 89,022,594	$ 81,417,907
Self-Insured Risk Groups	56,061,625	51,529,327
Comp MC Fees	29,935,412	27,740,472
Other Income	4,758,813	4,805,154
Total Operating Revenue	$ 179,778,444	$ 165,492,860

Investment in Limited Liability Company

The Company holds a 100% interest in HT Air, LLC. The Company is accounting for its investment in this company under the equity method of accounting since the assets and liabilities are not significant. The assets and liabilities of HT Air, LLC totaled $354,946 and $97,265 respectively as of June 30, 2021. The LLC had assets and liabilities of $410,879 and $195,847, respectively, as of June 30, 2020.

Property and Equipment

Property and equipment is stated at cost less accumulated depreciation. Depreciation is computed principally by accelerated methods over the estimated useful lives of the related assets. Artwork is carried at the lower of cost or market. Market values for artwork are determined using independent appraisers. The Company capitalizes certain costs to develop, purchase, or modify software for the internal use of the Company. The depreciation expense on assets acquired under capital leases, depreciated over the shorter of the term of the lease or their estimated useful lives, is included with depreciation expense on owned assets. Leasehold improvements are amortized over their estimated useful lives or the respective lease terms, whichever is shorter. The estimated economic useful lives are as follows:

Computer Equipment and Accessories, Including Software	3 to 5 Years
Furniture, Fixtures, and Equipment, Including Acquired	5 to 10 Years
Leasehold Improvements	3 to 10 Years

Impairment of Long-Lived Assets

The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. Assets to be disposed of are reported at the lower of carrying amount or the fair value less costs to sell.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Advertising

The Company expenses advertising costs as incurred.

Income Taxes

The Company, with the consent of its stockholders, has elected to be taxed under sections of federal and state income tax law, which provide that, in lieu of corporation income taxes, the stockholders separately account for their prorata shares of the Company's items of income, deductions, losses, and credits. The election was effective as of July 1, 1998. As a result of this election, no income taxes have been recognized in the accompanying consolidated financial statements.

Share-Based Compensation

The Company has issued Stock Appreciation Rights (SARs) and Stock Warrants to certain employees that require the Company to pay the fair value of the SAR and warrant to the employee at the date of exercise. These awards are considered to be liability awards as defined in Codification Topic 718 *Compensation – Stock Compensation.* These awards are more fully described in Note 7.

Pending Accounting Standards

In February 2016, the FASB issued amended guidance for the treatment of leases. The guidance requires lessees to recognize a right-of-use asset and a corresponding lease liability for all operating and finance leases with lease terms greater than one year. The accounting for lessors will remain relatively unchanged. The guidance changes the accounting for sale and leaseback transactions to conform to the new revenue recognition standard. The guidance also requires both qualitative and quantitative disclosures regarding the nature of the entity's leasing activities. The amendments in the guidance are effective for fiscal years beginning after December 15, 2021. Early adoption is permitted. Management is evaluating the impact of the amended lease guidance on the Company's consolidated financial statements.

In June 2016, the FASB issued ASU No. 2016-13, *Financial Instruments – Credit Losses (ASC Topic 326): Measurement of Credit Losses on Financial Instruments.* This standard replaces the incurred loss methodology with an expected loss methodology that is referred to as the current expected credit loss (CECL) methodology. The measurement of expected credit losses under the CECL methodology is applicable to financial assets carried at amortized cost, including certain receivables and held-to-maturity securities. It also applies to off-balance sheet credit exposures not accounted for as insurance and leases recognized by a lessor. In addition, the standard made changes to the accounting for available-for-sale debt securities, including any credit losses to be presented as an allowance rather than as a write-down on available-for-sale debt securities management does not intend to sell or believes that it is more likely than not they will be required to sell. ASU 2016-13 is effective for fiscal years beginning after December 15, 2022. Management expects this standard will not have a material impact on the Company's consolidated financial statements.

NOTE 2 PROPERTY AND EQUIPMENT

Property and equipment consists of:

	2021	2020
Computer Equipment, Accessories, and Software	$ 26,978,780	$ 28,492,513
Furniture, Fixtures, and Equipment	7,769,112	8,464,490
Leasehold Improvements	2,335,848	2,205,957
Total Property and Equipment	37,083,740	39,162,960
Less: Accumulated Depreciation	18,894,600	23,308,347
Property and Equipment, Net	$ 18,189,140	$ 15,854,613

Included in computer equipment, accessories, and software above are costs for internally developed software products. Total cost was $19,737,818 and $22,426,420, respectively, and accumulated depreciation was $9,933,693 and $13,552,898, respectively, for the years ended June 30, 2021 and 2020, respectively.

NOTE 3 INVESTMENT IN DEBT SECURITIES AND FAIR VALUE MEASUREMENTS

The following is a summary of the Company's investments in debt securities available for sale as of June 30, 2021:

	2021			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Corporate Bonds	$ 6,876,761	$ 12,352	$ (4,025)	$ 6,885,088
Municipal Bonds	200,202	19	-	200,221
Total	$ 7,076,963	$ 12,371	$ (4,025)	$ 7,085,309

The bonds included in debt securities available for sale at June 30, 2021 all mature within one year. Expected maturities may differ from contractual maturities because the issuers of debt securities may have the right to call or prepay their obligations without any prepayment penalties.

The *Fair Value Measurements and Disclosures* Topic of the FASB Standards Codification defines fair value and establishes a framework for measuring fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

In determining fair value, the Company uses various methods including market, income, and cost approaches. Based on these approaches, the Company often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Company utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs.

NOTE 3 INVESTMENTS IN DEBT SECURITIES AND FAIR VALUE MEASUREMENTS (CONTINUED)

Based on the observability of the inputs used in the valuation techniques, the Company is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values.

Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

Level 2 – Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third party pricing services for identical or similar assets or liabilities.

Level 3 – Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer, or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

The following are descriptions of the valuation methodologies used for instruments measured at fair value:

Debt Securities: Debt securities consisting of bonds in corporations, U.S government corporations and agencies, municipal bonds, and mortgage-backed securities are generally valued at the most recent price of the equivalent quoted yield for such securities, or those of comparable maturity, quality, and type. Such securities are generally classified within Level 2 of the valuation hierarchy.

The following table summarizes assets and liabilities measured at fair value on a recurring basis segregated by the level of the fair value hierarchy as of June 30, 2021:

	2021			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Corporate Bonds	$ -	$ 6,885,088	$ -	$ 6,885,088
Municipal Bonds	-	200,221	-	200,221
Total	$ -	$ 7,085,309	$ -	$ 7,085,309

NOTE 3 INVESTMENTS IN DEBT SECURITIES AND FAIR VALUE MEASUREMENTS (CONTINUED)

Securities with a decline in fair value below cost or amortized cost as of June 30, 2021, including the length of time of such decline, are shown in the following schedule. The Company does not consider the fixed income securities to be other than temporarily impaired, because management believes the Company carries high-quality securities and any fluctuations in fair value are due to changes in interest rates and the Company has the intent to hold such securities until maturity.

	2021					
	12 Months or More		Less than 12 Months		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Corporate Bonds	$ -	$ -	$ 3,215,320	$ (4,025)	$ 3,215,320	$ (4,025)
Municipal Bonds	-	-	-	-	-	-
Total	$ -	$ -	$ 3,215,320	$ (4,025)	$ 3,215,320	$ (4,025)

NOTE 4 ACCRUED EXPENSES

The Company's accrued expenses are summarized as follows at June 30:

	2021	2020
Payroll, Commissions, and Bonuses	$ 2,205,788	$ 2,014,402
Stock Appreciation Rights (Vested)	4,807,040	904,214
Stock Warrants	2,476,215	1,930,923
Other	1,774,485	1,115,827
Total Accrued Expenses	$ 11,263,528	$ 5,965,366

Under the CARES Act, the employer's 6.2% Social Security tax on wages paid from March 27, 2020 through December 31, 2020 is deferred. Fifty percent of the deferral is due on December 31, 2021, and the remaining 50% is due on December 31, 2022. The accrued (deferred) employer Social Security tax totaled $4,030,294 and $1,234,104 as of June 30, 2021 and 2020, respectively.

NOTE 5 DEBT

Line of Credit

The Company has a line of credit of $15,000,000 of which $-0- was used as of June 30, 2021 and 2020. Amounts drawn against the line of credit are payable on demand and bear interest at the lender's prime rate minus 0.50% for an effective rate of 2.75% at June 30, 2021 and 2020. The line of credit is collateralized by substantially all of the Company's assets. The line of credit matures on March 7, 2022.

NOTE 6 EMPLOYEE RETIREMENT PLANS

The Company sponsors a 401(k) savings plan under which eligible employees may choose to save a percentage of their salary on a pre-tax basis, subject to certain Internal Revenue Service (IRS) limits. The Company may make discretionary matching and profit sharing contributions to the plan. The Company did not make any matching or profit sharing contributions during the years ended June 30, 2021 and 2020.

The Company sponsors an Employee Stock Ownership Plan for the benefit of employees who meet certain eligibility requirements. The ESOP's shares were purchased by the ESOP with the proceeds of a note from the Company. The Company made annual contributions to the ESOP equal to the ESOP's debt service, less dividends received by the ESOP. As principal and interest were paid, shares were released from collateral and allocated to participants based on the proportion of debt service paid in the year. The ESOP allocates released shares to all participants who meet certain eligibility requirements. The ESOP's loan to the Company is paid off and all shares have been released into the ESOP.

Compensation expense is recorded for additional contributions paid to the ESOP for benefit payments to participants. Compensation expense for the ESOP was $4,200,000 and $3,150,000 for the years ended June 30, 2021 and 2020, respectively.

Company shares held in the ESOP and allocated to participants totaled 282,853 as of June 30, 2021 and 2020. In the event of termination from employment or if eligible participants elect to diversify their account balances, the Company may be required to purchase the shares from the participant at the shares' fair market value unless the ESOP fulfills this obligation. The repurchase obligation totaled approximately $70 million and $59 million as of June 30, 2021 and 2020, respectively.

NOTE 7 SHARE-BASED COMPENSATION

Stock Appreciation Rights (SARs)

Effective January 1, 2020, the Company issued 112,000 SARs to certain employees with a base value of $184.61 for each award and a vesting period of 33.33% each June 30. Through June 30, 2021, no SARs have been forfeited or exercised, resulting in 112,000 SARs outstanding as of June 30, 2021 and 2020 under the 2020 Plan. The vested portion of the outstanding SARs totaled $4,807,040 and $904,214 as of June 30, 2021 and 2020 and is included in Accrued Expenses in the accompanying consolidated balance sheets.

NOTE 7 SHARE-BASED COMPENSATION (CONTINUED)

Stock Warrants

In December 2013 and January 2014, the Company issued 46,504 stock warrants in connection with the redemption of stock held by individuals. The Holders have the option to exercise the warrants at any time. Included in the redemption agreement is a put option in which the individual exercising the warrants has the right to require the Company to purchase the warrants by paying the Holder an amount equal to the difference between the fair market value at the surrender date of the warrants and the warrant strike price of $107.32 per warrant. From 2013 through 2021, 29,025 warrants were exercised, resulting in 17,479 warrants outstanding as of June 30, 2021 (19,022 warrants outstanding at June 30, 2020). At June 30, 2021 and 2020, the fair value of the outstanding warrants totaled $2,476,215 and $1,930,923, respectively, and is included in Accrued Expenses in the accompanying consolidated balance sheets.

The fair market value of the vested portion of all outstanding SARs and stock warrants included in accrued expenses is determined by an independent appraiser as of the reporting date. The Company's stock price was valued at $248.99 and $208.83 as of June 30, 2021 and 2020, respectively. The expense for the SARs and stock warrants totaled $4,604,773 and $1,364,927 for the years ended June 30, 2021 and 2020, respectively, and is included in Personnel Salaries and Benefits in the accompanying consolidated statements of comprehensive income.

NOTE 8 INCOME TAXES

The Company files consolidated income tax returns in the U.S. federal jurisdiction and multiple states. The Company is a pass-through entity for income tax purposes whereby any income tax liabilities or benefits are attributable to the Company's members. Any amounts paid by the Company for income taxes are accounted for as transactions with the Company's members. Federal and state income tax returns are subject to examination by the IRS and state taxing authorities, generally for three years after they are filed.

NOTE 9 COMMITMENTS

Lease Commitments

The Company has entered into lease agreements for the buildings it currently occupies and for office equipment which it accounts for as operating leases. Under terms of the building leases, the lessor is responsible for insurance and taxes with the lessee responsible for routine maintenance and utilities. The following summarizes future commitments under these leases.

NOTE 9 COMMITMENTS (CONTINUED)

Year Ending June 30,	Amount
2022	$ 6,710,989
2023	6,624,123
2024	5,175,190
2025	4,144,714
2026	2,754,843
2027	2,058,652
Thereafter	4,642,089
Total	$ 32,110,600

Total rent expense incurred related to all operating leases totaled $7,821,228 and $8,037,715 for the years ended June 30, 2021 and 2020, respectively.

Deferred Lease Liability

Due to various rent abatements and escalation clauses included in certain office lease agreements, the Company has recorded a deferred lease liability. This liability reflects the difference between actual cash payments under the agreements and the straight-line expense to be recognized over the lease term. The deferred lease liability totaled $1,440,224 and $1,192,668 as of June 30, 2021 and 2020, respectively, with $1,251,073 and $1,080,683, respectively, reflected as a long-term liability in the accompanying consolidated balance sheets.

Stock Repurchase Commitment

The Company maintains stock repurchase agreements with all stockholders of the Company whereby at the stockholder's notification to the Company and the remaining stockholders of his intent to sell, the Company will repurchase the stockholder's stock at a price determined by an independent appraiser. The potential liability for the repurchase of shares held by the stockholders, other than the ESOP, is approximately $1,867,425 and $1,566,225 as of June 30, 2021 and 2020, respectively.

NOTE 10 CONTINGENT LIABILITIES

The Company is involved in litigation relating to various disputes with certain individuals and companies. The Company is vigorously defending its position in these cases and believes damages, if awarded to the defendants, will not be material. The Company includes in accrued expenses any expected settlements of these cases that are estimated to result in losses.

The Company acts as a third-party administrator of self-insurance programs for various businesses, governments, and pooled risk management associations. In carrying out these services, the Company has check signing authority over various cash accounts of these entities.

NOTE 11 SELF-INSURANCE

The Company is self-insured for health benefits provided to employees. Medical claims exceeding $375,000 in 2021 and $250,000 in 2020 on any one individual, and aggregate losses in excess of approximately $17,431,000 and $16,525,000 incurred and paid during the years ended June 30, 2021 and 2020, respectively, were covered by stop-loss insurance purchased from a commercial insurance carrier. The Company has estimated a liability for claims incurred but not reported (IBNR) of $1,120,379 and $1,094,939, which is included in accrued expenses in the accompanying balance sheet for the years ended June 30, 2021 and 2020, respectively. Claims expense under the self-insured health plan totaled $14,840,843 and $12,549,996 for the years ended June 30, 2021 and 2020, respectively.

NOTE 12 RISKS AND UNCERTAINTIES

The World Health Organization declared the spread of the Coronavirus Disease (COVID-19) a worldwide pandemic. The COVID-19 pandemic continues to have significant effects on global markets, human resources, business operations, and communities. Management believes the Company is taking appropriate actions to mitigate the negative impact. However, the full impact of COVID-19 is unknown and cannot be reasonably estimated as these events continue to develop.

NOTE 13 SUBSEQUENT EVENTS

Management evaluated subsequent events through October 5, 2021, the date the financial statements were available to be issued.

CCMSI HOLDINGS, INC.
CONSOLIDATING BALANCE SHEET
JUNE 30, 2021

	CCMSI Holdings, Inc.	CCMSI	Eliminations	Total
ASSETS				
CURRENT ASSETS				
Cash:				
Operating	$ 36,895	15,962,145	$ -	$ 15,999,040
Premium Trust	-	94,919	-	94,919
Debt Securities Available for Sale	-	7,085,309	-	7,085,309
Receivables:				
Management Fees, Net of Allowance of $200,000	-	19,988,150	-	19,988,150
Premiums	-	1,616,675	-	1,616,675
Other	-	1,066,087	-	1,066,087
Due From Related Party	-	0		
Prepaid Expenses and Other Assets	-	3,055,159	-	3,055,159
Total Current Assets	36,895	48,868,444	-	48,905,339
INVESTMENTS IN SUBSIDIARY AND LIMITED LIABILITY COMPANY	40,823,616	-	(40,595,075)	228,541
PROPERTY AND EQUIPMENT, NET	-	18,189,140	-	18,189,140
Total Assets	$ 40,860,511	$ 67,057,584	$ (40,595,075)	$ 67,323,020
LIABILITIES AND STOCKHOLDERS' EQUITY				
CURRENT LIABILITIES				
Accounts Payable	$ -	$ 4,626,130	$ -	$ 4,626,130
Accrued Expenses	7,283,256	3,980,272	-	11,263,528
Premium Accounts Payable	-	1,474,715	-	1,474,715
Payroll Tax Deferral - FICA Tax	-	2,015,147	-	2,015,147
Deferred Revenues	-	11,100,025	-	11,100,025
Total Current Liabilities	7,283,256	23,196,289	-	30,479,545
LONG-TERM LIABILITIES				
Payroll Tax Deferral - FICA Tax	-	2,015,147	-	2,015,147
Deferred Lease Liability	-	1,251,073	-	1,251,073
Total Long-Term Liabilities	-	3,266,220	-	3,266,220
Total Liabilities	7,283,256	26,462,509	-	33,745,765
STOCKHOLDERS' EQUITY				
Common Stock	2,903	4,107	(4,107)	2,903
Additional Paid-In Capital	4,797,112	6,229,207	(6,229,207)	4,797,112
Accumulated Other Comprehensive Income	8,346	8,346	(8,346)	8,346
Retained Earnings	28,768,894	34,353,415	(34,353,415)	28,768,894
Total Stockholders' Equity	33,577,255	40,595,075	(40,595,075)	33,577,255
Total Liabilities and Stockholders' Equity	$ 40,860,511	$ 67,057,584	$ (40,595,075)	$ 67,323,020

CCMSI HOLDINGS, INC.
CONSOLIDATING STATEMENT OF COMPREHENSIVE INCOME
YEAR ENDED JUNE 30, 2021

	CCMSI Holdings, Inc.	CCMSI	Eliminations	Total
OPERATING REVENUE	$ -	$ 179,778,444	$ -	$ 179,778,444
OPERATING EXPENSES				
Personnel Salaries and Benefits	8,804,773	123,025,423	-	131,830,196
Managed Care Services	-	14,103,870	-	14,103,870
Occupancy	-	11,060,183	-	11,060,183
Depreciation and Amortization	-	5,072,426	-	5,072,426
Supplies and Postage	-	1,967,776	-	1,967,776
Travel	-	1,816,111	-	1,816,111
Professional Fees	-	385,141	-	385,141
Consulting	-	958,630	-	958,630
Computer	-	2,856,448	-	2,856,448
Marketing and Sales	-	178,114	-	178,114
Miscellaneous	-	2,346,896	-	2,346,896
Total Operating Expenses	8,804,773	163,771,018	-	172,575,791
INCOME (LOSS) FROM OPERATIONS	(8,804,773)	16,007,426	-	7,202,653
OTHER INCOME (EXPENSES)				
Equity in Income from Subsidiary	16,031,252	-	(16,031,252)	-
Undistributed Equity in Income of Limited Liability Company	42,649	-	-	42,649
Interest Income	-	23,826	-	23,826
Total Other Income (Expense)	16,073,901	23,826	(16,031,252)	66,475
NET INCOME	7,269,128	16,031,252	(16,031,252)	7,269,128
OTHER COMPREHENSIVE INCOME				
Unrealized Gains on Debt Securities Available for Sale	-	8,346	-	8,346
COMPREHENSIVE INCOME	$ 7,269,128	$ 16,039,598	$ (16,031,252)	$ 7,277,474

CCMSI HOLDINGS, INC.
CONSOLIDATING STATEMENT OF CASH FLOWS
YEAR ENDED JUNE 30, 2021

	CCMSI Holdings, Inc.	CCMSI	Eliminations	Total
CASH FLOWS FROM OPERATING ACTIVITIES				
Net Income	$ 7,269,128	$ 16,031,252	$ (16,031,252)	$ 7,269,128
Adjustments to Reconcile Net Income to Net Cash				
Provided (Used) by Operating Activities:				
Depreciation	-	5,072,426	-	5,072,426
Amortization on Debt Securities	-	89,671	-	89,671
Provision for Bad Debts	-	(50,000)	-	(50,000)
Noncash Compensation Expense	4,604,773	-	-	4,604,773
Equity in Net Income from Subsidiary	(16,031,252)	-	16,031,252	-
Undistributed Equity in Income of Limited Liability Company	(42,650)	-	-	(42,650)
Effects of Changes in Operating Assets and Liabilities:				
Receivables	-	(2,232,477)	-	(2,232,477)
Prepaid Expenses and Other Assets	-	30,572	-	30,572
Accounts Payable	-	228,175	-	228,175
Accrued Expenses	(156,654)	1,620,616	-	1,463,962
Deferred Revenue	-	(748,320)	-	(748,320)
Payroll Deferral - FICA Tax	-	2,796,190	-	2,796,190
Deferred Lease Liability	-	170,390	-	170,390
Net Cash Provided (Used) by Operating Activities	(4,356,655)	23,008,495	-	18,651,840
CASH FLOWS FROM INVESTING ACTIVITIES				
Purchases of Equipment and Leasehold Improvements	-	(7,406,953)	-	(7,406,953)
Purchases of Debt Securities	-	(15,086,869)	-	(15,086,869)
Proceeds from Sales and Maturities of Debt Securities	-	7,920,235	-	7,920,235
Distributions from Common Stock of Subsidiary	4,356,656	-	(4,356,656)	-
Net Cash Provided (Used) by Investing Activities	4,356,656	(14,573,587)	(4,356,656)	(14,573,587)
CASH FLOWS FROM FINANCING ACTIVITIES				
Distributions to Stockholders	-	(4,356,656)	4,356,656	-
NET INCREASE IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH	1	4,078,252	-	4,078,253
Cash, Cash Equivalents, and Restricted Cash – Beginning of Year	36,895	11,978,811	-	12,015,706
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH – END OF YEAR	$ 36,896	$ 16,057,063	$ -	$ 16,093,959

CCMSI HOLDINGS, INC.

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED JUNE 30, 2019 AND 2018

CLAconnect.com

WEALTH ADVISORY

OUTSOURCING

AUDIT, TAX, AND CONSULTING

CCMSI HOLDINGS, INC.
TABLE OF CONTENTS
YEARS ENDED JUNE 30, 2019 AND 2018

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
CCMSI Holdings, Inc.
Danville, Illinois

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of CCMSI Holdings, Inc. and its subsidiary, which comprise the consolidated balance sheets as of June 30, 2019 and 2018, and the related consolidated statements of operations, stockholders' equity, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CCMSI Holdings, Inc. and its subsidiary as of June 30, 2019 and 2018, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information which includes the consolidating balance sheet, consolidating statement of operations, and the consolidating statement of cash flows is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Danville, Illinois
September 25, 2019

CCMSI HOLDINGS, INC.
CONSOLIDATED BALANCE SHEETS
JUNE 30, 2019 AND 2018

	2019	2018
ASSETS		
CURRENT ASSETS		
Cash:		
Operating	$ 11,005,514	$ 6,565,975
Premium Trust	50,488	147,444
Receivables:		
Management Fees, Net of Allowance for Doubtful Accounts of $223,984 and $225,000, Respectively	17,051,972	16,339,516
Premiums	707,191	620,081
Other	650,061	444,534
Prepaid Expenses and Other Assets	2,275,602	1,685,080
Total Current Assets	31,740,828	25,802,630
INVESTMENT IN LIMITED LIABILITY COMPANY	212,374	434,255
PROPERTY AND EQUIPMENT, NET	15,300,307	13,071,074
Total Assets	$ 47,253,509	$ 39,307,959
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable	$ 5,034,259	$ 3,608,103
Accrued Expenses	10,117,566	8,987,039
Premium Accounts Payable	628,969	627,992
Deferred Revenue	11,171,858	10,929,086
Total Current Liabilities	26,952,652	24,152,220
STOCKHOLDERS' EQUITY		
Common Stock; $0.01 Par Value, 1,000,000 Shares Authorized; 290,353 Issued and Outstanding	2,903	2,903
Additional Paid-In Capital	4,797,112	4,797,112
Retained Earnings	15,500,842	10,355,724
Total Stockholders' Equity	20,300,857	15,155,739
Total Liabilities and Stockholders' Equity	$ 47,253,509	$ 39,307,959

See accompanying Notes to Consolidated Financial Statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS
YEARS ENDED JUNE 30, 2019 AND 2018

	2019	2018
OPERATING REVENUE	$ 154,019,643	$ 143,823,403
OPERATING EXPENSES		
Personnel Salaries and Benefits	113,224,312	105,511,563
Managed Care Services	11,466,719	10,612,265
Occupancy	9,659,410	9,498,639
Depreciation and Amortization	4,443,978	4,603,329
Impairment of Goodwill	-	1,279,462
Supplies and Postage	2,025,591	2,087,126
Travel	3,456,778	3,769,872
Professional Fees	370,914	445,148
Consulting	880,567	919,307
Computer	1,024,702	773,524
Marketing and Sales	243,466	224,038
Miscellaneous	2,021,546	1,525,890
Total Operating Expenses	148,817,983	141,250,163
INCOME FROM OPERATIONS	5,201,660	2,573,240
OTHER INCOME (EXPENSE)		
Undistributed Equity in Loss of Limited Liability Company	(221,880)	(50,518)
Interest Income	165,338	1,338
Total Other Income (Expense)	(56,542)	(49,180)
NET INCOME	$ 5,145,118	$ 2,524,060

See accompanying Notes to Consolidated Financial Statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
YEARS ENDED JUNE 30, 2019 AND 2018

	Total	Common Stock	Additional Paid-In Capital	Retained Earnings (Accumulated Deficit)
BALANCE – JUNE 30, 2017	$ 12,631,679	$ 2,903	$ 4,797,112	$ 7,831,664
Net Income	2,524,060	-	-	2,524,060
BALANCE – JUNE 30, 2018	15,155,739	2,903	4,797,112	10,355,724
Net Income	5,145,118	-	-	5,145,118
BALANCE – JUNE 30, 2019	$ 20,300,857	$ 2,903	$ 4,797,112	$ 15,500,842

See accompanying Notes to Consolidated Financial Statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2019 AND 2018

	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES		
Net Income	$ 5,145,118	$ 2,524,060
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:		
Depreciation	4,443,978	4,393,006
Amortization and Impairment Loss	-	1,489,785
Provision for Bad Debts	-	(1,814)
Noncash Compensation Expense	3,578,961	1,715,051
Undistributed Equity in Loss of Limited Liability Company	221,880	50,518
Effects of Changes in Operating Assets and Liabilities:		
Premium Trust	96,956	3,984
Receivables	(1,005,093)	(143,237)
Prepaid Expenses and Other Assets	(590,521)	(26,672)
Accounts Payable and Accrued Expenses	(1,021,301)	(2,549,142)
Deferred Revenue	242,772	1,628,211
Net Cash Provided by Operating Activities	11,112,750	9,083,750
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Additional Interest in Limited Liability Company	-	(37,204)
Purchases of Equipment and Leasehold Improvements	(6,673,211)	(4,713,510)
Net Cash Used by Investing Activities	(6,673,211)	(4,750,714)
NET INCREASE IN OPERATING CASH	4,439,539	4,333,036
Operating Cash – Beginning of Year	6,565,975	2,232,939
OPERATING CASH – END OF YEAR	$ 11,005,514	$ 6,565,975

See accompanying Notes to Consolidated Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

CCMSI Holdings, Inc. (Company) is a holding company whose subsidiary provides third-party administration services for workers' compensation, property/casualty, and professional liability self-insurance programs of various businesses, governments, and pooled associations. The Company is subject to regulations of certain regulatory agencies and undergoes periodic examinations by those regulatory agencies.

The significant accounting and reporting policies for CCMSI Holdings, Inc. follow:

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and its wholly owned subsidiaries, Cannon Cochran Management Services, Inc. (dba: CCMSI) and Comp MC, Inc. The accounts of Comp MC, Inc. are included with the accounts of CCMSI for financial statement presentation. All significant intercompany accounts and transactions have been eliminated in the consolidation.

The consolidated financial statements of the Company have been prepared in conformity with accounting principles generally accepted in the United States of America and conform to predominant practice within the industry.

Use of Estimates in Preparing Financial Statements

In preparing the accompanying consolidated financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities as of the date of the consolidated financial statements and the reported amounts of revenues and expenses for the reporting period. Actual results could differ from those estimates. Material estimates which are particularly susceptible to significant change in the near term include the fair value of the Company's shares of common stock outstanding determined by an independent appraisal of the Company. The fair value estimates of the Company's common stock are used to determine share-based compensation liabilities, ESOP compensation expenses, and stock repurchase commitments.

Fiduciary Assets and Liabilities

The Company collects funds used to pay claims for self-insurance programs administered by CCMSI. The funds are not assets of the Company and, accordingly, are not included in the accompanying consolidated financial statements.

Cash

For the purposes of reporting cash flows, the Company has defined cash to exclude cash restricted for the payment of insurance sold in its capacity as an insurance agent. The Company maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Company has not experienced any losses in such accounts. The Company believes it is not exposed to any significant credit risk on cash.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Receivables

Receivables are uncollateralized customer obligations which generally require payment within thirty days from the invoice date. Payments of accounts receivable are applied to the specific invoices identified on the customer's remittance advice or, if unspecified, to the earliest unpaid invoices.

The carrying amounts of accounts receivable is reduced by a valuation allowance that reflects management's best estimate of amounts that will not be collected. The allowance for doubtful accounts is based on management's assessment of the collectability of specific customer accounts and the aging of the accounts receivable. If there is a deterioration of a major customer's credit worthiness or actual defaults are higher than the historical experience, management's estimates of the recoverability of amounts due the Company could be adversely affected. All accounts or portions thereof deemed to be uncollectible or to require an excessive collection cost are written off to the allowance for doubtful accounts.

Revenue Recognition and Deferred Revenue

Revenue includes compensation for management services, insurance commissions, and fees for services rendered in connection with the operation of self-insurance programs of various businesses, governments, and pooled associations. Insurance commissions for excess policies placed as a broker are recorded as of the effective date of the policy and recognized as income over the coverage period. Fees for services rendered are recorded as earned over the period which the service is to be provided. The Company may bill and collect fees in advance for services to be performed over a period of time and those fees are deferred and recognized ratably over that same period or as the services are provided. The Company may also bill and collect fees subsequent to the performance of the services and those fees are recognized as earned in the period which the service is provided.

The Company uses independent brokers in connection with the marketing of certain self-insurance programs. Operating revenue is stated net of commissions paid to these brokers.

Investment in Limited Liability Company

The Company holds a 100% interest in HT Air, LLC. The Company is accounting for its investment in this company under the equity method of accounting since the assets and liabilities are not significant. The assets and liabilities of HT Air, LLC totaled $388,757 and $147,242 respectively as of June 30, 2019. The LLC had assets and liabilities of $583,688 and $120,292 respectively as of June 30, 2018.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property and Equipment

Property and equipment is stated at cost less accumulated depreciation. Depreciation is computed principally by accelerated methods over the estimated useful lives of the related assets. Artwork is carried at the lower of cost or market. Market values for artwork are determined using independent appraisers. The Company capitalizes certain costs to develop, purchase, or modify software for the internal use of the Company. The depreciation expense on assets acquired under capital leases, depreciated over the shorter of the term of the lease or their estimated useful lives, is included with depreciation expense on owned assets. Leasehold improvements are amortized over their estimated useful lives or the respective lease terms, whichever is shorter. The estimated economic useful lives are as follows:

Computer Equipment and Accessories, Including Software	3 – 5 Years
Furniture, Fixtures, and Equipment, Including Acquired	5 – 10 Years
Leasehold Improvements	3 – 10 Years

Impairment of Long-Lived Assets

The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. Assets to be disposed of are reported at the lower of carrying amount or the fair value less costs to sell.

Goodwill and Intangible Assets Acquired

The Company records the assets acquired and liabilities assumed in business combinations at their respective fair values at the date of acquisition, with any excess purchase price recorded as goodwill. Valuation of intangible assets entails significant estimates and assumptions including, but not limited to, estimating future cash flows, developing appropriate discount rates, and approximating the useful lives of the intangible assets acquired. The Company has adopted FASB ASU 2014-18, *Accounting for Identifiable Assets in a Business Combination*. Under this standard, the Company has elected not to recognize the fair value of acquired noncompetition agreements and customer related intangible assets under the accounting alternative available to private companies.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Goodwill

The Company recognizes goodwill as an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. The Company has adopted the private company accounting alternative for subsequent measurement of goodwill detailed in Accounting Standards Update No. 2014-02, *Intangibles – Goodwill and Other (Topic 350): Accounting for Goodwill.* Under this accounting alternative, goodwill is amortized on a straight-line basis over a period of 10 years. The Company tests goodwill for impairment when triggering events occur that indicate that the fair value of the Company may be below its carrying amount. The Company has made an accounting policy election to test goodwill at the reporting unit level.

Advertising

The Company expenses advertising costs as incurred.

Income Taxes

The Company, with the consent of its stockholders, has elected to be taxed under sections of federal and state income tax law, which provide that, in lieu of corporation income taxes, the stockholders separately account for their pro rata shares of the Company's items of income, deductions, losses and credits. The election was effective as of July 1, 1998. As a result of this election, no income taxes have been recognized in the accompanying consolidated financial statements.

Share-Based Compensation

The Company has issued Stock Appreciation Rights (SARs) and Stock Warrants to certain employees that require the Company to pay the fair value of the SAR and warrant to the employee at the date of exercise. These awards are considered to be liability awards as defined in Codification Topic 718 *Compensation – Stock Compensation*. These awards are more fully described in Note 7.

New Accounting Standards

In May 2014, the FASB issued amended guidance to clarify the principles for recognizing revenue from contracts with customers. The guidance requires an entity to recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which an entity expects to be entitled in exchange for those goods or services. The guidance also requires expanded disclosures relating to the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. Additionally, qualitative and quantitative disclosures are required regarding customer contracts, significant judgements and changes in judgments, and assets recognized from the costs to obtain or fulfill a contract. The guidance will initially be applied retrospectively using one of two methods. The standard will be effective for the Company beginning July 1, 2019. The Company has not yet determined the impact that the accounting pronouncement will have on the Company's consolidated financial statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

New Accounting Standards (Continued)

In February 2016, the FASB issued amended guidance for the treatment of leases. The guidance requires lessees to recognize a right-of-use asset and a corresponding lease liability for all operating and finance leases with lease terms greater than one year. The accounting for lessors will remain relatively unchanged. The guidance changes the accounting for sale and leaseback transactions to conform to the new revenue recognition standard. The guidance also requires both qualitative and quantitative disclosures regarding the nature of the entity's leasing activities. The amendments in the guidance are effective for fiscal years beginning after December 15, 2020. Early adoption is permitted. Management is evaluating the impact of the amended lease guidance on the Company's consolidated financial statements.

NOTE 2 PROPERTY AND EQUIPMENT

Property and equipment consists of:

	2019	2018
Computer Equipment, Accessories, and Software	$ 24,301,321	$ 22,282,663
Furniture, Fixtures, and Equipment	7,630,197	6,384,766
Leasehold Improvements	1,832,383	1,548,535
Total Property and Equipment	33,763,901	30,215,964
Less: Accumulated Depreciation	18,463,594	17,144,890
Property and Equipment, Net	$ 15,300,307	$ 13,071,074

Included in computer equipment, accessories and software above are costs for internally developed software products. Total cost was $19,337,264 and $18,669,961, respectively, and accumulated depreciation was $10,962,782 and $10,139,035, respectively, for the years ended June 30, 2019 and 2018, respectively.

NOTE 3 GOODWILL

	Gross Amount	Accumulated Amortization	Net Amount
Balance – June 30, 2017	$ 2,103,226	$ (613,441)	1,489,785
Current Year Amortization	-	(210,323)	(210,323)
Current Year Impairment Loss	-	(1,279,462)	(1,279,462)
Balance – June 30, 2018	2,103,226	(2,103,226)	-
Current Year Amortization	-	-	-
Current Year Impairment Loss	-	-	-
Balance – June 30, 2019	$ 2,103,226	$ (2,103,226)	$ -

NOTE 3 GOODWILL (CONTINUED)

The Company had elected to amortize Goodwill over 10 years. During 2018, due to changes in customer retention and profitability related to the Vertical Claims Management, LLC (VCM) acquisition in 2015 which resulted in Goodwill, the Company determined that there was no ongoing value associated with this acquisition as of June 30, 2018. Therefore, the Company recognized an impairment loss of $1,279,462. The fair value of the reporting unit was determined by management's estimate of the present value of future cash flows related to the VCM service line. The impairment loss is included in the accompanying consolidated statements of operations for the year ended June 30, 2018.

NOTE 4 ACCRUED EXPENSES

The Company's accrued expenses are summarized as follows at June 30:

	2019	2018
Payroll, Commissions, and Bonuses	$ 2,696,602	$ 4,693,387
Stock Appreciation Rights (Vested)	4,178,005	1,163,197
Stock Warrants	1,980,170	1,416,017
Other	1,262,789	1,714,438
Total Accrued Expenses	$ 10,117,566	$ 8,987,039

NOTE 5 DEBT

Line of Credit

The Company has a line of credit of $7,000,000 at June 30, 2019 and 2018 for which there was no balance drawn. Amounts drawn against the line of credit are payable on demand and bear interest at the lender's prime rate minus 0.50% for an effective rate of 5.00% and 4.50% at June 30, 2019 and 2018, respectively. The line of credit is collateralized by substantially all of the Company's assets. The line of credit matures on March 7, 2020.

NOTE 6 EMPLOYEE RETIREMENT PLANS

The Company sponsors a 401(k) savings plan under which eligible employees may choose to save a percentage of their salary on a pre-tax basis, subject to certain Internal Revenue Service (IRS) limits. The Company may make discretionary matching and profit sharing contributions to the plan. The Company did not make any matching or profit sharing contributions during the years ended June 30, 2019 and 2018.

NOTE 6 EMPLOYEE RETIREMENT PLANS (CONTINUED)

The Company sponsors an Employee Stock Ownership Plan for the benefit of employees who meet certain eligibility requirements. The ESOP's shares were purchased by the ESOP with the proceeds of a note from the Company. The Company made annual contributions to the ESOP equal to the ESOP's debt service, less dividends received by the ESOP. As principal and interest were paid, shares were released from collateral and allocated to participants based on the proportion of debt service paid in the year. The ESOP allocates released shares to all participants who meet certain eligibility requirements. The ESOP's loan to the Company is paid off and all shares have been released into the ESOP.

Compensation expense is recorded for additional contributions paid to the ESOP for benefit payments to participants. Compensation expense for the ESOP was $3,350,000 and $2,645,000 for the years ending June 30, 2019 and 2018, respectively.

Company shares held in the ESOP and allocated to participants totaled 282,853 as of June 30, 2019 and 2018. In the event of termination from employment or if eligible participants elect to diversify their account balances, the Company may be required to purchase the shares from the participant at the shares' fair market value unless the ESOP fulfills this obligation. The repurchase obligation totaled approximately $52 million and $45 million as of June 30, 2019 and 2018, respectively.

NOTE 7 SHARE-BASED COMPENSATION

Stock Appreciation Rights (SARs)

Effective January 1, 2017, the Company issued 110,500 SARs to certain employees with a base value of $146.80 for each award and a vesting period of 33.33% each June 30. Through 2019, no SARs have been forfeited or exercised, resulting in 110,500 SARs outstanding as of June 30, 2019 and 2018 under the 2017 Plan. The vested portion of the outstanding SARs totaled $4,178,005 and $1,163,197 as of June 30, 2019 and 2018 and is included in accrued expenses in the accompanying consolidated financial statements.

Stock Warrants

In December 2013 and January 2014, the Company issued 46,504 stock warrants in connection with the redemption of stock held by individuals. The Holders have the option to exercise the warrants at any time. Included in the redemption agreement is a put option in which the individual exercising the warrants has the right to require the Company to purchase the warrants by paying the Holder an amount equal to the difference between the fair market value at the surrender date of the warrants and the warrant strike price of $107.32 per warrant. From 2013 through 2019, 20,884 warrants were exercised, resulting in 25,620 warrants outstanding as of June 30, 2019. At June 30, 2019 and 2018, the fair value of the outstanding warrants totaled $1,980,170 and $1,416,017, respectively, and is included in accrued expenses in the accompanying consolidated financial statements.

NOTE 7 SHARE BASED COMPENSATION (CONTINUED)

Stock Warrants (Continued)

The fair market value of the vested portion of all outstanding SARs and stock warrants included in accrued expenses is determined by an independent appraiser as of the reporting date. The Company's stock price was valued at $184.61 and $162.59 as of June 30, 2019 and 2018, respectively. The expense for the SARs and stock warrants totaled $3,578,962 and $1,715,051 for the years ending June 30, 2019 and 2018, respectively, and is included in personnel salaries and benefits in the accompanying consolidated financial statements.

NOTE 8 INCOME TAXES

The Company files consolidated income tax returns in the U.S. federal jurisdiction and multiple states. The Company is a pass-through entity for income tax purposes whereby any income tax liabilities or benefits are attributable to the Company's members. Any amounts paid by the Company for income taxes are accounted for as transactions with the Company's members.

Federal and state income tax returns are subject to examination by the IRS and state taxing authorities, generally for three years after they are filed.

NOTE 9 COMMITMENTS

Lease Commitments

The Company has entered into lease agreements for the buildings it currently occupies and for office equipment which it accounts for as operating leases. Under terms of the building leases, the lessor is responsible for insurance and taxes with the lessee responsible for routine maintenance and utilities. The following summarizes future commitments under these leases.

Year Ending June 30,	Amount
2020	$ 6,101,854
2021	4,921,812
2022	3,995,527
2023	3,042,466
2024	2,502,816
Thereafter	2,609,724
Total	$ 23,174,199

Total rent expense incurred related to all operating leases totaled $6,574,060 and $6,355,761 for the years ended June 30, 2019 and 2018, respectively.

NOTE 9 COMMITMENTS (CONTINUED)

Stock Repurchase Commitment

The Company maintains stock repurchase agreements with all stockholders of the Company whereby at the stockholder's notification to the Company and the remaining stockholders of his intent to sell, the Company will repurchase the stockholder's stock at a price determined by an independent appraiser. The potential liability for the repurchase of shares held by the stockholders, other than the ESOP, is approximately $1,384,575 and $1,219,000 as of June 30, 2019 and 2018, respectively.

NOTE 10 CONTINGENT LIABILITIES

The Company is involved in litigation relating to various disputes with certain individuals and companies. The Company is vigorously defending its position in these cases and believes damages, if awarded to the defendants, will not be material. The Company includes in accrued expenses any expected settlements of these cases that are estimated to result in losses.

The Company acts as a third-party administrator of self-insurance programs for various businesses, governments, and pooled risk management associations. In carrying out these services, the Company has check signing authority over various cash accounts of these entities.

NOTE 11 SELF-INSURANCE

The Company is self-insured for health benefits provided to employees. Medical claims exceeding $250,000 on any one individual, and aggregate losses in excess of approximately $17,300,000 and $13,500,000 incurred and paid during the years ended June 30, 2019 and 2018, respectively, were covered by stop-loss insurance purchased from a commercial insurance carrier. The Company has estimated a liability for claims incurred but not reported (IBNR) of $834,574 and $1,500,000, which is included in accrued expenses in the accompanying balance sheet for the years ended June 30, 2019 and 2018, respectively. Claims expense under the self-insured health plan totaled $11,516,171 and $11,622,841 for the years ended June 30, 2019 and 2018, respectively.

NOTE 12 SUBSEQUENT EVENTS

Management evaluated subsequent events through September 25, 2019, the date the financial statements were available to be issued.

CCMSI HOLDINGS, INC.
CONSOLIDATING BALANCE SHEET
JUNE 30, 2019

	CCMSI Holdings, Inc.	CCMSI	Eliminations	Total
ASSETS				
CURRENT ASSETS				
Cash:				
Operating	$ 36,895	$ 10,968,619	$ -	$ 11,005,514
Premium Trust	-	50,488	-	50,488
Receivables:				
Management Fees, Net of Allowance of $223,984	-	17,051,972	-	17,051,972
Premiums	-	707,191	-	707,191
Other	-	650,061	-	650,061
Prepaid Expenses and Other Assets	-	2,275,602	-	2,275,602
Total Current Assets	36,895	31,703,933	-	31,740,828
INVESTMENTS IN SUBSIDIARY AND LIMITED LIABILITY COMPANY	26,422,137	-	(26,209,763)	212,374
PROPERTY AND EQUIPMENT, NET	-	15,300,307	-	15,300,307
Total Assets	$ 26,459,032	$ 47,004,240	$ (26,209,763)	$ 47,253,509
LIABILITIES AND STOCKHOLDERS' EQUITY				
CURRENT LIABILITIES				
Accounts Payable	$ -	$ 5,034,259	$ -	$ 5,034,259
Accrued Expenses	6,158,175	3,959,391	-	10,117,566
Premium Accounts Payable	-	628,969	-	628,969
Deferred Revenues	-	11,171,858	-	11,171,858
Total Current Liabilities	6,158,175	20,794,477	-	26,952,652
STOCKHOLDERS' EQUITY				
Common Stock	2,903	4,107	(4,107)	2,903
Additional Paid-In Capital	4,797,112	6,229,207	(6,229,207)	4,797,112
Retained Earnings	15,500,842	19,976,449	(19,976,449)	15,500,842
Total Stockholders' Equity	20,300,857	26,209,763	(26,209,763)	20,300,857
Total Liabilities and Stockholders' Equity	$ 26,459,032	$ 47,004,240	$ (26,209,763)	$ 47,253,509

CCMSI HOLDINGS, INC.
CONSOLIDATING STATEMENT OF OPERATIONS
YEAR ENDED JUNE 30, 2019

	CCMSI Holdings, Inc.	CCMSI	Eliminations	Total
OPERATING REVENUE	$ -	$ 154,019,643	$ -	$ 154,019,643
OPERATING EXPENSES				
Personnel Salaries and Benefits	6,928,962	106,295,350	-	113,224,312
Managed Care Services	-	11,466,719	-	11,466,719
Occupancy	-	9,659,410	-	9,659,410
Depreciation and Amortization	-	4,443,978	-	4,443,978
Supplies and Postage	-	2,025,591	-	2,025,591
Travel	-	3,456,778	-	3,456,778
Professional Fees	-	370,914	-	370,914
Consulting	-	880,567	-	880,567
Computer	-	1,024,702	-	1,024,702
Marketing and Sales	-	243,466	-	243,466
Miscellaneous	-	2,021,546	-	2,021,546
Total Operating Expenses	6,928,962	141,889,021	-	148,817,983
INCOME (LOSS) FROM OPERATIONS	(6,928,962)	12,130,622	-	5,201,660
OTHER INCOME (EXPENSES)				
Equity in Income from Subsidiary	12,295,960	-	(12,295,960)	-
Undistributed Equity in Loss of Limited Liability Company	(221,880)	-	-	(221,880)
Interest Income	-	165,338	-	165,338
Total Other Income (Expense)	12,074,080	165,338	(12,295,960)	(56,542)
NET INCOME	$ 5,145,118	$ 12,295,960	$ (12,295,960)	$ 5,145,118

CCMSI HOLDINGS, INC.
CONSOLIDATING STATEMENT OF CASH FLOWS
YEAR ENDED JUNE 30, 2019

	CCMSI Holdings, Inc.	CCMSI	Eliminations	Total
CASH FLOWS FROM OPERATING ACTIVITIES				
Net Income	$ 5,145,118	$ 12,295,960	$ (12,295,960)	$ 5,145,118
Adjustments to Reconcile Net Income to Net Cash Provided (Used) by Operating Activities:				
Depreciation	-	4,443,978	-	4,443,978
Noncash Compensation Expense	3,578,961	-	-	3,578,961
Equity in Income from Subsidiary	(12,295,960)	-	12,295,960	-
Undistributed Equity in Loss of Limited Liability Company	221,880	-	-	221,880
Effects of Changes in Operating Assets and Liabilities:				
Premium Trust	-	96,956	-	96,956
Receivables	-	(1,005,093)	-	(1,005,093)
Prepaid Expenses and Other Assets	-	(590,521)	-	(590,521)
Accounts Payable and Accrued Expenses	-	(1,021,301)	-	(1,021,301)
Deferred Revenue	-	242,772	-	242,772
Net Cash Provided (Used) by Operating Activities	(3,350,001)	14,462,751	-	11,112,750
CASH FLOWS FROM INVESTING ACTIVITIES				
Purchases of Equipment and Leasehold Improvements	-	(6,673,211)	-	(6,673,211)
Distributions from Common Stock of Subsidiary	3,350,000	-	(3,350,000)	-
Net Cash Provided (Used) by Investing Activities	3,350,000	(6,673,211)	(3,350,000)	(6,673,211)
CASH FLOWS FROM FINANCING ACTIVITIES				
Distributions to Stockholders	-	(3,350,000)	3,350,000	-
NET INCREASE (DECREASE) IN OPERATING CASH	(1)	4,439,540	-	4,439,539
Operating Cash – Beginning of Year	36,896	6,529,079	-	6,565,975
OPERATING CASH – END OF YEAR	$ 36,895	$ 10,968,619	$ -	$ 11,005,514

CCMSI HOLDINGS. INC.

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED JUNE 30, 2017 AND 2016

CCMSI HOLDINGS. INC.
TABLE OF CONTENTS
YEARS ENDED JUNE 30, 2017 AND 2016

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
CCMSI Holdings. Inc.
Danville, Illinois

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of CCMSI Holdings. Inc. and its subsidiary, which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of operations, stockholders' equity, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CCMSI Holdings. Inc. and its subsidiary as of June 30, 2017 and 2016, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information which includes the consolidating balance sheet, consolidating statement of operations, and the consolidating statement of cash flows is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Danville, Illinois
October 4, 2017

CCMSI HOLDINGS. INC.
CONSOLIDATED BALANCE SHEETS
JUNE 30, 2017 AND 2016

	2017	2016
ASSETS		
CURRENT ASSETS		
Cash:		
Operating	$ 2,232,939	$ 15,532,896
Premium Trust	151,428	757,058
Receivables:		
Management Fees, Net of Allowance for Doubtful Accounts of $226,814 and $250,000, Respectively	15,934,595	13,826,006
Premiums	899,705	849,357
Other	424,780	523,302
Prepaid Expenses and Other Assets	1,658,408	1,467,927
Total Current Assets	21,301,855	32,956,546
INVESTMENT IN LIMITED LIABILITY COMPANY	447,569	365,723
PROPERTY AND EQUIPMENT, NET	12,750,570	12,902,009
GOODWILL, NET	1,489,785	1,700,108
Total Assets	$ 35,989,779	$ 47,924,386
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts Payable	$ 1,423,292	$ 922,105
Accrued Expenses	11,757,169	25,576,662
Premium Accounts Payable	876,764	1,419,563
Deferred Revenue	9,300,875	10,914,135
Total Current Liabilities	23,358,100	38,832,465
STOCKHOLDERS' EQUITY		
Common Stock; $0.01 Par Value, 1,000,000 Shares Authorized; 290,353 Issued and Outstanding	2,903	2,903
Additional Paid-in Capital	4,797,112	4,797,112
Retained Earnings	7,831,664	4,291,906
Total Stockholders' Equity	12,631,679	9,091,921
Total Liabilities and Stockholders' Equity	$ 35,989,779	$ 47,924,386

See accompanying Notes to Financial Statements.

CCMSI HOLDINGS. INC.
CONSOLIDATED STATEMENTS OF OPERATIONS
YEARS ENDED JUNE 30, 2017 AND 2016

	2017	2016
OPERATING REVENUE	$ 136,887,995	$ 130,780,335
OPERATING EXPENSES		
Personnel Salaries and Benefits	98,981,736	93,017,178
Managed Care Services	10,188,193	10,049,086
Occupancy	9,434,580	9,158,262
Depreciation and Amortization	4,342,652	4,624,083
Supplies and Postage	2,094,343	2,289,894
Travel	3,826,215	3,730,062
Professional Fees	444,709	289,629
Consulting	863,940	716,177
Computer	636,784	782,121
Marketing and Sales	208,402	233,660
Miscellaneous	1,915,783	1,696,839
Total Operating Expenses	132,937,337	126,586,991
INCOME FROM OPERATIONS	3,950,658	4,193,344
OTHER INCOME (EXPENSE)		
Undistributed Equity in Loss of Limited Liability Company	(414,704)	(1,919)
Interest Income	3,804	5,952
Total Other Income (Expense)	(410,900)	4,033
NET INCOME	$ 3,539,758	$ 4,197,377

See accompanying Notes to Financial Statements.

CCMSI HOLDINGS. INC.
CONSOLIDATING STATEMENTS OF STOCKHOLDERS' EQUITY
YEARS ENDED JUNE 30, 2017 AND 2016

	Total	Common Stock	Additional Paid-in Capital	Retained Earnings (Accumulated Deficit)
BALANCE – JUNE 30, 2015	$ 4,894,544	$ 2,903	$ 4,797,112	$ 94,529
Net Income	4,197,377	-	-	4,197,377
BALANCE – JUNE 30, 2016	9,091,921	2,903	4,797,112	4,291,906
Net Income	3,539,758	-	-	3,539,758
BALANCE – JUNE 30, 2017	$ 12,631,679	$ 2,903	$ 4,797,112	$ 7,831,664

See accompanying Notes to Financial Statements.

CCMSI HOLDINGS. INC.
CONSOLIDATING STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2017 AND 2016

	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES		
Net Income	$ 3,539,758	$ 4,197,377
Adjustments to Reconcile Net Income to Net Cash Provided (Used) by Operating Activities:		
Depreciation	4,132,329	4,413,761
Amortization	210,323	210,322
Provision for Bad Debts	8,389	33,558
Gain on Disposal of Property and Equipment	-	(1,029)
Noncash Compensation Expense	(147,279)	2,053,415
Undistributed Equity in Loss of Limited Liability Company	414,704	1,919
Effects of Changes in Operating Assets and Liabilities:		
Premium Trust	605,630	(574,702)
Receivables	(2,068,804)	69,278
Prepaid Expenses and Other Assets	(190,481)	515,966
Accounts Payable and Accrued Expenses	(13,713,826)	(2,567,987)
Deferred Revenue	(1,613,260)	618,767
Net Cash Provided (Used) by Operating Activities	(8,822,517)	8,970,645
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Additional Interest in Limited Liability Company	(496,550)	(88,452)
Proceeds on Sales of Equipment and Leasehold Improvements	-	2,855
Purchases of Equipment and Leasehold Improvements	(3,980,890)	(3,831,862)
Net Cash Used by Investing Activities	(4,477,440)	(3,917,459)
NET INCREASE (DECREASE) IN OPERATING CASH	(13,299,957)	5,053,186
Operating Cash – Beginning of Year	15,532,896	10,479,710
OPERATING CASH – END OF YEAR	$ 2,232,939	$ 15,532,896

See accompanying Notes to Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

CCMSI Holdings. Inc. (Company) is a holding company whose subsidiary provides third-party administration services for workers' compensation, property/casualty, and professional liability self-insurance programs of various businesses, governments, and pooled associations. The Company is subject to regulations of certain regulatory agencies and undergoes periodic examinations by those regulatory agencies.

The significant accounting and reporting policies for CCMSI Holdings, Inc. follow:

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and its wholly owned subsidiaries, Cannon Cochran Management Services, Inc. (dba: CCMSI) and Comp MC, Inc. The accounts of Comp MC, Inc. are included with the accounts of CCMSI for financial statement presentation. In July 2014, the Company acquired all of the assets and liabilities of Vertical Claims Management, LLC. This entity was presented as a wholly owned subsidiary in 2016. Effective July 1, 2016, Vertical Claims Management was merged into CCMSI. All significant intercompany accounts and transactions have been eliminated in the consolidation.

The consolidated financial statements of the Company have been prepared in conformity with accounting principles generally accepted in the United States of America and conform to predominant practice within the industry.

Use of Estimates in Preparing Financial Statements

In preparing the accompanying consolidated financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities as of the date of the consolidated financial statements and the reported amounts of revenues and expenses for the reporting period. Actual results could differ from those estimates. Material estimates which are particularly susceptible to significant change in the near term include the fair value of the Company's shares of common stock outstanding determined by an independent appraisal of the Company and the consideration of impairment of intangible assets. The fair value estimates of the Company's common stock are used to determine share-based compensation liabilities, ESOP compensation expenses, and stock repurchase commitments.

Fiduciary Assets and Liabilities

The Company collects funds used to pay claims for self-insurance programs administered by CCMSI. The funds are not assets of the Company and, accordingly, are not included in the accompanying consolidated financial statements.

Cash

For the purposes of reporting cash flows, the Company has defined cash to exclude cash restricted for the payment of insurance sold in its capacity as an insurance agent. The Company maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Company has not experienced any losses in such accounts. The Company believes it is not exposed to any significant credit risk on cash.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Receivables

Receivables are uncollateralized customer obligations which generally require payment within thirty days from the invoice date. Payments of accounts receivable are applied to the specific invoices identified on the customer's remittance advice or, if unspecified, to the earliest unpaid invoices.

The carrying amounts of accounts receivable is reduced by a valuation allowance that reflects management's best estimate of amounts that will not be collected. The allowance for doubtful accounts is based on management's assessment of the collectability of specific customer accounts and the aging of the accounts receivable. If there is a deterioration of a major customer's credit worthiness or actual defaults are higher than the historical experience, management's estimates of the recoverability of amounts due the Company could be adversely affected. All accounts or portions thereof deemed to be uncollectible or to require an excessive collection cost are written off to the allowance for doubtful accounts.

Revenue Recognition and Deferred Revenue

Revenue includes compensation for management services, insurance commissions, and fees for services rendered in connection with the operation of self-insurance programs of various businesses, governments, and pooled associations. Insurance commissions for excess policies placed as a broker are recorded as of the effective date of the policy and recognized as income over the coverage period. Fees for services rendered are recorded as earned over the period which the service is to be provided. The Company may bill and collect fees in advance for services to be performed over a period of time and those fees are deferred and recognized ratably over that same period or as the services are provided. The Company may also bill and collect fees subsequent to the performance of the services and those fees are recognized as earned in the period which the service is provided.

The Company uses independent brokers in connection with the marketing of certain self-insurance programs. Operating revenue is stated net of commissions paid to these brokers.

Investment in Limited Liability Company

The Company holds a 94% interest (84% in 2016) in HT Air, LLC. The Company is accounting for its investment in this company under the equity method of accounting since the assets and liabilities are not significant. The assets and liabilities of HT Air, LLC totaled $532,686 and $79,757 respectively as of June 30, 2017. The LLC had assets and liabilities of $404,441 and $67,865 respectively as of June 30, 2016.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property and Equipment

Property and equipment is stated at cost less accumulated depreciation. Depreciation is computed principally by accelerated methods over the estimated useful lives of the related assets. Artwork is carried at the lower of cost or market. Market values for artwork are determined using independent appraisers. The Company capitalizes certain costs to develop, purchase, or modify software for the internal use of the Company. The depreciation expense on assets acquired under capital leases, depreciated over the shorter of the term of the lease or their estimated useful lives, is included with depreciation expense on owned assets. Leasehold improvements are amortized over their estimated useful lives or the respective lease terms, whichever is shorter. The estimated economic useful lives are as follows:

Computer Equipment and Accessories, Including Software	3 – 5 Years
Furniture, Fixtures, and Equipment, Including Acquired	5 – 10 Years
Leasehold Improvements	3 – 10 Years

Impairment of Long-Lived Assets

The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. Assets to be disposed of are reported at the lower of carrying amount or the fair value less costs to sell.

Goodwill and Intangible Assets Acquired

The Company records the assets acquired and liabilities assumed in business combinations at their respective fair values at the date of acquisition, with any excess purchase price recorded as goodwill. Valuation of intangible assets entails significant estimates and assumptions including, but not limited to, estimating future cash flows, developing appropriate discount rates, and approximating the useful lives of the intangible assets acquired. The Company has adopted FASB ASU 2014-18, Accounting for Identifiable Assets in a Business Combination. Under this standard, the Company has elected not to recognize the fair value of acquired noncompetition agreements and customer related intangible assets under the accounting alternative available to private companies.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Goodwill

The Company recognizes goodwill as an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. The Company has adopted the private company accounting alternative for subsequent measurement of goodwill detailed in Accounting Standards Update No. 2014-02, *Intangibles – Goodwill and Other (Topic 350): Accounting for Goodwill.* Under this accounting alternative, goodwill is amortized on a straight-line basis over a period of 10 years. The company tests goodwill for impairment when triggering events occur that indicate that the fair value of the Company may be below its carrying amount. The company has made an accounting policy election to test goodwill at the entity level, which is the same as the reporting unit level.

Advertising

The Company expenses advertising costs as incurred.

Income Taxes

The Company, with the consent of its stockholders, has elected to be taxed under sections of federal and state income tax law, which provide that, in lieu of corporation income taxes, the stockholders separately account for their pro rata shares of the Company's items of income, deductions, losses and credits. The election was effective as of July 1, 1998. As a result of this election, no income taxes have been recognized in the accompanying consolidated financial statements.

Share-Based Compensation

The Company has issued Stock Appreciation Rights (SARs) and Stock Warrants to certain employees that require the Company to pay the fair value of the SAR and warrant to the employee at the date of exercise. These awards are considered to be liability awards as defined in Codification Topic 718 Compensation – Stock Compensation. These awards are more fully described in Note 7.

NOTE 2 PROPERTY AND EQUIPMENT

Property and equipment consists of:

	2017	2016
Computer Equipment, Accessories, and Software	$ 22,921,133	$ 23,888,306
Furniture, Fixtures, and Equipment.	5,517,427	6,349,171
Leasehold Improvements	1,349,681	1,476,312
Total Property and Equipment	29,788,241	31,713,789
Less: Accumulated Depreciation	17,037,671	18,811,780
Property and Equipment, Net	$ 12,750,570	$ 12,902,009

NOTE 2 PROPERTY AND EQUIPMENT (CONTINUED)

Included in computer equipment, accessories and software above are costs for internally developed software products. Total cost was $19,212,671 and $20,156,836, respectively, and accumulated depreciation was $10,512,049 and $11,893,730, respectively, for the years ended June 30, 2017 and 2016, respectively.

NOTE 3 GOODWILL

	Gross Amount	Accumulated Amortization	Net Amount
Balance – June 30, 2015	$ 2,103,226	$ (192,796)	1,910,430
Current Year Amortization	-	(210,322)	(210,322)
Balance – June 30, 2016	2,103,226	(403,118)	1,700,108
Current Year Amortization	-	(210,323)	(210,323)
Balance – June 30, 2017	$ 2,103,226	$ (613,441)	$ 1,489,785

Goodwill is being amortized over 10 years.

NOTE 4 ACCRUED EXPENSES

The Company's accrued expenses are summarized as follows at June 30:

	2017	2016
Payroll, Commissions, and Bonuses	$ 3,973,638	$ 2,594,103
Stock Appreciation Rights (Vested)	3,649,800	17,950,709
Stock Warrants	864,163	1,684,533
Other	3,269,568	3,347,317
Total Accrued Expenses	$ 11,757,169	$ 25,576,662

NOTE 5 DEBT

Line of Credit

The Company has a line of credit of $5,000,000 and $ 3,000,000 at June 30, 2017 and 2016, respectively, for which there was no balance drawn. Amounts drawn against the line of credit are payable on demand and bear interest at the lender's prime rate minus 0.50% for an effective rate of 3.75% and 3.00% at June 30, 2017 and 2016, respectively. The line of credit is collateralized by substantially all of the Company's assets. On September 1, 2017, the lender revised the agreement and increased the line to $7,000,000 with a maturity date of January 7, 2018.

The loan agreement relating to the line of credit with Old National Bank contains loan covenants based on cash flows. The Company was in violation at June 30, 2017, and has received a waiver from the bank. Management believes the Company was in compliance with its loan covenants for the year ending June 30, 2016.

The Company had a $-0- and $225,000 letter of credit at June 30, 2017 and 2016, respectively. This letter of credit was secured by substantially all of the Company's assets and is pledged to secure certain financial commitments of the Company.

NOTE 6 EMPLOYEE RETIREMENT PLANS

The Company sponsors a 401(k) savings plan under which eligible employees may choose to save a percentage of their salary on a pre-tax basis, subject to certain Internal Revenue Service (IRS) limits. The Company may make discretionary matching and profit sharing contributions to the plan. The Company did not make any matching or profit sharing contributions during the years ended June 30, 2017 and 2016.

The Company sponsors an Employee Stock Ownership Plan for the benefit of employees who meet certain eligibility requirements. The ESOP's shares were purchased by the ESOP with the proceeds of a note from the Company. The Company made annual contributions to the ESOP equal to the ESOP's debt service, less dividends received by the ESOP. As principal and interest were paid, shares were released from collateral and allocated to participants based on the proportion of debt service paid in the year. The ESOP allocates released shares to all participants who meet certain eligibility requirements. The ESOP's loan to the Company is paid off and all shares have been released into the ESOP.

Compensation expense is recorded for additional contributions paid to the ESOP for benefit payments to participants. Compensation expense for the ESOP was $2,954,124 and $3,020,000 for the years ending June 30, 2017 and 2016, respectively.

In the event of termination from employment or if eligible participants elect to diversify their account balances, the Company may be required to purchase the shares from the participant at the shares' fair market value unless the ESOP fulfills this obligation.

NOTE 7 SHARE-BASED COMPENSATION

Stock Appreciation Rights (SARs)

Effective January 1, 2007, the Company issued 364,000 SARs to certain employees with a base value of $59.67 for each award. From 2008 through 2017, 364,000 SARs have been either forfeited or exercised, resulting in no SARs outstanding as of June 30, 2017, under the 2007 Plan. The vested portion of the outstanding SARs totaled $-0- and $4,467,069 as of June 30, 2017 and 2016, respectively, and is included in accrued expenses in the accompanying financial statements.

Effective January 1, 2009, the Company issued 32,000 SARs to certain employees with a base value of $76.92 for each award and a vesting period of 20% per year. From 2009 through 2017, 32,000 SARs have been either forfeited or exercised, resulting in no SARs outstanding as of June 30, 2017, under the 2009 Plan. The vested portion of the outstanding SARs totaled $-0- and $698,800 as of June 30, 2017 and 2016, respectively, and is included in accrued expenses in the accompanying financial statements.

Effective April 1, 2012, the Company issued 172,500 SARs to certain employees with a base value of $77.28 for each award. From 2012 through 2017, 172,500 SARs have been either forfeited or exercised, resulting in 0 SARs outstanding as of June 30, 2017, under the 2012 Plan. As of June 30, 2017, the liability related to the excersie of 52,500 SARs had not yet been paid. This liability was paid in August 2017. The vested portion of the outstanding SARs totaled $3,649,800 and $11,992,200 as of June 30, 2017 and 2016, respectively, and is included in accrued expenses in the accompanying financial statements.

Effective January 1, 2013, the Company issued 20,000 SARs to certain employees with a base value of $89.00 for each award and a vesting period of 33.3% per year. From 2013 through 2017, 20,000 SARs were exercised, resulting in no SARs outstanding as of June 30, 2017, under the 2013 Plan. The vested portion of the outstanding SARs totaled $-0- and $780,300 as of June 30, 2017 and 2016, respectively, and is included in accrued expenses in the accompanying financial statements.

Effective August 1, 2014, the Company issued 1,000 SARs to a certain employee with a base value of $134.46 for each award and a vesting period of 50% per year. From 2014 through 2017, 1,000 SARs have been either forfeited or exercised, resulting in no SARs outstanding as of June 30, 2017, under the 2014 Plan. The vested portion of the outstanding SARs totaled $-0- and $12,340 as of June 30, 2017 and 2016, respectively, and is included in accrued expenses in the accompanying financial statements.

Effective January 1, 2017, the Company issued 110,500 SARs to certain employees with a base value of $146.80 for each award and a vesting period of 33.33% each June 30. Through 2017, no SARs have been forfeited or exercised, resulting in 110,500 SARs outstanding as of June 30, 2017, under the 2017 Plan. The vested portion of the outstanding SARs totaled $0 as of June 30, 2017 and 2016.

NOTE 7 SHARE-BASED COMPENSATION (CONTINUED)

Stock Warrants

In December 2013 and January 2014, the Company issued 46,504 stock warrants in connection with the redemption of stock held by individuals. The Holders have the option to exercise the warrants at any time. Included in the redemption agreement is a put option in which the individual exercising the warrants has the right to require the Company to purchase the warrants by paying the Holder an amount equal to the difference between the fair market value at the surrender date of the warrants and the warrant strike price of $107.32 per warrant. From 2013 through 2017, 20,884 warrants were exercised, resulting in 25,620 warrants outstanding as of June 30, 2017. At June 30, 2017 and 2016, the fair value of the outstanding warrants totaled $864,163 and $1,684,533, respectively, and is included in accrued expenses in the accompanying financial statements.

The fair market value of the vested portion of all outstanding SARs and stock warrants included in accrued expenses is determined by an independent appraiser as of the reporting date. The Company's stock price was valued at $141.05 and $146.80 as of June 30, 2017 and 2016, respectively. The expense for the SARs and stock warrants totaled ($147,279) and $2,053,415 for the years ending June 30, 2017 and 2016, respectively, and is included in personnel salaries and benefits in the accompanying financial statements.

NOTE 8 INCOME TAXES

The Company files consolidated income tax returns in the U.S. federal jurisdiction and multiple states. The Company is a pass-through entity for income tax purposes whereby any income tax liabilities or benefits are attributable to the Company's members. Any amounts paid by the Company for income taxes are accounted for as transactions with the Company's members.

Federal and state income tax returns are subject to examination by the IRS and state taxing authorities, generally for three years after they are filed.

NOTE 9 COMMITMENTS

Lease Commitments

The Company has entered into lease agreements for the buildings it currently occupies and for office equipment which it accounts for as operating leases. Under terms of the building leases, the lessor is responsible for insurance and taxes with the lessee responsible for routine maintenance and utilities. The following summarizes future commitments under these leases.

Year Ending June 30,	Amount
2018	$ 5,947,026
2019	5,308,836
2020	3,554,077
2021	2,186,923
2022	1,139,922
Thereafter	1,745,011
Total	$ 19,881,795

Total rent expense incurred related to all operating leases totaled $6,261,705 and $5,641,998 for the years ended June 30, 2017 and 2016, respectively.

Stock Repurchase Commitment

The Company maintains stock repurchase agreements with all stockholders of the Company whereby at the stockholder's notification to the Company and the remaining stockholders of his intent to sell, the Company will repurchase the stockholder's stock at a price determined by an independent appraiser. The potential liability for the repurchase of shares held by the stockholders, other than the ESOP, is approximately $1,058,000 and $1,101,000 as of June 30, 2017 and 2016, respectively.

NOTE 10 CONTINGENT LIABILITIES

The Company is involved in litigation relating to various disputes with certain individuals and companies. The Company is vigorously defending its position in these cases and believes damages, if awarded to the defendants, will not be material. The Company includes in accrued expenses any expected settlements of these cases that are estimated to result in losses.

The Company acts as a third-party administrator of self-insurance programs for various businesses, governments, and pooled risk management associations. In carrying out these services, the Company has check signing authority over various cash accounts of these entities.

NOTE 11 SELF-INSURANCE

The Company became self-insured in 2017 for health benefits provided to employees. Medical claims exceeding $250,000 on any one individual, and aggregate losses in excess of approximately $9,925,000 incurred and paid during the year were covered by stop-loss insurance purchased from a commercial insurance carrier. The Company has estimated a liability for claims incurred but not reported (IBNR) of $934,951, which is included in accrued expenses in the accompanying balance sheet for the year ended June 30, 2017. Claims expense under the self-insured health plan totaled $10,913,188 for the year ended June 30, 2017.

NOTE 12 SUBSEQUENT EVENTS

Management evaluated subsequent events through October 4, 2017, the date the financial statements were available to be issued.

CCMSI HOLDINGS. INC.
CONSOLIDATING BALANCE SHEET
JUNE 30, 2017

	CCMSI Holdings, Inc.	CCMSI	Eliminations	Total
ASSETS				
CURRENT ASSETS				
Cash:				
Operating	$ 24,100	$ 2,208,839	$ -	$ 2,232,939
Premium Trust	-	151,428	-	151,428
Receivables:				
Management Fees, Net of Allowance of $226,814	-	15,934,595	-	15,934,595
Premiums	-	899,705	-	899,705
Other	-	424,780	-	424,780
Prepaid Expenses and Other Assets	-	1,658,408	-	1,658,408
Total Current Assets	24,100	21,277,755	-	21,301,855
INVESTMENTS IN SUBSIDIARY AND LIMITED LIABILITY COMPANY	17,121,542	-	(16,673,973)	447,569
PROPERTY AND EQUIPMENT, NET	-	12,750,570	-	12,750,570
GOODWILL, NET	-	1,489,785	-	1,489,785
Total Assets	$ 17,145,642	$ 35,518,110	$ (16,673,973)	$ 35,989,779
LIABILITIES AND STOCKHOLDERS' EQUITY				
CURRENT LIABILITIES				
Accounts Payable	$ -	$ 1,423,292	$ -	$ 1,423,292
Accrued Expenses	4,513,963	7,243,206	-	11,757,169
Premium Accounts Payable	-	876,764	-	876,764
Deferred Revenues	-	9,300,875	-	9,300,875
Total Current Liabilities	4,513,963	18,844,137	-	23,358,100
STOCKHOLDERS' EQUITY				
Common Stock	2,903	4,107	(4,107)	2,903
Additional Paid-in Capital	4,797,112	6,229,207	(6,229,207)	4,797,112
Retained Earnings	7,831,664	10,440,659	(10,440,659)	7,831,664
Total Stockholders' Equity	12,631,679	16,673,973	(16,673,973)	12,631,679
Total Liabilities and Stockholders' Equity	$ 17,145,642	$ 35,518,110	$ (16,673,973)	$ 35,989,779

CCMSI HOLDINGS. INC.
CONSOLIDATING STATEMENT OF OPERATIONS
YEAR ENDED JUNE 30, 2017

	CCMSI Holdings, Inc.	CCMSI	Eliminations	Total
OPERATING REVENUE	$ -	$ 136,887,995	$ -	$ 136,887,995
OPERATING EXPENSES				
Personnel Salaries and Benefits	2,806,845	96,174,891	-	98,981,736
Managed Care Services	-	10,188,193	-	10,188,193
Occupancy	-	9,434,580	-	9,434,580
Depreciation and Amortization	-	4,342,652	-	4,342,652
Supplies and Postage	-	2,094,343	-	2,094,343
Travel	-	3,826,215	-	3,826,215
Professional Fees	-	444,709	-	444,709
Consulting	-	863,940	-	863,940
Computer	-	636,784	-	636,784
Marketing and Sales	-	208,402	-	208,402
Miscellaneous	-	1,915,783	-	1,915,783
Total Operating Expenses	2,806,845	130,130,492	-	132,937,337
INCOME (LOSS) FROM OPERATIONS	(2,806,845)	6,757,503	-	3,950,658
OTHER INCOME (EXPENSES)				
Equity in Income from Subsidiary	6,761,307	-	(6,761,307)	-
Undistributed Equity in Loss of Limited Liability Company	(414,704)	-	-	(414,704)
Interest Income	-	3,804	-	3,804
Total Other Income (Expense)	6,346,603	3,804	(6,761,307)	(410,900)
NET INCOME	$ 3,539,758	$ 6,761,307	$ (6,761,307)	$ 3,539,758

CCMSI HOLDINGS. INC.
CONSOLIDATING STATEMENT OF CASH FLOWS
YEAR ENDED JUNE 30, 2017

	CCMSI Holdings, Inc.	CCMSI	Eliminations	Total
CASH FLOWS FROM OPERATING ACTIVITIES				
Net Income (Loss)	$ 3,539,758	$ 6,761,307	$ (6,761,307)	$ 3,539,758
Adjustments to Reconcile Net Income (Loss) to Net Cash Provided (Used) by Operating Activities:				
Depreciation	-	4,132,329	-	4,132,329
Amortization	-	210,323	-	210,323
Bad Debt Expense	-	8,389	-	8,389
Noncash Compensation Expense	(147,279)	-	-	(147,279)
Equity in Income from Subsidiary	(6,761,307)	-	6,761,307	-
Undistributed Equity in Loss of Limited Liability Company	414,704	-	-	414,704
Effects of Changes in Operating Assets and Liabilities:				
Premium Trust	-	605,630	-	605,630
Receivables	-	(2,068,804)	-	(2,068,804)
Prepaid Expenses and Other Assets	-	(190,481)	-	(190,481)
Accounts Payable and Accrued Expenses	(14,974,000)	1,260,174	-	(13,713,826)
Deferred Revenue	-	(1,613,260)	-	(1,613,260)
Net Cash Provided (Used) by Operating Activities	(17,928,124)	9,105,607	-	(8,822,517)
CASH FLOWS FROM INVESTING ACTIVITIES				
Purchases of Equipment and Leasehold Improvements	-	(3,980,890)	-	(3,980,890)
Purchase of Additional Interest in Limited Liability Company	(496,550)	-	-	(496,550)
Distributions from Common Stock of Subsidiary	18,426,619	-	(18,426,619)	-
Net Cash Provided (Used) by Investing Activities	17,930,069	(3,980,890)	(18,426,619)	(4,477,440)
CASH FLOWS FROM FINANCING ACTIVITIES				
Distributions to Stockholders	-	(18,426,619)	18,426,619	-
NET INCREASE (DECREASE) IN OPERATING CASH	1,945	(13,301,902)	-	(13,299,957)
Operating Cash – Beginning of Year	22,155	15,510,741	-	15,532,896
OPERATING CASH – END OF YEAR	$ 24,100	$ 2,208,839	$ -	$ 2,232,939

CCMSI HOLDINGS, INC.
FISCAL YEAR 2016
(JULY 1, 2015 THROUGH JUNE 30, 2016)
MANAGEMENT DISCUSSION & ANALYSIS

COMPANY OVERVIEW

CCMSI is a leading third party administrator of self-insurance plans for individual companies and association groups. CCMSI provides services from a national network of 34 offices to clients throughout the United States.

CCMSI is majority owned (97.4%) by the CCMSI Employee Stock Ownership Plan, which provides all employees with ownership stake in CCMSI. This ownership structure allows CCMSI to focus on long-term success without overemphasizing short-term profit results.

FISCAL YEAR 2016 REVIEW

2016 was another year of improvement for many third party administrators, including CCMSI. After several challenging years due to adverse U.S. economic conditions, claim counts increased in many industry segments. Payrolls in many of our Group clients also demonstrated improvement resulting in higher revenue for CCMSI. New Business opportunities continue to place a buying emphasis on low price versus quality of service and value.

As we begin 2017, we are very comfortable with our position in the marketplace and are confident that we will continue our steady revenue growth and solid earnings levels.

STATEMENT OF OPERATIONS

CCMSI continues to experience steady revenue growth throughout most operating regions. **Operating Revenue** for the most recent five years was as follows:

2016	$130,780,335	6.2% Increase
2015	$123,130,040	4.8% Increase
2014	$117,446,772	4.1% Increase
2013	$112,829,836	6.4% Increase
2012	$106,043,866	9.4% Increase

Operating Revenue increased 6.2% in 2016 and has increased 35.0% from 2011 levels. Growth was primarily attributable to new relationships with Individual Employers plus smaller additions in Group revenue.

2016 **Operating Expenses** were $126,586,991, an increase of $8,385,785, or 7.1% from $118,201,206 in 2015. ESOP Contributions were $3,020,000 in 2016, an increase of $870,000 from $2,150,000 in 2015.

2016 **Net Income** was $4,197,377 compared with $4,787,383 in 2015.

CCMSI has worked aggressively to align our service personnel and infrastructure to meet work volume demands, client service expectations and contractual commitments as efficiently as possible.

BALANCE SHEET

CCMSI maintains and actively utilizes a $3,000,000 **Line of Credit** for operational cash flow requirements throughout the year. There was no Line of Credit Payable as of June 30, 2016 or 2015. CCMSI continues to maintain adequate liquidity for operational requirements.

Included in the $25,576,662 of **Accrued Expenses** grouped in Current Liabilities is $17,950,709 related to Stock Appreciation Rights and $1,684,533 related to Stock Warrants. These are considered current liabilities for financial statement purposes, since they will be exercised prior to December 31, 2016. CCMSI may defer portions of the SAR liability beyond 2016 should those funds be needed by CCMSI, eliminating the potential for any strain on CCMSI's financial position or operating abilities.

Total Stockholders' Equity was $9,091,921 and $4,894,544 as of June 30, 2016 and 2015, respectively. The $4,197,377 increase in 2016 was attributable to retention of Net Income.

CCMSI is committed to improving our proprietary software applications and the hardware technology utilized by our claims professionals to service clients. Total capital expenditures during 2016 for facilities improvements, software development and technology hardware were $3,831,864, or 2.9% of Operating Revenue.

ADDITIONAL INFORMATION

Please direct any requests for additional information to:
John E. Kluth II
Chief Financial Officer
jkluth@ccmsi.com

CCMSI HOLDINGS, INC.
Danville, Illinois

CONSOLIDATED FINANCIAL STATEMENTS
June 30, 2016 and 2015

CliftonLarsonAllen

TABLE OF CONTENTS

CliftonLarsonAllen

CliftonLarsonAllen LLP
www.cliftonlarsonallen.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
CCMSI Holdings, Inc.
Danville, Illinois

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of CCMSI Holdings, Inc. and its subsidiaries, which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations, stockholders' equity, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CCMSI Holdings, Inc. and its subsidiaries as of June 30, 2016 and 2015, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information which includes the consolidating balance sheet, consolidating statement of operations, and the consolidating statement of cash flows is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Danville, Illinois
October 10, 2016

CCMSI HOLDINGS, INC.
CONSOLIDATED BALANCE SHEETS
June 30, 2016 and 2015

ASSETS

	2016	2015
CURRENT ASSETS		
Cash:		
Operating	$ 15,532,896	$ 10,479,710
Premium trust	757,058	182,356
Receivables:		
Management fees, net of allowance for doubtful accounts of $250,000 and $244,443, respectively	13,826,006	14,006,823
Premiums	849,357	998,255
Other	523,302	296,423
Prepaid expenses and other assets	1,467,927	1,983,893
Total current assets	32,956,546	27,947,460
INVESTMENT IN LIMITED LIABILITY COMPANY	365,723	279,190
PROPERTY AND EQUIPMENT, NET	12,902,009	13,485,734
GOODWILL, NET	1,700,108	1,910,430
TOTAL ASSETS	$ 47,924,386	$ 43,622,814

LIABILITIES AND STOCKHOLDERS' EQUITY

	2016	2015
CURRENT LIABILITIES		
Accounts payable	$ 922,105	$ 1,397,454
Accrued expenses	25,576,662	25,585,872
Premium accounts payable	1,419,563	1,449,576
Deferred revenue	10,914,135	10,295,368
Total current liabilities	38,832,465	38,728,270
STOCKHOLDERS' EQUITY		
Common stock; $.01 par value, 1,000,000 shares authorized; 290,353 issued and outstanding	2,903	2,903
Additional paid-in capital	4,797,112	4,797,112
Retained earnings	4,291,906	94,529
Total stockholders' equity	9,091,921	4,894,544
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 47,924,386	$ 43,622,814

The accompanying notes are an integral part of the financial statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS
Years Ended June 30, 2016 and 2015

	2016	2015
OPERATING REVENUE	$ 130,780,335	$ 123,130,040
OPERATING EXPENSES		
Personnel salaries and benefits	93,017,178	85,986,853
Managed care services	10,049,086	9,733,977
Occupancy	9,158,262	8,904,800
Depreciation and amortization	4,624,083	4,139,540
Supplies and postage	2,289,894	2,210,600
Travel	3,730,062	3,366,479
Professional fees	289,629	450,522
Consulting	716,177	581,883
Computer	782,121	543,846
Marketing and sales	233,660	187,452
Miscellaneous	1,696,839	2,095,254
Total operating expenses	126,586,991	118,201,206
Income from operations	4,193,344	4,928,834
OTHER INCOME (EXPENSE)		
Undistributed equity in loss of limited liability company	(1,919)	(145,931)
Interest income	5,952	4,480
Total other income (expense)	4,033	(141,451)
NET INCOME	$ 4,197,377	$ 4,787,383

The accompanying notes are an integral part of the financial statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
Years Ended June 30, 2016 and 2015

	Total	Common Stock	Additional Paid-in Capital	Retained Earnings (Accumulated Deficit)
BALANCE, JUNE 30, 2014	$ 107,161	$ 2,903	$ 4,797,112	$ (4,692,854)
Net income	4,787,383	-	-	4,787,383
BALANCE, JUNE 30, 2015	4,894,544	2,903	4,797,112	94,529
Net income	4,197,377	-	-	4,197,377
BALANCE, JUNE 30, 2016	$ 9,091,921	$ 2,903	$ 4,797,112	$ 4,291,906

The accompanying notes are an integral part of the financial statements.

CCMSI HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
Years Ended June 30, 2016 and 2015

	2016	2015
CASH FLOWS FROM OPERATING ACTIVITIES		
Net income	$ 4,197,377	$ 4,787,383
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Depreciation	4,413,761	3,946,744
Amortization	210,322	192,796
Provision for bad debts	33,558	-
Gain on disposal of property and equipment	(1,029)	(11,795)
Non-cash compensation expense	2,053,415	2,384,438
Undistributed equity in loss of limited liability company	1,919	145,931
Effects of changes in operating assets and liabilities:		
Premium trust	(574,702)	548,927
Receivables	69,278	(2,061,211)
Prepaid expenses and other assets	515,966	(865,565)
Accounts payable and accrued expenses	(2,567,987)	(1,448,371)
Deferred revenue	618,767	(233,774)
Net cash provided by operating activities	8,970,645	7,385,503
CASH FLOWS FROM INVESTING ACTIVITIES		
Net purchase of additional interest in limited liability company	(88,452)	(98,750)
Proceeds on sales of equipment and leasehold improvements	2,855	11,205
Purchases of equipment and leasehold improvements	(3,831,862)	(5,108,066)
Purchase of subsidiary company, net of cash acquired	-	(1,505,396)
Net cash used in investing activities	(3,917,459)	(6,701,007)
NET INCREASE IN OPERATING CASH	5,053,186	684,496
OPERATING CASH, BEGINNING OF YEAR	10,479,710	9,795,214
OPERATING CASH, END OF YEAR	$ 15,532,896	$ 10,479,710

The accompanying notes are an integral part of the financial statements.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

CCMSI Holdings, Inc. (Company) is a holding company whose subsidiaries provide third-party administration services for workers' compensation, property/casualty, and professional liability self-insurance programs of various businesses, governments and pooled associations. The Company is subject to regulations of certain regulatory agencies and undergoes periodic examinations by those regulatory agencies.

The significant accounting and reporting policies for CCMSI Holdings, Inc. follow:

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and its wholly-owned subsidiaries, Cannon Cochran Management Services, Inc. (d/b/a CCMSI), Vertical Claims Management, LLC (VCM), and Comp MC, Inc. The accounts of Comp MC, Inc. are included with the accounts of CCMSI for financial statement presentation. All significant intercompany accounts and transactions have been eliminated in the consolidation.

The consolidated financial statements of the Company have been prepared in conformity with accounting principles generally accepted in the United States of America and conform to predominant practice within the industry.

Use of Estimates in Preparing Financial Statements

In preparing the accompanying consolidated financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities as of the date of the consolidated financial statements and the reported amounts of revenues and expenses for the reporting period. Actual results could differ from those estimates. Material estimates which are particularly susceptible to significant change in the near term include the fair value of the Company's shares of common stock outstanding determined by an independent appraisal of the Company and the consideration of impairment of intangible assets. The fair value estimates of the Company's common stock are used to determine share-based compensation liabilities, ESOP compensation expenses, and stock repurchase commitments.

Fiduciary Assets and Liabilities

The Company collects funds used to pay claims for self-insurance programs administered by CCMSI and VCM. The funds are not assets of the Company and, accordingly, are not included in the accompanying consolidated financial statements.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Cash

For the purposes of reporting cash flows, the Company has defined cash to exclude cash restricted for the payment of insurance sold in its capacity as an insurance agent.

The Company maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Company has not experienced any losses in such accounts. The Company believes it is not exposed to any significant credit risk on cash.

Receivables

Receivables are uncollateralized customer obligations which generally require payment within thirty days from the invoice date. Payments of accounts receivable are applied to the specific invoices identified on the customer's remittance advice or, if unspecified, to the earliest unpaid invoices.

The carrying amounts of accounts receivable is reduced by a valuation allowance that reflects management's best estimate of amounts that will not be collected. The allowance for doubtful accounts is based on management's assessment of the collectability of specific customer accounts and the aging of the accounts receivable. If there is a deterioration of a major customer's credit worthiness or actual defaults are higher than the historical experience, management's estimates of the recoverability of amounts due the Company could be adversely affected. All accounts or portions thereof deemed to be uncollectible or to require an excessive collection cost are written off to the allowance for doubtful accounts.

Revenue Recognition and Deferred Revenue

Revenue includes compensation for management services, insurance commissions, and fees for services rendered in connection with the operation of self-insurance programs of various businesses, governments and pooled associations. Insurance commissions for excess policies placed as a broker are recorded as of the effective date of the policy and recognized as income over the coverage period. Fees for services rendered are recorded as earned over the period which the service is to be provided. The Company may bill and collect fees in advance for services to be performed over a period of time and those fees are deferred and recognized ratably over that same period or as the services are provided. The Company may also bill and collect fees subsequent to the performance of the services and those fees are recognized as earned in the period which the service is provided.

The Company uses independent brokers in connection with the marketing of certain self-insurance programs. Operating revenue is stated net of commissions paid to these brokers.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Investment in Limited Liability Company

The Company holds an 84% interest in HT Air, LLC. The Company is accounting for its investment in this company under the equity method of accounting since the assets and liabilities are not significant. The assets and liabilities of HT Air, LLC totaled $404,441 and $67,865, respectively, as of June 30, 2016.

Property and Equipment

Property and equipment is stated at cost less accumulated depreciation. Depreciation is computed principally by accelerated methods over the estimated useful lives of the related assets. Artwork is carried at the lower of cost or market. Market values for artwork are determined using independent appraisers. The Company capitalizes certain costs to develop, purchase or modify software for the internal use of the Company. The depreciation expense on assets acquired under capital leases, depreciated over the shorter of the term of the lease or their estimated useful lives, is included with depreciation expense on owned assets. Leasehold improvements are amortized over their estimated useful lives or the respective lease terms, whichever is shorter. The estimated economic useful lives are as follows:

	Years
Computer equipment and accessories, including software	3 to 5
Furniture, fixtures and equipment, including acquired	5 to 10
Leasehold improvements	3 to 10

Impairment of Long-Lived Assets

The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. Assets to be disposed of are reported at the lower of carrying amount or the fair value less costs to sell.

Goodwill and Intangible Assets Acquired

The Company records the assets acquired and liabilities assumed in business combinations at their respective fair values at the date of acquisition, with any excess purchase price recorded as goodwill. Valuation of intangible assets entails significant estimates and assumptions including, but not limited to, estimating future cash flows, developing appropriate discount rates, and approximating the useful lives of the intangible assets acquired. Effective for the year ended June 30, 2015, the Company adopted *FASB ASU 2014-18, Accounting for Identifiable Assets in a Business Combination.* Under this standard, the Company has elected not to recognize the fair value of acquired noncompetition agreements and customer related intangible assets under the accounting alternative available to private companies.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Goodwill

The Company recognizes goodwill as an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. The Company has adopted the private company accounting alternative for subsequent measurement of goodwill detailed in *Accounting Standards Update No. 2014-02, Intangibles – Goodwill and Other (Topic 350): Accounting for Goodwill.* Under this accounting alternative, goodwill is amortized on a straight-line basis over a period of 10 years. The company tests goodwill for impairment when triggering events occur that indicate that the fair value of the Company may be below its carrying amount. The company has made an accounting policy election to test goodwill at the entity level, which is the same as the reporting unit level.

Advertising

The Company expenses advertising costs as incurred.

Income Taxes

The Company, with the consent of its stockholders, has elected to be taxed under sections of federal and state income tax law, which provide that, in lieu of corporation income taxes, the stockholders separately account for their pro rata shares of the Company's items of income, deductions, losses and credits. The election was effective as of July 1, 1998. As a result of this election, no income taxes have been recognized in the accompanying consolidated financial statements.

Share-Based Compensation

The Company has issued Stock Appreciation Rights (SARs) and Stock Warrants to certain employees that require the Company to pay the fair value of the SAR and warrant to the employee at the date of exercise. These awards are considered to be liability awards as defined in Codification Topic 718 *Compensation – Stock Compensation.* These awards are more fully described in Note 7.

NOTE 2 - PROPERTY AND EQUIPMENT

Property and equipment consists of:

	2016	2015
Computer equipment, accessories and software	$ 23,888,306	$ 21,614,531
Furniture, fixtures, and equipment	6,349,171	6,366,511
Leasehold improvements	1,476,312	1,419,208
	31,713,789	29,400,250
Less accumulated depreciation	18,811,780	15,914,516
Total	$ 12,902,009	$ 13,485,734

Included in computer equipment, accessories and software above are costs for internally developed software products. Total cost was $20,156,836 and $17,912,529, respectively, and accumulated depreciation was $11,893,730 and $9,468,660, respectively, for the years ended June 30, 2016 and 2015, respectively.

NOTE 3 - GOODWILL

	Gross Amount	Accumulated Amortization	Net Amount
Balance, June 30, 2014	$ -	$ -	$ -
Goodwill recognized	2,103,226	-	2,103,226
Current year amortization	-	(192,796)	(192,796)
Balance, June 30, 2015	$ 2,103,226	$ (192,796)	$ 1,910,430
Current year amortization	-	(210,322)	(210,322)
Balance June 30, 2016	$ 2,103,226	$ (403,118)	$ 1,700,108

As disclosed in Note 11, the Company acquired a third party administrator on July 31, 2014. The goodwill amortization is 10 years.

NOTE 4 - ACCRUED EXPENSES

The Company's accrued expenses at June 30, 2016 and 2015 are summarized as follows:

	2016	2015
Payroll, commissions and bonuses	$ 2,594,103	$ 1,992,695
Stock appreciation rights (vested)	17,950,709	19,190,093
Stock warrants	1,684,533	1,557,419
Other	3,347,317	2,845,665
Total	$ 25,576,662	$ 25,585,872

NOTE 5 - DEBT

Line of credit
The Company has a $3,000,000 line of credit for which there was no balance drawn as of June 30, 2016 and 2015. Amounts drawn against the line of credit are payable on demand and bear interest at the lender's prime rate minus .50% for an effective rate of 3.00% and 2.75% at June 30, 2016 and 2015, respectively. The line of credit is collateralized by substantially all of the Company's assets and matures on December 7, 2016.

The loan agreement relating to the line of credit with Old National Bank contains loan covenants based on cash flows. Management believes the Company was in compliance with its loan covenants for the years ended June 30, 2016 and 2015.

The Company maintained a $225,000 letter of credit at June 30, 2016 and 2015. This letter of credit was secured by substantially all of the Company's assets and is pledged to secure certain financial commitments of the Company.

NOTE 6 - EMPLOYEE RETIREMENT PLANS

The Company sponsors a 401(k) savings plan under which eligible employees may choose to save a percentage of their salary on a pre-tax basis, subject to certain IRS limits. The Company may make discretionary matching and profit sharing contributions to the plan. The Company did not make any matching or profit sharing contributions during the years ended June 30, 2016 and 2015.

The Company sponsors an Employee Stock Ownership Plan for the benefit of employees who meet certain eligibility requirements. The ESOP's shares were purchased by the ESOP with the proceeds of a note from the Company. The Company made annual contributions to the ESOP equal to the ESOP's debt service, less dividends received by the ESOP. As principal and interest were paid, shares were released from collateral and allocated to participants based on the proportion of debt service paid in the year. The ESOP allocates released shares to all participants who meet certain eligibility requirements. The ESOP's loan to the Company is paid off and all shares have been released into the ESOP.

NOTE 6 - EMPLOYEE RETIREMENT PLANS (CONTINUED)

Compensation expense is recorded for additional contributions paid to the ESOP for benefit payments to participants. Compensation expense for the ESOP was $3,020,000 and $2,150,000 for the years ending June 30, 2016 and 2015, respectively.

In the event of termination from employment or if eligible participants elect to diversify their account balances, the Company may be required to purchase the shares from the participant at the shares' fair market value unless the ESOP fulfills this obligation.

NOTE 7 - SHARE-BASED COMPENSATION

Stock Appreciation Rights (SARs)
Effective January 1, 2007, the Company issued 364,000 SARs to certain employees with a base value of $59.67 for each award. From 2008 through 2016, 312,731 SARs have been either forfeited or exercised, resulting in 51,269 SARs outstanding as of June 30, 2016 under the 2007 Plan. All awards issued are fully vested and may be exercised at any time until December 31, 2016. The vested portion of the outstanding SARs totaled $4,467,069 and $6,488,198 as of June 30, 2016 and 2015, respectively, and is included in accrued expenses in the accompanying financial statements.

Effective January 1, 2009 the Company issued 32,000 SARs to certain employees with a base value of $76.92 for each award and a vesting period of 20% per year. All awards issued are fully vested and may be exercised at any time until December 31, 2016. From 2009 through 2016, 22,000 SARs have been either forfeited or exercised, resulting in 10,000 SARs outstanding as of June 30, 2016 under the 2009 Plan. The vested portion of the outstanding SARs totaled $698,800 and $1,118,075 as of June 30, 2016 and 2015, respectively, and is included in accrued expenses in the accompanying financial statements.

Effective April 1, 2012 the Company issued 172,500 SARs to certain employees with a base value of $77.28 for each award. All awards issued are fully vested and may be exercised at any time until December 31, 2016. The vested portion of the outstanding SARs totaled $11,992,200 and $10,958,925 as of June 30, 2016 and 2015, respectively, and is included in accrued expenses in the accompanying financial statements.

Effective January 1, 2013 the Company issued 20,000 SARs to certain employees with a base value of $89.00 for each award and a vesting period of 33.3% per year. All awards issued are fully vested and may be exercised at any time until December 31, 2016. From 2013 through 2016, 6,500 SARs were exercised, resulting in 13,500 SARs outstanding as of June 30, 2016 under the 2013 Plan. The vested portion of the outstanding SARs totaled $780,300 and $621,720 as of June 30, 2016 and 2015, respectively, and is included in accrued expenses in the accompanying financial statements.

NOTE 7 - SHARE-BASED COMPENSATION (CONTINUED)

Stock Appreciation Rights (SARs) (Continued)

Effective August 1, 2014 the Company issued 1,000 SARs to a certain employee with a base value of $134.46 for each award and a vesting period of 50% per year. All awards issued are fully vested and may be exercised at any time until December 31, 2016. The vested portion of the outstanding SARs totaled $12,340 and $3,175 as of June 30, 2016 and 2015, respectively, and is included in accrued expenses in the accompanying financial statements.

Stock Warrants

In December 2013 and January 2014, the Company issued 46,504 stock warrants in connection with the redemption of stock held by individuals. The Holders have the option to exercise the warrants at any time. Included in the redemption agreement is a put option in which the individual exercising the warrants has the right to require the Company to purchase the warrants by paying the Holder an amount equal to the difference between the fair market value at the surrender date of the warrants and the warrant strike price of $107.32 per warrant. From 2013 through 2016, 3,836 warrants were exercised, resulting in 42,668 warrants outstanding as of June 30, 2016. At June 30, 2016 and 2015, the fair value of the outstanding warrants totaled $1,684,533 and $1,557,419, respectively, and is included in accrued expenses in the accompanying financial statements.

The fair market value of the vested portion of all outstanding SARs and stock warrants included in accrued expenses is determined by an independent appraiser as of the reporting date. The Company's stock price was valued at $146.80 and $140.81 as of June 30, 2016 and 2015, respectively. The expense for the SARs and stock warrants totaled $2,053,415 and $2,384,438 for the years ending June 30, 2016 and 2015, respectively, and is included in personnel salaries and benefits in the accompanying financial statements.

NOTE 8 - INCOME TAXES

The Company files consolidated income tax returns in the U.S. federal jurisdiction and 30 states. The Company is a pass-through entity for income tax purposes whereby any income tax liabilities or benefits are attributable to the Company's members. Any amounts paid by the Company for income taxes are accounted for as transactions with the Company's members.

Federal and state income tax returns are subject to examination by the IRS and state taxing authorities, generally for three years after they are filed.

NOTE 9 - COMMITMENTS

Lease commitments
The Company has entered into lease agreements for the buildings it currently occupies and for office equipment which it accounts for as operating leases. Under terms of the building leases, the lessor is responsible for insurance and taxes with the lessee responsible for routine maintenance and utilities. The following summarizes future commitments under these leases.

Year Ending June 30	Amount
2017	5,895,796
2018	5,586,570
2019	4,926,523
2020	3,238,780
2021	1,926,888
Thereafter	2,241,234
Total	$ 23,815,791

Total rent expense incurred related to all operating leases totaled $5,641,998 and $5,716,646 for the years ended June 30, 2016 and 2015, respectively.

Stock repurchase commitment
The Company maintains stock repurchase agreements with all stockholders of the Company whereby at the stockholder's notification to the Company and the remaining stockholders of his intent to sell, the Company will repurchase the stockholder's stock at a price determined by an independent appraiser. The potential liability for the repurchase of shares held by the stockholders, other than the ESOP, is approximately $1,101,000 and $1,056,000 as of June 30, 2016 and 2015, respectively.

NOTE 10 - CONTINGENT LIABILITIES

The Company is involved in litigation relating to various disputes with certain individuals and companies. The Company is vigorously defending its position in these cases and believes damages, if awarded to the defendants, will not be material. The Company includes in accrued expenses any expected settlements of these cases that are estimated to result in losses.

The Company acts as a third-party administrator of self-insurance programs for various businesses, governments, and pooled risk management associations. In carrying out these services, the Company has check signing authority over various cash accounts of these entities.

NOTE 11 - BUSINESS COMBINATION

On July 31, 2014, the Company acquired all of the assets and liabilities of Vertical Claims Management, LLC, a Pennsylvania limited liability company. The acquisition was primarily to expand the Company's services related to professional liability programs for medical facilities and providers. The transaction was accounted for as a business combination in accordance with the acquisition method under Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 805 *Business Combinations.* Assets, including identifiable intangible assets acquired, and liabilities assumed, were measured at fair value as of the acquisition date.

The amount of the purchase price exceeding the fair value of assets acquired and liabilities assumed was recorded as goodwill, which primarily reflects the value of adding VCM to CCMSI to create a more fully integrated suite of services for medical facilities and providers, and includes customer related intangible assets that are not being separately recognized under the adopted accounting standard as discussed in Note 1. The estimates of fair values recorded were determined by management based on various market and income analyses.

The following table summarizes the consideration exchanged and the estimated fair values of the assets acquired and liabilities assumed at the transaction date:

Cash Paid	$	1,512,500
Other Costs		16,436
Total Consideration Exchanged	$	1,528,936
Cash	$	23,540
Accounts Receivable		41,236
Prepaid Expenses		12,540
Goodwill		2,103,226
Total Assets Acquired		2,180,542
Accounts Payable		49,496
Deferred Revenue		602,110
Total Liabilities Assumed		651,606
Purchase Price of Net Assets Acquired	$	1,528,936

NOTE 12 - SUBSEQUENT EVENTS

Management evaluated subsequent events through October 10, 2016, the date the financial statements were available to be issued.

SUPPLEMENTARY INFORMATION

CCMSI HOLDINGS, INC.
CONSOLIDATING BALANCE SHEET
June 30, 2016

ASSETS

	CCMSI Holdings, Inc.	CCMSI	VCM	Eliminations	Total
CURRENT ASSETS					
Cash:					
Operating	$ 22,155	$ 15,454,678	$ 56,063	$ -	$ 15,532,896
Premium trust	-	757,058	-	-	757,058
Receivables:					
Management fees, net of allowance of $250,000	-	13,791,693	34,313	-	13,826,006
Premiums	-	849,357	-	-	849,357
Intercompany	-	70,584	-	(70,584)	-
Other	-	523,302	-	-	523,302
Prepaid expenses and other assets	-	1,447,625	20,302	-	1,467,927
Total current assets	22,155	32,894,297	110,678	(70,584)	32,956,546
INVESTMENTS IN SUBSIDIARIES AND LIMITED LIABILITY COMPANY	28,705,008	1,382,008	-	(29,721,293)	365,723
PROPERTY AND EQUIPMENT, NET	-	12,854,709	47,300	-	12,902,009
GOODWILL, NET	-	-	1,700,108	-	1,700,108
TOTAL ASSETS	$ 28,727,163	$ 47,131,014	$ 1,858,086	$ (29,791,877)	$ 47,924,386

LIABILITIES AND STOCKHOLDERS' EQUITY

	CCMSI Holdings, Inc.	CCMSI	VCM	Eliminations	Total
CURRENT LIABILITIES					
Accounts payable	$ -	$ 922,105	$ -	$ -	$ 922,105
Intercompany payables	-	-	70,584	(70,584)	-
Accrued expenses	19,635,242	5,936,183	5,237	-	25,576,662
Premium accounts payable	-	1,419,563	-	-	1,419,563
Deferred revenues	-	10,513,878	400,257	-	10,914,135
Total current liabilities	19,635,242	18,791,729	476,078	(70,584)	38,832,465
STOCKHOLDERS' EQUITY					
Common stock	2,903	4,107	-	(4,107)	2,903
Additional paid-in capital	4,797,112	6,229,207	2,204,311	(8,433,518)	4,797,112
Retained earnings (accumulated deficit)	4,291,906	22,105,971	(822,303)	(21,283,668)	4,291,906
Total stockholders' equity	9,091,921	28,339,285	1,382,008	(29,721,293)	9,091,921
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 28,727,163	$ 47,131,014	$ 1,858,086	$ (29,791,877)	$ 47,924,386

CCMSI HOLDINGS, INC.
CONSOLIDATING STATEMENT OF OPERATIONS
Year Ended June 30, 2016

	CCMSI Holdings, Inc.	CCMSI	VCM	Eliminations	Total
OPERATING REVENUE	$ -	$ 128,513,346	$ 2,266,989	$ -	$ 130,780,335
OPERATING EXPENSES					
Personnel salaries and benefits	5,073,415	86,128,181	1,815,582	-	93,017,178
Managed care services	-	10,049,086	-	-	10,049,086
Occupancy	-	9,006,956	151,306	-	9,158,262
Depreciation and amortization	-	4,408,311	215,772	-	4,624,083
Supplies and postage	-	2,258,702	31,192	-	2,289,894
Travel	-	3,624,606	105,456	-	3,730,062
Professional fees	-	288,429	1,200	-	289,629
Consulting	-	691,917	24,260	-	716,177
Computer	-	588,968	193,153	-	782,121
Marketing and sales	-	218,704	14,956	-	233,660
Miscellaneous	-	1,682,180	14,659	-	1,696,839
Total operating expenses	5,073,415	118,946,040	2,567,536	-	126,586,991
Income (loss) from operations	(5,073,415)	9,567,306	(300,547)	-	4,193,344
OTHER INCOME (EXPENSES)					
Equity in income from subsidiaries	9,272,711	(300,547)	-	(8,972,164)	-
Undistributed equity in losses of investee companies	(1,919)	-	-	-	(1,919)
Interest income	-	5,952	-	-	5,952
Total other income (expense)	9,270,792	(294,595)	-	(8,972,164)	4,033
NET INCOME	$ 4,197,377	$ 9,272,711	$ (300,547)	$ (8,972,164)	$ 4,197,377

CCMSI HOLDINGS, INC.
CONSOLIDATING STATEMENT OF CASH FLOWS
Year Ended June 30, 2016

	CCMSI Holdings, Inc.	CCMSI	VCM	Eliminations	Total
CASH FLOWS FROM OPERATING ACTIVITIES					
Net income	$ 4,197,377	$ 9,272,711	$ (300,547)	$ (8,972,164)	$ 4,197,377
Adjustments to reconcile net income to net cash provided by (used in) operating activities:					
Depreciation	-	4,408,311	5,450	-	4,413,761
Amortization	-	-	210,322	-	210,322
Bad debt expense	-	33,558	-	-	33,558
Gain on disposal of property and equipment	-	(1,029)	-	-	(1,029)
Non-cash compensation expense	2,053,415	-	-	-	2,053,415
Equity in income from subsidiaries	(9,272,711)	300,547	-	8,972,164	-
Undistributed equity in loss of limited liability company	1,919	-	-	-	1,919
Effects of changes in operating assets and liabilities:					
Premium trust	-	(574,702)	-	-	(574,702)
Receivables	-	(325,276)	394,554	-	69,278
Intercompany receivable and payable	3,505	411,998	(415,503)	-	-
Prepaid expenses and other assets	-	500,181	15,785	-	515,966
Accounts payable and accrued expenses	(3,165,685)	599,750	(2,052)	-	(2,567,987)
Deferred revenue	-	667,011	(48,244)	-	618,767
Net cash provided by (used in) operating activities	(6,182,180)	15,293,060	(140,235)	-	8,970,645
CASH FLOWS FROM INVESTING ACTIVITIES					
Purchases of equipment and leasehold improvements	-	(3,786,920)	(44,942)	-	(3,831,862)
Sales of equipment and leasehold improvements	-	2,855	-	-	2,855
Net purchase of additional interest in limited liability company	(88,452)	-	-	-	(88,452)
Distributions from common stock of subsidiaries	6,222,162	-	-	(6,222,162)	-
Net cash provided by (used in) investing activities	6,133,710	(3,784,065)	(44,942)	(6,222,162)	(3,917,459)

	CCMSI Holdings, Inc.	CCMSI	VCM	Eliminations	Total
CASH FLOWS FROM FINANCING ACTIVITIES					
Distributions to stockholders	$ -	$ (6,222,162)	$ -	$ 6,222,162	$ -
NET INCREASE IN OPERATING CASH	(48,470)	5,286,833	(185,177)	-	5,053,186
OPERATING CASH, BEGINNING OF YEAR	70,625	10,167,845	241,240	-	10,479,710
OPERATING CASH, END OF YEAR	$ 22,155	$ 15,454,678	$ 56,063	$ -	$ 15,532,896

CCMSI

Exhibit 3 – Corporate Claims Handling Best Practices

…delivering what matters most.

"CLAIMS EXCELLENCE"

Corporate Claims Best Practices

Table of Contents

To directly go to a section – hold down CTRL on keyboard and click on link below.

Introduction

CCMSI's Corporate Claim Best Practices are intended to provide a general framework to help all claim professionals achieve the best overall result on each claim on behalf of our clients. The best result is achieved by pursuing actions and initiatives that mitigate our client's exposure, which includes resolving cases expeditiously and economically.

It is CCMSI's objective and responsibility to our clients to investigate and pay compensable or meritorious claims promptly and fairly. Each claim should be evaluated on specific actions and initiatives taken to assess and mitigate exposure in the areas of compensability, liability, causation/damages, injury evaluation, and negotiations, as well as medical and litigation management.

The designated claim professional is at all times responsible and accountable for the handling and direction of each claim file. All claims are to be aggressively and proactively managed to reach appropriate resolution quickly, effectively and efficiently.

If any language in the CCMSI Corporate Claims Best Practices is contrary to any state or federal jurisdictional rules, statutes, or case law, CCMSI and its affiliates will comply with the applicable rules, statutes, or case law.

If there is a conflict between a CCMSI Corporate Claims Best Practice and a specific carrier or client service commitment, the stricter guideline will be followed.

Section 1 - First Notice of Loss (FNOL)

General Philosophy Statement – CCMSI's designated claim professional begins evaluating a case the moment the first notice of loss is received and continues this process throughout the life of the file.

Internal Process

The first notice of loss (FNOL) will be date stamped and reviewed immediately upon receipt of the loss. The FNOL will be reviewed for completeness of information, compensability, liability**,** subrogation, severity of injury or property damage, lost-time or medical only classification, and for fraud by a qualified claim professional.

Medical Only Definition: Claims which have no issues of lost time, no evidence of other indemnity benefit exposure, no obvious question of compensability, no evidence of potential subrogation or second injury recovery, and no evidence of problematic medical issues; can be referred to the Medical Only Adjuster for handling.

Indemnity Claim Definition: Claims involving lost-time, questionable compensability, legal involvement, subrogation, second injury fund, probable permanent impairment, jurisdictional issues, coverage issues, or complex medical issues.

Property & Casualty Definition: Claims involving any other line of coverage to include property, auto, general liability, professional liability, maritime, D & O, E & O, malpractice and any other policy coverage that we handle for current clients.

Minimum Claim Best Practices

1. Qualified claim professionals will review and evaluate all FNOL's on a daily basis and make assignments to appropriate levels of staff.

2. Indemnity/questionable/complex medical claims will be input and activated within 1 business day of the first notice of injury.

3. Medical only claims will be input, activated and claims management initiated within 2 business days of the first notice of injury.

4. All Property & Casualty claims will be input and activated within 1 business day of the first notice of claim.

Minimum System Requirements

1. All mandatory claim fields and client-defined fields must be completed to activate the claim.

2. A brief description of the accident/incident as documented on the FNOL will be logged into the claim log notes under the appropriate heading. (Investigation Heading)

3. All set-up/investigation instructions will be completed and logged into the claim log notes under the appropriate heading. (Supervisor Heading)

4. Based on state regulation, claim staff will comply with EDI mandates.

Benefit

All claims are reviewed by a "trained eye" to detect any and all issues to make sure appropriate claim assignments are made based on complexity of the claim and experience of the claim professional. It is our belief that this allows for more aggressive and pro-active claims management, which will impact the total cost of a claim.

Section 2 - Coverage

General Philosophy Statement – CCMSI's designated claim professional will obtain an accurate coverage analysis. Coverage analysis will involve comparing the relevant facts of each case to the appropriate policy language to determine defenses and or indemnity obligations prior to the acceptance/payment of a claim.

Coverage analysis includes, but is not limited to the following:

- Confirm that the entity listed on the FNOL is a named or additional insured on the policy
- Determine whether the accident date falls within the policy period
- Confirm policy limits, sublimits, deductibles, Actual Cash Value, Replacement Cost, where applicable
- Confirm that the jurisdiction of the claim is a covered state
- Confirm that the claim is not excluded by policy or statutory provisions/exclusions
- Reinsurance Provisions or other policy limitations/provisions impacting the claim file

Minimum Claim Best Practices

1. The designated claim professional will verify that there is an active/valid policy for the date of loss. (Automated within claim system)

2. When appropriate, identify and review all potentially applicable insurance policies and/or service contracts that may apply to a reported claim.

3. Identify and pursue, in conjunction with the client, other carriers or parties who may have a defense and/or indemnity obligation to the client.

4. For Property & Casualty claims, coverage documentation will include the coverage type, insurance carrier/company, policy number, effective dates of policy, policy limits, deductible or retention amount, reporting level, replacement cost vs. actual cost value if applicable, sub limits, and any applicable endorsements that apply.

5. For all Workers' Compensation claims, coverage information including the coverage type, insurance carrier/company, policy number, policy period, deductible or retention amount and reporting level is automated in the system.

6. For claims with Deductible coverage, this information should also be documented in the claim log notes under the appropriate heading, using the "Add Coverage Note" option from the Policy tab. (Coverage Analysis)

7. The designated claim professional will verify coverage within 10 business days from receipt of loss or prior to the acceptance or payment of any benefits.

Minimum System Requirements

1. All information regarding potential coverage issues will be documented in the claim log notes within 10 business days from receipt of loss. Claim log notes need to confirm coverage or coverage issues under the appropriate heading (Coverage Analysis). Any coverage defense should be identified and a strategy should be outlined under the appropriate heading. (Action Plan/Diary Review)

2. If the designated claims professional is unable to confirm/verify coverage within 10 business days, a follow-up diary must be established and maintained until all coverage issues are resolved.

3. If a claim is still under investigation regarding coverage, compensability, liability or being handled under reservation of rights, the "Claim Under Investigation" box on the claim screen should be checked.

Benefit

CCMSI recognizes the importance of verifying coverage to ensure that appropriate benefits are paid on claims.

Section 3 - Initial Contact

General Philosophy Statement – It is important to begin each claim investigation in a prompt manner. The intent of promptness is to determine compensability/liability while the facts are still fresh. On claims where compensability or liability has been accepted, prompt contact can also serve to build a positive working relationship with the claimant.

Minimum Claim Best Practices

1. Indemnity, Questionable or Atypical claims

    a. Claimant Contact: Verbal attempt within 2 business days of the first notice of injury *(day 1 is the day the claim is received by CCMSI, day 2 is the very next business day)* to gather all the pertinent information regarding the alleged accident. Failed attempts at any contact should be followed within 3 business days until contact is complete. If contact attempts are suspended, written rationale will be found in the claim log notes. The designated claim professional will obtain a verbal, recorded or written statement as indicated by client or claim supervisor instructions. Claimant contact could include, but not limited to, explanation of benefits, claimant information, accident information, and expectations for future handling**.** All conversations and/or statements with the claimant will be summarized in the claim log notes under the appropriate heading (Claimant Heading). Claim log notes must reflect continuous and consistent follow-up attempts until contacts are made, when possible. If verbal contact is unsuccessful, written follow-up should be sent promptly to the claimant requesting contact.

    b. Client Contact: Verbal and/or written contact attempt within 2 business days of the first notice of injury *(day 1 is the day the claim is received by CCMSI, day 2 is the very next business day)* to gather all the pertinent information regarding the alleged accident. Failed attempts at any contact should be followed within 3 business days until contact is complete. If contact attempts are suspended, written rationale will be found in the claim log notes. Client contact could include, but is not limited to, verification of claimant information, whether there are any questions or concerns about the claimant or the claim, accident or subrogation details and expectations for future handling. For deductible claims, if the claim is reported 5 or more days after the notice of loss, the client will be questioned as to the cause of the late report and counseled on the importance of timely reporting.

    c. Provider Contact: Verbal and/or written contact within 2 business days of the first notice of injury *(day 1 is the day the claim is received by CCMSI, day 2 is the very next business day)* to gather all the pertinent medical treatment and work status information with regard to the alleged injury unless prohibited by applicable law. Information obtained must include, but is not limited to, diagnosis, prognosis, medical history, causation and treatment plan**.** **Note:** If appropriate medical records were received with the initial report of the claim those records should be logged within 2 business days thus meeting the 2 business day provider contact requirement.

2. Medical Only Claims

    a. Three-point contact is not required. The need for and type of contact with the claimant, client, and provider will be at the discretion of the designated claim professional and/or supervisor.

b. If a medical only/incident only claim is converted to an indemnity claim, the above 3-point contact must be attempted within 2 business days upon knowledge by the designated claim professional.

3. Property & Casualty Claims

a. First Party Property Claims – One point contact with the insured on all first party property claims - Verbal and/or written attempt within 2 business days of the first notice of claim to gather all the pertinent information regarding the incident. Failed attempts at any contact should be followed within 3 business days until contact is complete. If contact attempts are suspended, written rationale will be found in the claim log notes. The designated claim professional will obtain a verbal, recorded or written statement as indicated by client or claim supervisor instructions. All statements and/or conversations will be summarized in the claim log notes under the appropriate heading. All questionable property claims will require a recorded statement.

b. Third Party Property Claims - Two point contact with claimant and insured on all third party property damage claims – Verbal attempt with the claimant and verbal and/or written attempt with the insured within 2 business days of the first notice of claim to gather all the pertinent information regarding the incident. Failed attempts at any contact should be followed within 3 business days until contact is complete. If contact attempts are suspended, written rationale will be found in the claim log notes. The designated claim professional will obtain a verbal, recorded or written statement as indicated by client or claim supervisor instructions. All statements and/or conversations will be summarized in the claim log notes under the appropriate heading. All questionable property claims will require a recorded statement.

c. Third Party Injury Claims - Two-point contact with the claimant and insured on all third party injury claims – Verbal attempt with the claimant and verbal and/or written attempt with the insured within 2 business days of the first notice of injury to gather all pertinent information regarding the alleged accident. Failed attempts at any contact should be followed within 3 business days until contact is complete. If contact attempts are suspended, written rationale will be found in the claim log notes. The designated claim professional will obtain a verbal, recorded or written statement as indicated by client or claim supervisor instructions. All statements and/or conversations will be summarized in the claim log notes under the appropriate heading. All pertinent authorizations should be sent to claimant as deemed necessary.

4. Recommended Guidelines for Taking a Recorded Statement

a. Questionable compensability/liability or coverage

b. Subrogation/recovery or potential apportionment with another party exists

c. Atypical Injuries (i.e. – stroke, heart-attack, stress, alcohol/drug related injuries, etc.)

d. Incidents involving multiple employees

e. Incidents where criminal or civil violations may have occurred

f. Severe or catastrophic injuries

Minimum System Requirements

1. Claim staff must complete appropriate fields on the miscellaneous screen as well as documenting a brief explanation in the comment field with the contact name and/or comment. <***If this screen is completed appropriately, a report can be run from the system showing our initial contact compliance***>

2. All contact information must be summarized promptly in the claim log notes under the appropriate headings. (i.e. Claimant, Client, Medical)

Benefit

It is our belief that making meaningful, prompt initial contact allows us to meet our objectives and responsibilities to our clients to investigate and pay compensable/liable claims promptly and fairly while aggressively defending fraudulent claims on the client's behalf.

Section 4 - Documentation

General Philosophy Statement - If it is not documented it does not exist! Claim files should contain a complete history of the claim's activity documented in the log notes. File documentation should reflect the designated claim professional's clear understanding of the current position of the claim as well as their thoughts as to how the claim should be brought to conclusion. All correspondence from the designated claim professional to outside sources must be professional, concise and well written.

Minimum Claim Best Practices and System Requirements

1. On all claim files, a summary of all highly sensitive correspondence, executed/approved settlement documents and releases, contacts (i.e. email, faxes) or information that changes the exposure of a claim will be logged and attached in the claim notes within 2 business days of receipt. All other correspondence and pertinent information will be logged in claim notes and attached to the appropriate claim file within 10 business days of receipt. The log notes should reflect the impact the correspondence/information may have on the outcome of the claim, under the appropriate heading.

   When an attachment is placed in a claim file a note with a **brief** summary of the attachments content must be documented in the corresponding log note.

   Please see examples of properly logged medical at the end of Section 4.

2. All verbal contact must be handled/responded to appropriately and documented within 2 business days under the appropriate heading.

3. All correspondence must be date-stamped and marked appropriately upon receipt.

4. For claims with Deductible coverage, the name of the Issuing Carrier will be clearly identified on all correspondence, state forms and settlement documents. This applies to all faxes and paper correspondence going to insureds, claimants, attorneys and anyone else entitled to payments under insurance policies (e.g., medical providers that have provided services to workers' compensation claimants). ***For AIG and Zurich, this also applies to all e-mail communication.***

5. The designated claim professional will complete the AWW field on the Workers Comp Specific tab of the Claim Screen whenever a wage statement is obtained and the rates are calculated. This benefits the designated claim professional when reserving and issuing indemnity payments as the amounts are displayed on those screens. If the TTD, PPD and Daily TTD rates are completed, these are displayed as well.

6. Transfer of files

   a. Medical Only to Indemnity - When a file is transferred from a Medical Only to an Indemnity/Questionable/Denied, the Indemnity adjuster should follow all handling requirements for the file, as if it were a new claim. Three-point contact should be made/verified within 2 business days of knowledge that claim needs to be converted, indexing should be completed, compensability should be determined/verified, subro ruled

out, reserves reviewed/adjusted, system fields completed, in conjunction with Best Practices timelines.

b. Between adjusters – If a small group of files (1-30) is transferred from one adjuster to another due to workload issues, new clients, etc., the new adjuster is to review each file within 30-60 days to confirm all aspects of the claim have been addressed. This would include an updated action plan, a review of the reserve adequacy, system requirements, etc. If appropriate, a letter should be sent to the client/claimant/attorneys.

c. For large transfers of files, the Account Manager may modify the required timeframes.

7. Please find below current log note headings and recommendations on how they should be used.

Please find below log note headings:

Action Plan/Diary Review – Explain what your strategy will be going forward on the claim. Use this to convey what your current plan is, outlining the necessary steps to bring the file to resolution. A routine look at the claim by the designated claim professional. The claim log notes should reflect what you have done when reviewing the claim.

Carrier Reporting – Document any contact with the excess or deductible carrier including first reports, updates, requests for information, etc.

Claimant – Any contact with the claimant or a person near them (wife, child, etc.), which includes a summary of any recorded statement. This heading should also be used to document the request and receipt of medical authorization forms.

Client – Any contact with the member/insured/client. It can also be used to document any contact with an agent for the insured/member/client. Many agents monitor the handling of the claims for the insured.

Client-External – This heading is used by one external client who is entering notes to their claim files directly. No internal CCMSI user should use this heading.

Contact Information – Document pertinent contact names, addresses and phone numbers for a given file. Note: *This log note can be modified after 24 hours.*

Coverage Analysis – Document all coverage information as well as any potential coverage issues under this heading. Coverage information documented should include, but is not limited to carrier name, coverage type, policy effective dates, policy number, policy limits, deductibles, reporting level, replacement cost vs. actual cost value, and any applicable endorsements that apply.

Damages – Document and analyze the property and/or casualty damages being claimed in the loss. For medical malpractice, list the alleged condition that we caused by the alleged malpractice.

Denied/Disputed (TX Only) – This heading will be used for *Texas claims only* to outline each PLN1 (denials) and PLN11 (disputes) that have been completed on the file to capture the exact language filed with the state. This heading will also be updated when the designated claim professional retracts a previously filed denial/dispute.

EDI – This is used to document any EDI submission requests by claims staff to "EDI Data Entry" which can be used as evidence of timely submissions. Automated responses from "EDI Data Entry" or acknowledgments from the state will be downloaded to this note heading. Do not use this note heading to document State Form Filings.

General – This heading is used to communicate and provide direction to other internal team members working on a claim. This heading should be used when no other heading applies.

High Priority – iCEbar provides the capability of making notes "high priority". Use this at the direction of the client/Account Manager to flag a note as high priority. There are no required notes to use this on, per the Best Practices.

Indemnity Payment – This heading is used to document any indemnity payment created through the Indemnity Payments or Scheduled Payments screens. The payee name, amount and time period will be recorded in a system-generated log note.

Index/Prior Claims – Document ISO/index search results and follow up activity as necessary, as well as any prior injury results. This is not intended for use of documenting the prior medical records.

Investigation – Should be the initial note in the claim file summarizing the initial description of injury or loss. All compensability/liability issues should be documented under this heading. Also, a summary of all fieldwork, scene photos, etc.

Legal – Document any contact with the legal counsel or their office. This would be calls, e-mails, voicemails, letters, etc.

Liens – This heading is used to document any potential lien information on a claim, including wage garnishments, attorney fees, child support liens, etc. *This does not include any CMS (Medicare, Medicaid, MAPS) or subrogation liens (Subrogation, SIF, Salvage).*

Medical – Document when ordering records, writing to the doctor, speaking with the office, speaking w/ PT, logging the medical notes, etc. into the claim system. Any information regarding IME appointments and results should be logged under this heading.

Medical Case Mgmt – Document any contact or correspondence received with regard to the internal nurse/case manager, external case managers reports, etc. The internal case managers/telephonic case management nurse to relay their recommendations on the claim should use this heading. The heading "Medical" should be used whenever contact is made with the treating physician when applicable.

Medicare Compliance – This heading is to be used to document any and all issues that arise on a particular claim regarding SCHIP Reporting / Medicare / CMS. Examples of appropriate use of this heading include: Evaluation of Medicare Set Aside (MSA) or Claim Settlement Allocation (CSA) exposure by the claim professional (i.e. why a MSA/CSA is/is not required on the claim); document decision to refer claim to a vendor who will provide the MSA/CSA evaluation; summary of MSA/CSA report; documentation pertaining to the submission of the MSA to CMS for approval; CMS liens; and acknowledgement of any claim reported under SCHIP requirements.

Pre-Cert/UR – Document all Pre-Cert information, Utilization Review determinations, CA Requests for Authorizations (RFA), case notes and other activity pertaining to the role of the Pre-Cert or Utilization Review personnel. Do not use this note heading for medical case management or other claim adjuster notes.

Private Note – iCEbar provides the capability of making notes "private". The Private note is intended to be used for communication and/or documentation only for use within CCMSI – **not** external. The private note option should be used with great care and discretion. When considering whether to make a note private also weigh your other options for communicating this message - i.e. phone call, e-mail, memo or verbal communication.

Provider – Document any discussion with providers regarding bills. Negotiated savings on bills, when negotiating a rate for services, or when negotiating a rate which varies from the state fee schedule or U&C rates should be logged under this heading. This heading should NOT be used to document medical information.

Provider Statement – This heading is used when a statement is received from a provider. A statement is a bill that does not have enough information to qualify for payment (i.e. ICD-9 or CPT codes.) *This heading is not for the claimant's recorded statement or interview summary.*

Reserves – This heading is for the designated claim professional or supervisor to use when discussing the reasoning of the reserve levels set. "Reserve Rationale".

RISK ASSESSMENT – This heading is used for the system-generated note include the Claim Risk Assessment. This is also to be used to discuss any changes to the Risk Assessment, as well as the 90-day reviews.

Rx/Prescription – This heading is to be used to document any and all information related to Rx/Prescription Medication requests, utilization, alerts, billing, Rx reports, etc.

Settlement/Evaluation – This heading is for the designated claim professional to use when analyzing and/or evaluating the exposure of the case, final results, or when logging receipt of approved contracts and/or legal settlement documents.

State – In many states, regular correspondence is required on claims. This would be used when forms are sent to or received from the State. Example: when notifying the State of a claim, or updating the State that TTD has started or ended, State required employer filings, etc. Also log any conversations with the State here. Do not use this note heading for any EDI submissions or acknowledgements.

Subro/Recovery/Salvage – This heading is used to document whether there is or is not potential subrogation/recovery, contribution versus joint-tortfeasor and/or risk transfer opportunity for claim defense and indemnification versus contractual third-party Indemnitors. Also used to summarize anything related to subrogation/recovery/contribution/ risk transfer investigation, follow up, etc. Also used to summarize anything related to subrogation/recovery investigation, follow up, etc. This heading would also be used to document if salvage was involved and how it was handled.

Supervisor – This heading is for the supervisor to document the monthly or routine look at the claim. Log what you have done when reviewing the claim and any recommendations for future handling. It should also be used for the adjuster or supervisor to input the setup instructions into the claim system.

Surveillance – Document surveillance results, background checks and any contact with the surveillance company.

UB itemization – This heading is used for the itemization of a UB92 bill.

Vendors/Independent Adjuster – This heading is used by P&C adjusters to document all assignments to independent adjusters, rental car companies, medical record copy vendors, translation vendors, as well as receipt/payment of these bills. Continue to use the Investigation or Damages headings to document the results received.

Voc Rehab – Any contact with vocational rehabilitation person; reports, phone calls, etc.

Wage Information – This heading is used to attach wage statements, document the detailed wage rate calculations and summary of wage rates (AWW, TTD/CR, daily TTD, PPD)

Witness – Document any contact with a witness or witness statements received on a file. This would be calls, e-mails, voicemails, letters, etc.

Please find below approved and industry accepted Workers' Compensation abbreviations/definitions:

&	And
@	At
AOE/COE	Arising Out Of Employment/Course Of Employment
APPT	Appointment
ASAP	As Soon As Possible
ATTY	Attorney
AWW	Average Weekly Wage
AX	Accident
CA	Claimant's Attorney
CC	Carbon Copy
CLMT	Claimant
C/O	Complains Of
CT (SCAN)	Computed Tomography Scan
CTS	Carpal Tunnel Syndrome
DA or D/A	Defense Attorney
DDD	Degenerative Disc Disease
DJD	Degenerative Joint Disease
DOH	Date of Hire
DOL	Date of Loss
DOS	Date of Service
DR	Doctor
DX	Diagnosis
EE	Employee
EKG	Electrocardiogram
EMG	Electromyograph or Electromyogram (nerve study)
EMT	Emergency Medical Technician
EOB	Explanation of Benefits

EOH	End of Healing
EOR	Explanation of Review
ER	Employer
ERTW	Early Return to Work
EVAL	Evaluation
FCE	Functional Capacity Evaluation
FCM	Field Case Manager
FD or F/D	Full Duty
FROI	First Report of Injury
F/U	Follow Up
FX	Fracture
HX	History
IME	Independent Medical Examination
IR	Impairment Rating
IW	Injured Worker
LM or L/M	Left Message
LD	Light Duty
LOV	Last Office Visit
LT	Lost Time
LTD	Long Term Disability
MCM	Medical Case Manager
MD	Medical Doctor
MMI	Maximum Medical Improvement
MO	Medical Only
MRI	Magnetic Resonance Imaging
MVA	Motor Vehicle Accident
NCM	Nurse Case Manager
NLT	No Lost Time
NOV	Next Office Visit
OP	Operative/Operation
ORIF	Open Reduction Internal Fixation
OT	Occupational Therapy or Overtime
PA	Petitioner's/Plaintiff Attorney
P/C	Phone Call or Placed Call
PCP	Primary Care Physician
POST OP	Post Surgery/Post Operative
PPD	Permanent Partial Disability
PPI	Permanent Partial Impairment
PRN	As needed
PT	Physical Therapy, Patient
PTD	Permanent Total Disability
REC'D	Received
REIMB	Reimbursed/Reimbursement
REPT	Report
REP'D	Reported
REQ	Request
REQ'D	Requested
ROI	Report of Injury

ROM	Range of Motion
RPO	Report Only
RTC	Returned to Status Call, Return to Clinic
RRTW	Release to Return to Work
RTW	Return to Work
RX	Prescription
SEB	Supplemental Earnings Benefits
SIF	Second/Subsequent Injury Fund
SSN	Social Security Number
STD	Short Term Disability
SX	Symptoms, Surgery
TPD	Temporary Partial Disability
TTD	Temporary Total Disability
TX	Treatment
VOC REHAB	Vocational Rehabilitation
UNAUTH	Unauthorized
WC	Worker's Compensation
W/	With
W/O	Without
WH	Work Hardening
WHP	Work Hardening Program
WP or W/P	Waiting Period
WS	Work Status

Please find below the approved and industry accepted Property & Casualty abbreviations/definitions

ACV	Actual Cash Value
ARB	Arbitration
ATTY	Attorney
AVG	Average
BI	Bodily Injury
C/B	Call Back
CLM	Claim
COL	Cause of Loss
CV	Curriculum Vitae
DA	Defense Attorney
DC	Chiropractor
DEF	Defense
DEPO	Deposition
DIV	Driver of Insured Vehicle
DJ	Declaratory Judgment
DOCS	Documents
DOI	Date of Injury
DOV	Driver of Other Vehicle
DUI	Driving Under the Influence
DWP	Dismissed With Prejudice
DX	Diagnosis
ER	Emergency Room or Employer

EVAL	Evaluation
FTYROW	Failure to Yield Right of Way
FTRS	Failure to Reduce Speed
H/A	Headache
HX	History
IME	Independent Medical Exam
INJ	Injury
IV	Insured Vehicle
JNOV	Judgment Notwithstanding Verdict
LOU	Loss of Use
LOC	Loss of Consciousness
LW	Loss Wages
MDV	Motion for Directed Verdict
MSJ	Motion for Summary Judgment
ORIF	Open Reduction Internal Fixation
OV	Other Vehicle
P&S	Pain and Suffering
PA	Plaintiff Attorney / Public Adjuster
PD	Property Damage
PI	Personal Injury
PIV	Passenger of Insured Vehicle
PLT or PLTF	Plaintiff
POI	Point of Impact
POL	Proof of Loss
POO	Proof of Ownership
POV	Passenger of Other Vehicle
PR	Police Report
PTY	Party
PX	Pain or Prognosis
RCV	Replacement Cost Value
R/E	Rear-ended
R/O	Rule Out
ROGS	Interrogatories
R/S	Recorded Statement
S&C	Summons and Complaint
SOL	Statute of Limitations
SUPV	Supervisor
TBI	Traumatic Brain Injury
TF	Tortfeasor
TL	Total Loss
TPC	Third Party Complaint
U&C	Usual and Customary
USDC	United States District Court
WIT	Witness

Benefit

It is expected that claim professionals will document all claim files professionally, concisely and timely so that claims staff and clients can fully understand each claim.

Medical Notes Documentation Examples:

ALWAYS REVIEW RECORD AND SUMMARIZE BRIEFLY – SOAP
**** Subjective, Objective, Assessment, Plan****

Example 1 (OFFICE VISIT)

8/15/17 Alton Ortho Clinic/John Stirnaman MD, OV
Subjective: L hand dominant, last seen in March for what I felt was deQuervain's stenosing tenosynovitis on right. Injected at that time and pt did well until about 6 wks ago. Returns c/o pain. Certain motions bother her, feels she is getting worse. Patient did a have fall last year when I initially saw her in December.
Objective: Complaining of R wrist pain. Tender over first dorsal compartment. Positive Finkelstein's test. Little crepitus. Tender.
Assessment: DeQuervain's disease/tenosynovitis R wrist
Plan: Decompression first dorsal compartment R wrist. Patient wants to proceed.

Example 2 (OFFICE VISIT)

4/09/18 SBO/Dr. Smith OV
Shoulder right ROTATOR CUFF TEAR - SUPRASPINATOUS
She is progressing as expected. I gave her a prescription for Percocet. If she needs more pain pills after that, which I would not be surprised, she will call in. At that point we'll change her over to Norco.

Example 3 (WORK STATUS)

8/30/17 Alton Ortho Clinic/John Stirnaman MD Work Status
Continue no work until NOV
NOV 10/3/17

Example 4 (WORK STATUS)

5/07/18 SBO/Dr. Smith work status
Right shoulder
No use of extremity
MMI 3-4 months
NOV 6/06/18

PHYSICAL THERAPY

Often, the therapist will document a lot of good information in the PT/OT notes that can be helpful in identifying potential issues with a claimant. These notes should be reviewed when being attached to the claim file, and a brief summary should include the date of service, provider name and record type (PT notes). *Other items that may be included:*

- Attendance history, and any no-shows or excuses given (helps to identify noncompliance of medical treatment)
- The visit # (ex: 8 of 12) (helps to confirm if the number of therapy visits, and can help determine if appropriate)
- Subjective complaints (watch if the claimant is steadily improving, plateauing, or goes back and forth)
- Any observations documented by the therapist (examples: moving over the weekend, hurt themselves lifting a child, improved until they fell over the weekend at home (intervening accident), etc.)

Example 1 (PHYSICAL THERAPY)

04/01/18 – 04/30/18 Gateway Rehab PT
Rescheduled 3 of 8 appts, was sick with the flu.
Pt giving full effort and making steady gains.

Example 2 (PHYSICAL THERAPY)

03/01/18 ARM PT
Patient reports that his back is feeling great. He reports no complaints of any pain at all, and feels that he is 95% better than when he walked in the door of our clinic. Feels that minimal tingling has occurred into the LE's lately.

Example 3 (PHYSICAL THERAPY)

04/20/18 ABC PT
Patient reports the right arm has gotten sorer with moving into active motion. She is doing her HEP 3 times a day, followed by ice plus icing before bed. She is only doing light household activities such as folding and putting away laundry. Rates right shoulder pain at 5/10. Still off work secondary to restrictions.

E-mail Notes Documentation:

All users need to paste e-mails into the log notes in a consistent manner. The objective is to keep the integrity of the e-mail, use common sense on what to include in the log notes, and not waste space on redundant information. All users need to be aware that anything entered into the notes is discoverable, should the claim become litigated. Use discretion when pasting in e-mails, making sure to maintain professionalism throughout the log notes.

Other items to follow:

- Include the to/from/date/subject on all e-mails
- Delete personal content
- Delete slanderous or unprofessional content
- Delete the string of confidentiality statements at the end of e-mails
- Delete the signature lines at the end of e-mails
- Delete information on other claimants
- Do not repeat the same chain of e-mails again and again. Either enter the full e-mail one time, or paste only the new information/updates since the last e-mail was pasted into the notes.

E-MAIL EXAMPLE:

From: Adjuster Jane Smith
Sent: Thursday, May 10, 2018 2:07 PM
To: Case Manager White
Subject: RE: John Doe

Authorized.

-----Original Message-----
From: Case Manager White [mailto:CMWhite@xyz.com]
Sent: Thursday, May 10, 2018 2:03 PM
To: Adjuster Jane Smith
Cc: Tom Huck
Subject: John Doe

Dr. Williams is requesting an MRI of his shoulder and then follow up after. Please confirm this is approved. I am working on scheduling now.

Settlement Evaluations are to consider the following items when logging into the claim notes.

Settlement Evaluation Checklist (WC):

- Exposure of file based on jurisdiction
- TTD disputes
- PPD range
- Medical disputes
- MSA Exposure
- Chances of successful litigation
- Demands received to settle
- Offers made to date

Settlement Evaluation Checklist (First and Third Party Auto Property Damage):

- Identify coverage for Auto Comprehensive/Collision (1st Party)
- Identify coverage for Auto Property Liability (3rd Party), including deductibles
- Investigation completed that supports the liability determination
- Damage investigation details (estimates, appraisals, damages consistent with point of impact, etc.)
- ACV, depreciation, diminution in value or diminished value considerations
- Rental or loss of use damages

Settlement Evaluation Checklist (BI):

- Injury information
- Treatment type/frequency to date
- Future treatment recommended
- Pre-Existing conditions and prior treatment
- General Damages including any permanency issues
- Wage Loss
- Special Damages including liens/out of pocket expenses
- Personal Profile of Claimant
- Liability including mitigating factors
- Venue considerations on settlement value

Section 5 – Investigation/Claim Risk Assessment

General Philosophy Statement – Investigation is gathering, analyzing and evaluating the "who, what, when, where, why and how" of each occurrence. Upon completion of the initial investigation and periodically thereafter, the designated claim professional should outline the pertinent issues involved with each claim and document an appropriate action plan. Files with a strategic plan achieve better results!

The **Claim Risk Assessment** will be utilized by CCMSI's designated claim professionals on all indemnity, questionable or atypical Workers' Compensation, Jones Act and USL&H claims for all clients. The Claim Risk Assessment will not be required on medical only claims unless specifically requested by the client, carrier or Account Manager. The form is built into our claim professional's statement process to provide an assessment of the claim based on the answers provided. A rating of low, moderate or high will be given once the Claim Risk Assessment is completed.

Mitigation Strategies for moderate risk (yellow) or high risk (red) claims could include, but are not limited to the following:

- Nurse case management
- Utilization Review
- Independent Medical Exams / 2nd Opinions
- Close monitoring of Rx drug regimen
- Surveillance
- Pre-litigation attorney intervention
- Aggressive pursuit of early RTW opportunities
- Frequent reserve analysis to ensure reserve adequacy
- More collaboration with supervisor/client/carrier where applicable
- Early settlement

Employer Investigation could include, but is not limited to, the following:

- Verification of pertinent employee and accident information
    - Personal information (name, address, phone #, SS#, DOB, etc.)
    - Employment information (length of employment, job description, concurrent employment, etc.)
    - Accident information (When, where, how, witness info, injury info, return to work info, etc.)
    - Medical Provider Information (If aware of prior injuries to same body part)
- Verification and identification of damages
- Information surrounding the injury/incident
- Subrogation potential/faulty equipment/at-fault party information/importance of preserving evidence if any potential liability
- Identification and investigation of any red flags, especially if the client questions the claim
- Discussion of applicable local and state laws impacting compensability/liability

Employee Investigation could include, but is not limited to, the following:

- Verification of pertinent personal and accident information
    - Personal information (name, address, phone #, SS#, DOB, etc.)
    - Background (education, government programs, children, military experience, health insurance coverage, etc.)
    - Employment information (i.e. length of employment, job description, concurrent employment, etc.)

- Accident information (i.e. when, where, how, witness info, injury info & etc.)
- Injury History (Prior surgeries, prior injuries, prior claims, ISO score, etc.) Prior medical records should be obtained if the same body part is involved.
- Medical Provider Information (i.e. list of providers, treatment history, prescriptions, etc.)
- Health history/Lifestyle information (Height, weight, health history, activities, lifestyle, etc.)
- Subrogation potential/faulty equipment/at-fault party information

Provider Investigation could include, but is not limited to, the following:

- Verification of provider name, address, phone number, type of practice (i.e. occupational medicine, Ortho, Neuro, etc.), and referral source, where applicable
- Information regarding date of first treatment, causation, diagnosis, prognosis and treatment to date and plan

Minimum Claim Best Practices

1. The designated claim professional will, on all Workers' Compensation indemnity claims, Property & Casualty claims, questionable claims and/or atypical claims, attempt to develop a full accounting of the facts and information concerning the claimant's incident, medical condition or property damage within 10 business days of receipt of the FNOL. Information obtained during investigation efforts must include, but should not be limited to the verification of claimant information, thorough accident description/investigation, witness statement/information (when the witness has a material impact on the compensability/liability determination), subrogation potential, comprehensive medical history (past, current and future) confirmation that the mechanism of injury reported matches what is in the medical records and what the claimant initially reported on the FNOL, or detailed description and estimates of property damage.

2. The designated claim professional will, on all Workers' Compensation indemnity claims, questionable claims and/or atypical claims, complete the Claim Risk Assessment with the available information gathered during the investigation within 10 business days of receipt of the first notice of injury. If we are unable to reach the claimant, or if they are represented by an attorney, a questionnaire will be sent to gather the information. If this is returned, the CRA will then be completed. In addition, the medical records will be reviewed to gather all information possible, including co-morbidities, etc. which may affect the outcome of the claim. This includes, but is not limited to height, weight, health conditions, smoking or drinking habits, etc. If a Medical-Only claim becomes Indemnity, the CRA will be completed. In the event the transfer is due to receipt of a PPI rating, the CRA is not required to be completed. Fatalities are the other common exception. Any other exceptions must have a clearly documented rationale.

Minimum System Requirement

1. All investigation results**/**conclusions must be documented in the claim log notes such as: what investigation was completed, results of the investigation, as well as any additional investigation that should be completed to fully evaluate the claim under the appropriate heading. (Investigation Heading)

2. All information collected in the Claim Risk Assessment will be documented and attached in the claim log notes at the time of completion under the appropriate heading. (Claimant, Client, Investigation, and Risk Assessment)

3. If the CRA generates an initial rating or any subsequent rating of moderate risk (yellow) or high risk (red), it must be evident in the claim log notes what action is being taken to mitigate the anticipated exposure on the claim under the appropriate heading. (Risk Assessment)

4. If the rating changes due to automatic system updates with the Medicare status, legal tab or age, an automatic diary will generate if the CRA risk level changes. The designated claim professional must review the automatic system updates/changed risk rating and document what action is being taken to mitigate the anticipated exposure. Use the appropriate heading at the time of diary completion. (Risk Assessment)

5. If the CRA will not be completed, the designated claim professional will establish appropriate indemnity reserves, then mark the box on the CRA tab and add the rationale as to why the CRA will not be completed. A system-generated note will be created with the rationale provided. (Risk Assessment)

6. If any guidance/direction on future claim handling strategies is needed to mitigate the anticipated exposure based on the CRA, the supervisor will provide this in their regular review under the appropriate heading. (Supervisor)

7. The designated claim professional will document the receipt of wage information as well as a "Brief" explanation of how the benefits/rates were calculated in the claim log notes under the appropriate heading. (Wage Statement Heading)

Benefit:

Effective and timely investigation is the key to pro-active aggressive claims management that will reduce the overall costs & potential litigation of a claim.

CCMSI recognizes the importance of capturing additional and meaningful claimant information through use of the Claim Risk Assessment. This will help the designated claim representative, supervisor and client properly evaluate the claimant's injury and related medical and socio-economic factors which could affect the claimant's recovery and claim cost. Its purpose is to provide support for our claims analysis and assist with identifying potential outliers such as claims that appear routine but eventually develop into high value losses, as well as early identification of complex claims, fraud and realistic reserving earlier in the claims process and identify opportunities to achieve better outcomes.

Example WC Investigation Documentation:
Example 1
Claim is compensable as injury arose out of and in the course of her employment a nurse – **INSUFFICIENT**

Example 2

Investigation Summary: Review of the FNOL as well as information gathered from the client, claimant and provider were all consistent and confirmed that the claimant sustained a low back injury lifting a heavy patient on the date of the alleged injury. The claim was reported timely, documentation supports the injury and the claimant was clearly in the scope of her duties when the injury occurred resulting in a compensable injury. No witnesses to the injury nor was there any information that is contrary to the facts provided by all pertinent parties. – **SUFFICIENT**

Example 3

This is a compensable claim, as the injury arose out of and in the course of the employment. The employee is a material handler who injured his R shoulder lifting a box. This is a typical function of his job. EE reported injury the day it occurred and the medical records correspond with EE's description of the accident. There are no Index matches and EE denied prior injuries to his shoulder and any health conditions that could have caused shoulder pain. – **SUFFICIENT**

Wage Calculation Documentation Examples:

Example 1

Reviewed wage statement sent from employer, showing 52 weeks history, gross pay of $26,000. Based on this, the AWW = $26,000/52 = $500, TTD = $500 x 2/3 = $333.34, Daily TTD = $333.34/7 = $47.62, PPD = $500 X .6 = $300.

Example 2

Received wage statement
13 weeks of history
Total gross pay: $5,824.26
AWW = $448.02 ($5,824.26 divided by 13 weeks)
TTD & PPD = $298.68 ($448.02 x 2/3)
Daily TTD = $298.68/7 = $42.67

Example 3

Per employer, this employee only worked for them 2 weeks. Due to this, have requested wage information for a like-EE, Mr. Jones. History provided is for 42 weeks prior to the date of accident, or $18,525. Based on this, AWW = $18,525/42 = $356.25, TTD = $356.25 X 2/3 = $237.50, Daily TTD = $237.50/7 = $33.93, PPD = $356.25 X .6 = $213.75.

P & C Liability Investigation Examples:

Example 1 (Auto)

Discussed accident with client contact and they confirmed that our driver is at fault for the accident since they hit the claimant vehicle. – **INSUFFICIENT**

Example 2 (Auto)

Investigative Summary: Obtained a statement from client driver. Client vehicle was SB on Cicero Avenue in left of two southbound lanes and pulled into intersection on a green traffic signal at 111th St., waiting for traffic clearance to make a left turn onto EB 111th St. Client driver misjudged proximity of OV (other vehicle) and proceeded with turn yet impacted OV at left front fender, despite evasive brake application by OV. Police Report is consistent with our client's statement and noted POI to vehicles. Client cited for failure to yield. Liability is 100% to client driver for failure to yield right of way with no subrogation potential. FL is a pure comparative negligence state. Based on the investigation, there is no indication of comparative negligence.
– **SUFFICIENT**

Example 3 (General Liability)

There is no liability to the client for this slip and fall accident on the client's premises at Entrance No. 3, Building K, for the claimant should have been aware of weather conditions at the time (rain/snow mixture) and been more careful when entering the building. – **INSUFFICIENT**

Example 4 (General Liability)

The student claimant admitted in her recorded statement the weather was a mixture of rain/snow while driving to the campus and walking from the parking lot to the building. The roads and walkways were slippery in spots as well. Upon entering the building, she noticed several other people wiping their feet on the entrance mat before walking on the tile floor yet opted to walk around them. The claimant indicated that she noticed a Caution-Slippery Surface Warning Sign posted at both ends of the entrance. We have CCTV coverage of the claimant walking around the entrance mat. The client is responsible for the maintenance and placed the Warning Signs. Since the claimant failed to mitigate the known hazard and because "tracked in" precipitation constitutes a natural weather accumulation, the premise owner is not liable as a matter of statutory and common law.
Thus, the claim should be denied. – **SUFFICIENT**

Example 5 (General Liability)

Investigative Summary: A client custodian was mopping a hallway and went to retrieve the normal Caution-Wet Floor Signs to place within the hallway to warn of a wet floor. The custodian did leave the mop and water bucket centered in the hallway while he made his way to the utility room. A video camera revealed a client patron, while traversing the same hallway, was looking downward at his cell phone while walking, slipped on a wet portion of the floor and fell on his left side, resulting in injury. The investigation revealed that while the custodian was liable for failure to warn of a slippery and wet floor hazard, the claimant was comparatively at fault for failure to maintain a proper lookout while walking. Liability apportionment was calculated 70-30% against the client. – **SUFFICIENT**

Example 6 (First Party Property – Structure & Contents Investigation)

Broken pipe resulting in damages. – **INSUFFICIENT**

Example 7 (First Party Property – Structure & Contents Investigation)

The investigation revealed that on 09-05-2013 a water main located within the Trade and Industry Building of the pool member Lakeshore Technical College broke at the pipe's elbow, resulting in water compromise to the Millwright and Robotics Labs, two class rooms, a rest room and a steel rack supply room of the Building, a single story brick structure constructed on a concrete slab on grade in 1975 measures roughly 2,000 square feet, divided into multiple labs and rooms.

The water main, located in the southeast corner of the unit, is the original plumbing and is owned, maintained and controlled by the Member College. As a result of the peril, the Member incurred moderate water exposure and/or damage to floor tile, carpet, drywall, classroom tables and chairs, shelves and millwork and robotic equipment.

Also, a structural engineer from Rimkus, Inc., Mr. Wai-Ho Chang, has opined that the structural integrity of the foundation of the building has been compromised via hydrostatic water pressure, which could result in interior wall bowing and erosion of the soil grade underneath the slab foundation in the future. Thus, the engineering expert is recommending mud jacking procedures to shore up the slab foundation of the structure to maintain overall structural integrity and safety.

The broken pipe in question is the original water main feed pipe within the structure, installed in 1975 under building's footing. It was broken clean through as a result of corrosion and general wear and tear. There was no indication of any installation negligence and since the product was near 40 years in age, the applicable Statute of Repose would preclude any product liability subrogation. – **SUFFICIENT**

Section 6 - Compensability / Liability

General Philosophy Statement - The designated claim professional must confirm and document that the reported loss meets the criteria and requirements for a compensable/liable claim in the appropriate State of Jurisdiction.

Minimum Claim Best Practices

1. Compensability determination will be made within 10 business days of the first notice of injury when possible. Investigation results should be documented prior to stating the compensability determination in the claim notes. If the designated claim professional is unable to complete their investigation and determine compensability within this time frame, the claimant and other pertinent parties should be notified as to the status of the investigation, which will likewise be documented in the claim log notes under the appropriate heading. (Investigation Heading)

2. Liability determination will be determined within 30 calendar days of the first notice of claim when possible or otherwise documented as to why liability determination cannot be made. Investigation results should be documented prior to stating the liability determination in the claim notes. If the designated claim professional is unable to complete the investigation and determine liability within this time frame, the claimant and/or other pertinent parties should be notified as to the status of the investigation, which will likewise be documented in the claim log notes under the appropriate heading (Investigation Heading). Liability should be expressed as a percentage and/or percentage range as well as type**.** (i.e. insured 60 to 70% liable) (i.e. pure comparative, comparative or contributory) If there are multiple co-defendants that may have liability, this should also be expressed as a percentage and/or percentage range.

3. Denial of compensability or liability must be provided in writing to all pertinent parties immediately upon denial of claim. (i.e. claimant or legal, insured, medical provider, etc.)

Minimum System Requirements

1. The compensability/liability rationale must be documented in the claim log notes under the appropriate heading. (Investigation Heading)

    a. If compensable – Why (Compensability Rationale)

    b. If Liable - Why (Liability Rationale) Liability should be expressed as a percentage and/or percentage range as well as type (i.e. 60 to 70%) (i.e. pure comparative, comparative or contributory)

    c. If denied/no liability – Why

    d. If additional investigation is necessary – What type of investigation, why investigation is needed, as well as time frame for same.

2. The compensability/liability decision should also be documented in the edit screen's claim summary field.

a. Compensable claim or liability confirmed

b. Questionable claim/under investigation

c. Denied claim/no liability

3. If a claim has been denied, the “Claim Denied” box should be checked on the claim edit screen.

Benefit

It is our belief that our ability to make appropriate/fair compensability/liability decisions promptly will allow us to build a strong relationship with our clients and claimants.

Section 7 - Reserves

General Philosophy Statement - All Claims are to carry reserves which reflect the expected financial result of the claim. Each claim will be reserved on its own merits. However, if minimal information is available on a claim, a minimum bulk reserve can be established at a level deemed appropriate by the designated claim professional.

Clients rightfully demand realistic and appropriate reserves reflective of their exposure. Formula, bulk, and step reserving are not acceptable.

Minimum Claim Best Practices

1. Initial reserve will be established and input into the claim system within 10 business days from receipt of loss.

2. Reserves will be re-evaluated every 30-90 calendar days thereafter depending on activity and severity of the claim.

3. Reserves will be evaluated and adjusted within 10 business days based on any new information known that significantly changes our exposure on the claim. If additional information is required to fully evaluate the exposure, the additional information necessary will be requested timely.

4. The maximum reserve authority levels for all claim professionals are shown below. These are the maximums, which may be lowered as deemed appropriate by the supervisor/management.

Title	Maximum Reserve Authority
Chief Operating Officer	$3,000,000 & greater
V.P. Claims	$3,000,000
Regional V.P.	$1,000,000
Branch Manager/State Director	$500,000
Account Manager/Claim Manager/National Account Manager	$250,000
Sr. Claim Supervisor / Claim Supervisor/ Claim Specialist	$200,000
Claim Consultant	$100,000
Claim Representative	$50,000
Claim Associate/Claim Assoc. I Level Up/ Claim Assoc. II Level Up	$25,000
Medical Only Claim Representative	$5,000
Claim Clerk	$0

Please find below a brief description of claim titles:

Claim Supervisor/Claim Specialist – senior level indemnity or Property & Casualty adjuster that has a minimum of 10+ years of experience.

Claim Consultant – senior level indemnity or property & casualty adjuster that has a minimum of **5**+ years of experience.

Claim Representative – An indemnity or property & casualty adjuster that has a minimum of 1-5 years of experience.

Claim Associate – Claim professional that provides technical support to indemnity or property & casualty adjuster as well as manage a small amount of indemnity or property & casualty claims under close supervision. This position may also handle medical only claims, contested medical only claims and basic indemnity claims under supervision.

Medical Only Adjuster – Claim professional that handles clearly compensable medical only claims.

Claim Clerk – Clerical support person to claim staff.

Minimum System Requirements

1. The designated claim professional must document their reserves and the rationale for those reserves in the reserve worksheet. This is required for initial reserves and all subsequent reserve changes. When the reserves are saved, a reserve worksheet will automatically be saved into the log notes. (Reserve Heading)

2. Anticipated PPD exposure should be documented in the claim edit screen in the claim summary field.

Benefit

CCMSI recognizes the importance of establishing appropriate and timely reserves on all cases which reflect the expected financial results of each case. It is important that clients and carriers are confident in the reserves and can budget for their losses.

Reserve Rationale Documentation Examples (WC):

Example 1

Established 6 weeks TTD, 20% of a leg, $20,000 in medical, $1,000 in expense to cover expected exposure on claim – **INSUFFICIENT**

Example 2

Established 6 weeks of TTD based on claimant's age, anticipated recovery and the fact that employer has an excellent early return to work program. This has a PPD value of 20-25% of the leg. Surgery will be arthroscopic, we anticipate a good recovery, and claimant is not represented, so will set this at 20% of the leg. Medical was established at $20,000 to cover medical expenses associated with the surgery and post op recovery process. Lastly, $1,000 was added in expense to cover anticipated expenses associated

with our CompMC program and misc. expenses associated with medical records requests & etc. – **SUFFICIENT**

Example 3

Insufficient: ESTABLISHED RESERVES
MED - $3000
EXP - $350
TTD - 6 WEEKS

Example 4

Sufficient: Medical - $3000 to cover conservative tx, several weeks of p/t, possible MRI & Rx. There is no indication for surgery
Expense - $350 to cover bill re-pricing charges
TTD – 6 weeks as ER cannot commit to providing modified duty

Reserve Rationale Examples (P&C):

Example 1 (General Liability BI)

Setting BI reserve at $32,683 for total meds and BI settlement value. – **INSUFFICIENT**

Example 2 (General Liability BI)

We have set our BI reserve at 100% of the full value of this slip and fall based on the condition of the slippery floor that was invisible, therefore a hidden danger to the claimant but known to the client.
The claimant a 48 year old male who is 5'7" 184 lbs sustained an aggravation to preexisting injuries. He was seen at the ER the day of the incident on 8/15/13 and again on 8/23/13; he had multiple diagnostic tests done (CT scan & MRI's) that were negative for an acute injury. He sustained a bump on the back of his head and complained of neck and back pain. He was referred to PT 3x per week for 8 weeks and he will be reevaluate at that time. He has complained of headaches, muscle spasms and low back pain that is resolving but he is still treating. Diagnosis: Aggravation to the cervical and lumbar spine.
Special Damages: $16, 683 confirmed $13,651 is related to diagnostic tests. PT is estimated at $5500
Total Medical Specials: $22,183
General Damages: Potential BI settlement based upon the above injury and treatment to date is $9,500-$10,500 for this venue.
Total Reserve Increase: $32,683 representing total medicals and BI settlement value. – **SUFFICIENT**

Example 3 (Auto BI)

Increasing reserve to $16,500 based on medicals received to date. – **INSUFFICIENT**

Example 4 (Auto BI)

This 39 yo sustained soft tissue injuries to the neck and left shoulder. No initial ER treatment. First treatment date was 6 days post-accident with a chiro. X-rays were negative. Claimant had 27 chiro visits

over a 4 month period and was pain free as of 4/12/13. No lost wages and no pre-existing injuries. We have a PIP lien in the amount of $5,500.00. Liability is 100% again our client as this is a rear end collision. Potential settlement value in this venue based upon the above injuries and treatment is $9,500-$10,500 plus the PIP lien of $5,500 for a total of $15,000-$16,500. Increasing our reserve to reflect the potential full value of $16,500. – **SUFFICIENT**

Example 5 (First Party Property)

Increasing PD reserve to $30,403.00 based on attached estimate of repairs. – **INSUFFICIENT**

Example 6 (First Party Property)

Setting property damage reserve at $30,403 based upon the following damage assessment:

* DRYWALL: 180 linear feet of drywall and 3 feet high were damaged resulting in replacement of a total of 540 square feet. 20 Sheets of water resistant, mold guard (4' X 8') @ $13.00 per sheet = $ 260.00, plus tear out and installation labor (taping, mudding and painting) projected at $2.20 per square foot = $1,188.00. Total: $260 + $1,188.00 = $1,448.00-Replacement Cost

* COMPUTERS: ACV Coverage-6 HP Laptops destroyed-all 2 years old with purchase price of $1200 each. $4,800, depreciated by 25% annually with useful life of 4 years. ACV of $2,400.

* PRINTERS: ACV Coverage- 2 HP Enterprise 500 color laser jet printers-5 years old with $1500 purchase price for each, depreciated at 10% annually with useful life of 10 years. ACV = $1,500.

* PHOTOCOPIER: 1 Sharp MX-350 photocopier-4 years in age with a $1,500 purchase price- Replacement Coverage Cost of $1,855.

* REMEDIATION: All carpet, rugs, tile, classroom tables, chairs, desks, shelves millwork and robotic equipment were vacuum dried, cleaned and sanitized by a 4-person crew-10 hour duration- $10,400.00 labor total.

* EXTERIOR MUDJACKING: 2000 square foot foundation, necessitating 5-man crew at 8 hours, plus product, equipment usage = $6.40 per square foot at 2,000 square feet- Materials, equipment and labor total of $12,800.00 – **SUFFICIENT**

Section 8 - Standard Claim Summary

Minimum Claim Summary Standard for all Workers' Compensation Indemnity, Questionable or Atypical Claims

1. **JURISDICTION/ADJUSTER**:
    a. Jurisdiction State
    b. Adjuster's Name
2. **COMPENSABILITY DETERMINATION**:
    a. Compensable Claim
    b. Denied Claim
    c. Claim Under Investigation
    d. Compensable Claim *** Benefits Terminated as of xx/xx/xx Per IME *** (Be specific if possible
3. **CLAIMANT INFO**:
    a. Sex
    b. Age
    c. Occupation
    d. Date of Hire
4. **MEDICARE ELIGIBILITY:**
    a. Medicare Eligible – yes or no
    b. Medicaid Eligible – yes or no
    c. SSDI – yes or no
    d. MAPS – yes or no
    e. MSP compliance information (status of allocation or protective language and status of lien research)
5. **ACCIDENT DESCRIPTION**:
    a. Brief description of how the accident occurred
    b. Injury sustained and body parts affected
6. **WORK STATUS**: (Both paid and disputed periods)
    a. Dates of Temporary Disability (i.e. 1/5/09 – 3/2/09)
    b. Date RTW – please identify if RTW is full duty or light duty.
    c. If light duty – provide details of restrictions both physical and hour restrictions.
    d. If light duty – need light duty disability dates and the date claimant RTW regular duty
7. **MEDICAL STATUS**:
    a. Current diagnosis and current body parts affected
    b. Treating providers and dates of treatment
    c. Pertinent treatment information such as surgeries, diagnostics, 2nd opinions
    d. Current Medical treatment plan/status
8. **SUBRO/RECOVERY**:
    a. Subro – yes or no. (log notes must state subro rationale, i.e. why there is or is not subro/3rd party recovery)
    b. If yes – with whom, when our lien was sent and final lien amount when available
    c. 2nd Injury Fund – if yes – when was it reported and anticipated recovery amount
    d. Any other potential 3rd party recoveries
9. **LEGAL**:
    a. Pro se
    b. Petitioner Attorney

c. Defense Attorney
d. Current legal status

10. **PERM. DISABILITY/IMPAIRMENT**:
    a. PPD or impairment rating exposure (% and/or amount)
11. **CARRIER REPORTING:**
    a. Reported – yes or no. If yes – to whom, SIR/Deductible amount, policy #, their claim #, when reported
12. **ACTION PLAN**:
    a. What actions or activity is needed to bring this claim to conclusion
    b. Please be detailed to ensure the direction of the claim is clear

Workers' Compensation Claim Summary Example:

JURISDICTION/ADJUSTER: IL/Jane Smith

COMPENSABILITY: Compensable Claim

CLAIMANT INFO: Female, age 42, RN, employed since 8/12/01

MEDICARE ELIGIBILITY: Yes – claimant is Medicare eligible. Conditional payment research has been initiated; awaiting results. Claimant does not participate in any MAPS.

ACCIDENT DESCRIPTION: Claimant was transferring a patient from the bed to a wheelchair when she felt a pulling pain in her lower back

WORK STATUS: Off work 6/5/09 – 9/12/09; RTW light duty 8/13/09 full time with no lifting greater than 20 lbs. Light duty 9/13/09 – 11/2/09. RTW regular duty 11/3/09 with no restrictions.

MEDICAL STATUS: Diagnosis: L4-5 herniated disc. 1st treatment – ABC Occupational Health 6/5/09. Clmt off work, meds, and PT ordered. Treated conservatively for 6 weeks with minimal improvement. MRI 7/30/09 – positive for L4-5 disc herniation. Referred to Dr. Jones (Ortho surgeon) 8/5/09. Dr. Jones recommended an L4-5 discectomy. Surgery 8/20/09 L4-5 microdiscectomy. Continued off work. Dr. Jones - Post op appt. 8/30/09 – doing well and ordered to start PT 3 times a week. Dr. Jones 9/12/09 – Claimant released to RTW light duty and continue PT. Dr. Jones – 11/1/09 – released to RTW regular duty with no restrictions on 11/2/09. Last OV 1/15/10 – claimant released from care at MMI.

SUBRO/RECOVERY: None

LEGAL: PA: John Greedy – Greedy & Greedy Assoc.
DA: Dave Goodman – Goodman & Assoc.
Status: Defense council requested a settlement demand from the PA to resolve the claim on 1/20/10. Awaiting response.

PERM DISABILITY/IMPAIRMENT: 30% MAW = $45,325

CARRIER REPORTING: Yes, CNA, SIR $300,000, policy # 10285735414, claim # E3A07964, reported 8/3/11

ACTION PLAN: Case is now in position for settlement resolution or trial. DA has requested a settlement demand from the PA to resolve the claim on 1/20/10. Awaiting response. If no response in 30 days will follow up with both DA and PA to initiate settlement discussions.

Minimum Claim Summary Standard for all Property & Casualty Claims

1. **JURISDICTION/ADJUSTER**:
    a. Jurisdiction State
    b. Adjuster's Name
2. **POLICY INFORMATION**:
    a. Line of coverage
    b. Carrier name, policy #, effective dates
    c. Limits of liability
    d. Is the coverage an SIR or Deductible program?
    e. List the applicable SIR or Deductible limits.
    f. Reporting limit
    g. For first party property damage, include all applicable policy limits and type of coverage applicable (RCV, ACV, any special limits of coverage and applicable deductibles)
3. **CARRIER REPORTING:**
    a. Reported – yes or no. If yes – when reported and their claim #
4. **COVERAGE**:
    a. Note coverage issues if applicable
    b. Indicate whether a denial or ROR letter issued
    c. Identify coverage counsel, if assigned
    d. If coverage litigation is pending, prepare brief summary.
5. **ACCIDENT/INCIDENT DESCRIPTION**:
    a. Accident location
    b. Brief description of how accident occurred
    c. Authorities responded
    d. Citation(s) issued and to what party
6. **CLAIMANT INFO**:
    a. Name, address, phone number, age, marital status, employment – if available
7. **MEDICARE ELIGIBILITY:**
    a. Medicare Eligible – yes or no
    b. Medicaid Eligible – yes or no
    c. SSDI – yes or no
    d. MAPS – yes or no
    e. MSP compliance information (status of allocation or protective language and status of lien research)
8. **LIABILITY/INVESTIGATION**:
    a. Investigation
    b. Standard of care
    c. State Specific Negligence Laws (i.e. contributory, pure comparative or modified comparative fault)
    d. Identify potential 3rd party Tortfeasors with estimated % of liability to each party
9. **DAMAGES/INJURIES**:
    a. For property damage claims:
        i. If auto loss, state the year, make & model

ii. If 1st or 3rd party GL property loss, show the description of damages
iii. Description and estimate of damages for both auto and GL property loss

b. For bodily injury claims:
i. Description of injuries
ii. Description of treatment to date, prognosis & future treatment
iii. Describe impact on activities, i.e. unable to work
iv. Identify any pre-existing injuries related to our loss, status of treatment, prior disability ratings
v. Summary of special damages: medical bills & lost wages, current and future
vi. Description of general damages, i.e. pain and suffering, permanency, etc.
vii. Damage value range & damage value adopted for this claim
viii. Multiple % of fault assigned to insured against damage value to arrive at loss reserve

10. **SUBRO/RECOVERY/LIEN/SALVAGE**:
    a. Subro – yes or no. (log notes must state subro rationale, i.e. why there is or is not subro/3rd party recovery)
    b. If yes – name of company, name of their insured and claim#
    c. Date put on notice of lien OR lien holder
    d. Current lien amount
    e. Salvage
11. **LEGAL**:
    a. Plaintiff attorney
    b. Defendant attorney
    c. Venue and Case#
    d. Date suit filed
12. **LEGAL STATUS**:
    a. Brief description of legal status
13. **ACTION PLAN**:
    a. Provide an overview of claim activity/change in claim status since last documented Action Plan
    b. What actions or activity is needed to bring this claim to conclusion
    c. Please be detailed to ensure the direction of the claim is clear and what additional information/investigation is needed going foward
14. **CONCLUSION**:
    a. Complete once claim is concluded
    b. Claim closed (month & year)

Property & Casualty Claims Sample Claim Summary – GLB:

JURISDICTION/ADJUSTER: IL/John Smith

POLICY INFORMATION: GL - Genesis #1052264, effective dates: 6/1/08 – 5/31/09, $5M, SIR $3M, reporting limit $1.5M

CARRIER REPORTING: This fatality claim has been reported to excess carrier on 4/1/13. Genesis claim number 0202021, John Smith Genesis Consultant decontrolled file on 4/8/13.

COVERAGE: No coverage issues identified.

ACCIDENT/INCIDENT DESCRIPTION: Vehicle driven by claimant was traveling west on Shady Lane crossing Smithtown Road. Shady Lane has stop signs on east and west sides, Smithtown Road traffic has the right of way. Claimant was struck and killed by a vehicle traveling north on Smithtown Road. Logan County Sheriff and State Police responded and they suspect claimant was texting while driving and failed to observe the stop sign.

CLAIMANT INFO: Female, age 16, student

MEDICARE ELIGIBILITY: Yes – claimant is Medicare eligible. Conditional payment research has been initiated; awaiting results. Claimant does not participate in any MAPS.

LIABILITY/INVESTIGATION: Both roads are located in the township's jurisdiction. Stop sign was erect and visible. There is no liability on the part of the township.

DAMAGES: Fatality. Claimant was pronounced dead at the scene and died from blunt force trauma to the head and chest.

SUBRO/RECOVERY/LIEN/SALVAGE: None.

LEGAL: PA: Jason Klee @ Terrance Law Firm.
DA: Harry Tater @ Sully, Brady & Shaw Law Firm. Suit filed 5/1/09 in Logan County Circuit Court, case#09-46-554.

LEGAL STATUS: Discovery process continues. Depositions for sheriff deputy and accident reconstructionist from the state are scheduled for 2/1/10.

ACTION PLAN: Once depositions have been completed defense will file a Motion for Summary Judgment.

CONCLUSION:

Property & Casualty Claims Sample Claim Summary – FPPC:

JURISDICTION/ADJUSTER: IL/John Smith

POLICY INFORMATION: The Village of Algoinquin is insured with Chubb Group, with policy no. 35848754CHI, policy period 07/01/2014 - 07/01/2015. Risk Type: Deductible-$50,000.00. Reporting Limit: 50.00. FPPC Coverage for Town hall building insured at RC $168,550, contents $1000 ACV, $250 deductible applies.

CARRIER REPORTING: Not reported to carrier

COVERAGE: No coverage issues identified

ACCIDENT/INCIDENT DESCRIPTION: Reading Township town hall located at 110 East North Street in Danville IL sustained wind damage to roof. High winds/ storms in the area blew off the roof of the building.

CLAIMANT INFO: First party claim

MEDICARE ELIGIBILITY: n/a

LIABILITY/INVESTIGATION: Wind gusts of up to 80 miles an hour were reported. Building is listed on policy. Wind / rain are covered perils. RAC Independent Adjuster scoped the loss with insured contact Jim Beavers.

DAMAGES/INJURIES: Inspection reveals scattered wind damage to the built up roofing. As a direct result of the roof damage, water entered the building causing damage to the ceiling tiles in the gym. The complete roof area covers approx 9,000 square feet. The damaged area of the built up roofing is 2,200 square feet and 5,800 square feet of roof coating. The gym ceiling is approx 5,000 square feet. The damaged gym ceiling tile covers an area of 2,000 square feet and estimated painting of the complete ceiling. RAC reached agreed price w/contractor, John Williams. Actual cash value is $20,281.67 - $250 deductible = $20,031.67. Replacement cost coverage totals $28,447.99.

SUBROGATION/RECOVERY/SALVAGE: None

LEGAL/LEGAL STATUS: None

ACTION PLAN: Actual cash value has been paid and member signed proof of loss. Repairs are complete, letter to township requesting proofs to justify replacement cost payment. Monitor for response and final invoices showing total repairs.

CONCLUSION:

Minimum Claim Best Practice and System Requirement

1. The initial claim summary must be established within 10 business days from receipt of loss and updated every 30-90 calendar days in conjunction with claim diaries and new file developments. (Old information out/new updated information in)

Section 9 – Workers' Compensation Medical & Disability Management

General Philosophy Statement – Effective management of the medical and disability aspects of a claim is crucial in order to achieve an optimal result. A primary goal in all lost time claims is to safely return the injured employee to either the pre-injury job or a transitional duty job at the earliest possible time. The designated claim professional must verify that an injured employee's disability has been authorized prior to distribution of any benefits. The designated claim professional should document any and all significant changes to the claimant's diagnosis or prognosis and provide an evaluation as to how the change will affect the potential outcome of the claim. It is expected that the designated claims professional will maintain regular contact with the injured employee throughout the life of the file as applicable.

Minimum Claim Best Practices

1. Active TTD files and/or claims wherein the claimant is off work: The designated claim professional will verify off work status, attempt to obtain treatment status and treatment compliance within 10 business days after each known appointment. The designated claim professional will obtain treatment plans and anticipated duration of treatment from the treating physician and document the claim file. If the treatment is prolonged (exceeds the plan or medical guidelines), this will be questioned immediately and specific plans will be outlined and documented. (i.e. IME, peer review, UR, etc.)

2. The designated claim professional will request transitional duty restrictions from the treating physician and present these to the employer to help facilitate an early return to work for the injured worker. When appropriate, a job description will be obtained from the employer and presented to the treating physician to assist in determining restrictions. As the transitional duty restrictions change, the designated claim professional will present these to the employer. If the employer specifically states or has a policy that no early return to work is available, the designated claim professional shall state this in the notes. The designated claim professional will always verify off work status prior to releasing any TTD payments.

3. Claims in which the injured employee is back to work, but still under active medical care: The designated claim professional will verify medical status and current treatment within 30 calendar days of each known appointment when possible.

4. The designated claim professional shall respond to treatment authorization requests within jurisdictional requirements or 2 business days, whichever is sooner. All authorizations should be followed up in writing using appropriate jurisdictional protective language allowing all charges to be subject to bill review reductions such as fee schedule, U&C, Utilization Review, or PPO reductions as appropriate. This is not required when using contracted vendors or partners such as IME, diagnostic, Rx networks (i.e. Med-Eval, MedRisk, Universal SmartComp/Align, NPS/Castia, Objective Dx, One-Call Medical, etc.)

5. On workers' compensation files, all requests for medical information should include the following statement:

NOTE: Workers' Compensation Requests Are Exempt From HIPAA

Pursuant to 45 CFR, Sect. 164.512(1) a covered entity may without penalty under HIPAA disclose protected health information to the extent necessary to comply with the law relating to workers' compensation.

6. Monitor any anticipated liens and document how the lien affects the exposure and the impact of the claim in the claim log notes under the appropriate heading (Lien).

7. For accounts using a Drug Card Program (NPS/Castia, PMOA/Emeric), a High Utilization Pattern Alert Notification (HUPAR) will be generated if there is a potential for abuse identified. The designated claim professional should review the report and determine if this needs to be addressed with the treating doctor or if an Rx Clinical Review should be performed. A summary of the content of the report and the designated claim professional's review/actions taken should be documented in the claim notes under the appropriate heading (Rx/Prescription).

Minimum System Requirement

1. All correspondence and conversations relating to the medical and disability management will be summarized and documented in the claim log notes under the appropriate headings. (i.e. authorizations, diagnosis, prognosis, treatment plans, etc.) (Medical Heading)

2. It is expected that the designated claims professional will maintain regular contact with the injured employee throughout the life of the file, as applicable.

3. If a potential lien exists, mark the lien box in the miscellaneous screen.

Benefit

Effective management of the medical and disability aspects of a claim is crucial in order to achieve optimal results.

Section 10 – Property & Casualty Medical/Disability

Minimum Claim Best Practices

1. Attempt to obtain medical records and/or wage information must be documented in the log notes. When appropriate, a medical authorization should be considered in obtaining medical records. All requests should be summarized under the appropriate heading in the log notes.

2. In auto bodily injury liability claims, the designated claim professional should consider contacting the PIP or AMP carrier, when appropriate, to obtain medical and treatment status. Additional investigation tools to determine medical status may include, but are not limited to, social networking investigation, hospital/medical check/canvass for medical records, activity check, neighborhood canvass, surveillance, IME, medical records peer review and/or nurse case manager medical review.

3. Attempts should be made periodically to monitor and obtain medical treatment intermittently and at treatment conclusion. A formal request for complete specials (i.e. medical record, payments, bills, wage information and any demand for reimbursement) should be made at the conclusion of treatment unless already received. All information should be summarized under the appropriate heading in the log notes. (Medical Heading)

4. Monitor any anticipated liens and document in the claim log notes under the appropriate heading how the lien affects your exposure and the impact on your claim.

Minimum System Requirement

1. If a potential lien exists, mark the lien box in the miscellaneous screen.

Section 11 - Action Plan/Diary Review

General Philosophy Statement – Files with a strategic plan of action achieve better results! An action plan should outline the intended strategy of the designated claim professional as to what steps are necessary to bring the claim to a successful conclusion. Action plans are to be revised periodically as the claim progresses to reflect any changes in the exposure or as additional information becomes available.

Minimum Claim Best Practices

1. Medical Only Claims

    a. The designated claim professional will complete the initial action plan/diary review within 30 calendar days and maintain a recurring action plan/diary every 30 to 90 calendar days until claim closure. All action plans/diary reviews will be documented in the claim log notes under the appropriate headings. (Action Plan/Diary Review)

2. Indemnity/Questionable Claims/Property & Casualty Claims

    a. The designated claim professional will complete the initial action plan/diary review within 30 calendar days and subsequent action plans/diary reviews every 30-90 calendar days depending on severity and activity of the claim. All action plans/diary reviews will be documented in the claim log notes under appropriate headings. (Action Plan/Diary Review)

3. Diaries will be maintained on an on-going basis. All diaries are to be completed within 10 business days of the due date.

Minimum System Requirements

1. All action plans/diary reviews must be documented in the claim log notes under the appropriate heading. (Action Plan/Diary Review heading) The claim professional must document what they reviewed, their findings and recommendations for future handling. It is not acceptable for the designated claim professional to log into the claim notes – "Claim Reviewed". Document what was done/reviewed, or what action is necessary to bring the claim to conclusion.

Benefit

CCMSI strongly believes that files with strategic plans achieve better results.

Action Plan/Diary Review Examples (WC):

Example 1

Reviewed claim, will pay bills and close file – **INSUFFICIENT**

Example 2

Claimant is in his sixth week of PT and continues to progress. CM is assigned to file and confirms complaints are in line with objective findings. NOV is in 2 weeks, and we anticipate LD RTW at that time. Will pay TTD until he has RTW. If he does not get released to LD, will discuss whether IME is warranted. – **SUFFICIENT**

Example 3

Clmt currently working LD and TPD being paid until he is back to FD. Will follow up weekly with employer to get his hours worked and pay TPD. NOV is on 4/15, and we anticipate a FD release at that time. Reserves established to cover the anticipated TPD payments through that time, as well as the continued PT and office visits and Rx. Once clmt at MMI, will request rating from MD and then get clmt's agreement and pay PPI award. – **SUFFICIENT**

Action Plan/Diary Review Examples (P&C):

Example 1 (Auto Liability Bodily Injury Claim)

Action Plan:
Handle BI claim; close file – **INSUFFICIENT**

Example 2 (Auto Liability Bodily Injury Claim)

FILE STATUS: This is a very minor auto loss at which liability is not disputed.
The client driver rear ended the claimant vehicle at a red light. However, the claimant attorney alleged the vehicle was not drivable as a result of the loss. The PD appraiser determined the claimant had a dead battery. Photos of claimant vehicle did not reveal any notable damages to the rear bumper. The client driver also stated the claimant's mentioned they had problems starting the truck. The PD investigation continues under x-ref file XYZ.
We have received a letter of rep for injury for both the claimant vehicle driver and passenger - this is highly questionable for this minor loss. The damages to the client fleet vehicle were so minor that an appraisal was not initially completed by the client. In light of the 2 BI exposures we have requested an estimate and photos of our client's vehicle.

Action Plan:
1. Send acknowledgement letter to claimants' attorney
2. Determine if claimant made any repairs to vehicle; consider a mechanic expert to review, if claim warrants.
3. Pursue recorded statements from the claimant driver and passenger through their attorney
4. Run ISO's
5. Obtain PR
6. Send Medical auth forms to attorney
7. Consider SIU investigation/referral once investigation completed. – **SUFFICIENT**

Example 3 (General Liability Property Claim)

Action Plan:
Obtain invoice for damages; pay and close file. – **INSUFFICIENT**

Example 4 (General Liability Property Claim)

Our client's driver was making a delivery at Slow Stop Store with a pallet jack when the pallet jack struck and damaged a window. Liability has been determined 100% against our client based upon our employee's statement admitting the pallet jack was moving too fast and he was unable to stop to avoid striking the window.
We have requested a copy of the $1,500.00 repair invoice and photos from the claimant.

Action Plan:
1. Upon receipt of repair invoice and photos, confirm damages consistent with employee's statement
2. Review damages to ensure proper depreciation was applied
3. Send PD release to claimant
4. Upon return of executed release, issue settlement check and close file. – **SUFFICIENT**

Example 5 (First Party Property Claim)

Action Plan:
Obtain repair estimate; pay & subrogate. – **INSUFFICIENT**

Example 6 (First Party Property Claim)

A tractor trailer struck and damaged a traffic light owned by our client, The Unknown City. Our client made immediate repairs and replacements to the traffic light. Total bill has not been received to date by our client. However, the estimated damages are 25k. The owner of tractor trailer has been identified as 'Jackknife Specials' insured with 'Inexperienced CDL Drivers Inc.' under policy #1234678. We have placed the carrier on notice of our subrogation claim. The handling adjuster is Jimmie Jack, direct dial 100-200-3333, claim #yme09542. OVC has accepted liability. Initial reserves were set at 25k based upon our client's estimate of damages.

Action Plan:
Obtain a copy of the repair/replacement estimate from our client.
Review the repair invoice to determine if any applicable depreciation would apply to the damages.
Pay our insured less the applicable $1,000.00 deductible under the policy.
Prepare our subrogation package to include our client's $1,000.00 deductible and send to OVC.
Diary and follow up with OVC for subrogation payment.
Once full subrogation received from OVC, issue a reimbursement check to our insured for the $1,000.00 deductible. – **SUFFICIENT**

Section 12 - Supervision

General Philosophy Statement – Supervision of files is an integral part of claims management. The supervisor should diplomatically oversee the handling of claims to protect both the interests of the claim professional as well as the client. Direction should be provided when needed, as should insight based on their experience and knowledge. Regular involvement in claims management will help the supervisor stay in tune with trends of the various industries we serve.

Minimum Claim Best Practices

1. Medical Only Claims
    a. If the total incurred reaches $5,000, the claim will be reviewed by the indemnity adjuster or supervisor within 30 calendar days and further direction provided. All documentation regarding this review should be logged into the claim log notes under the appropriate heading. (Supervisor)
    b. If diary is discontinued, the supervisor must document in the claim log notes why it was taken off the diary system.

2. Indemnity/Questionable Claims/Property & Casualty Claims
    a. The supervisor will complete an initial diary review within 30 calendar days and subsequent diary reviews every 30-90 calendar days depending on severity, activity and experience of the designated claim professional.
    b. Any initial set up instructions do not replace the need to complete the 30-day review.
    c. If diary is discontinued, the supervisor must document in the claim log notes why it was taken off the diary system.
    d. The claim supervisor may NOT discontinue their active diary if the claim is associated with a large deductible policy with a carrier or the client requires an active diary.
    e. The supervisor must maintain a 30-90 calendar day diary on all claims involving the below.
        - Any claim that has reached or is anticipated to reach the carrier reporting threshold
        - Any claim involving third party action, subrogation and/or second injury fund
        - Active Litigation or Complex Litigation
        - MSA Involvement
        - Lien Notice on file
        - Claims Under Investigation
        - Coverage Disputes
        - Disputed/Denied claim with indemnity exposure

    f. If a Claim Supervisor/Manager is handling a caseload as an adjuster, the diary supervision will be handled on an as needed basis depending on the complexity and severity of the case.

Minimum System Requirements

1. All supervisory reviews must be documented in the claim log notes under the appropriate heading. (Supervisor) The supervisor must document what they reviewed, their findings and recommendations for future handling. It is not acceptable for the supervisor to log into the claim

notes – “Claim Reviewed”. Document what was done/reviewed, or what action is necessary to bring the claim to conclusion.

Benefit

CCMSI clearly recognizes the importance of having another “set” of experienced eyes looking at all files in its efforts to achieve the best results for our clients.

Supervisory Review Examples (WC):

Example 1

Reviewed file. – **INSUFFICIENT**

Example 2 (basic review)

Review of file. Good investigation and follow up with all parties to date. Need to index claim still, and review those results. Wage statement has been requested, but still not received, so need to re-request and then document rates/calculations and send the initial TTD payment out. Treatment plan is clear. Follow up to see that claimant is improving at NOV and see if we can get LD restrictions. Reserves appropriate for current exposure. – **SUFFICIENT**

Example 3 (intermediate review)

Follow up with the claimant for her recorded statement. Need to determine if she has ever had any prior problems with her hands. Also, find out which is her dominant hand. Need to obtain a job description from employer to determine how many hours per day she types or does repetitive activity. The claimant has a follow up appointment on 6/11 with Dr. Smith. Obtain the current medical and work status and enter into the notes. Also need to update the action plan. Reserves appropriate for current exposure. – **SUFFICIENT**

Example 4 (in-depth review)

Reviewed reopened file (due to litigation) - EE had tx compliance issues from the beginning of the claim. EE stopped showing up for work and then was terminated almost a year ago. We appear to be awaiting the initial review/assessment from d/a Dave Kowert. If Dave does not address compensability, please confer with him. In my initial note of 7/2/09 I asked whether it was w/i EE's job description to intervene in an argument. Apparently EE went to unlock an apartment and an argument ensued, causing EE to be hit in the back for unknown reasons. While I realize that fighting compensability might be a difficult argument, it might give us something to use when negotiating a settlement - i.e. raise the compensability issue to lower the value of the claim.

I see that a wage statement has been requested from ER. Please document AWW calculations in notes upon receipt, as this is a litigated file and AWW may be raised as an issue. Please also f/up on the subrogation issue. It appears that we are waiting on final word from ER about subrogation. At the time, ER seemed reluctant to ok subro pursuit as EE was still working in the same location. Now that EE has been terminated that should not be an issue. Admittedly, recovery will be difficult, but we need to address the issue.

Reserve Review - PPD & Legal reserves appear to be appropriate based on what we know at this early date. I wonder if we really need $3500 in Expense reserves. Given that the IME would potentially cost around $1500, what is the additional $2000 for in "exp fees?" What else do you anticipate paying as an expense? Surveillance? I also think that we should consider having at least a small reserve under Medical as well. We don't know if a/a will demand treatment, but it is certainly possible. Overall, I suggest a more detailed explanation of your reserves.

I agree that an IME might be needed, but it will be interesting to see how a/a proceeds. He has alleged psych injury on the Claim for Comp. Based on what tx has been provided to date there does not appear to be a legit basis for this allegation. A/a would have to obtain some medical evidence to pursue this allegation, and I question that he will want to spend the money to do so.

Please change the Loss Cause & Body Part coding on this Misc. screen as it does not accurately reflect the nature of the injury & type of injury. – **SUFFICIENT**

Supervisory Review Examples (P&C):

Example 1 (ALP)

Plan of action is noted. Please be more aggressive in follow up. Will diary for 90 days and monitor for resolution. – **INSUFFICIENT**

Example 2 (ALP)

1. There is no need to index the claimant unless the claimed auto damages exceed $10,000.

2. Please call the claimant and secure her recorded statement verifying details of the loss. Importantly, please confirm there were no personal injuries. (Given the speed the parties were driving at when the loss occurred, I would be concerned about possible BI). Verify the claimant submitted the claim through her own carrier, State Farm, and secure the adjuster information and claim number. Thereafter, contact State Farm to acknowledge receipt of the claim and request subro support documentation. Determine if damages exceed $5,000 and is so, determine with the insured if they would like us to send out an appraiser.

3. There is no need to secure the insured driver's recorded statement unless bodily injuries are alleged. However, were the police involved? The loss notice is unclear. If so, please secure a copy of the police report. The insured's risk management department might already have it.

4. Complete the claim summary, misc. and recovery fields.

5. Create subro, coverage and reserve notes.

6. I'll diary for 7 days and monitor for status of investigation. – **SUFFICIENT**

Example 3 (GLP)

Please address coverage issues. – **INSUFFICIENT**

Example 4 (GLP)

Please do the following:

1. Index the claimant as the third party property damages appear to be in excess of $10,000.
2. Draft a report to the carrier placing them on notice of this loss and request permission to investigate the loss under a reservation of rights. Forward your draft report to me for approval prior to submitting to the carrier. At first review, I note the following coverage issues:
    A. The insured's policy is excess if they are covered under another party's policy. (It is possible the insured is an additional insured under some other parties' policy);
    B. The named insured is Acme, LLC. However, the letter of representation was submitted to XYZ Corp. and John Doe Enterprises. The Builder's Risk General Clauses contains a Commercial General Liability Warranty wherein the named insured warrants that the Contractor and Sub-Contractors carry adequate CGL coverage.
    C. Coverage is limited to losses arising out of the ownership, maintenance or use of the insured location.
    D. Although the insured's business is described as "General Contractor," the Non-Ccontractor's GL endorsement was attached to the policy. I have asked underwriter to clarify if this was an error and that the Contractor's GL endorsement should have been attached.
3. Once the ROR is issued, please call the insured and verify the relationship between the named insured and XYZ Corp. and John Doe Enterprises. Request copies of all contracts between the insured and these entities along with any approved plans for the removal of trees and excavation work at the job site.
4. Send the claimant's attorney an acknowledgment letter. Request photos of damage, repair estimates and any and all evidence supporting the allegations outlined in his letter of representation. Please determine, what, if any steps, the claimant took on 5/28/13 to mitigate her damages. Determine if the claimant filed a claim with her homeowner’s carrier and if so, secure the contact information for her adjuster.
5. Complete the claim summary, misc., legal and recovery fields.
6. Create subro, coverage and reserve notes.
7. I'll diary for 10 days and monitor for completion of the above. – **SUFFICIENT**

Example 5 (First Party Property)

Please follow up with the insured. – **INSUFFICIENT**

Example 6 (First Party Property)

Please do the following:

1. Call the insured contact, John Smith, to acknowledge receipt of the loss and secure his e-mail address. Determine if the police have any suspects and if any of the stolen items have been recovered. Send an acknowledgment e-mail to the insured and broker.
2. Start developing an Excel spreadsheet of the insured’s damages. Secure a list of stolen items from the fire trucks (including make, model and serial numbers, if available) and request purchase

records documenting their purchase. Ask the insured to further provide you with estimates for the cost of replacing these items.

3. Given the amount of damages, we should send out a field adjuster. The preferred account vendor for field adjusting services is NCC. Please contact NCC and ask that their Bakersfield, CA office go out and handle the field investigation. Follow up your call to NCC with an e-mail outlining the tasks you are authorizing. Request they address/confirm the cause of loss, the scope of damages and the cost of repairing same. In addition, request the field adjuster secure photos of the damage.
4. Secure a copy of the police report.
5. Complete the claim summary, misc. and recovery fields.
6. Create subro, coverage and reserve notes.
7. I'll diary for 14 days and will monitor for completion of the above. See me with any questions. – **SUFFICIENT**

Section 13 - Claim Payments

General Philosophy Statement - Appropriate benefits should be paid in accordance with the jurisdictional state. Bill Payment 101 – pay appropriate bills accurately and timely!

Minimum Claim Best Practices

1. All appropriate bills will be paid within 30 calendar days of receipt unless we have disputes, claim under investigation or awaiting additional information. All bills should be reviewed/approved in the claim system by the designated claim professional within 10 business days of receipt.

2. The designated claim professional should not request a credit, void or subrogation recovery in the claim system without appropriate supporting documentation. (i.e. actual check, confirmation of stop payment, etc.)

3. All credits, voids, and posting of recoveries should be done within 10 business days of receipt.

4. Stop Payments – Settlement/Indemnity Payments – The designated claim professional should not request a stop payment on a Settlement or Indemnity check issued to a claimant for a minimum of 10 business days from the print date of the check.

   Prior to re-issuing a check originally sent to an attorney, but never received by their office, the designated claim professional must request email confirmation from the attorney's office that they will return the original check if eventually received.

   Prior to re-issuing a check originally sent directly to a claimant, but never received or an attorney and forwarded to a claimant, the designated claim professional must send the claimant either:
   - A "Replacement Check Request Form" for all payments under $5,000 or
   - The "Affidavit for Replacement Check Form" for payments $5,000 or more.

   Both forms and a cover letter are available in Form Filler. These forms require the payee (claimant) to acknowledge they will not cash the original check if later received. Once accounting has placed the stop payment and void, and the claimant has signed and returned the form, the designated claim professional can issue a replacement check. Attach all forms to the claim log notes.

5. Stop Payments – All Other Payments (Mileage, IME/Second Opinions, Pre-payment of Medical, etc.) – The designated claim professional should not request a stop payment or reissue the payment in question for a minimum of 10 business days from the time the check was printed. In addition, the designated claim professional must notify the payee that we have issued a stop pay on the original check and that a subsequent check has been issued to replace the check in question. Thus, the payee should not cash the original check if it is later received (no forms, cover letter or signature required).

6. The designated claim professionals are responsible for promptly pursuing the recovery of any overpayment of benefits made on the claim file as allowed by jurisdictional requirements.

7. The maximum payment authority levels for all claim professionals are shown below. These are the maximums, which may be lowered as deemed appropriate by the supervisor/management.

Title	Maximum Payment Authority
Chief Operating Officer	$3,000,000 & greater
V.P. Claims	$3,000,000
Regional V.P.	$1,000,000
Branch Manager/State Director	$500,000
Account Manager/Claim Manager/National Account Manager	$250,000
Sr. Claim Supervisor / Claim Supervisor/ Claim Specialist	$200,000
Claim Consultant	$100,000
Claim Representative	$50,000
Claim Associate/ Claim Assoc. I Level Up/ Claim Assoc. II Level Up	$25,000
Medical Only Claim Representative	$5,000
Claim Clerk	$0

Minimum System Requirements

1. All authority levels will be automated in the claim system.

2. Any overpayment is to be documented along with a plan for recovery in the Action Plan of the Claim Summary. In addition, the "Overpayment on Claim" box on the General tab of the Miscellaneous screen should be checked, with the amount of the overpayment entered and the details summarized in the comment box. Once the overpayment is recovered, these fields can be cleared.

Benefit

We recognize that not paying appropriate bills/benefits accurately and timely can increase the value of a case as well as sour any relationship that we have built with the client and/or claimant. Therefore, we clearly recognize the importance of paying appropriate bills/benefits timely and accurately.

Section 14 - Subrogation/Recovery/Salvage/ Subsequent Injury Fund

General Philosophy Statement – Claims with subrogation, recovery, salvage, and subsequent injury fund potential are to be fully investigated and vigorously pursued for recovery at the earliest possible time. Due to our client's various business relationships, the client should be made aware that subrogation will be investigated thoroughly and upon completion of the preliminary investigation, a recommendation will be made to the client regarding the outcome of that investigation and the viability of recovery. Should the client wish not to have subrogation/recovery pursued, the designated claim professional will consult with the governing entity when applicable.

We can reduce the cost of a claim by identifying, pursuing and achieving optimal recoveries when applicable.

Potential types of claims that may involve subrogation include but are not limited to:

- Animal bites
- Slips and falls (on or off insured premises)
- Aircraft, train, or boat accidents
- Motor vehicle accidents
- Construction site accidents
- Machinery accidents
- Product-related claims
- Losses involving an explosion or fire
- Lifting/Loading/Unloading accidents
- Inhalation/Exposure claims
- Criminal interaction claims

Minimum Claim Best Practices

1. The designated claim professional must rule out or identify any subrogation/recovery/salvage/SIF potential within 10 business days from receipt of loss when possible**.** All potentially responsible parties should be put on notice immediately and a request for written acknowledgement from their insurance carrier (including their adjuster name, their claim number and the policy limits, if applicable) should be requested/pursued until obtained. Follow-up should be completed at a maximum every 30 calendar days. All information should be documented in the claim log notes under the appropriate heading. (Subro/Recovery/Salvage Heading)

2. The designated claim professional must notify the client of anticipated recovery opportunities and the impact that this has on the expected exposure/payout.

3. If applicable for the state of jurisdiction, the designated claim professional must put the claimant on notice that if there is a third party action, we will pursue this and they cannot settle without our involvement (cite the statute).

4. For any non-litigated claims, the designated claim professional will inform the responsible party of any material changes (significant changes in exposure, upcoming hearings/litigation, etc.) throughout the life of the claim until the subrogation lien is resolved/recovered.

5. If notice of representation is received, the designated claim professional must send the lien notice to the claimant's attorney requesting acknowledgement of our lien. Follow up for this acknowledgement should be completed every 30-60 calendar days.

6. Once the claimant is done treating, fully evaluate the claim to confirm all bills are received and paid, as well as confirm any potential PPD exposure prior to requesting reimbursement of our lien. If there is PPD potential, consider negotiating the lien as a part of the settlement.

7. The designated claim professional must provide the final lien amount to the responsible third party and request reimbursement every 60-90 days until received. If requests are not regularly sent, written rationale will be found in the claim log notes.

8. If the claimant has not initiated a cause of action on his/her own, the designated claim professional will contact the client and/or carrier at the earliest appropriate time in accordance with the applicable statute seeking client's/carrier's approval after providing recommendations on pursuing recovery through litigation or claim closure.

9. The designated claim professional will not waive their lien or accept any reduction of recovery without a clear rationale and approval from their designated supervisor/manager, client or carrier. All related requests and approvals will be clearly documented in the log notes.

Minimum System Requirements

1. Document in log notes – Yes we have subrogation/recovery/salvage/SIF potential or no we do not. If we do, who is it against? How likely are we to recover this? i.e. uninsured motorist vs. fully insured. If we do not, document the reason why there is no subrogation, and make it applicable to the claim facts. If there is salvage, document how it was disposed of and fees collected or expenses associated with the salvage. All subrogation/salvage/SIF rationales will be documented in the claim log notes under the appropriate heading. (Subro/Recovery/Salvage)

2. Document the claim summary if subro/recovery/salvage/SIF potential identified.

3. The designated claim professional must complete the miscellaneous screen under the recovery tab. The appropriate status fields should be checked, the estimated dollar amount will be updated to reflect the most recent lien amount provided to any third party, and the Statue of Limitations Date will be entered for pursuing recovery through litigation, in accordance with the applicable statute. If subrogation potential exists but is closed out due to a successful recovery, a client directive to not pursue (such as a customer relationship), a lack of coverage by the third party, or another documented reason, the subrogation field should be marked as "closed". In addition, the Statute of Limitations Date should be entered in case the direction of the subrogation pursuit changes in the future.

4. Document in the log notes all potential parties to the claim and what liability impact they have on the case.

5. If negotiating a reduction to the subrogation lien, a clear rationale must be documented under the appropriate heading (Subro/Recovery/Salvage). *Not all jurisdictions allow.

6. If waiving our lien, document in the log notes our lien evaluation, recommendation and approval from pertinent parties. Most carriers do not allow lien waivers, and in the rare occasion they do, it must be provided in writing. Please refer to the carrier requirements on your account.

Benefit

We can reduce the cost of a claim by identifying, pursuing and achieving optimal recoveries when applicable.

Subrogation Rationale examples:

Example 1

n/a *(or as part of a cut/paste of claim summary under Action Plan)* – **INSUFFICIENT**

Example 2

No Subrogation. – **INSUFFICIENT**

Example 3

There is no subrogation as there was no third party involvement *(yet this was caused by a student who hit the teacher).* – **INSUFFICIENT**
*** Need to state the facts of the claim and make the rationale applicable to the claim.*

There is no subrogation as the student was a minor child who cannot be held legally responsible for their actions, and it is the client's policy to not pursue legal actions against a student. – **SUFFICIENT**

Example 4

There is no subrogation as the cause of this loss was human error. – IN**SUFFICIENT**

** A rationale of "HUMAN ERROR" or "ACT OF GOD" alone is never sufficient. Virtually, any accident is the result of human error. Was the error on the part of the claimant, or a third party? An "Act of God" may have resulted in property damage or bodily injury but a legal entity may have liability for the ensuing damages.

There is no subrogation potential as there is no third party. The claimant hit himself in the hand with his own hammer, so this was an accidental self-injury. – **SUFFICIENT**

Example 5

There is no subrogation potential as our client is 100% liable for the accident. – IN**SUFFICIENT**
*** This statement lacks facts to support the decision. What is the basis for this statement?*

The client sustained damage to a municipal building following a 10" rain event. The client had previously experienced water damage to this building and subsequently contracted with an engineering firm and contractor to design and install a system to prevent water from entering the building but it failed. We believe there is an opportunity to recover damages from the engineer and or contractor and will be pursued. **– SUFFICIENT**

Or;
The client had installed a system to prevent water from entering during a severe rain event but the system requires routine maintenance of the check valves that was neglected and allowed water to enter. There is no subrogation potential in this claim because the client failed to properly maintain the system. **– SUFFICIENT**

Example 6

There could be subrogation potential for this incident, but we will not pursue this since it was caused by an unruly patient who hit the claimant. We have confirmed the hospital does not wish to subrogate against patients. – **SUFFICIENT**

Example 7

There is subrogation potential against the manufacturer of the machine. We are gathering information from the client and will put the manufacturer on notice *(include all detailed information, if known).* – **SUFFICIENT**

Subrogation Investigation Guide & Checklist

CCMSI's designated claim professionals should address a subrogation investigation when addressing a new claim. The purpose of the investigation is to identify potentially responsible third parties. Once identified and evidence developed, the designated claim professional should consult with the client for approval, and thereafter, pursue recovery against the responsible party(ies) and its carrier. By effectively pursuing subrogation, we are able to reduce the cost of a claim and improve the insured's loss history.

Success in subrogation recoveries lies in our investigation, assessment, and prosecution of subrogation claims. No claim is exactly alike and each claim requires a careful plan of action. The extent of the subrogation investigation will depend on the accident or loss details. Our investigation should be focused on establishing legal liability of the responsible party. Without a well-developed theory of liability, subrogation is seldom successful.

Investigations should be done as soon as possible. Witnesses' memories will fade with time, so their testimony should be locked in before it is forgotten or influenced by other sources. Likewise, Evidence must be obtained and preserved prior to being lost or destroyed, thus avoiding a spoliation of evidence argument. The designated claim professional should identify potential roadblocks early, i.e. waiver agreements, to avoid wasting resources on a claim that is unlikely to succeed. Finally, designated claim professionals should give timely notice to responsible parties and governmental entities to avoid waiving any rights to pursue at a later date. A solid subrogation investigation can include the following:

1. Statements/recordings from witnesses
    a. Written, recorded or video
    b. Complete as soon as possible after the loss
    c. Confirm key information for locating witness later
    d. Format should be Q&A, not narrative
    e. Generate a checklist of questions
    f. Confirm the witness's testimony is true and correct, to the best of their knowledge
2. Photographs
3. Preserving evidence
    a. Failure to preserve can result in a spoliation of evidence defense
    b. Avoid destructive testing;
    c. Provide notice to all interested parties of inspections
4. Taking measurements and preparing diagrams
5. Obtaining documents, contracts or reports (police, weather, inspection)
6. Engaging experts
    a. Select the correct kind of expert
    b. No written reports
    c. Notify the expert what you are looking for/expect to find
7. Provide proper notice, particularly when governmental agencies are involved.
8. Engaging subrogation counsel, when warranted
9. Review appropriate laws, codes and ordinances and confirm the applicable statute of limitations for filing a complaint to recover if unable to do so short of litigation.

The following is a guide to assist designated claim professionals in identifying and perfecting a subrogation claim against a responsible third party.

The purpose of a subrogation investigation is to identify responsible third parties. To that end, the designated claim professional should consider who can be sued and your theory of liability against that party. When identifying potential parties to pursue, the designated claim professional should consider contractors, other parties involved in causing the loss, public entities, product manufacturers, medical providers, property owners/landlords, etc. In order for a third party to be responsible, the must owe a duty of care to the injured worker which they breached, causing the injured worker's injuries. Theories of liability include premises liability, general negligence, medical malpractice and products liability.

Premises liability claims typically involve slip and falls or injuries resulting from hazards in the premises. The designated claim professional should document the condition which caused the loss. The designated claim professional should also determine how long the condition existed and whether the party responsible for it had notice, actual or constructive, and a reasonable period of time to correct it. The designated claim professional should determine if lighting was adequate and whether there were any warnings in place. Did the landowner outsource tasks to any third parties, i.e. property managers, janitorial services, snow removal contractors?

When a worker is injured in an automobile accident involving a third party or defect in the roadway, she should consider the following factors:

1. Did all drivers maintain a safe lookout?
2. Did both vehicles operate properly?
3. Who had the right of way?
4. Were all traffic rules and regulations followed and obeyed?
5. Were any citations issued?
6. What was the condition of the loss location?

After sustaining an injury and receiving treatment, medical providers may error in providing treatment, thus worsening an existing condition or causing additional injuries. When evaluating whether a medical provider is guilty of malpractice, the designated claim professional should determine whether the provider exercised the degree of care exercised by other doctors in the same or similar position. However, a provider will generally not be responsible for a mistake in judgment or reasonably foreseeable complications. Of note, specialists are held to a higher degree of care.

Products liability is often overlooked when considering subrogation. It can be an expensive proposition as experts are required as well as a more detailed investigation. As such, a cost-benefit analysis should be considered. If cost effective, then a prompt investigation is required. Products liability is typically based on the following theories: defective design (the product 's design renders it unreasonably dangerous), defective manufacturing (when the product bends, breaks, fails, leaks, ignites, explodes or does something different than as designed) or failure to properly warn (seller failed to warn of product dangers or provide instructions for the safe use of the product). The designated claim professional should do the following:

1. Secure the product;
2. Obtain a statement from the operator;
3. Identify the manufacturer, model number and serial number;
4. Determine when the product was purchased and from whom;
5. Determine if the product was modified and who repaired/maintained it;
6. Secure a copy of the owner's/service manual; and
7. Engage an expert (do NOT have them reduce their opinions to writing pending the filing of suit!)

To succeed on a subrogation claim, we must establish the product was defectively designed, manufactured or marketed and was unreasonably dangerous. Moreover, the defect must to a substantial factor in causing the worker's injuries.

In construction cases, the designated claim professional **should focus on the following as part of his investigation:**

1. The names of all contractors and general contractors;
2. Identify those present at the time of loss and secure their recorded statements;
3. Secure copies of all relevant contracts/agreements and review for indemnification, waiver or statutory employer defense;
4. Document, via testimony, and photograph the condition giving rise to the loss;
5. Consider borrowed servant defenses;
6. Secure all official reports, i.e. OSHA and Police; and
7. Retain an expert, if warranted.

When in doubt, the designated claim professional should consult with his or her supervisor on how best to proceed with a subrogation investigation. Nevertheless, this guideline should help you in formulating and completing your subrogation investigation and evaluation.

SUBROGATION CHECKLIST

The following checklist is a guideline for claims professionals to use when there is an injury or damages that could involve subrogation or third-party liability. Three of the most common third-party liability situations resulting in an injury or damages are as a result of motor vehicle accidents, products, and conditions of the premises. The following lists are not all inclusive, but contain information that could be vital in a subrogation investigation.

Motor Vehicle Accidents

- Driver and passengers statements
- Any restrictions on driver's licenses?
- Witness Statements
- Obtain copies of any client internal investigation reports
- Detailed description of the accident scene - location, traffic signals/signs, road construction, driving conditions, etc.
- Consider scene investigation including photos, diagrams, etc.
- Any third party contributing cause to accident? Ex: brake failure, obstructed stop sign, etc.
- If a reconstruction expert will be considered, preserve the vehicle for inspection
- Photos of damaged vehicles
- Insurance coverage for each vehicle involved in the accident
- Police reports and other reports of public authorities
- Available media coverage
- Names of owners of vehicles involved in the accident (if no police report is available)
- The year, make, and model of the vehicles involved in the accident (if no police report is available)
- If commercial truck involved, determine if black box data has been saved

Product Liability

- Request the client secure the actual product or piece of equipment with no modifications or repairs and store for future investigation and potential expert inspections
- Client/Claimant/Witness Statements
- Obtain copies of any client internal investigation reports about the incident
- Names of all parties involved in the incident
- Information about the product or equipment involved in the incident - name, model, manufacturer, distributor, intended use, purchase date, the original purchase order for the product or equipment, etc.
- Detailed description of the incident - location, nature of activity, etc.
- Describe any modifications made to the product or equipment since the purchase plus who performed them and when
- Determine how long the product or equipment has been in use and whether it was used in accordance with manufacturer's guidelines at the time of the incident
- Determine if any safety equipment was used at the time of the incident, and whether it was required in order to operate the equipment or product
- Available maintenance records of the equipment
- Photographs of the product or equipment
- Identify what expert witnesses are needed

Premises Injury (slip, fall, etc.)

- Client/Claimant/Witness Statements
- Obtain copies of any client internal investigation reports about the incident
- Surveillance footage available?
- Names of all parties involved in the incident
- Detailed description of the incident - location, nature of activity, lighting conditions, floor/surface type, etc.
- Name of the location loss/building owner
- Name of tenant/leaseholder; obtain copy of lease, as applicable
- Insurance coverage of third parties involved (owner, tenant, builder, etc.)
- Name of architect who designed building, as applicable
- Name of contractors and subcontractors who constructed the building, as applicable
- Maintenance service records - type of service, dates, and who performed; obtain copies of contracts as applicable
- Photographs of the incident location
- Weather reports needed?

Please find a sample Subrogation Timeline example under the O:\Corporate Claims\Corporate Claims Training & Forms\Resource Material folder.

Section 15 – Litigation Management

General Philosophy Statement - In the event a claim becomes litigated, the designated claim professional is responsible for directing defense counsel's activities and assuring that counsel is not performing duties more appropriately accomplished by the designated claim professional. When appropriate, the designated claim professional should attend hearings, mediations and/or informal legal conferences.

Defense counsel billings should be closely reviewed to address any charges which appear unclear or unsubstantiated.

The designated claim professional should maintain regular contact with the claimant's attorney to effect a prompt resolution of the claim prior to referring the claim to defense counsel when applicable.

See attached CCMSI Litigation Management Policy for more detail.

Minimum Claim Best Practices

1. All pertinent legal information/requests that require a response will be handled and documented appropriately and timely. All general legal correspondence will be handled appropriately and documented in the claim log notes within 15 calendar days upon receipt/knowledge under the appropriate heading. (Legal Heading)

2. The designated claim professional must acknowledge the petitioner's/plaintiff's attorney in writing within 10 business days and document in the claim log notes under the appropriate heading. (Legal Heading)

3. For work comp claims - In states where counsel files an answer, send file copy including log notes and financials along with a referral letter to include initial litigation management issues and provide direction within 10 business days of receipt, guaranteed delivery, e-mail with return receipt, fax or hand deliver when possible. (i.e. Certified Mail, Airborne Express, etc.)

4. For property & casualty claims - In states where counsel files an answer, send file copy including log notes and financials along with a referral letter to include initial litigation management issues and provide direction within 3 business days of receipt, guaranteed delivery, e-mail with return receipt, fax or hand deliver when possible. (i.e. Certified Mail, Airborne Express, etc.)

5. The initial litigation review/evaluation, and strategy from defense counsel, should be received and documented in the claim log notes within 30 calendar days from referral.

    a. If the initial review/evaluation is not received within 30 calendar days from referral, the designated claim professional is to regularly request this again from the defense counsel until it is received.
    b. A litigation budget is recommended for workers' compensation claims that are questionable, disputed and or denied. These are claims that in all likelihood will proceed to trial / arbitration / mediation.
    c. A litigation budget is required for <u>all deductible coverage claims</u> (both workers' compensation and property/casualty), within 30-60 calendar days, regardless of the likelihood of proceeding to trial, etc. A litigation budget shall be requested upon referral

and the designated claim professional is to follow up with the defense counsel until this is returned. A revised budget should be updated, when needed.

**Sample litigation budget form named "Litigation Budget Report form" located at O:\Corporate Claims\Corporate Claims Training & Forms\

d. A litigation budget is recommended for Property & Casualty claims 30-60 calendar days after assignment of the lawsuit. Defense counsel should separate the budget into the various stages of the litigation (i.e. through the end of discovery, through dispositive motion, through trial) so that a cost-benefit analysis can be completed at various stages of the case and a well-informed decision can be made to continue the litigation or settle the case.
e. For Property & Casualty claims, it is recommended that the designated claim professional and defense counsel evaluate and reach an agreement as to if and when resources should be spent on potentially dispositive motions. (i.e. if a motion to dismiss is likely to result in an amendment rather than complete resolution of a case it might be better to wait to raise the same issues on summary judgment and fully dispose of the case.)
f. The designated claim professional (both workers' compensation and property/casualty) must document review and approval of all defense counsel bills in the log notes under the LEGAL heading for all deductible coverage claims before submitting for payment.

Minimum System Requirements

1. All legal correspondence and discussions will be summarized (date of correspondence, who from/to, content summary) in claim log notes under the appropriate headings. (Legal Heading)

2. The claim summary will contain defense attorney/petitioner attorney information, when applicable.

3. The designated claim professional will complete the defense attorney/petitioner attorney tabs on the legal screen when applicable.

4. For Deductible claims, the designated claim professional will add the legal budget amount to the defense attorney tab on the legal screen. This is for both workers' compensation and property/casualty claims.

Benefit

The designated claim professional is ultimately responsible for the outcome/results of a case. The designated claim professional needs to take charge of the litigation management of a claim rather than depending entirely on defense counsel.

CCMSI Litigation Management Policy/Guidelines

Purpose

- These guidelines lay out the foundation to assist all claim professionals in the litigation management of claims to ensure that a proper and professional defense is provided for our clients and/or insurance carriers. From the beginning of litigation until the final resolution, the designated claim professional and defense counsel should be in regular communication and pursue the earliest opportunity to resolve the claim effectively and economically favorable for our client/insurance carriers.

Goal

- Identify the results to be achieved and implement realistic strategies to achieve those results at the earliest opportunity
    - The CCMSI claim professional should strive for all litigated claims to be resolved quickly and efficiently to achieve the best possible outcome for our clients/insurance carriers
    - The CCMSI claim professional is responsible for the development, implementation and monitoring of litigation strategies. The CCMSI claim professional is also responsible for directing defense counsel activities
    - The CCMSI claim professional is responsible for monitoring and controlling legal expenditures to ensure they are reasonable, necessary and appropriate
    - The log notes in each litigated case must document direction provided by the CCMSI claim professional to defense counsel
    - It is not appropriate for the CCMSI claim professional to refer the case to defense counsel and allow defense counsel to direct the activities on the case

Defense Counsel Selection - Defense counsel can be selected in several ways:

- CCMSI claim professional's referral
- Client direction – where applicable
- CCMSI legal panel
- Carrier legal panel

Great care must be taken with defense counsel selection, especially for large deductible clients. Most carriers have approved legal panels for large deductible policies and require (or at a minimum strongly encourage) use of approved defense counsel. If non-panel counsel is used, the CCMSI claim professional must have written approval from the carrier. If a client directs the CCMSI claim professional to use non-approved counsel, the carrier must be notified immediately.

Defense Counsel Case Referral

Early exchange of information with defense counsel is encouraged on all potentially litigated claims. This will ensure that the most appropriate and effective strategies can be developed and implemented to resolve the claim.

The designated claim professional should provide defense counsel with the following information:

- Pertinent claim information such as claimant name, claim #, date of loss, and CCMSI claim professional contact information
- Petitioner/Plaintiff Counsel's name, firm and contact information, where applicable
- The allegations/issues involved in the case
- Any critical issues that are known or immediate legal services anticipated within the first 30 calendar days
- A formal assignment letter/form with the claim professional's directions to defense counsel and copies of all relevant documents needed to prepare our litigation strategies
- One attorney will be primarily responsible for each case
- If others attorneys in the firm must become involved, primary counsel should discuss this need with the CCMSI claim professional

Initial Evaluation & Litigation Plan

- Defense counsel must provide an initial written evaluation of every referred case within 30 calendar days (CCMSI Corporate Claims Best Practices, Section 15, Best Practice #5)
- The initial evaluation should include, but is not limited to the following:
    - A brief summary of the case facts
    - Identify all legal issues and disputes
    - Identify any and all additional investigation opportunities
    - An evaluation of compensability/liability and/or damages associated with the case
    - Defenses where applicable
    - Settlement evaluation / exposure
    - Identify upcoming legal activities such as, written discovery, depositions, and any court-mandated deadlines
    - Identify the preferred outcome and recommended strategies to achieve that outcome
- The litigation plan must reflect an agreement on strategy between defense counsel and the CCMSI claim professional
- Defense counsel should not perform duties that are appropriate for the CCMSI claim professional (CCMSI Corporate Claims Best Practices, Section 15, First Paragraph)
- The CCMSI claim professional should conduct investigations and activity versus defense counsel where appropriate
- Potential conflicts of interest must be reviewed upon initial assignment and throughout the life of the case

Communication/Documentation

CCMSI recognizes that the designated claim professional and defense counsel should maintain regular contact throughout the life of the case to ensure that opportunities to resolve the case where appropriate are pursued. Defense counsel should immediately communicate, verbally and in writing, important case developments to the designated claim professional, such as:

- settlement discussions/demands
- Any new defense strategies, new information obtained through discovery or other means
- Settlement conferences, mediations, arbitrations hearings or trial dates

CCMSI does not require defense counsel to exchange every document received during the course of a lawsuit or litigation. However, CCMSI does recommend that the following documents (but not limited to the below) be sent to the designated CCMSI claim professional in a timely manner

- Copies of substantive pleadings or motions
- State documents
- The answer to any complaint or response/filing to any legal proceeding, any amended complaints and any third party pleadings
- Written discovery (interrogatories)
- Statements of damages
- All settlement demands or offers; written or oral
- Any releases, dismissals or final judgments, awards and all orders of the court
- All discovery responses and deposition summaries
- Briefs
- Releases
- Detailed case summaries

Legal Budget

- When required or recommended (CCMSI Corporate Claims Best Practices, Section 15, Best Practice #5a & 5b), the legal budget should be provided within 30-60 calendar days of assignment of case
    - Worker's Compensation Claims – questionable, dispute or denied cases that are likely to proceed to trial/arbitration/mediation
    - Property/Casualty Claims –where discovery has been conducted and Motion to Dismiss/Motion for Summary Judgment has been denied. These are cases that are likely to proceed to mediation and/or trial
- The legal budget must address all legal services necessary to execute the litigation plan. The legal budget must be reviewed & updated as necessary.
- A legal budget should include, but is not limited to the following:
    - Legal tasks that counsel will initiate
    - Legal tasks that plaintiff counsel is anticipated to initiate
    - Legal tasks that the court or others involved in the case are anticipated to initiate
    - Legal tasks relating to case management, reporting and communications
    - Expenses

Billing

- CCMSI will not pay for the defense firm's cost of preparing new attorneys and/or paralegals to become familiar with the case.
- Research will only be paid for issues unique to the case, not for general legal issues that arise routinely.
- Quarterly billing is preferred at the hourly rate in effect when the case is initially referred.
- Final invoices on resolved or settled cases should be submitted within 60 days of the case's resolution.
- The CCMSI claim professional is responsible for reviewing defense counsel bills for and unclear or unsubstantiated charges.
- CCMSI retains the right to have legal bills audited.
- Defense counsel shall not bill for standard overhead costs such as opening/closing files, conflict checking, preparing bills or filing.
- Travel reimbursement will be made for trips exceeding 25 miles.

Case Resolution

- Alternative dispute resolution/arbitration/mediation should be explored when appropriate.
- Counsel and the CCMSI claim professional should discuss strategy well in advance of any event. Strategy discussions should include, but is not limited to the following:
    - Selection of the mediator, arbitrators or other neutrals when not established by the court
    - Who should attend the event, and whether the attendance should be in person or via other medium
    - Define the expected roles of counsel, the claim professional, and third party participants, when applicable
    - Settlement options (monetary and non-monetary)
    - Structured settlements should be considered where appropriate
    - Compliance with MMSEA requirements, including resolution of conditional payments (Medicare "liens")
    - Potential outcomes of the case if it does not settle
- Defense counsel will consult with the CCMSI claim professional before going to trial, accepting a verdict or filing an appeal.

Section 16 – Carrier Reporting

General Philosophy Statement – Should a claim meet the criteria for reporting to the Excess/Reinsurance carrier, the designated claim professional will forward all pertinent information to the appropriate carrier in a timely fashion. It is our responsibility to protect our client's rights so that they may receive appropriate consideration, direction and potential recovery from the carrier.

Minimum Claim Best Practices

1. All claims meeting the carrier's reporting criteria should be reported immediately as required and quarterly updates provided thereafter unless directed otherwise by the carrier.

2. The designated claim professional must review all open workers' compensation claims that are open 60 months or longer and all liability claims if a suit is filed, regardless of the total incurred for reporting to the carrier. A clear rationale must be documented in the claim notes of their review of the reporting triggers and why the claim is or is not being reported to the carrier. For example, if the ultimate exposure is already known and under the monetary reporting level, state this clearly in the claim notes.

3. The designated claim professional will provide notice to the carrier, including all excess/umbrella carriers if there are multiple layers of coverage, on all liability claims that have a known or anticipated trial date regardless of the incurred amount as early as possible, but no later than 60 calendar days prior to the trial date. Client/Carrier special handling or reporting instructions will prevail.

4. **Initial Reporting:** When a potential excess or reinsurance claim is initially reported to a carrier, the notice shall be sent via certified mail or in such a manner in which proof of receipt is provided. Such proof of the receipt will be located in the claim file for future reference. The designated claim professional will **diary the claim file every 15 calendar days** until (a) the signed proof of receipt is returned and (b) an acknowledgement is received from the carrier. All activity is to be logged in the claim notes to confirm requests have been sent and proof of receipt is received back. **NOTE:** when reporting a claim to a carrier, each claim should be reported with its own letter. The claim professional should **NOT** report multiple claims in the same letter. In addition, the name of the Underwriting Company (Issuing Insurance Company) is to be included on **all written communications**, including the recovery phase.

5. Multiple Excess/Umbrella Carriers/Layers of Coverage: If there are multiple carriers and/or multiple layers of coverage, once a demand is received that exceeds the primary layer of coverage, the designated claim professional will report the claim to all carriers that could have exposure within the demand.

6. The designated claim professional will notify the client of anticipated recovery opportunities and timeframe, when appropriate.

Minimum System Requirements

1. All claims reported to the carrier must have documentation in the claim log notes under the appropriate heading when, why and who claim was reported. (Carrier Reporting)

2. The designated claim professional must complete all carrier fields on the claim edit screen.

3. All workers' compensation claims that are open 60 months must have documentation in the claim notes that the file was reviewed for reporting to the carrier. If the decision is made to not report the claim at that time, the file will be reviewed annually for reporting to the carrier until the claim is closed.

Sample Criteria for Reporting Claims to a Carrier

1. Fifty percent of the insured retention level per occurrence;

2. Permanent total disability as defined by statute;

3. Fatalities;

4. Paraplegics and quadriplegics;

5. Serious burns;

6. Brain injury;

7. Spinal cord injury;

8. Amputation of a major extremity;

9. Any occurrence which results in serious injury to two or more employees; and

10. Any claim where anticipated disability is expected to reach or exceed 9 months of disability.

NOTE: Many carriers have instituted policies and procedures as it relates to settlements including resignations and/or global releases. Please refer to your carrier handling instructions if your claim involves claim resolution that includes a resignation or a global release.

Benefit

It is important that the claim staff be familiar with all excess/reinsurance carrier reporting guidelines so that CCMSI can recover, on our clients' behalf, possible monies spent on such claims. It is our responsibility to protect our client's interest as well as eliminating any potential E&O claims due to our failure to report appropriate claims.

Section 17 - Fraud/SIU

General Philosophy Statement – All claims staff will attend mandatory fraud training on an annual basis. This is required by most states and insurance carriers. The designated claim professional will identify potential fraud and comply with fraud reporting requirements based on state jurisdiction.

Minimum Claim Best Practices and System Requirements

1. All potential fraud issues must be documented in log notes under the appropriate heading. (Investigation Heading)

2. When fraud indicators are present, the designated claim professional shall consider a referral to CCMSI's fraud program FIRE. (FIRE – Fraud Identification Recovery Edge)

3. If a designated claim professional wishes to process a claim for fraud and present to authorities, the designated claim professional is required to first obtain authority from our Corporate Compliance Manager, Carl Ayestas. He will confirm we have written approval from the client to pursue, and then will give final approval to the designated claim professional to submit to Covent Bridge.

4. The Fraudulent Indicator found on the WC Specific drop-down of the Claim tab will default to "Not Fraudulent" on all claims. If the claim is later referred to Covent Bridge to process a claim for fraud and present to authorities, the designated claim professional will change the Fraudulent Indicator to "Partially Fraudulent". If the claimant is ultimately convicted, the designated claim professional will change the Fraudulent Indicator to "Fully Fraudulent".

Sample Fraud Language:

"Any person who knowingly and willfully presents a false or fraudulent claim, and who knowingly and willfully presents false information regarding a claim is guilty of a crime and may be subject to fines and/or confinement in prison."

Note: Above is sample fraud language that can be used if jurisdictional language is not required. Please keep in mind that many states have specific fraud language that must be used in that jurisdiction.

Section 18 - Privacy Standards

General Philosophy Statement - We should treat all files in compliance with applicable confidentiality standards. Information should not be released to anyone who does not have legal entitlement to it. If the designated claim professional is unclear, the best rule to follow is to secure a written authorization prior to releasing information.

On workers' compensation files where privacy issues such as HIPAA surface, the following statement should be included on all requests for medical information.

Note: Workers' Compensation Requests Are Exempt From HIPAA.

Pursuant to 45 CFR, Sect. 164.512(1) a covered entity may without penalty under HIPAA disclose protected health information to the extent necessary to comply with the law relating to workers' compensation.

Section 19 - Indexing

General Philosophy Statement – It is recommended that the following types of claims be indexed through ISO to comply with industry standards and the OFAC/Patriot Act:

- Indemnity
- Third Party Injury
- Third Party Property Damage Claims > $10,000
- Auto Theft
- Suspected Fraud
- Burglary, Theft and Fire Losses under a Property Insurance Policy
- Any other claims as mandated by State, carrier or client

Minimum Claim Best Practices

1. All indexing of Workers' Compensation and P&C claims should be generated through the automated ISO feature, where possible. The P&C coverage codes that are not automated should be generated manually with a national search which includes an OFAC/Patriot Act search compliance feature upon initial claim set-up and/or upon receipt of necessary information.

2. Indexing with the automated ISO feature provides automatic updates for matches, as received, for one year subsequent to the initial index. After the first year, automatic updates are no longer provided, so the claim needs to be re-indexed 18 months from the initial index and then every 6 months thereafter until the claim is closed or settled.

3. The P&C coverage codes that are not automated must be manually entered initially and every 6 months thereafter until the claim is closed or settled.

Minimum System Requirements

1. A review of the index results and any action necessary, follow up attempts, responses from other carriers or a decision to discontinue to follow up should be documented in the log notes under the appropriate heading (General Heading). The designated claim professional must complete of the 'Date Sent' and 'Date Re-indexed' fields in the miscellaneous screen if the index search was generated manually. **NOTE:** For workers' compensation claims and most P&C coverage codes, the date indexed and the date re-indexed fields in the miscellaneous screen no longer need to be completed due to system automation. Designated claim professionals must confirm completion when reviewing the Miscellaneous screen.

2. If any automated updates for matches are received during the 12 months after the initial index, the designated claim professional must review the index results and document any action necessary, follow up attempts, responses from other carriers or a decision to discontinue follow up under the appropriate heading (INDEX/PRIOR CLAIMS).

3. Upon notification by CCMSI's OFAC/Patriot Act Compliance Officer all hits/findings with regard to OFAC/Patriot Act should be documented in the log notes under the appropriate heading (General Heading).

Section 20 - General Claim Handling Requirement

All instances of suspected bad faith, E&O exposure, penalties, fines, and/or complaints by the Department of Insurance or like entity should be immediately brought to the attention of the Chief Operating Officer by the respective Manager, State Director or Regional Vice President and Carl Ayestes, Corporate Compliance Officer.

Requirements for handling DOI (Department of Insurance) complaints

1. Should any CCMSI office receive a complaint from a DOI, a copy of the complaint in it's entirety must be sent to Corporate Compliance on the date of receipt. Thereafter, Corporate Compliance has 24 hours to provide a copy of the report to the Carrier (not the response).
2. Responsible office will need to start working on a response immediately upon receipt of the complaint and coordinate the response with Corporate Compliance.
3. Response to the complaint will always require the following information:
    a. DOI complete address and name of representative
    b. DOI file number
    c. Correct Carrier NAIC number
    d. Correct writing company
    e. Carrier claim number (if applicable)
    f. Policy number
    g. TPA claim number
    h. Date of loss
    i. Type of coverage
4. All CCMSI offices are required to follow our specific requirements on all DOI complaints; and designated claim professionals, supervisors or managers should not provide a direct response to the state or the carrier.

NOTE: It is very important that specific Carrier Requirements for DOI complaints are followed.

Following are requirements for six of the major Carriers that we represent:

ACE/CHUBB

- If DOI complaint is addressed to ACE/CHUBB:
    - ACE/CHUBB will contact TPA, gather a copy of TPA's file, and they will respond directly to DOI.
- If DOI complaint is addressed to the TPA/Insured directly with no notice to ACE/CHUBB:
    - TPA will respond directly to the DOI, and there is no need to involve ACE/CHUBB.
- If DOI complaint is addressed to TPA/Insured and ACE/CHUBB is copied:
    - The TPA is allowed to respond to the DOI directly. However, ACE/CHUBB has to review and approve the response before it goes out.

AIG/CHARTIS

- Copies of all complaints with corresponding responses are to be forwarded to AIG/CHARTIS immediately upon receipt.
- Responses to the DOI must be completed within 10 days or sooner.
- AIG/CHARTIS will review and approve all responses prior to being sent out by TPA.

HARTFORD

- If complaint is received by HARTFORD, a scanned version will be sent to TPA.
- TPA is responsible for drafting a response to the DOI by a VP or above.
- TPA will comply with all required reporting elements.
    - (e.g.) NAIC #, Claim numbers, etc.
- TPA will send copy of response to TPA Services for final approval prior to sending to DOI.

MIDWEST EMPLOYERS

- If DOI complaint is directed to the Carrier, they will request information from CCMSI, and they will respond to the complaint.
- If CCMSI receives the complaint, immediate notification needs to be given to Carrier. Within 7 – 10 days, CCMSI will need to provide information to Carrier, and they will respond to the complaint.

SAFETY NATIONAL

- Complaints received by Carrier are investigated by the Carrier by obtaining information from the TPA, but the Carrier files response with the DOI.
- Complaints received by the TPA are typically reported to the Carrier, and the Carrier files the response with details provided by the TPA.
- All complaints are monitored by SAFETY NATIONAL'S Legal Department.

ZURICH

- Complaints received by ZURICH will be immediately directed to TPA.
- Complaints received by TPA must be forwarded to ZURICH within 24 hours of receipt.
- All complaints will be answered on or before due date.
- Only VP's and above are allowed to respond to complaints on behalf of ZURICH.
- TPA will respond on their own letterhead with authorized signature.
- ZURICH needs to approve TPA's response.

Section 21 - Outside Vendors

Whenever applicable, the client service instructions should be followed regarding the use of outside vendors. All outside vendors must have appropriate certificates of insurance.

Outside vendors could include, but are not limited to: Nurse/Medical Case Management, Vocational Rehabilitation, IME's, Surveillance, & etc.

As the assignor of services, the designated claim professional's minimum responsibilities include:

1. The designated claim professional will document their rationale for the referral to an outside vendor as well as a "brief" description of the scope of the assignment.
2. Obtain an initial cost cap and monitor those expenses on-going where applicable.
3. Keep the vendor on track with the strategy as outlined.
4. Document the outcome of the vendor(s) as part of the larger strategy. (Are they reaching their goals?)

Section 22 – Storage of Evidence

Evidence obtained during the investigation in a claim must be properly maintained and documented by the designated claim professional. Proper documentation and clear identification of evidence will assist in protecting the preservation of the evidence for future use, defense of the claim and maintenance of the chain of custody.

Please note specific carrier or client guidelines may override portions of the procedures as stated below.

Evidence includes, but is not limited to the following:

- Surveillance tapes
- X-rays
- Electronically stored data such as recorded statements, photographs, etc. must be attached to the electronic claim file
- Printed photographs to be scanned and attached to the electronic claim file
- All tangible pieces of evidence

The log notes should reflect a description of all evidence obtained during the investigation of the claim and should include the following information:

- The location where the evidence is being stored;
- The date the evidence was received and by whom;
- How the evidence was received including the name of the person delivering the evidence if the evidence was delivered to our office.

Evidence Maintained in Claim Files

All evidence maintained in the claim file should be properly labeled with the claim number, claimant name and date of loss. This will ensure each piece of evidence is clearly marked for identification purposes should the evidence become separated from the file.

Photographs that are maintained in the claims files should be clearly labeled as noted above. If the photographs are originals, the log notes should reflect the same and note where the negatives are being maintained. Digital photos may be downloaded on discs and stored in accordance with the above procedures; or may be maintained on a common drive by each office.

Micro cassette tapes containing recorded statements are to be maintained in a secured envelope in the claims file and labeled with the claim number, date of loss, client name, claimant name, name of witness being recorded and the date of the recording.

Storage of Evidence Outside of the Claim File

All evidence stored outside of the claim file within a CCMSI office should be stored in a central location within the office. A log should be maintained for each client account containing a list of all evidence being stored within the office.

All evidence stored outside of the claim file within a CCMSI office should be labeled with the following information:

- Assign an Inventory # by Office – ie 01/DAN Office

- Claim #
- Date of loss
- Client name
- Claimant name
- Date received
- Evidence received from (name of individual)
- Client Property location (optional)

The Account Manager, or other designated local office personnel, is responsible for ensuring an evidence log exists at the local office level for their assigned accounts. A log should be established by client information to include the above labeled information as well as a destruction date based upon the prevailing state file retention statutes and/or the client's retention program which ever is longer. The evidence spreadsheet/log should be maintained on the 'O' drive\Corporate Claims\Procedures-Memos\Evidence Log under a subfolder labeled for each office, by client, for easy accessibility in the event of a disaster recovery.

Each claim file jacket should be labeled to identify the evidence being stored within the office to include the following information:

- Evidence Stored (ie, surveillance tape, x-rays, etc.)
- Location of Evidence
- Destruction date of evidence (to be determined once file is closed)

The claim log notes should reflect all actions taken with any evidence stored within the office. If the evidence is moved or inspected by an individual, the log notes should be documented to reflect the name of the person removing the evidence from storage, the date of removal, reason for removal and the date of return. Note, when removing tangible physical evidence from storage and/or the office location, supervisory approval is required and should be properly documented in the log notes. If possible, have a second employee witness the removal of the evidence to further ensure the chain of custody is protected. Again, the log notes should reflect the name of any witnesses to the removal of the evidence. If the evidence is being removed from the office, we must obtain a signed dated receipt from the individual removing the evidence. If the evidence is subsequently returned to our office, once again, our log notes should clearly document the name of the person returning the evidence, date of return and any specific reasons for returning the evidence.

Large pieces of physical evidence that are stored offsite by an approved vendor and/or expert should be properly documented in the log notes.

If our client is storing evidence at the client location, our claim file notes should be properly documented with the description of the evidence being stored and the client storage location. A letter must be sent to the client confirming the evidence they are storing and the location information.

In the event of a program take-over, proper documentation of the evidence received from the prior handling TPA is required.

Section 23 – Medicare Compliance

General Philosophy Statement – In the event that a claim involves a Medicare eligible claimant, the designated claim professional is responsible for compliance with Mandatory Insured Reporting (MIR) and Medicare Secondary Payer (MSP) compliance. The designated claim professional is responsible for ensuring Medicare eligibility is verified and to determine how best to demonstrate Medicare's interest was taken into consideration prior to any settlement.

See attached CCMSI Medicare Compliance Background and Policy/Guidelines for more detail.

Mandatory Insurer Reporting (MIR), Medicare Query Function (MQF), On-going Responsibility for Medical (ORM), and Total Payment Obligation to Claimant (TPOC)

Minimum Claim Best Practices

1. The designated claim professional must collect on all claims involving a workers' compensation injury or bodily injury the claimant's "big five" data elements:
    a. Claimant's legal first name (as shown on their Social Security card)
    b. Claimant's legal last name (as shown on their Social Security card)
    c. Date of Birth
    d. Gender
    e. Social Security Number or Health Identification Claim Number
        i. Effective January 5, 2015 CMS will allow the population of the last five (5) digits of the injured party's Social Security Number (SSN) if the full SSN cannot be obtained.
        ii. The partial SSN's should only be used as a last resort as it may decrease the accuracy of the monthly Medicare Query process.
2. Once the above data elements are available in our system the Medicare Query Function (MQF) is automated.
    a. All claims with the above 5 data elements will be sent for query monthly until the claim is closed.
    b. If any of the "Big Five" data elements are changed during the life of the claim the system will automatically update and send the newly updated information for Medicare Query (MQF).
3. If the claimant/plaintiff or plaintiff's counsel is unwilling to supply the injured party's Social Security Number (SSN), the designated claim professional should send CMS's official refusal to provide SSN document within 10 business days to the claimant/plaintiff and/or their counsel for completion.
    a. This document explains the need for the SSN to determine Medicare's Interests in the case and asks for an explanation if it is not being supplied. (This form can be found under the SCHIP Tab in iCEBAR.)
    b. Document your efforts to obtain the "Big Five" data. This will support evidence of a "Good Faith Effort" to identify Medicare Beneficiary Status.

Minimum System Requirements

1. The MIR and MQF process has been automated in CCMSI's propriety claim system.
2. An automated log note will be placed in the file when the initial query is sent and then again when the MQF results are received. If the claimant is Medicare eligible a diary will be sent directly to the designated claim professional with the "Yes" Medicare eligible result.
3. The designated claim professional will not receive monthly query results after the initial results are received unless there is a change in status.
4. ORM is also automated in the system at the time the first medical payment is made and then ORM termination is automated at the time of settlement and at claim closure.
5. If a designated claim professional needs to add an ORM termination date, the designated claim professional will need to contact their Corporate Claims Committee member to have the ORM termination date reviewed, approved and added or edited manually to the system.*
6. When entering a settlement payment, the designated claim professional is required to answer the Future Medical questions accurately. The designated claim professional will be prompted to enter TPOC Amount(s) and Date(s) in the system.*
7. If a designated claim professional needs to modify a TPOC date and/or amount, the designated claim professional will need to contact their Corporate Claims Committee member to have the TPOC date/amount reviewed, approved and added or edited manually to the system.*
8. All information regarding Medicare eligibility, MQF process/history, SCHIP reporting dates, ORM dates, TPOC date(s) and amount(s) can be viewed on the SCHIP tab.
9. All information/documentation regarding Medicare compliance must be logged under the note heading – "Medicare Compliance".

Please reference CCMSI Medicare Compliance Background and Policy/Guidelines for more detail, if necessary.

Conditional Payments

Minimum Claim Best Practices

On all Medicare eligible claimants and those who are expected to become eligible "within 30 months" contact opposing counsel to determine if the Medicare Lien Information has already been obtained.

1. If the Medicare Lien Information has not been obtained or if the claimant does not have legal counsel, the designated claim professional should obtain the required authorization form and contact ExamWorks Clinical Solutions (ECS) to perform a Conditional Payment Research (CPR). CPR should be requested at a **MINIMUM of 60 days** prior to any settlement negotiations/discussions.

    a. For workers' compensation, a Letter of Authority can be used if the client signs it and puts it on their letterhead. This release can be used for all conditional payment cases related to the client. Find a sample Letter of Authority on the SCHIP tab in iCEBAR.
    b. For Liability, a Beneficiary Proof of Representation is required to be signed by plaintiff, legal guardian or executor of the estate. Letters of guardianship or estate letters should

be attached to the executed release if signed by a person other than the plaintiff. Find the Beneficiary Proof of Representation form on the SCHIP tab in iCEBAR.

2. Once the Lien is received, review to determine if the payments are related and negotiate the lien amount, as necessary. The designated claim professional may decide to negotiate the lien themselves or they may contact ExamWorks Clinical Solutions (ECS) to conduct lien negotiations.
3. When a settlement or the Full and Final Release are signed, contact ECS to request a final lien demand from CMS. Once the final lien demand is received, the designated claim professional has **60 days** to repay the final lien amount.
4. Incorporate repayment of the Lien into the settlement or release documents detailing which party is responsible for the repayment.

Minimum System Requirements

All information/documentation regarding conditional payment research, negotiations and the final demand resolution must be logged under the note heading – "Medicare Compliance".

Medicare Advantage Plans (Part C), Prescriptions Drug Plans (Part D) and Medicaid

Minimum Claim Best Practices

1. If the claimant is determined to be Medicare Eligible by the Medicare Query Function ("Y" Response), the designated claim professional must contact opposing counsel or the claimant to ask if the claimant participates in a Medicare Advantage Plan (Part C) or a Prescriptions Drug Plan (Part D).
2. If the claimant is participating in a Medicare Advantage Plan (MAP) or a Prescription Drug Plan, the designated claim professional must request the carrier information (contained on the claimant's MAPS card). A MAP carrier can change year to year so it is important for the designated claim professional to request a copy of the MAP card for every year the claim is open. This information should be provided to ECS to perform MAP Lien Research prior to any settlement, judgment or award. A signed release will be required, which ECS can provide.
3. The designated claim professional must also verify with opposing counsel or the claimant if the claimant is on Medicaid. A claimant may be on Medicaid and not be Medicare Eligible. If the claimant is a Medicaid recipient, we must contact ECS to conduct Medicaid Lien Research prior to any settlement, judgment or award. A signed release will be required, which ECS can provide.
4. All lien research should be initiated a **minimum of 60 days** prior to settlement and updated as necessary if some time has elapsed (6 months or longer) between the last lien research and the actual settlement.
5. Incorporate repayment of the MAPS or Medicaid lien into the settlement or release documents detailing which party is responsible for the repayment.

Minimum System Requirements

1. All information/documentation regarding Medicare Advantage Plans (MAPS), MAPS lien research, negotiations and the final demand resolution must be logged under the note heading – "Medicare Compliance".

Medicare Allocations (MSP Compliance)

Minimum Claim Best Practices

Workers' Compensation:

1. When the total settlement is over $25,000 (including Medicare Lien Amount, Indemnity, Medical and Attorney Fees) and involves a Medicare Beneficiary (Class I), a Medicare Set-Aside Allocation is recommended. (See CCMSI Medicare Compliance Background and Policy/Guidelines for Class I & Class II Medicare Beneficiary definitions.)
2. When the total settlement is over $250,000 (including Medicare Lien Amount, Indemnity, Medical and Attorney Fees) and involves an injured claimant that will likely become Medicare Eligible within 30 months (Class II), a Medicare Set-Aside Allocation is recommended.
3. Submit MSAs that fall into the above categories to CMS for approval. (See the Allocation Referral section below for detailed instructions on submitting to ECS or other vendor.) The following documents and information are required:

    a. HIPAA Release. Find the HIPAA Release on the SCHIP tab in iCEBAR.
    b. Estimated Settlement Total (includes Medicare Lien Amount, Indemnity, Medical & Attorney Fees)
    c. Funding Method (Annuity or Lump Sum). It is recommended that we determine the funding method prior to submission to CMS for approval. If the funding method is modified/changed after approval, all pertinent parties must agree to the change/modification.
    d. Administration of Settlement Funds (by injured party or Professional Administration)
    e. Updated Medical Records, Payment History & RX List to cover the period since the MSA's completion may be requested.
4. Once the MSA has been submitted to CMS for approval the designated claim professional must follow up with the vendor on the status of the approval after 16 weeks have lapsed and then every 30 calendar days until the approval is received.
5. All standard MSA allocations > $25,000 will include an annuity proposal option. The designated claim professional must document their review of the annuity proposal, document their discussion with the client and defense counsel (if applicable) as to our corporate protocol to annuitize all allocations > $25,000 and the cost savings available to the client. If the designated claim professional proceeds to pay the allocation in a lump sum, their rationale must be clearly documented in the log notes under note heading "Medicare Compliance".
6. For settlements that do not meet the above thresholds, consider a Claim Settlement Allocation (CSA). The CSA Referral requires the same documentation as a standard MSA, but is a cost effective alternative to the MSA. This is also a good alternative if the parties will not submit the allocation to CMS for approval. Contact ECS for the CSA Referral.
7. For settlements that do not meet the above thresholds and no future medical care is anticipated, consider using protective language. (Sample protective language for various settlement scenarios can be found on the SCHIP tab in iCEbar for both workers' compensation and liability claims.)

8. For settlements where future medical clearly exists and the parties do not wish to fund an allocation, the parties may agree to leave medical open.
9. For settlements where future medical may exist and all pertinent parties have determined they will not submit the Medicare Allocation to CMS for approval, an Evidence Based Medicare Set Aside EBiMSA can be considered. (See Medicare Compliance Background & Policy Guidelines – alternatives to Medicare Set Aside Allocations.)

Liability:

1. When the settlement or Full and Final Release amount is over $250,000 and involves a Medicare Eligible claimant, a Liability Medicare Set-Aside allocation (LMSA) is recommended.
2. When the settlement or Full and Final Release amount is under $250,000 and involves a Medicare Eligible claimant, a Claim Settlement Allocation (CSA) is recommended. The CSA Referral requires the same documentation as a standard MSA, but is a low cost alternative to the MSA. This is also a good alternative if the parties will not submit the allocation to CMS for approval. Contact ECS for the CSA Referral.
3. For settlements or Full and Final Releases that do not meet the above thresholds and no future medical care is anticipated, consider using protective language. (Sample protective language for various settlement scenarios can be found on the SCHIP tab in iCEbar for both workers' compensation and liability claims.)
4. All LSMA allocations > $25,000 will include an annuity proposal option. The designated claim professional must document their review of the annuity proposal, document their discussion with the client and defense counsel (if applicable) as to our corporate protocol to annuitize all allocations > $25,000 and the cost savings available to the client. If the designated claim professional proceeds to pay the allocation in a lump sum, their rationale must be clearly documented in the log notes under note heading "Medicare Compliance".
5. For settlements where future medical may exist and all pertinent parties have determined they will not submit the Medicare Allocation to CMS for approval, an Evidence Based Medicare Set Aside EBiMSA can be considered. (See Medicare Compliance Background & Policy Guidelines – alternatives to Medicare Set Aside Allocations.)

Minimum System Requirements

All information/documentation regarding Medicare Allocations (MSP Compliance) must be logged under the note heading – "Medicare Compliance".

Allocation Referrals – Workers' Compensation and Liability

Minimum Claim Best Practices

1. When referring a claim out for a MSA/LMSA/CSA/EBiMSA the designated claims professional will prepare a cover letter and summary of the claim that should include the following:
    a. A clear explanation of the reason for the referral and our expectations
    b. Current/updated iCEbar claim summary.

c. An outline of the compensable injuries/body parts as well as details of any disputed injuries/body parts.
d. A chronologic listing of all pertinent medical treatment, medications and diagnostics. If there is something important in the notes such as causation, intervening accidents, IME, etc. make sure those are clearly documented.
e. A complete payment report showing all transactions made on the claim.
f. Do not include legal correspondence, but if we have information in our legal correspondence that summarizes our case and our defenses it would be appropriate to cut and paste the appropriate detail into our cover letter/summary.

2. When an MSA/LMSA/CSA/EBiMSA is completed, the designated claim professional must complete the MSP Final Summary Form (located in Form Filler) and attach to the claim log notes under the note heading "Medicare Compliance".
3. If the allocation does not meet our expectations, contact the vendor to discuss.
4. If the MSA/LMSA/CSA/EBiMSA is not received within 30 calendar days of the referral the designated claim professional must follow up with the vendor every two weeks until the report is received.

Minimum System Requirements

1. All information/documentation regarding Allocation Referrals must be logged under the note heading – "Medicare Compliance".

Benefit

It is our belief that determining Medicare Eligibility early and using all resources at our disposal to demonstrate compliance and that Medicare's interest was adequately considered in a proactive manner will result in compliance, eliminate or reduce unnecessary litigation and provide better results to our clients.

Medicare Compliance Background & Policy/Guidelines

1. Mandatory Insurer Reporting
    a. Medicare Query Function
    b. Claim Input File/CMS Response File
    c. Ongoing Responsibility For Medical Care/ORM Determination
    d. $1,000 Penalty for MIR Noncompliance/SMART Act
2. Part A and B Conditional Payments
    a. Current Conditional Payment Resolution Process
    b. Proposed Conditional Payment Resolution Process
    c. Conditional Payments Right of Appeal
3. Medicare Advantage Plans (Part C) and Prescription Drug Plans (Part D), Medicaid and Reimbursement of Medicaid Liens
4. Medicare Set Asides/MSA Allocations
5. MSA Allocation Referrals
6. Alternative to Medicare Set Aside
7. Determining Medicare Exposure
8. Reducing Medicare Exposure
9. Prescription Management
10. Recommended Settlement Language
    a. Settlement Language for Conditional Payments
    b. Settlement Language for Workers' Compensation Medicare Set Asides
    c. Settlement Language for Liability Medicare Set Asides
11. Miscellaneous System Features
    a. SCHIP Claim Status / Prompt Claim for Settlement – How to Update
    b. SCHIPHOLD Status –What triggers a payment to be placed on SCHIPHOLD?

Purpose

The intent of the CCMSI Medicare Compliance Background and Policy/Guidelines are to provide CCMSI claim staff with insights into the direct and indirect impact of Mandatory Insurer Reporting (MIR), Conditional Payments (CP), Medicare Set Asides (MSA) and overall Medicare Secondary Payer (MSP) compliance. In addition, we will assist staff in identifying key areas of interest, potential risks, negative impacts and positive effects on workers' compensation and liability claims.

Prior to MIR, Medicare had no way to track MSP compliance in workers compensation, liability and no-fault auto cases. With the new reporting requirements, vast amounts of data are being provided to Medicare on a regular basis allowing identification and recovery on past conditional payments as well as access to settlement documents to ensure Medicare's interests have been considered when future exposure exists. As a result, it is imperative that Conditional Payments are resolved and that CCMSI's claim staff, on behalf of our clients, demonstrate that Medicare's interests were taken into consideration with any settlement, judgment or award when dealing with a class I or class II beneficiary. This must be done in certain workers compensation, liability and no fault auto cases to protect CCMSI, its clients, plaintiff & claimants and other involved parties.

Goal

The CCMSI Medicare Compliance Background and Policy/Guidelines will provide background information, a framework, guidelines and tools to assist staff in their efforts to comply with Medicare compliance. The CCMSI Medicare Compliance Background and Policy/Guidelines are not meant to be all-inclusive of all scenarios that exist today or in the future. This should be perceived as a guide and a reference tool.

1. Mandatory Insurer Reporting (MIR)

In 2007, Congress passed and the President signed into law the Medicare, Medicaid SCHIP Extension Act (MMSEA). Section 111 of the MMSEA amended the Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)) and provides for:

- Mandatory Insurer Reporting (MIR) by non-group health plan arrangements, including:
  - Liability insurance (including self-insurance)
  - No-fault insurance
  - Workers' compensation

- Effective July 1, 2009, (delayed until 1-1-2011 for WC & 1-1-2012 for Liability) the plans were required to:
  - Determine whether a claimant is entitled to Medicare benefits; and, if so,
  - Report the identity of such claimant and provide such other information as the CMS may require to properly coordinate Medicare benefits in the future
  - CMS may specify after the claim is resolved through a settlement, judgment, award or other payment (regardless of whether or not there is a determination or admission of liability) how they will handle/coordinate future Medicare benefits

a. **Medicare Query Function (MQF) -** Medicare Query Function is accomplished by sending CMS the required "Big 5" data elements, which are:

- Claimant's legal first name (as shown on their Social Security card)
- Claimant's legal last name (as shown on their Social Security card)
- Date of Birth
- Gender
- Social Security Number or Health Identification Claim Number

- **This process is automated, but requires the input of this data.**

b. **Claim Input File/CMS Response File –** The Medicare Query Function will result in one of two responses from Medicare:
   - "U" indicating that the Medicare beneficiary status is "undetermined/unknown".
     - A "U" (undetermined/unknown) response means that CCMSI will continue to send that claim monthly for the Medicare Query Function (MQF) to CMS until such time as the claim is closed.
   - "Y" indicating that yes, the injured party is a Medicare beneficiary.
     - A "Y" response (yes) will lead to additional claim data being sent from CCMSI to CMS through its reporting agent, ExamWorks Clinical Solutions (ECS), automatically through our Claim Input File. The additional information is often referred to as "backfill data", and the specific information includes:
       - The Medicare Beneficiary (such as legal name, address, date of birth, and social security number)
       - The accident or incident (such as a description of the accident/incident, alleged injuries sustained)
       - The responsible party or parties (such as name and address of employer/carrier, corporate defendant/insurer, self-insured/TPA)
       - Representatives of the parties (such name and addresses of plaintiff and defense counsel)
       - Resolution of case (such as settlement date, settlement amount, attorney fees and costs charged)

   - **This process has been automated in CCMSI's claim system and requires no action from claim staff. The information is automatically extracted for the Claim Input File sent to ECS weekly.**

c. **Ongoing Responsibility For Medical Care (ORM)/ORM Determination** – Pursuant to the MMSEA Act of 2007, entities that are responsible for paying claims to beneficiaries, also known as Responsible Reporting Entities (RRE), must electronically report to Medicare on the occurrence of accepting ongoing responsibility for medical care (ORM) related to the claim or upon settlement, judgment, award, or other payment.

   - **Prior to October 1, 2015** once a medical payment was made on a claim the ICD-9 codes were captured and reported to CMS. **This process was automated.**

   - **Effective October 1, 2015** an ICD-10 code is required to activate a claim in order to comply with the ICD-10 mandate by the U.S. Department of Health and Human Services and

applies to all injury claims subject to MIR. **This process requires designated claim professional action.**

- A claim has accepted ORM when medical payments are issued to providers and/or claimants.
- Once a payment is made for medical treatment, CCMSI's automated I.T. process will change ORM from "No" to "Yes", and the claim will be reported on the next RRE Quarterly Report if the reporting criteria thresholds are met. **No designated claim professional action is required.**
- Once ORM is "Yes" it can never be changed to "No". However, ORM can be terminated if certain criteria are met as follow:
    - Claim is settled and we close out the claimant's future medical rights.
        - When the designated claim professional enters the settlement payment, the system will ask whether future medical is being closed. If the medical is being closed, the system will require entry of an ORM Termination Date and TPOC amount.
        - Note: If the medical is not being closed, ORM will remain "Yes", and the TPOC amount will be reported.
        - **This process is automated and will prompt the designated claim professional with the appropriate questions.**
    - Statute of limitations has expired therefore closing out the claimant's rights for future medical benefits. The ORM termination date would be the date the statute of limitations expired. **This process is automated and the system will prompt SOL questions at the time of closure.**
    - Future medical rights are later closed out by way of a settlement, judgment, award, court order or other jurisdictional allowance. The ORM termination date will be the date specified in the settlement, judgment, award, court order or other jurisdictional allowance. The automation will work as shown in the first option. **The system will prompt the designated claim professional with appropriate questions.**
    - Designated claim professional obtains a signed letter by the claimant's treating physician indicating that no further medical care is warranted or anticipated with regard to his/her injury. ORM Termination Date will be the date of the physician's letter. **Designated claim professional action is required.** Send a copy of the letter along with the ORM Termination Date to your assigned CCMSI Corporate Claims Committee Member requesting to update the ORM Termination Date.
- Closing a file does not necessarily mean an ORM termination date should be established. ORM termination dates can be entered when the claim is closed by statute of limitations or the future medical rights are later closed out. **The designated claim professional must contact their Corporate Claims Committee (CCC) representative to have their request reviewed, approved and added manually into the system. Clear supporting documentation must be provided in order to obtain the approval. The designated claim professional has no ability to enter an ORM termination date into the system at this time.**
- Currently, all Medicare eligible claims (ORM "Yes" or ORM "No") that settle or have a Full & Final Release greater than $750 must report through MIR on the RRE Quarterly Report. This applies to workers' compensation, liability, and no fault insurance.

- All Medicare eligible claims where ORM is "Yes" and the total medical paid is greater than $750 are reportable, per mandatory insured reporting (MIR) guidelines. **This process has been automated and requires no designated claim professional action.**

d. **$1,000 Penalty for MIR Noncompliance/SMART Act -** In 2012, Congress passed, and in 2013, the President signed into law the Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act). The SMART Act amended the MSP Act to state that applicable plans that fail to comply with the reporting requirements may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant.

2. Medicare Part A and B Conditional Payments (CP)

In some but not all cases, Medicare will have paid for medical services received by a beneficiary following an injury. Medicare is said to have paid "conditionally" subject to their right to reimbursement from the primary payer at the time of settlement, judgment, award, or other payment.

Primary Payers are defined as…

- Liability carriers or Plans
- Automobile No Fault Plans
- United States Longshore Harbor (USL&H) Plans
- Workers' Compensation Plans
- Jones Act Plans

In addition, 42 U.S.C. §1395y(b)(2)(b) allows for recovery of double damages, plus interest, and costs of litigation against Primary Payers/RRE (CCMSI Clients) who fail to reimburse Medicare for conditional payments.

- An Example of "Double Damages"
  - If the Medicare Conditional Lien Amount is $5,000, and the amount is not reimbursed to CMS, the US Treasury Department can double the lien to $10,000 and demand payment from the Primary Payers/RRE (CCMSI Client).

Accordingly, it is critical to identify the proper amount of the conditional payment(s) made by Medicare in any claim and to be certain that Medicare's subrogation rights have been satisfied. Failure to resolve conditional payments could result in CMS recovering up to the entire settlement amount (minus certain procurement costs) from the Medicare beneficiary and seeking double damages from the primary payer as noted above, but not to exceed the total amount of the settlement.

a. Current Conditional Payment Resolution (CPR) Process

If as a result of Medicare Query Function (MQF), CCMSI determines that the claimant or plaintiff is a Medicare beneficiary, and if a settlement is being contemplated, then it is highly recommended that **60 days** prior to settlement negotiations, CCMSI initiate Conditional Payment Research (CPR). CCMSI claim staff must review all conditional payments submitted by CMS to determine what charges are related or not related to the designated claim. CCMSI claim staff must communicate any challenges of services or amounts that CMS has presented as part of their conditional payment lien. After settlement of the claim, CCMSI on behalf of the client may then seek a final recovery demand letter from Medicare's contractor.

Upon receipt of the final demand, CCMSI on behalf of the client has within **60 days** to pay the requested amount or otherwise incur penalties and interest on the unpaid amount. Failure to respond within the specified time frame may result in the initiation of additional recovery procedures, including the referral of the debt to the Department of Justice for legal action and/or the Department of the Treasury for further collection action.

As a reminder, the settling parties have an affirmative duty to resolve any conditional payment liens at the time of a settlement. Under the Medicare Secondary Payer (MSP) laws (42 U.S.C. 1395y(b), Medicare does not pay for items or services to the extent that payment has been or may reasonably be expected to be, made through a no-fault, liability or workers' compensation plan. In addition, if the designated claim professional becomes aware that Medicare has made payments which should have or should have reasonably been expected to be made by the employer/carrier it has an obligation to notify Medicare to resolve the lien even if there is **NO** settlement on the case.

In the past, the Medicare Secondary Payer Recovery Contractor supplied conditional payment information. That agency was combined into the Coordinator of Benefits Department. The combined agency is now called the Benefits Coordination & Recovery Contractor (BCRC). Effective October 5, 2015 the BCRC will transition a portion of the recovery workload to the Commercial Repayment Center (CRC). The CRC will assume responsibility for recovery of conditional payments on cases where ORM is reported as yes and the identified primary debtor is an insurer/self-insurer.

Benefits Coordinator Recovery Center Recovery Process (BCRC)
The recovery process by the BCRC will remain unchanged. The BCRC will continue to handle recovery on cases on claims reported **prior to October 5, 2015** and on cases where the identified debtor is the beneficiary. This includes liability cases where there has been no medical payments issued or where there has been no reported TPOC.

There is no responsibility to satisfy the lien until the claim is settled and a Final Demand Letter is received. Payment is due within 60 days or interest will be assessed every 30 calendar days from the date of the Final Demand Letter. Failure to respond to the Final Demand Letter may result in a referral to the Department of Treasury for further action.

Commercial Repayment Center Recovery Process (CRC)
On cases assigned to the CRC the recovery process requires immediate attention. Beginning October 25, 2015 the CRC will issue Conditional Payment Notices (CPNs) on claims that have ORM yes. CPNs may be issued throughout the life of the claim. Upon receipt of the CPN, the designated claim professional must review the CPN to determine if the charges are related to the claim **within 30 calendar days**.

If the CPN charges are related to the claim and are accepted, there is no response required. The CRC will issue a Demand Letter within 30 calendar days from the issue date of the CPN. The designated claim professional then has 60 days from receipt of the final demand letter to satisfy the lien. If payment is not made within 60 days interest will be assessed.

If the CPN includes charges that are not related to the claim, then a response is required within **30 calendar days** from the date the CPN. This is the only opportunity to dispute medical claims on the CPN.

To dispute unrelated charges on the CPN, the designated claim professional is required to provide a written response to the CRC along with supporting documentation and/or payment ledger to support the dispute by the due date noted in the CPN within 30 calendar days. The CRC will review the dispute and respond. There is no guaranteed response time by the CRC for disputes. The CRC will then issue a Demand Letter.

Interest begins to accrue once a Demand Letter is issued by the CRC and is assessed if the lien is not resolved within 60 days. Interest will be assessed every 30 calendar days until the lien is resolved. Demand Letters will have appeal instructions and note a deadline to appeal. Failure to resolve may result in a referral to the Department of Treasury for further action.

b. Conditional Payments Right of Appeal

Until 1-1-2016 only the claimant has a right of appeal a Final Demand Amount.

Only the claimant has the right of appeal on Final Demand Letters issued by the BCRC. The applicable plan has the right of appeal on Demand Letters issued by the CRC.

3. Medicare Advantage Plans (Part C) and Prescription Drug Plans (Part D)

Medicare Part C, also known as Medicare Advantage Plans (MAP), is a replacement of the traditional Medicare Part A & B (Hospitalizations & Physician Care) and Part D (Drug) coverage by a private insurance company.

On 12-5-2011 CMS issued a Memorandum stating MAPs had the same conditional payment reimbursement rights as traditional Medicare. Since that time a number of court cases have sided with that opinion. Therefore, upon a Full & Final Release or settlement, MAPs may assert their right to reimbursement.

Medicaid

Medicaid and Medicare are different and, at this time, MIR does not review Medicaid eligibility. In addition, a claimant can be on both Medicare and Medicaid and lien research must be handled independently of each other.

The Medicaid program provides medical benefits to aged, disabled, and low-income people. Although the federal government establishes general guidelines for the program, the Medicaid program requirements are actually established by each state. Whether or not a person is eligible for Medicaid will depend on the state where he or she lives. States are required to include certain types of individuals or eligibility groups under their Medicaid plans, but may also include other groups. Because of the different eligibility requirements and benefits available from state to state, it is highly recommended that whenever an employer/carrier, corporate defendant/insurer, self-insured/TPA settles a claim with a Medicaid beneficiary, have ECS, determine whether Medicaid has a lien. If so, incorporate repayment of the lien into the settlement or Full & Final Release documents.

Reimbursement of Medicaid Lien

Section 1902(a)(25) of the Social Security Act, 42 C.F.R. §433.135, requires that states take all reasonable measures to ascertain the legal liability of third parties to pay for medical services furnished to a Medicaid recipient. Pursuant to 1902(a)(25), all states have passed statutory authority providing a specific state agency to collect all amounts paid by the state Medicaid system that are determined to be related to a liable third parties. Most state statutes around the country require that recipients or their legal representatives,

and most recently the employer/carrier, corporate defendant/insurer, or self-insured/TPA, notify the state agency of the existence of any third party settlement, judgment, award, or other benefit.

Under most state laws, the state agency has a statutory lien for the full amount of medical care furnished and paid for by the Medicaid program. Therefore, much like Medicare conditional payments, upon receipt of a settlement, judgment or award, benefits that have been paid by the state must be reimbursed according to State and Federal Law. Failure to repay a Medicaid lien may result in interruption of benefits and/or litigation. As a result, it is highly recommended you contact ECS to determine whether Medicaid has a lien, and if so, assist with reimbursement of same.

4. Medicare Set Asides (MSA) and MSA Allocation

While not a legislative requirement, CMS has taken the position that MSAs are the most effective way to protect Medicare's interests regarding future medical care post settlement or full & final release.

Although not specifically mentioned in the Medicare Secondary Payer (MSP) Act, nor in any of its Code of Federal Regulations, CMS has continued to regulate **Workers Compensation** Medicare Set Asides through published policy memos, website announcements and alerts, and a review contractor guided by a published and revised Reference Guide. The consistent principle throughout these is that the establishment of a Medicare Set Aside account is designed to relieve Medicare of the obligation to provide future medical care for a beneficiary who requires continued care related to an accident when the beneficiary has been provided a settlement, judgment, award, or other payment.

To date, Medicare has not established a similar process for beneficiaries or primary payers to use to meet their MSP obligations with respect to future medicals in **Liability Insurance** (including self-insurance) situations. However, CMS Memoranda have continually stated there are no safe harbors for liability cases and allocations are appropriate for a Full and Final Release involving a Medicare beneficiary.

As a result, whether a workers compensation case or a liability case, it is highly recommended that set aside allocations be completed for Medicare beneficiaries that settle or release future medical benefits, or for workers' compensation claimants who will become Medicare beneficiaries within thirty (30) months of settlement. While CMS has not provided a memorandum regarding "reasonable expectation of Medicare eligibility within 30 months" for liability claims it is recommended that an allocation be considered in cases where significant future medical care is anticipated and there is a reasonable expectation that the claimant will become Medicare eligible within thirty (30) months. Failure to do so may result in denial of Medicare coverage and benefits to the beneficiary, continued conditional payment lien accrual, and/or litigation commenced by the beneficiary against the primary payer (client or carrier), or by CMS against the beneficiary, beneficiary's counsel, or the primary payer.

Medicare Set Aside Allocation

MSAs are created by Life Care Plan Experts at ECS. These experts review the claimant's gender, state of jurisdiction, life expectancy, medical records, administrative decisions & other aspects of the claim to determine the future medical treatment anticipated for the claimant that would be covered by Medicare. The analysis necessary in each individual case to arrive at an appropriate amount to fund the MSA is complex. Every case is different. Each claimant will have different needs.

5. MSA Allocation Referrals

If a workers' compensation claims where the Total Payment Obligation to Claimant (TPOC) meets settlement thresholds, CMS recommends a MSA be completed and submitted to CMS for approval of the amount that will be allocated toward future medical expenses.

TPOC is the total amount of a claim's settlement, judgment or award or Full & Final Release.

CMS Workers Compensation Threshold Levels

- Class I Beneficiary (includes Medicare Lien Amount, Indemnity, Medical & Attorney Fees) – If the uncommuted value of the settlement is over $25,000 (including Medicare Liens) then CMS recommends obtaining a MSA and submitting it to CMS for approval.

- Class II Beneficiary (Reasonable Expectation of Medicare Eligibility with 30 months) – If the uncommuted value of the settlement is over $250,000 (includes Medicare Lien Amount, Indemnity, Medical & Attorney Fees), then CMS recommends obtaining a MSA and submitting it to CMS for approval. Class II Beneficiaries include:

    - Over 62 ½ but under 65 years of age
    - Filed for SSDI, been denied and/or appealing denial
    - Currently receiving SSDI, but for less than 2 years

Involving CMS in the determination of the amount that will be allocated toward future medical expenses ensures Medicare eligibility after the funds are exhausted. The only way to truly ensure ongoing and future coverage is to secure CMS approval of the amount before finalizing the settlement. Otherwise, an unrecognized MSA allocation can affect the beneficiary's eligibility for Medicare services and primary payers' responsibilities regarding same.

As a reminder, it has been made clear by CMS that their review threshold is not a safe-harbor or substantive dollar threshold. Whether a review threshold is met or not, all settlements (workers' compensation and liability) where future medical care is anticipated as part of a settlement must evaluate the specific facts of the case to determine if Medicare has a legitimate secondary payer interest in the settlement. Where Medicare has an interest as a secondary payer, the interest must be protected.
While the Submission Process is recommended by CMS, it is voluntary. If a client elects to opt out of the Submission Process, this must be obtained in writing from the client and approved by CCMSI's VP of Corporate Claims and COO.

6. Alternative to the Standard Medicare Set Aside

a. If the parties involved in a full and final settlement have determined they will not submit the Medicare Allocation to CMS for approval, a Claim Settlement Allocation (CSA) can be used in place of the MSA. The CSA Referral requires the same documentation as a standard MSA. The CSA reviews the same medical records reviewed for a MSA and provides an allocation figure that is equal to the MSA figure. You cannot submit a CSA to Medicare for approval. Contact ECS for CSA Referrals.

Discuss with the client and consider the CSA when…

- The parties will not submit the allocation to CMS for approval.
- When the settlement figure does not meet CMS thresholds for submission.
- As a cost effective alternative to the MSA.

- For Liability Release under $250,000

b. If all parties involved in a full and final settlement agree to not submit the allocation to CMS an Evidence Based Medicare Set Aside EBiMSA can be considered. An Evidence Based Medicare Set Aside is created using quantitative and qualitative clinical analysis utilizing established evidence based standards of care.
   - EBiMSA is not intended for submission to CMS for review
   - ExamWorks Clinical Solutions will defend all rationale and methodologies used and demonstrate the EBiMSA is not intended to shift responsibility to Medicare
   - EBiMSA **requires** structured settlement funding
   - EBiMSA **requires** professional administration of funds
   - Should the client/RRE decide not to structure the EBiMSA funds and/or professionally administer the funds, Carrie Milholland, V.P. of Corporate Claims, must give approval
   - Client/RRE approval to use an EBiMSA is required and must be documented in the claim notes

Discuss risks and benefits of an EBiMSA with the client and consider an EBiMSA when:
- All parties agree the allocation will not be submitted to CMS as a part of their "voluntary" review process
- Claim involves multiple medications or brand name RX's are being used
- Claims where the claimant is a "candidate" for future surgeries and/or procedures and there is uncertainty that the claimant will even proceed with these mentioned surgeries or procedures
- Claims where a medication may have only been paid previously once or twice, but currently not taking them

An EBiMSA is a cost effective alternative to the standard MSA. Please note some carriers (Chubb and Zurich) mandate that all MSAs must be submitted for approval. Therefore, an EBiMSA cannot be used for clients and carriers who require submission to CMS for approval.

In the future should CMS deem the allocation was insufficient, ExamWorks Clinical Solutions will indemnify, defend and hold harmless CCMSI, the client and the carrier as long as the EBiMSA is obtained by ExamWorks Clinical Solutions, the funds are annuitized by Chronovo, and the funds are professionally administered by Ametros.

7. Determining Medicare Exposure

Medicare exposure may be higher than expected due to Medicare guideline requirements. When managing a complex claim involving a Medicare Beneficiary, predicting Medicare Exposure Levels prior to contemplation of a settlement or Full & Final Release may identify areas of Medicare Exposure that require management/reduction to promote a legitimate settlement value. Medicare Cost Projections (MCP) can be used to determine exposure prior to settlement or Full & Final Release of a claim, and provide proactive actions to reduce future medical costs.

8. Reducing Medicare Exposure

When Medicare exposure from the MCP, CSA or MSA allocation is high, ECS can determine the cause of the high exposure. Consider contacting ECS to perform a MCP in the following claim situations to determine where future medical exposure can be reduced.

- Medicare Eligible Claims – early in the claim
- Catastrophic Claims – early in the claim
- Open Indemnity Claim over 3 years old
- Claimant/Plaintiff is over 62 ½ years old
- Claimant/Plaintiff is applied for SSDI
- Claimant/Plaintiff is on SSDI

9. Prescriptions Management

The Part D Portion of the MSA relates to Medication in a claim.

Currently, more than half (55%-86%) of injured workers are prescribed opioids for pain management, and opioids represent 30% of prescription drug spend (40% or more in claims over 3 years old). From a national scope, the United States consumes 80% of the world's opioids, despite making up 4% of the population. In December 2012, The American Insurance Association called opioid abuse "the most urgent issue facing workers' compensation". Drug overdose death rates have tripled in the United States since 1990.

Early Intervention

The greater the delay in prescription drug review, the higher the probability that costs will escalate. Therefore, it is imperative to begin a review of prescription medications early in the claim management process. Most opioid guidelines indicate possible addiction after 21 days, and typical first scripts from treating physicians are for a 30 day supply or longer. It is imperative to work with the physician once opioids are prescribed.

An Rx Analysis should be considered when any claim has high prescriptions, utilization and/or cost; or when a Medicare eligible claim is being considered for settlement.

For all claims with high medical costs the Rx Analysis should be considered when:

- When 3 or more medications are being prescribed;
- When the claimant is receiving medication from more than one doctor;
- When there are monthly or bi-monthly medication payments in the claim over the last months; or
- When medications costs total $500 or more per month

Upon Settlement or Full and Final Release

When considering a settlement or full and final release, a thorough review of prescription medications 12-18 months prior to the expected closure date is appropriate if possible. The Workers Compensation Review Contractor (WCRC) requires inclusion of a Medication prescribed within 6 months to a year prior to completion of an allocation (CSA or MSA). **If a medication is included in future care, the CMS requires it be paid at average wholesale pricing for the remainder of the claimant's life expectancy.** This can lead to significant increases in the Part D (Drug) portion of an allocation.

The designated claim professional may consider doing the following when considering settlement of a case that involves a Medicare eligible claimant.

- Pull and review the transaction/payment report to determine which PBM or pharmacies are being used over the past year and;
- If prescription payments were made to the PBM or pharmacy, the designated claim professional should request an Rx list that includes name, dosage, quantity, frequency, and NDC code information.

Prescription Management Procedures

Workers' Compensation:

1. If medications are prescribed early in a claim and continue throughout the claim, consider early intervention with the treating doctor to discuss their treatment and RX Plan going forward.

2. If early intervention is necessary, Field Case Managers can be secured to work directly with the physician to control medication. Designated claim professionals may also consider contacting ECS to set up a RX Analysis. An Rx Analysis may be considered when the following is involved.

    - When 3 or more medications are being prescribed;
    - When the claimant is receiving medication from more than one doctor;
    - When there are monthly or bi-monthly medication payments in the claim over the last months; or
    - When medications costs total $500 or more per month

3. Prior to settlement discussions, review the Provider Payment Log History to see if medication payments were made in the previous year. If medications were prescribed/utilized in that time period, consider contacting the medical providers to see if we can get written documentation on future needs of those impacting medications. We may also consider contacting ECS to have a RX Analysis completed.

Liability:

1. When a full and final release is considered, review available medical records for prescriptions in the past year. If medications were prescribed/utilized in that time period, consider contacting the medical providers to see if we can get written documentation on future needs of those impacting medications. We may also consider contacting ECS to have a RX Analysis completed.

10. Recommended Settlement Language

ECS has contributed to thousands of settlement documents in both workers compensation and liability cases. As a result of this vast experience, ECS has crafted proposed or recommended settlement language that can be used in virtually all settlement situations that involve Medicare to assist employers, carriers, Self-Insured entities and TPAs.

a. Settlement Language for Conditional Payments
b. Settlement Language for Workers Compensation Medicare set Asides
c. Settlement Language for Liability Medicare Set Asides

If assistance is needed contact ECS to review and provide feedback on appropriate settlement or release language prior to having the documents approved. Also, available under the SCHIP Tab is ECS's proposed settlement language templates that can be used for various situations for both workers' compensation and liability claims.

11. Miscellaneous System Features

a. SCHIP Claim Status / Prompt Claim for Settlement

When dealing with a Medicare Eligible claimant it is recommended that the designated claim professional update the SCHIP Claim Status in iCEBAR as soon as they believe the claim is ready for settlement or will be ready for settlement in the near future. It is recommended that where possible this be updated 90 days prior to settlement. This can be done by answering the following questions under the Update SCHIP Claim Status field:

- Do you want to position the claim for settlement? Yes or No
- Are you attempting to close future medical payments? Yes or No

Auto feature – the system will automatically alert the designated claim professional and prompt them to answer these above questions the first time the claim is opened by the designated claim professional once we have received the MQF results indicating "Yes" – the claimant is Medicare eligible. At that time the claim may not be in a position to settle and that is when you may need to update these questions later as described above.
When both of these questions are answered yes the following auto process will occur:

- CCMSI in their weekly input claim file to ECS will let them know this claim has been positioned for settlement and that it is our desire to attempt to close out future medical by way of settlement if possible.
- In addition to the above data – CCMSI will also provide the total outstanding reserve so that ECS has an idea what the exposure amount is on the designated claim.
- ECS will then reach out by e-mail or phone to the designated claim professional to discuss the case, determine if assistance is needed with Conditional Payment Research (CPR) and MSP compliance involving a possible allocation.

b. SCHIPHOLD Status

CCMSI has integrated system automation features to safe guard and flag payments on Medicare eligible claimant's wherein certain compliance activities have not been done. At that time the claim will be placed on SCHIPHOLD until such activity is completed or can be overwritten by a supervisor or higher. Below are the triggers that push an indemnity/settlement payment to SCHIPHOLD:

- If the Medicare Query Function (MQF) has not been performed when trying to make a "settlement" payment then the following prompt is shown:

  The SCHIP for Medicare Eligibility has not been performed for the claim.
  Settlement Payments may be prohibited until results are known.
  The settlement transactions may be created with the status of "SCHIPHOLD"

- After the payment is saved, if the user attempts to forward the payment to check printing, then the following is displayed:

Workflow status is “SCHIPHOLD”
Settlement will not be forwarded to Check Printing until authorization to release has been given from ExamWorks Clinical Solutions.
Select “OK” to override” SCHIPHOLD” Status.

- If the MQF has been performed, but the results are not back and posted to the claim file (same prompt as above).
- If the MQF returned a “Yes” result, but we have not yet conducted Conditional Payment Research or obtained an MSA or CSA from ECS. When trying to make a “settlement” payment when this situation is involved the following prompt will appear:

  The claimant is Medicare Eligible and compliance status from ExamWorks Clinical Solutions is “incomplete”.
  The settlement transaction may be crated with a status of “SCHIPHOLD”

  The user is then asked if they are closing future medical.
  Select “OK” to close future medical. (This will terminate ORM).

When might we use the SCHIPHOLD overwrite feature?

- If we use an outside vendor other than ECS to perform Conditional Payment Research (CPR) or prepare the allocation. CCMSI claim system is only automated to receive compliance alters that these have been performed from ECS.
- No allocation was necessary and the settlement/release documents used protective language to demonstrate that Medicare’s interests were considered.
- An MQF was not done, but we have verified that claimant was not Medicare Eligible

Medicare Compliance Abbreviations:

BCRC – Benefits Coordination & Recovery Contractor
CMS – Centers of Medicare and Medicaid Services
CP – Conditional Payment(s)
CPD – Conditional Payment Dispute (same as CPN these abbreviations are often interchanged and mean the same thing)
CPN – Conditional Payment Negotiations or Conditional Payment Notice
CPR – Conditional Payment Research
CRC – Commercial Repayment Center
CSA – Claim Settlement Allocation
EBiMSA – Evidence Based Medicare Set Aside (i stands for annuitizing funds)
ECS – ExamWorks Clinical Solutions (formerly Gould and Lamb, LLC - G&L)
LMSA – Liability Medicare Set-Aside
MAPS – Medicare Advantage Plans
MCP – Medical Cost Projection
MIR – Mandatory Insured Reporting
MMSEA – Medicare, Medicaid SCHIP Extension Act
MSA – Medicare Set-Aside
MSP – Medicare Secondary Payer
MQF – Medicare Query Function

ORM – Ongoing Responsible for Medical
RA – Reporting Agent
RRE – Responsible Reporting Entity
SCHIP – State's Children Health Insurance Plan
SMART Act – Strengthening Medicare and Repaying Taxpayers Act 2012
TPOC – Total Payment Obligation to Claimant
WCRC – Workers' Compensation Review Contractor
TPOC – Total Payment Obligation to Claimant
WCRC – Workers' Compensation Review Contractor

Claims Policies and Procedures

Sewickley Office – Medical Malpractice Division

2020

VCM Purpose Statement

To actively partner with our clients;
To design & implement unique and innovative programs; and
To create dynamic claims, litigation & information management solutions!

TABLE OF CONTENTS

Mission Statement

We are an organization that breaks down walls to find claims solutions. We are diverse from the inside out. We are as close as your desktop. Service is our passion. We are VCM

A. Who we are

VCM, A CCMSI Division ("VCM") is a company of Claims Professionals who handle Professional Liability (PL) claims for doctors, hospitals, long term care facilities, and other healthcare entities. We also manage General Liability (GL) claims for hospital programs with GL coverage included in their insurance program. We primarily handle claims for self- insured entities. We investigate, negotiate and mediate claims to their rightful conclusion. We offer our clients a unique, unbiased claims handling solution that will give them excellent results demonstrated by our expertise in the industry. We have been in existence since February of 2002 and started out with our first client who needed claims expertise, but with the demise of dedicated Medical Malpractice carriers, there was no one to cover their risk. So, hospitals in Pennsylvania began to use VCM as a Third Party Administrator (TPA).

We adhere to the CCMSI/VCM approved Best Practices for claims and are licensed in all jurisdictions in which we do business. We evaluate each claim and apply reserving policies that are in line with individual clients' guidelines. We evaluate coverage, liability and damages in order to advise our clients of their options.

B. What we do

Healthcare providers across the country continually face the need to actively manage their professional liability claims. Many providers have entered the alternative risk transfer market, using self-insured risk retention groups or captive insurance companies, and are accepting increasingly larger amounts of self-insured risk. The success or failure of alternative risk programs is driven by the proper management of the claims and litigation experienced in the program. VCM specializes in the management of professional and general liability claims and litigation management for the healthcare industry.

The program developed by VCM to serve healthcare providers includes:

- Expert claims and litigation investigation and management;
- Interactive, real-time, internet based information technology;
- Productivity-enhancing features focused on communication and cost control;
- Litigation cost effectiveness via trending, budgeting and control;
- Comprehensive capture of data and risk management analysis.
- Auditing and new Program Set Up assistance.

You, as a VCM Claims Representative, are an integral part of this *claims process*. It is important that you become familiar with the form documents contained in this manual, and with *Trideo,* the web-based IT platform that supports *our claim process.*

C. Trideo and Internet based Technology

VCM uses the web-based *Trideo* program to provide a total management system for the review, analysis and defense of claims from the initial notice of incident through settlement and/or litigation. *Trideo* utilizes the highest encryption programs permitted by law to be certain that all information on the system remains confidential. By allowing password protected access to all parties involved in a claim, *Trideo* provides an avenue of

open communication between you, your supervisor, the healthcare provider, and the defense counsel (should the claim proceed to litigation).
Trideo will allow VCM Claims Personnel, your client and defense counsel access to view all file information relating to the suits and files you will be handling for Program. This three-party claims management system will serve as the formal claim file and depository of all correspondence, pleadings and documentation
You will receive training on the Trideo software from the VCM Client Services Manager, your Claim Manager and other claims staff.

D. Telecommuting Employees

1. **CCMSI Telecommuting Policy: All employees are expected to comply with the CCMSI Telecommuting policy contained in the CCMSI Employee handbook, Section 6.05.**

2. **VCM Telecommuting Policy: In addition, the following apply to employees based out of the Sewickley PA office:**

   If you are an employee that telecommutes you are required to supply the following:
   - A dedicated office space with a door that is separate from your family living space.
   - A dedicated Internet connection. *You will be reimbursed up to $60 per month for your internet line.

   While Telecommuting provides a convenient way of conducting business from a remote location, it is important to appreciate that the rules of proper business behavior do not disappear just because your commute does. In fact, in some ways, they become even more important as employers want to be assured that the off-site employees are approaching their work with the same professionalism and work ethic as on-site employees. In determining eligibility for telecommuting, the supervisor and employee should review the criteria listed below.

3. **Company Expectations of the Telecommuting Employee**

   - It is the expectation of the company that the employee will be in their office and available during VCM/CCMSI business hours. (8:00am-5:00pm EST) The employee is entitled to a 60 minute lunch break. It is anticipated that there may be times and/or projects with client-driven deadlines which may require our professionals to complete them prior to being done for the day.
   - If the employee is to be away from his/her office for personal reasons, he/she must seek prior approval from his/her supervisor. PTO or elective time must be used and taken in no less than 3.75 hour increments. All PTO requests must also be requested in ADP at the time the PTO approval is submitted to the supervisor.
   - If the employee is away from his/her office for a half day or longer, he/she is expected to change voice mail and email messages indicating same.

- All approved time away from the home office is to be entered on both the Global Calendar and the Employee's personal Outlook calendar.
- The telecommuting employee must proactively communicate with his/her supervisor, the status of assignments and projects they are working on, and any planned meeting they will be attending in person.
- The supervisor may require weekly email updates from the employee indicating the status of assignments and projects.
- The supervisor may require weekly or bi-weekly phone-conferences with the employee.

4. **Requests for Home Office Support**
   To make the following requests, you must submit an email to vcm.admin@vcm-llc.com

   Supply Ordering

   Letter Mailing – VCM is paperless. Most of what you send can be done via e-mail or fax. At times there may be a hard copy which must go out. When this occurs, complete the letter, sign the letter (electronically or signed and scanned) and attach it to the email.

   UPS Mailings – Anything which requires a tracking number.

   Status of Medical Records – Some clients send their medical records via hard copy to the Home Office. These are scanned into Trideo when received. Please be sure you check Trideo for your records prior to requesting a status from Home Office.

   The following tasks can be self-completed and a request should not be sent to the Home Office.

   Faxing – All staff have access to Fax Finder. Instructions are located in Common at: K:\Common\Fax Procedure

   Go To Meeting set ups – Training will be provided if needed

   Individual Travel – All staff have the ability to book their own travel and training is provided. For group events or when specifically requested by management, travel will be booked through the home office.

Remember: Treat your home office like a "Corner Office" paying due respect to your responsibilities, colleagues and clients.

E. VCM Client Programs - Claims Procedure Manuals (CPM)

Claim Procedures Manuals (CPM) were developed for each client at the time the program was rolled out as a VCM Client. These processes have been presented and approved by the Client and document the procedures and services that have been agreed upon in our

contract for services. The Claims Procedures are developed to document each programs specific needs and requirements.
As a VCM Claims Representative, you are responsible for learning and reviewing the specific program's Claims Procedures.
The Claims Procedure Manual for each client is updated on an annual basis by the assigned Claim Representative and Program Manager. You will be provided a copy of the Claims Procedure Manual for your clients.

Claims process – Getting Started

A. Your Computer

As a VCM/CCMSI employee you will be supplied with the following equipment:

- Laptop computer and docking station
- Dual Monitors
- Phone
- Combination Printer-Fax-Scanner
- Required office supplies

You will be responsible for this equipment per the **CCMSI Computer System Usage and Standards Agreement** as outlined in the CCMSI Employee Handbook, Section 6; Communication Systems Policies & Agreements.

B. Initial File Assignment

The Claims Manager or Account Manager will assign all new matters in Trideo to the appropriate Claims Professional. All claims will be setup by the VCM Claims Professional within 1 (one) business day for all suits and 3 (three) business days for all PCE's and Claims.

C. Initial Set up

Each program will have available specific criteria and written guidelines for file set up available for the Claims Professional to follow.
The VCM Claims Professional will do an initial review of coverage, set initial reserves, assign defense counsel and send retention letters if indicated, and notify all excess carriers or reinsurers per the client specific guidelines. If indicated the appropriate State Reporting will be submitted.
The timelines outlined in the individual client Claims Procedures must be adhered to.

Claims Process – Initial File Review

A. Coverage Evaluation

It is the responsibility of the Claims Professional to determine if there is proper coverage available

- For the stated allegations.
- For the time frame in which the alleged act occurred.
- For the person(s), entities and/or employees named in the suit or for which coverage has been requested by the client.

The Coverage Evaluation Worksheet is located in the Appendix. This must be attached to all claims within forty eight (48) business hours of assignment.
If there is any question or concern about coverage the Claim Representative will consider issuing a Reservation of Rights letter and/or denial of coverage letter. Drafts of coverage letters should be sent to the VCM Claims Manager and the VCM Compliance officer for approval before sending to the client and/or additional insureds. Client authorization is needed to send to named additional insured defendants.
The Claim Representative will review the Complaint for common allegations which often are excluded in the policy or excluded by statute:

1. **Punitive/Exemplary Damages**
   - Specific allegations of punitive or exemplary damages are either allowed on a direct or vicarious nature and should be addressed by jurisdictions.
   - In NY State there is a Nursing home statute 2801(d) which specifically allows for Punitive Damages to be claimed.
   - Attached in the Appendix is a summary of States in which VCM services clients which outlines whether a Punitive claim is allowed under the law or not allowed.

2. **Retro Dates/Date of Report/Date of Loss**
   - In a "claims made" policy, these are the dates that coverage extends to historically, for the current coverage period.

3. **Covered Events**
   - A covered event is one that qualifies for coverage under the insuring agreement of the entity involved in the event either under the Claims Made Policy or Occurrence based policy.
   - Common allegations that are usually **NOT** covered include HIPAA violations and allegations of battery or sexual assault.

B. Reservation of Rights/Coverage Determinations/State Reporting

Reservation of Rights (ROR) and Denial of Coverage letters should be sent out promptly to the insured and any additional named insured defendants. Permission should be obtained from the client before sending out letters to additional insureds. If permission is not granted, the Trideo file should be documented to reflect the client wishes.

Once you have completed the first draft of the letter you will review it with your VCM Claims Manager and Compliance Officer. The draft should then be sent to the client for review and approval. When a case involves complex coverage issues additional review may be indicated by the Management Team and/or outside coverage counsel may be indicated. Client approval is indicated before outside coverage counsel is retained. Letters should be sent by certified mail.
Letters should identify:

1. **The policy number**
2. **The policy dates**
3. **The named insured and any additional named insureds**
4. **VCM Policy number**
5. **The name of the claimant/plaintiff**
6. **The Date of Loss and date of Report**
7. **The letter should specifically identify the paragraphs of the Complaint that are in question.**
8. **Specific exclusions should be cited from the policy for each identified coverage issue.**

C. State Reporting

VCM contracts to provide State Reporting to some of our clients. The CPM will reflect the obligations of the Claims Professional regarding State Reporting as well as the procedures for reporting. Attached in the Appendix is a summary of State Reporting Requirements for the States in which VCM services clients. Regardless of whether you report to the state for your client, you should be aware of the requirements for the venue in which your client resides.

D. VCM Standard Reserve Guidelines

1. **Reserving – VCM Initial Reserve Recommendations – See individual Client Claims Procedure Manual for approved reserve setting.**

   VCM recommends the following proposed guidelines for initial reserves to be used at the time of a file opening when information is not readily available regarding a file:

   - $5,000 Indemnity/$1,000 Expense – initial reserve for **claims not in litigation** and with no defense counsel assigned, to be set while initial claim investigation is pending and a determination is to be made as to potential liability exposure. If counsel is assigned an initial expense of $5,000 is recommended.

- $10,000 Indemnity/$25,000 Expense – initial reserve for **claims in litigation**, to be set while initial claim investigation is pending and a determination is to be made as to potential liability exposure.
- $0 Indemnity and $10,000 expense for Admin Defense.
- $0 Indemnity and Expense reserves for PCE, Notice Only.

2. **Reserves at the Conclusion of Investigation – (90 days after file set-up) At the conclusion of the initial investigation, based upon a review of liability potential and the severity of the injury, the indemnity reserves should be reviewed with recommendations made, if possible to reflect a more accurate idea of the value of the file. In addition, the expense reserves should be based upon the current defense or resolution strategy.**

3. **Reserves should be evaluated and addressed at the time of the 90 day review by the Claim Representative. This should be the settlement value and/or ultimate resolution value reserve for the file. VCM strives to set a final reserve with 12 (twelve) months, however, the Claim Representative will make reserve recommendations throughout the life of the file.**

4. **Reserve recommendations will be documented in the Liability Analysis tab/Claim Summary Report every 90 (ninety) days.**

   All reserve recommendations made to a client must also include an updated CSR saved to Notes explaining the recommended changes.

5. **When a reserve is changed, a comment must be added in the reserve field as to why and/or when the reserve is being changed.**

Please review the client specific reserve guidelines in the Claims Procedure Manual for each client.

E. Investigation and Reporting Requirements

1. **Diary**
   - Diary should be set for a CSR review at 90 (ninety) day intervals using the "Tasks" feature in Trideo. Reserves should be reviewed each time a file is picked up and reviewed.

2. **Obtain medical records and review if requested by the client.**
   - Medical records from the event should be secured from the client. The records from the event should be reviewed for pertinent facts and a medical chronology completed
   - A task should be set for 30 days from report date to follow up for client medical records.

3. **Interview the key personnel if requested by the client.**

- Work with client to setup meetings with witnesses who are key to the medical process.
- A task should be set for 45 days from report date for witness interviews.

4. **Obtain expert review if requested by the client.**
   - Working with the client to determine the extent and nature of the case will determine the type of expert needed. If not in suit keep in mind the need for a BAA from the expert or an authorization from the claimant.
   - A task should be set for 60 days from report date to complete expert reviews.
   - An expert report/memo should be completed within three (3) business days of discussion with expert to memorialize the expert's opinions.

5. **Liability Analysis Report/Claim Summary Report.**
   - This should be completed every 90 (ninety) days from the report date on a file. A task should be set on every file using the "Tasks" feature in Trideo. In addition, there should be a task for relevant updating on each file (i.e. follow for deposition report, medical record review, trial date, etc.). The 90 day CSR should summarize your activity to date as well as your mental impressions, opinions and conclusions as to Liability, causation, damages and settlement v defense. A copy of the completed CSR should be posted to the "Notes" section of Trideo every 90 days. There should be no blank fields on these CSRs.

F. Excess and Reinsurance Reporting Policy

1. **Initial Excess and Reinsurance Reporting: VCM has contracted with some clients to provide Excess and/or Reinsurance reporting pursuant to the policy requirements of the Excess and/or Reinsurance carrier. For those clients:**

   - The initial Notice of Loss (NOL) will be sent to the appropriate carrier(s) at the time of initial set up by email to each carrier, with a copy of the Trideo generated Notice of Claim (NOC) or Claim Summary Report (CSR). Claim representatives should request email confirmation that the email was received.
   - The initial NOL should be uploaded into Trideo along with the carrier's acknowledgement. In cases where the reports are done via bordereaux, the spreadsheets should never be attached to the claim as they will contain other claimant information, a potential HIPAA violation

2. Supplemental NOL is required for any matter:
   a. Reserved in excess of 25% of the per-claim or per-occurrence limit of liability of the Applicable Underlying Insurance, or;
   b. Cases that have a demand in excess of the underlying available limit;
   c. Cases in a policy year that is close to aggregate exhaustion or is exhausted.
   d. Any file in which the Excess or Reinsurance Carrier has requested to follow.

- A current CSR should be sent to the appropriate carrier(s) by the Claim Representative. Consideration should be given to expense reserves and/or payments if such reserve or payment reduces the underlying insurance (inside the limit). The email and CSR should be sent to the general email box for the carrier and/or the assigned Claim Representative if known. Claim Representatives should request email confirmation that the email was received.

- **Quarterly reports should also be sent until such time as the matter has resolved.**

- **Reporting should be documented in the Reimbursement module for the specific claim. These reports should be designated "supplemental NOL" until such time as the case resolves and a "final NOL" is sent. A copy of the email to each excess or reinsurer should be attached as well as the carrier's acknowledgement of receipt.**

G. Report Request Process

1. **All reports needed from Trideo or by a Client must be requested. Any and all reports that go outside of VCM must follow the below process:**

   To request a report, the Report Request form which is in the appendix, should be completed and emailed to vcm.admin@vcm-llc.com.

   All reports will be formatted using consistent verbiage and format and all requests will be documented in order to provide statistics on the type and amount of reports we are generating for each client companywide.

Claims Process - File Management and Diary

All claim dashboards in Trideo will be reviewed and monitored by your Claim Manager (Supervisor) weekly to ensure compliance with these deadlines as well as those stated in the client specific claims procedures.

A. <u>Initial report</u>

- Completed within 30 days of the opening of the claim.
  - All tabs and fields in Trideo must be filled in with all knowledge available during initial set up and during the course of the investigation. This includes adding all defendants and witnesses to their corresponding tabs.
- Summary of loss known to date
- Plan to complete investigation
- Reserve Recommendation/Review

B. <u>Liability Analysis/Claim Summary Report</u>

1. **<u>Done at 90 (ninety) day intervals following file setup. A task for 90 Day CSR (form is located in the appendix) should be set, based on report date, via the "Tasks" section of Trideo on every file.</u>**

2. **<u>Update Liability Analysis tab every 90 (ninety) days until closure of the file</u>**

   a. <u>Facts – While this is self-explanatory proper completion should include:</u>

   - The names of all medical providers mentioned in the claim or suit;
   - Identification of the date of loss;
   - Identification of the medical care rendered by each insured medical provider:
   - The injury(s) and the allegation of negligence should be noted

   <u>b. Updates – What has occurred or about to occur in the litigation or claims process.</u>
   <u>c. Recommendation – What are your mental impressions opinions and conclusions? What is the value of the case? What is your reserve recommendation for both indemnity and expense? Are there excess reporting issues or exposure?</u>

   <u>The flag for discussion box must be checked prior to saving the Liability Update tab if this case is one to be reviewed with the client.</u>

3. **<u>There should be no blank fields on the completed CSR. That means that all of the fields that pull into the CSR from Trideo must be completed and updated as the case develops.</u>**

4. **<u>Update Liability Analysis tab every 90 (ninety) days until closure of the file. Again this review should include a review of all fields previously completed to be certain that the information remains accurate as the case develops.</u>**

Claims Process - Litigation Management

1. **<u>Defense firms are pre-approved by the client at the time they begin their contract with VCM. Litigation Guidelines have been drafted by VCM and are recommended to the client at the time of retention of the firms. The client makes the decision whether to accept and utilize the Litigation Guidelines. A copy of the Litigation Guidelines and the Billing Matrix, if applicable, for your clients and accounts will be made available to you on the Common Drive under the Program name.</u>**
   - Approved firms are set up in Trideo with a pre-approved panel of attorney and rates.
   - Attorneys not approved and set up in Trideo will not be able to bill on the file.
   - If accepted by the client, VCM sends the Litigation Guidelines and/or the Billing Matrix to each defense firm on the clients list of panel firms.
   - VCM will also send retainer letters (either once or by file as approved by the client) as well as an acknowledgement to be signed and returned by the Lead Partner for the firm. The Acknowledgement must be returned to you prior to the firm being paid for any invoices submitted through Trideo.
   - The guidelines and/or matrix are often edited, reviewed and customized by the client. All edits and changes must also be sent to the firms with a new acknowledgement signed.
   - Budgets may or may not be required by the client. If they are they should be carefully reviewed in accordance with the Guidelines and Matrix before being approved.
   - Issues regarding the failure of counsel to follow the Litigation Guidelines and/ Billing Matrix should be discussed with the client before any action is taken. Your recommendation should be documented in the claim file in Trideo under the note category Invoice Documentation.
   - The Client will make the final decision regarding any billing issues. The notes in Invoice Documentation should reflect all communication to and from the client regarding their decision about the invoice and our recommendation.
   - To add new attorneys to the panel, the firm should send a CV to the client and VCM for approval.

2. **<u>If a client is utilizing the Billing Matrix, then the process to review invoices is as follows:</u>**
   - Export the invoice to excel and drop in the following two columns
     - One next to "Code" titled "Correct Code"
     - One next to "Hours/Units" titled "Corrected Hours/Units"
   - Compare each line item to the Matrix for use of correct coding based on description of activity performed, and correct the coding as necessary
   - Compare hours/units to the correct code of the matrix and adjust the hours/units to the allowable amount indicated on the matrix
   - Save the excel spreadsheet with claim number and invoice number and upload to a note in the claim file, viewable by claims only, with a notification to the

assigned claim representative (if review completed by other than assigned claim representative)

- Claim representative to review corrections/adjustments and make judgement calls based on his/her knowledge of the particulars of the claim, and/or call defense counsel for clarification as needed.
- Uploaded final adjusted invoice to a note in Trideo, viewable by all, with a dashboard notification to defense counsel
- Reject invoice so that defense counsel can make required corrections and resubmit
- Compare resubmitted invoice with final adjusted excel spreadsheet and approve as appropriate.

3. **If a client has opted not to require the Litigation Guidelines, the Claim Representative will use Best Practices when dealing with counsel and billing issues.**

4. **Defense counsel will submit legal invoices and vendor invoices into Trideo pursuant to the Litigation Guidelines, Trideo Manual and Claims Procedure Manual.**

   - The Litigation Guidelines will contain specific billing criteria including specified costs for copying and mileage.
   - Documentation for expenses is required
   - Trideo uses ABA codes
   - Defense firms enter invoices electronically into Trideo.

5. **Legal Invoices are paid once month. Vendor invoices are to be paid by the firm and submitted on their monthly legal invoices. Payment may be made by VCM or for some accounts directly by the client.**
   - Some clients have carved out a threshold for firms when fronting expenses. Please be sure to be familiar with the Claims Procedures for your client programs to know whether these thresholds have been established or not.

6. **All information in the Suit Information tab of Trideo should also be kept up to date as the case evolves. Be sure to add the key dates if defense counsel does not so all reports to the clients for trial and medication calendars are accurate.**

Claims Process – File Resolution

A. Settlement

1. **Settlement is at the discretion of the client. Successful resolution should be the product of team effort by the client, defense counsel and VCM Claim Representative and/or Manager.**

2. **All settlement offers, demands and authority provided to defense counsel shall be documented in the Settlement/Disposition tab in Trideo.**
   - The final offer (settlement amount) must be marked as "Accepted" in the Settlement and Negotiations tab

3. **Prior to settlement discussions you need to consider:**
   - Medicare, Medicaid liens and CMS implications
   - Aggregate Erosion and available settlement funds.
   - Release language and non-disclosure agreements.
   - NPDB allocation

4. **All settlement agreements must be added to the disposition tab with the settlement amount as an approved amount in the financials tab of Trideo when the settlement is reached not when the check is paid.**

5. **Be sure to check the "Is Resolved" box on the Claim Summary tab of Trideo as well.**

6. **Indemnity checks may be issued by VCM or by the client. However, copies of all indemnity checks should be posted in the Trideo file.**

B. Settlement without Payment

Cases that are resolved without payment should reflect the method of resolution. Certificate of Discontinuance, Motion for Summary Judgment, Defense Verdict etc. should be documented in the file. The "is Resolved" check box should be ticked on the Claim Summary tab at the time the resolution of the file is made known to the VCM Professional. A disposition should be added to Trideo for these cases as well. Trials
All involved parties need to be notified of any trial dates. It is the responsibility of the VCM Claims Representative to update any excess carriers/reinsurers of the impending trial and keep them up to date via defense counsel.
All trials will be noted in Trideo's Suit Information Tab and updated with the most recent trial dates. All results should be documented in the "Negotiations/Disposition" tab.
If the Litigation Guidelines require counsel to communicate with you at the end of every trial day – be sure to get that communication so that you can make proactive suggestions through the course of the trial.

C. NPDB and CMS Reporting

1. **If a payment has been made on behalf of a Medicare recipient, VCM on behalf of the client will file a Section 111 report on the due date for the client for quarterly reporting.**

The Claim Representative is responsible for filling in the data in that report. The Compliance Officer will review and submit the quarterly report.

2. **If the settlement or verdict payment is made on behalf of a licensed medical Practitioner as defined by the NPDB, a NPDB report should be submitted within 30 (thirty) days of payment of the settlement or verdict. After approval by the client the proposed NPDB should be sent to the Compliance Officer for review and submission to the NPDB and the State Reporting Agencies.**

D. Claims Process – Payment Process

VCM issues Indemnity checks and Expense payments on behalf of some of its clients. See the attached Appendix document "Payment Procedures per Client". Regardless of whom issues the check, VCM has contracted to provide updated and correct financial information via quarterly loss runs. The VCM Claim Representative is responsible for understanding and following the payment processes to ensure accurate financial reporting for their clients.

1. **Expense Payments**
   - Invoices from Defense Counsel are submitted to VCM by the law firms through the claims system and are reviewed by the claim representative for accuracy and reasonableness in comparison to the litigation budget and guidelines maintained on the system.
   - Invoice from third parties (i.e. expert witnesses and court reporters) if not paid by the defense firm per Claims Procedures, are also submitted into the claims system, either by the law firm or by the claim representative.
   - All invoices submitted must contain the Tax ID number of the party seeking payment through the client program. All Vendor and Legal invoices must have a W-9 attached.
   - All invoices to be submitted to the client for approval in any given month must be reviewed and approved on the system by the claim representative no later than the next to the last business day of each month.
   - VCM will pull from the claims system, a monthly report of all invoices submitted to each client program, and prepare a report to the client for approval of the expenses. The expense report will include information identifying the claim that the expense is connected to; the vendor name and Tax ID Number, as well as the amount submitted and the amount approved by the claim representative managing the file.
   - The expense report, along with supporting invoices (if the client is issuing their own checks), is then forwarded to the client contact for approval. The expense report and invoices (if applicable) will be housed in the Trideo Admin System.
   - Once the client approves the expenses, funding is initiated. The funding instructions are client specific and are maintained in the client specific claims procedures. .

- Once the Client Escrow Account is funded, VCM will issue the vendor and legal expense checks.
- The expense check numbers and dates are then noted on the claims expense report and the checks are forwarded to vendors.
- VCM provides monthly reconciliation reports to each client program for all expenses paid through a VCM managed Client Escrow Account.
- Vendor and law firm expenses are paid once a month based on approval given by the Claims Representative during the prior month. There is a minimum 45 (forty-five) day turnaround for the processing of expense payments.

2. **Medical/Other Indemnity Payments**
   - Medical Indemnity payments are paid as submitted, based on receipt of written approval by the client and all necessary settlement documentation. . Medical/Other Indemnity payments are processed outside of the monthly expense payment process.
   - All Medical/Other Indemnity payment requests made through the Claims Representative must be forwarded to the Client Systems Coordinator in the home office for process for payment.
   - Upon receipt of a written authorization of the client, along with correct social security number, the Client Systems Coordinator will immediately take steps to assure that there is adequate funding in the Client Escrow Account.
   - Once adequate funding is assured, the medical/other indemnity check is prepared, reviewed and signed by the Senior Vice President, CCMSI VCM Division Leader. In the event it is an amount in excess of $10,000, the check is also signed by the CFO of CCMSI.
   - The Medical/Other Indemnity payment in the claims system is noted with the check number and payment date and the payment is sent to the proper party.

3. **Indemnity Payments**
   - Indemnity (Settlement) payments are paid as submitted, based on receipt of written approval by the client and all necessary settlement documentation. Indemnity payments are processed outside of the monthly expense payment process.

   - All Indemnity payment requests issued directly by VCM must be posted to the Trideo file by way of Note forwarded to the appropriate Claim Manager and VCM Finance. Attached as an Appendix are detailed instructions;
     - "Appendix E - Internal Indemnity Payment Process"
     - "Appendix C - Check Request Authorization Form Instructions"
     - "Appendix G - Indemnity Process Closing Checklist"
     - "Appendix H – Claims Manager Approval Checklist"

   - When Indemnity check requests are made, the following must be included in the note sent to Finance via dashboard:

a. Original, unsigned PDF version of the check request(s)
b. Signed PDF check request(s)
c. Any and all paperwork required for settlement purposes, included but not limited to:
    - Receipt(s) – Must equal amount requested)
    - Settlement agreement with all signatures
    - CMS and other lien documentation
    - General release (as required)
    - Letters from defense and/or plaintiff attorneys, client claimant etc.
d. Current signed W-9

- The Claim Representative will:
    a. Attach a copy of the Release and signed Client Approval Form and check payment instructions to the note.
    b. Enter the appropriate disposition on the "Negotiations and Disposition" tab in Trideo.
    c. Enter the appropriate payment amount on the financial tab
    d. A separate disposition/payment amount must be entered for each check that is to be issued.
    e. The global amount of the settlement will be entered in the TPOC field.
    f. Obtain a W-9 form for each payee including Plaintiff's attorney.
    g. Claims Procedures may call for additional Client Specific Documentation

- If a client program does not maintain a Client Escrow Account through VCM, the client specific claims procedures will contain specific instructions for the submission and payment of expenses and indemnity payments through the client's preferred payment process.

- Clients that issue their own Indemnity Payments will be instructed to forward a copy of the check to the VCM Claim Representative who will enter the entire payment into the financial section of the file, along with a copy of the signed Release.

Claim Process - Closing the File

1. **The Claim Representative should complete a comprehensive note outlining the details of the global resolution including the allocation among all defendants of any indemnity dollars paid. For a shared limit file each defendant should be identified and the amount being paid on their behalf.**

2. **Documentation of settlement including the signed Release and/or other documents reflecting the reason for payment (verdict slip, mediation agreement, annuity documentation, arbitration order, discontinuance of suit, client request to pay without release).**

3. **Copy of the signed Check Authorization from Client (for clients for whom we issue checks). Copy of the email from the client approving a payment without a release.**

4. **Filled-in financial tab for the approved payment including the global TPOC amount.**

5. **For clients who issue their own checks; a copy of the check posted to notes. The financial tab should be filled in completely with payment information.**

6. **Completed and filled in defendant tab reflecting who is paying what and who has been dismissed. Especially important for insured defendants in shared limit cases. Compliance Officer uses this information to respond to medical credentialing requests.**

7. **Copy of the discontinuance or other document ending the litigation. Most important for all insured defendants for whom we are NOT making a payment. The file should clearly reflect the non-payment or payment for credentialing purposes.**

8. **Complete note on the need for NPDB reporting or more importantly why NPDB reporting is not necessary.**

9. **Copies of the filled in NPDB form. For most clients the Compliance Officer will post the final submission and fill in the report date on the Claim Summary Tab. If the client submits the NPDB it is important to follow up and confirm that the report was filed.**

10. **Completed Quarterly Report in the CMS Module for payments made to Medicare Beneficiaries.**

11. **Note to defense counsel requesting final bills within 90 days.**

12. **Notice to excess or reinsurer as needed or indicated regarding the final resolution of the case.**

13. **All files with a disposition, whether temporary or permanent, must have one of the following dispositions added under the Negotiations & Disposition tab. The, "Is resolved" box, located in the Claim Status tab must also be checked.**

    - Dismissed/Discontinued without prejudice
    - SJM
    - ORM's without release
    - Settled with release

A. The CPM for each client will direct the frequency, attendees and format of Claim Reviews.

1. In general these are held once a quarter at the client's facility. Attendees may include the following either in person or by phone; the Claim Representative(s) and/or Claim Manager; the primary client contact(s); Board members of the client, CFO or personnel with reserving and settlement authority and Defense counsel.
    - VCM strives to conduct at least two (2) of the claim reviews per year in person.
    - At least one (1) claim review per year will be attended by the Claim Representative's direct supervisor or Account Manager.
    - The scope of the Claim Review is at the discretion of the client and may include; a review of all open matters; select or high risk claims; review of suits only; review of suits or claims reserved at a certain level or severity; cases on a trial list; resolution of cases.
    - The Claim Representative is responsible for proactively identifying cases to be reviewed in the quarterly meeting.
    - Prior to the quarterly meeting (see processing times and process below) the Claim Representative will prepare an agenda and/or index of the claims to be discussed. Pursuant to the clients wishes the Claims Representative will provide updated Claims Summary Reports for the files to be discussed.

B. Processing Times for Meeting Materials

1. Claims Meetings Materials:

- Materials for Claims Meetings need to be received by the administrative staff at VCM **30 days** prior to the meeting.
- Materials will be provided to the client for internal review **within 15 days** prior to the meeting.
- Delivery of final reports will occur **7 days** before the meetings to client and internal staff. Most clients require the materials to be delivered a period of time prior to the actual meeting.

2. Board Meeting Materials:

- The Account Manager will let the Client Services Manager know when the reports are needed when the Account Manager gets confirmation of the meeting – **about 30 to 45 days** before the meeting.
- The Account Manager then requires a draft of the books **about 14 days** before the meeting to add her analysis and changes. She does her review and makes any changes before the client requested review.
- Then, the materials need to be delivered to the Captive Manager **7 days** before the meeting so they distribute the materials to the board and attendees of the meeting.

C. Requesting Meeting Materials from Home Office

a. The interactive Materials Request Form should be completed by the Claim Representative and sent to the Administrative Assistant
b. Unless the client prefers otherwise and it is specified on the form, each booklet will be bound book-style using our binding machine with a clear cover, a disclaimer, a cover page, an Excel Index for each section, and tabs dividing each section.
c. An Excel index will act as the index for each section.
d. The index should include the claim number, last name, first name, indemnity reserve, indemnity paid, expense reserve, and expense paid, sorted in alphabetical order by claimant last name.
e. A sample index can be found on the Common Drive under _Master FORMS > Materials Request Form

Audit and Compliance

A. VCM Managers will conduct audits of VCM files assigned to each Claim Representative to ensure that employees maintain files in accordance with the Best Claim Practices contained both in these procedures as well as the individual program claims procedures and litigation guidelines. The VCM Internal Audit Form is annexed to these guidelines. These internal audits shall include but are not limited to the following:

1. Compliance with file set up timelines and procedures.

2. Proper coverage determination including policy year selection, policy type (GL v OCC), coverage form and ROR is indicated.

3. Completed and updated data entry in all Tabs of Trideo.

4. Compliance with client directed reserving.

5. Prompt conflict check and assignment to counsel.

6. Review with client if indicated as part of the CPM for that client.

7. Compliance with 90 day CSR diary.

8. Compliance with settlement procedure and completed financial documentation.

9. Prompt review and processing of legal and third party vendor invoices.

10. Compliance with setting appropriate tasks for proper adherence to diary and with claim handling in accordance with Best Practices.

CCMSI

Exhibit 4 – Jefferson Parish Special Account Handling Guidelines

CLIENT SPECIFIC INSTRUCTIONS
JEFFERSON PARISH

Key Contacts:

Maria Leon, Director of Risk Management
mleon@jeffparish.net
1221 Elmwood Park Blvd.
Suite 315
Jefferson, LA 70123
504-736-6907

Frances Buckman
FBuckman@jeffparish.net
1221 Elmwood Park Blvd.
Suite 315
Jefferson, LA 70123
504-736-8372

Brian Verrette
bverrette@jeffparish.net
1221 Elmwood Park Blvd.
Suite 315
Jefferson, LA 70123
504-736-6910

Claim Management:
Effective 5/1/2019 all claims will be managed and handle out of CCMSI system. CCMSI will continue to print checks, request funding, balance bank statements and reconcile escrow, provide monthly check register, yearly 1099's

Lines of Business Serviced
General Liability, Automobile Liability, Professional Liability
Workers Compensation, Property, Public Officials, SELA

Initial Reports
The client will entered all new incidents in iCE as a "claim" or and "report only" for all coverages.

Public Officials (POL) incidents will be reviewed by the client on a case-by-case basis relative to the current Commercial POL policy:

1) Claim coverage is excluded (fully self-funded)
    a. Unlimited reserves; no deductible applies.
    b. Enter claim into CCMSI's iCE claims system.
    c. At iCE claim reporting set-up, **client** user selects "Program" = "Self-funded".
    d. TPA does not report to the commercial insurer.
    e. TPA sets reserves **(as instructed by client)** and manages the claim until closure.
2) Claim coverage is not excluded (Commercially Insured)
    a. Limited reserves; deductible applies.
    b. Enter claim into CCMSI's iCE claims system.
    c. For iCE claim reporting set-up, **client** user selects "Program" = "Commercially Insured Tracking".
    d. TPA provides no reporting to a commercial insurer; JP RM Dept reports a claim to its commercial insurer based upon if the claim is expected to exceed the current policy deductible ($250K deductible).
        i. If Yes, then reported to commercial insurance carrier
            1. TPA does not manage the claim; TPA sets expense reserves **(as instructed by client)** only.

2. Insured uses iCE to pay expenses/legal fees & to track expenses for reimbursement from the carrier.
3. Insurance carrier sets the reserves; this incurred value is not available to the insured on a loss run until the claim is closed.

ii. If No, then TPA **conditionally** sets reserves **(as instructed by client)** and manages the claim until closure.

Banking/Check Issuance:
The client will establish 2 bank accounts at its financial Institution – Capital One. We will reconcile the bank accounts. Monthly copies of the bank account statement and of the reconciliations are to be emailed to Frances Buckman fbuckman@jeffparish.net and Jeannine Ureta jureta@jeffparish.net. For both accounts, e-mail Frances Buckman fbuckman@jeffparish.net and Jeannine Ureta jureta@jeffparish.net when a check in excess of $50,000 is to be issued. All checks require 2 laser signatures – we will use Bryan Thomas and John Kluth. Monica Moretto will reconcile the bank accounts and will request replenishment

The accounts are:

1. Jefferson Parish, Workers Compensation Claims Fund
   Administered by CCMSI

2. Jefferson Parish, Liability/Property Claims Fund
   Administered by CCMSI

All checks will be printed in CCMSI's corporate office; WC checks will print on Tuesdays and Thursdays, NON WC checks will be printed daily.

1) For any special funding, e.g. large check over $50,000, email is to be sent to Monica Moretto mmoretto@ccmsi.com who will request funds as outlined above. The email needs to include the claimant name, claim number, amount of check and date of loss. (We can do this on the front end when we know about the check, and the adjusters will need to review their payment screens before releasing checks to see what has downloaded.)
2) **CCMSI Treasury only** - CCMSI will send the advance funding to the client if our records reflect the available funds are less than $150,000.

Reserve Recommendations

The adjuster is to email a brief reserve rational to Brian Verrette on reserve increases of $75,000 or more

Settlement Authority
CCMSI has $10,000 settlement authority for Liability and Property Lines.
CCMSI has $10,000 settlement authority for Workers Compensation.

Anything above that should be submitted to the-Risk Manager, Maria Leon, with a settlement evaluation and a request for authority.

Any proposed settlement over $40,000 must be approved by the Parish Council.

Excess/Carrier Reporting
Workers Compensation claims – adjuster is responsible for excess/carrier reporting to include follow update as dictated by the carrier adjuster.
Liability claims – Claims where the adjuster identifies as meeting excess reporting requirements are to be discussed with Brian Verrette. Brian Verrette will submit the initial reports to the excess/carrier and will provide a copy of the report to the handling adjuster. The adjuster is to provide update status reports as dictated by the carrier adjuster.

SCHIP/MSA/CMS

All SCHIP reporting requirements are through CCMSI. Medicare quires are automated into the claim notes. The adjuster is to go to the "Medicare" heading for the query results. Conditional payment research is required on all settlement of $750 or more.

MSA – Examsworks, Inc

Loss Notices/Initial Contact

W/C Loss notices will be entered into ICE by Brian Verrette as a claim or report purposes only. A claim number or report purposes only number will be generated automatically once submitted in ICE.

A diary for the supervisor is also set automatically upon submission of a claim for initial review, assignment to an adjusters depending on complexity and provide initial instructions.

The adjuster will make initial contact Brian Verrette on new claims involving lost time or questionable to complete the investigation. Request the post-employment medical questionnaires for Second injury Fund from Brian Verrett if the claim appears to have potential for a Second Injury Fund approval.

Auto & General Liability claims will be entered by Brian Verrette into ICE. Brian Verrette will send incident only, report purposes only, to CCMSI to enter into ICE. CCMSI is to discuss entering claims/incidents into ICE if noticed is received by CCMSI without client's knowledge.

Denials: Notify Brian Verrette via email of our recommendation of the denial of a claim and proceed with the denial. A copy of the denial letter is to be emailed to Brian Verrette.

> Denials/Fire Fighter – Both Brian Verrett and Mike Joseph, mjoseph@jeffparish.net, is to receive a copy of the denial letter sent to the employee.

Payment Entry:
The adjusters will enter their own settlement payments only.
WC adjusters are to enter indemnity payments.
All other payments will be entered by CCMSI's Bill Processing Unit.

VOIDS/RECOVERIES/REFUNDS:
All original checks returned, refund checks and recovery checks are to be given to Tara Melancon. Tara will make a copy of the check and process the appropriate CCMSI form (in form filler). Once Tara completes the form, a copy of the check with the appropriate form will be emailed to Monica Moretto to input into icebar. The actual checks will be given to Karen Thurman with the deposit slip completed by Tara for depositing.
Initial treatment:

Non-emergency treatment:
West Jefferson Industrial Medicine-Westbank
4475 Westbank Expressway Ste A, Marrero, LA 70072
504-347-8741; fax 504-340-2885

West Jefferson Industrial Medicine
107 Wall Blvd Ste A, Gretna, LA 70056
504-433-5070; fax 504-433-5077

Ochsner Occupational Health
3530 Houma Blvd, Ste 201, Metairie, LA 70006
504-779-2667; fax 504-889-7120

Service Standards:
CCMSI Best Practices will apply unless otherwise instructed by the client, Jefferson Parish.

W/C Specific Instructions:

Wage information – All employees, except the Fire Department, email Karen Lachute klachute@jeffparish.net, Keyon Kent kkent@jeffparish.net and copy Shea Green SGreen@jeffparish.net

First Indemnity check:

Send an email to Shea Green, Karen Lachute and Keyon Kent (and Ali Mutz if FD) when entering the first indemnity check to the employee. Employees name, check amount, the pay period and the date the check will print are to be inclued in the email.

Contact Brian Verrette 736-6910, bverrette@jeffparish.net for the following:

Availability of Light Duty
An Employee pre-employment medical questionnaire for SIF purposes is to be requested IF the potential exist to qualify for Second Injury Fund.
Subrogation approval

Fire Fighters
Wage information for the Fire Department, email request to Ali Mutz, amutz@jeffparish.net, copy Karen Lachute klachute@jeffparish.net and Shea Green SGreen@jeffparish.net as they will provide the hours per week. Shea 504-364-2880

Indemnity checks should be issued to the firefighter.

All active fire fighters checks will print daily, with a check copies send to Donnell Langley, and mailed to employees directly.

Upon receipt of the fire fighters check copies, CCMSI will email them to Ali Mutz, amutz@jeffparish.net, Karen Lachute klachute@jeffparish.net and Shea Green SGreen@jeffparish.net .

Indemnity checks for firefighters are issued to coincide with the regular pay cycles. Adjust the first indemnity check to get on cycle.

Information on pension offsets for Firefighters on SEB can be obtained from Jason Starnes. Current wages and retirement information can be obtained from Ali Mutz 736-6203 amutz@jeffparish.net . Brian Verrette 736-6910 bverrette@jeffparish.net has information on medical releases, RTW dates, etc.

All firefighters are drug tested post-accident/incident. We will put a process in place to obtain positive drug screen information.

There is no light duty for firefighters. We will send a letter to retired firemen to determine if they have withdrawn from the workforce or are seeking retraining or job placement assistance.

Indemnity Payments
Indemnity checks are issued to coincide with the Parish's regular pay cycles. This applies to all employees. A list of all indemnity payments to be emailed to Brian Verrette bverrette@jeffparish.net every two weeks after checks print. Also inform him of new indemnity payments being made on new claims.

Workers' Compensation –

Send medical releases, RTW date, etc to Brian Verrett
Send medical release, RTW dats, etc to Mike Joseph, mjoseph@jeffparish.net, with a copy to Brian Verrett

Liability files
A separate claim is to be set up for each claimant when there are multiple due to one incident. Each claim should have its own diary and/or action plan review. The legal updates are documented in each companion claim.

Individual companion files are reserved and checks are issued off the companion files.

Files (Open & Closed) will be kept on the clients premises.

Approved Vendors

Vendors for Case Management and Vocational Rehab - obtain the Client's permission

Bailey-McCaffery LLC
1904 Clearview Pkwy Ste A Metairie, LA 70001
504-734-6310; fax 504-734-6311

CoreCare Management
PO Box 1201 Mandeville, LA 70470
504-273-0984; fax 504-556-2827
Couret Rehabilitation Consulting, LLC
Jennifer Couret
PO Box 664 Destrehan, LA 70047
(504) 473-6923

Paul W Jacquillard
1113 Focis St,Metairie, LA 70005-2219
(504) 831-8719

Surveillance:
Obtain the Client's permission for surveillance except for Auto, General Liability or the Fire Dept. On FD claims surveillance is to be initiated once the employee has been out of work for 30 days. For all other departments, were the employee is out of work for 30 days or more and there are red flag indicator, surveillance may be considered.

Bill Review
Bill repricing is done by CompMc
Precertification
Precerts by Novare (effective 3/18/2021)
Pharmacy Vendor:
Mitchell/PMOA– mail order and retail/card program. The adjuster is to activate the drug card ICEBAR and deactivate if claim has been denied or settled.

Defense Counsel:
The Client's Law Department will assign non-W/C claims to the counsel of their choice. CCMSI will consult regarding W/C litigation assignment. For the most part, these claims are handled by Connick & Connick, 2551 Metairie Road, Metairie, LA 70001
(504) 838-8777

Indexing
WC claims are to be reindexed every 12 months. Liability BI claim are indexed once the adjuster secures a social security number and reindex every 12 months thereafter. All Property Damage claims over $10,000 are to be indexed.

Workers Compensation CRA
Per the client the adjuster is to complete reach out to the client for the Employer History section, however the following questions are to not to be send and should be marked NA

* Does the employee belong to a union?
* Is the employee a good, marginal, or poor employee?
* Any known conflicts with supervisor, management, or co-workers?
* Does the employee have any known financial or legal issues?

Second Injury Fund
RCI handles SIF claims for the parish. SIF reimbursements are sent directly to Jefferson Parish via ETF from La Second Injury Fund, no physical check will be received. RCI will notify us of the EFT reimbursement amounts which will be posted to the financials for the appreciate claim as SIF recovery. Danielle Cabiran will post the reimbursement at the time the RCI invoice is processed. .

Subrogation
Jefferson Parish attorneys will handle some cases for pursuit of subrogation. We are to email James Roth, jroth@jeffparish.net, Shelly Samrow, ssamrow@jeffparish.net, and Reed Smith, rsmith@jeffparish.net and copy Brian Verrette on all emails to them. Recovery checks should be made payable to Jefferson Parish Pooled Cash.

Claims Administration fees

CCMSI claim administration fees are paid monthly and requires an "AFFIDAVIT "to be included with our invoice.

CCMSI

CCMSI

Exhibit 5 – Data Disaster Recovery Plan

CCMSI

Data Center Recovery Plan

283

CCMSI®

Table of Contents

2

Emergency Contacts

I. Emergency Contacts

Reviewed/Updated – February 8, 2022

CCMSI Information Systems provides services that, in some manner, virtually every other team at CCMSI are dependent upon. Without telephones, data networks, or any of several critical servers, some aspect of our business would be negatively impacted. In recognition of these dependencies, it is critical that the Information Systems Team is prepared to respond to a Significant Business Disruption (SBD) in an orderly, timely and efficient fashion.

Our Data Center Recovery Plan describes the process that the Information Systems Team will use in the event that a SBD affects CCMSI operations and services. It includes an identification of the services most critical to company operations, and how these services will be reconstituted following a disaster.

Our primary emergency contact persons are:

- Rodney Golden – Chief Operating Officer
  Phone 217-444-1127 / Cell 217-474-7041
  rgolden@ccmsi.com
- John Kluth – Chief Financial Officer
  Phone 217-444-1115 / Cell 217-390-7924
  jkluth@ccmsi.com
- Rhonda Stuebe – VP, Human Resources
  Phone 217-444-1172 / Cell – 217-714-1880
  rstuebe@ccmsi.com
- Bill Spicer – VP, Technology Systems and Information Security
  Phone 217-444-1339 / Cell – 217-260-0021
  bspicer@ccmsi.com
- Kristin Meeker – VP, Application Development
  Phone 217-444-1286 / Cell – 217-649-4179
  kmeeker@ccmsi.com
- Chris Dupuy – VP, Enterprise Architecture
  Phone 504-883-8467 / Cell – 225-327-4833
  cdupuy@ccmsi.com
- Tracy Reynolds – Facilities Manager
  Phone 217-444-1249 / Cell – 831-262-5608
  treynolds@ccmsi.com

CCMSI Policy/Business Description

II. CCMSI Policy

CCMSI has developed a Data Center Recovery Plan (DRP) on how we will respond to events that significantly disrupt our business. Since the timing and impact of disasters and disruptions is unpredictable, we will have to be flexible in responding to actual events as they occur. Our policy is to respond to a Significant Business Disruption (SBD) by safeguarding employees' lives and our property, quickly recovering and resuming operations and allowing our clients to continue to transact business.

Significant Business Disruptions (SBDs)

Our plan anticipates two kinds of SBDs -- Local and Regional.

Local SBDs affect only our ability to communicate and do business from a specific office location. Examples of Local SBDs include a fire or gas leak in our building, or a loss of data connectivity. Regional SBDs prevent the operation of all, or most, businesses in a geographic area. Examples of Regional SBDs include a tornado/hurricane, terrorist attack, a flood, or a wide-scale, regional disruption.

Regional SBDs can vary in their scope, impacting only CCMSI, a single office building housing a CCMSI office, a business district where CCMSI is located, the city where our office are located, or the whole region (potentially impacting multiple CCMSI office locations).

Within each of these areas, the severity of the disruption can also vary from minimal to severe:

Plan Location and Access

Our firm will maintain copies of its DRP plan and the annual reviews, and the changes that have been made to it for inspection. An electronic copy of our plan is located on the CCMSI "O' Drive in the Business Continuity-Data Center Recovery Plans Directory.

III. Business Description

CCMSI is an insurance third-party administrator. The majority of our employees administer claims for self-insured programs –both groups and individual employers.

Our local offices (outside of corporate headquarters) typically have narrow operational responsibilities and are generally limited to the administration of claims for self-insured programs. Other services provided by the local offices would be incidental to the administration of claims, such as nurse case management, utilization review and loss control services.

Corporate functions including Human Resources, Accounting, Information Systems, Underwriting, Central Indexing, Central Processing and Excess are located in the CCMSI Danville location. The Customer Service and EDI Units are located in the Metairie office location.

CCMSI provides services to only business clients.

IV. Scope of Plan

This DRP identifies areas of substantial risk and exposure to disaster, and provides Information Systems with the ability to restore CCMSI core information systems in the event of a SBD.

This DRP is not intended to be a detailed, step-by-step series of instructions to follow. Rather, it is intended to be a roadmap to lead the recovery team from the SBD, through a clear decision making process, to implementation of restored services. Although it is targeted at the most likely types of SBDs that could be encountered, it may be adapted as necessary for recovery from othersituations.

SBD Scenarios

The main focus of the DRP is recovering from a SBD that involves our CCMSI Data Center. Likely Local SBDs include fire, tornado damage, water or gas leaks, and major snow events. Likely Regional SBDs include tornado damage and major snow events.

CCMSI houses its core systems in the Data Center located in the CCMSI Danville office location. A Backup Data Center for network and server recovery is located in Indianapolis, Indianapolis. All data is replicated to our Backup Data Center.

V.Current Practices and Procedures

An understanding of the fundamental business practices currently followed by Information Systems is essential to recovering operations. The key practices include:

- Fault Tolerant Data Center
- Data Backup and FaultTolerance
- Replication and Backup DataCenter
- Critical Systems

A.Fault Tolerant Data Center

The Data Center at CCMSI is protected by a fire suppression system. The room also has a panel driven battery backup system that is also supported by a natural gas generator in case of power outage. Auto dialers call technicians when temperature exceeds threshold, battery or generator activation or fire suppression activation.

B.Backups and Backup Data Center

Full backups are performed nightly on all servers to multiple disk based vaults for redundancy. One vault resides in Danville and the other resides in our Backup Data Center in Indianapolis. Database servers are backed up hourly. Key servers across all platforms are included in the backup schedule. All servers are also replicated daily to our Backup Data Center in Indianapolis.

Servers are configured with fault-tolerant technology to provide failover in case of failure.

C.Critical Systems

The systems, services and functions identified as necessary to current business operations are documented and located on the Danville file server under Disaster Recovery folder. This folder is also replicated to our Backup Data Center in Indianapolis, IN.. Some systems listed are located outside of our corporate office in Danville, but are listed here due to their dependency at CCMSI. Without awareness of these remote systems, it is possible that an oversight during a restoration could result in a continued outage at a remote site.

VI. Recovery Operations

Re-establishing operations after a disaster requires:

- A recovery process to utilize as a guide for recovery activities
- Identification of the most critical services
- Priorities for re-establishing those services
- System configuration information

A. Recovery Process

The recovery process consists of two basic phases:

- An initial reaction phase where notifications are made, the staff assembled, information gathered, and an action plan developed.
- The recovery phase, where resources are acquired, data recalled, and services are restored as much as possible.

The steps to be followed are:

1. Notification of the Emergency Contacts listed above. Each of these people will notify others, as appropriate.

- Information Systems team members
- CCMSI executives and Regional VPs
- Local authorities (911) in the event outside assistance is necessary

2. Initial organization and preparation for the recovery:

- Notify & assemble the recovery team (Tech Services, Data and Development)
- Review the DRP with the recovery team
- Organize for damage assessment
- Establish communications systems for the recovery team
- Assign duties and responsibilities to the recovery team

3. Perform a damage assessment:

- Conduct a site survey of the affected area
- Inventory any salvageable or usable equipment
- Compile a master inventory of salvageable equipment
- Review the overall damage with the recovery staff

4. Plan for recovery:

- Develop a detailed action plan
- Determine if full failover to Indianapolis is necessary
- Communicate status to executive staff
- Notify the appropriate vendors and service providers

5. Re-establish services in their order of priority:

- Priority 1 services
- Priority 2 services
- Priority 3 services

B. Critical Services Identification & Recovery Priorities

Recovery operations are prioritized based on company needs. These priorities have been determined to be as follows:

Priority 1

- Circuits (MPLS /Internet/Azure)
- Firewall Changes
- DNS Changes (Internal/External)
- Systems
- Hardware
- Failover to Backup Data Center in Indianapolis if needed.
- Domain Controllers,
- VMware Servers (Applications/Web)
- SQL Servers
- DNS Changes

Priority 2

- Re-establishment of Mission Critical Systems (Refer to Business Continuity Plan)
- Critical Areas: Accounting, Payroll, Indexing Unit, Treasury Check Printing

Priority 3

- Re-establishment of all remaining services

C. System Configuration Information

The services listed above will require configuration to restore reasonable levels of service. The information, data, applications, and instructions required for this are:

- Administrative passwords for servers, applications, and network hardware. This information is currently located at our Backup Data Center in Indianapolis.
- Configuration information for existing critical systems. This knowledge is currently shared across the Tech Services staff, with documentation in place. This information is located on our secure Danville file server as well as replicated to our Backup Data Center.
  Future documentation will be stored here as it is developed. This directory will be included in the backup and replication schedule to ensure the information is present for recovery purposes. .
- Media containing operating systems, applications, and licenses are stored at our Backup Data Center in Indianapolis. This information can also be downloaded from our vendor support portals.

All other applications will be obtained from normal vendors.

VII. Recovery Time

CCMSI has built redundancy into our systems to reduce downtime and recoverability in case of a SBD. With redundant near line servers and Backup Data Center in Indianapolis, CCMSI's expected recovery time is less than 12 hours.

VIII. Plan Testing

Testing the DRP is essential to ensure the success of business recovery and is a key element of preparedness. This will help ensure that not only the procedures are adequate and systems are capable but that the team members are properly trained.

The VP of Technology Systems will schedule recovery tests on a biannual basis and is responsible for reporting the success or failure of any element of the process. If there is a failure or issue in any area the recovery, the VP of Technology Systems will work with the relevant subject matter experts to evaluate the issue, make changes as needed, and reschedule the testing if required. In any event, any issue encountered during the recovery test must be documented and addressed.

Tested areas of the plan must include at least the following to ensure their recoverability and/or availability:

1. Network Services
2. Recovery of Data
3. Server Recovery

7

Critical Vendors/CCMSI Locations/Updates and Annual Review

IX. Critical Vendors and Service Providers

A. CDW (Computer Discount Warehouse)

Next Day Delivery to anywhere in the US. Same day in some areas. Massive inventory ready for disasters. (Servers, PC's, Network Equipment, etc)

Account Manager: Andy Woerfel
andywoe@cdw.com
312-705-4552

B. Dell Computers

Possible next day delivery if inventory permits. (Servers, PC's, Switches)

Account Manager: Mary Hugo
Mary.Hugo@dell.com
512-513-9404

Technical Support
800-234-9999

Gold Support on nodes
800-234-9999 (option 1) ext. 60301
Gold Support on servers
800-945-3355

C. Lumen (Century Link)

Lumen NOC 877-886-6515 option 1

Account Manager: Chris Dray
773-835-5550
chris.dray@lumen.com

D. Co-Pilot Support Dell/Compellent Storage

866-397-8673
HSN -42219/42220

E. CommVault Support

877-780-3077
CommServ ID - FD929
ma.commvault.com

X. CCMSI Danville Data Center (Headquarters)

Address:
CCMSI
2 E. Main Street, Towne Centre
Building Danville, IL 61832

XI. CCMSI Backup Data Center

Address:
Life Line Data Center
401 North Shadeland Avenue
Indianapolis, IN 46219

XII. Updates and Annual Review

CCMSI will update this DRP whenever we have a material change to our operations, structure, business or locations. At a minimum, CCMSI will review this DRP annually, during the first quarter of our fiscal year, to modify it for any changes in our operations, structure, business or locations.

CCMSI

Exhibit 6 – Business Continuity Plan

CCMSI

Business Continuity Plan

Table of Contents

2

Emergency Contacts

I. Emergency Contacts

Updated/Reviewed – February 8, 2022

We plan to quickly recover and resume business operations after a significant business disruption and respond by safeguarding our employees and our property, protecting our data and records, and allowing our clients to continue to transact business with minimal disruption. In short, our business continuity plan is designed to permit CCMSI to resume operations as quickly as possible, given the scope and severity of the significant business disruption.

Our business continuity plan addresses: all mission critical systems; financial and operational assessments; alternative communications with customers and employees; alternate physical locations of employees; critical vendors; and regulatory reporting.

Data backup and recovery is addressed separately under the CCMSI Data Center Recovery Plan.

Our primary emergency contact persons are:

- Rodney Golden – Chief Operating Officer
  Phone 217-444-1127 / Cell 217-474-7041
  rgolden@ccmsi.com
- Rhonda Stuebe – VP – Human Resources
  Phone 217-444-1172 / Cell – 217-714-1880
  rstuebe@ccmsi.com

CCMSI Policy/Business Description/Office Locations

II. CCMSI Policy

CCMSI has developed this Business Continuity Plan on how we will respond to events that significantly disrupt our business. Since the timing and impact of disasters and disruptions is unpredictable, we will have to be flexible in responding to actual events as they occur. Our policy is to respond to a Significant Business Disruption (SBD) by safeguarding employees' lives and our property, quickly recovering and resuming operations and allowing our clients to continue to transact business with minimal disruption.

Significant Business Disruptions (SBDs)

Our plan anticipates two kinds of SBDs -- Local and Regional.

Local SBDs affect only our ability to communicate and do business from a specific office location. Examples of Local SBDs include a fire or gas leak in our building, or a loss of data connectivity. Regional SBDs prevent the operation of all, or most, businesses in a geographic area. Examples of Regional SBDs include a tornado/hurricane, terrorist attack, a flood, or a wide-scale, regional disruption.

Regional SBDs can vary in their scope, impacting only CCMSI, a single office building housing a CCMSI office, a business district where CCMSI is located, the city where our office is located, or the whole region (potentially impacting multiple CCMSI office locations). Within each of these areas, the severity of the disruption can also vary from minimal to severe.

Plan Location and Access

Our firm will maintain copies of its BCP plan and the annual reviews. An electronic copy of our plan is located on the CCMSI "O' Drive in the Business Continuity-Data Center Recovery Plans Directory and on the company Intranet.

III. Business Description

CCMSI is an insurance third-party administrator. The majority of our employees administer claims for self-insured programs –both groups and individual employers.

Our local offices (outside of corporate headquarters) typically have narrow operational responsibilities and are generally limited to the administration of claims for self-insured programs. Other services provided by the local offices would be incidental to the administration of claims, such as account management, nurse case management and loss control services.

Corporate functions including Human Resources, Accounting, Information Systems, Underwriting, Central Indexing, Central Processing and Excess are located in the CCMSI Danville (Illinois) location. The Customer Service, Compliance and EDI Units are located in the CCMSI Metairie (Louisiana) office location.

CCMSI provides services to only business clients.

IV. Office Locations

The current interoffice Phone Listing is available on the CCMSI O: drive and the company Intranet.

V. Alternative Physical Location(s) of Employees

In the event of an SBD, we will have the following alternatives for our staff, depending on the expected duration of the unavailability of the office location:

- Staff may work from home. All staff have the ability to work remotely if needed. This model was used during the COVID 19 Pandemic where CCMSI employees worked from home for over a year with great success.
- Staff may relocate to a client office location, if available and practicable
- Move our staff from affected office(s) to the closest of our unaffected office location(s) if practicable
- Each location has their own local Business Continuity Plan that identifies alternate facilities to relocate staff as well as call trees, staffing requirements and client contacts.
- Office Relocation

In a disruption affecting our business district, city, or region, we will transfer our operations to a site outside of the affected area, and recover and resume critical business operations within one business day.

The CCMSI Danville office location is the designated primary backup for all other office locations – both short-term and medium-term – to assist in the continuity of normal business operations in the event of a Regional SBD.

We will transfer our operations to an appropriate alternative location or locations (among the alternatives above) and expect to recover and resume critical business operations within one business day.

VI. Data Back-Up and Recovery (Hard Copy and Electronic)

Data backup and recovery is addressed separately under the CCMSI Data Center Recovery Plan.

VII. Operational Assessments

Operational Risk

Operational risk includes the firm's ability to maintain communications with clients and to retrieve key data records through its mission critical systems.

In the event of an SBD, we will immediately identify what means will permit us to communicate with our clients, employees, and critical business vendors. Although the effects of an SBD will determine the specific means of alternative communication, the communications options we will employ will include our website, telephone voice mail, secure email, etc.

.

VIII. Mission Critical Operations

Our firm's "mission critical operations" are those that ensure prompt and accurate processing of transactions and the maintenance of client records.

We have responsibility for establishing and maintaining our business relationships with our clients and have sole responsibility for our mission critical operations.

Recovery-time objectives provide concrete goals to plan for and test against. They are not, however, hard and fast deadlines that must be met in every emergency situation, and various external factors surrounding a disruption, such as time of day, scope of disruption and status of critical infrastructure—particularly telecommunications—can affect actual recovery times.

Recovery refers to the restoration of basic claims processing activities after a wide-scale disruption; resumption refers to the capacity for all claims processing activities, from acceptance of a new claim notification through payment issuance, after a wide-scale disruption.

Claim Notification

CCMSI receives new claim notifications from clients primarily via telephone, fax and the iCE claims application on the internet. During an SBD, either Local or Regional, we will continue to receive new claim notifications through any of these methods that are available and reliable. It is expected that iCE will be continually accessible under any Local or Regional SBD scenario.

We will inform our clients when communications become available to tell them what alternatives they have to submit new claims. Clients will be informed of alternatives by telephone and a posting on the CCMSI website (www.ccmsi.com).

Claim Payments

CCMSI is responsible for the timely payment of claims for our clients. Certain types of claim payments, such as TTD, PPD and Settlements, are considered higher priority and must be handled without interruption regardless of the type of SBD.

The CCMSI Danville office location is designated as the backup to all other office locations to assist in the continuity of normal claim payments for all local office locations. The CCMSI Metairie office location is designated as the backup for the CCMSI Danville office location. BothDanville and Metairie have access, if required, to assume responsibility for claims administered by local offices for the purpose of releasing required claim payments.

The CCMSI Champaign (Illinois) office location is designated as the backup for Treasury Check Printing, which includes the physical printing and mailing of all claim payments.

It is expected that this approach will allow for uninterrupted claims payments under any Local or Regional SBD scenario. CCMSI successfully utilized this approach during Hurricane Katrina and Hurricane Sandy.

Medical Bill Processing

The CCMSI Danville office location is designated as the backup to all other office locations to assist in the continuity of necessary medical bill processing for all local office locations. The CCMSI Metairie office location is designated as the backup for the CCMSI Danville office location. Both Danville and Metairie have access, if required, to assume responsibility for claims administered by local offices for the purpose of medical bill processing. It is expected that this approach will allow for uninterrupted claims payments under any Local or Regional SBD scenario.

IX. Alternate Communications between CCMSI and our Clients and Employees

Clients

We now communicate with our clients using telephone, fax, email, U.S. mail and in-person. In the event of an SBD, we will assess which means of communication are still available to us, and use the means closest in speed and form (written or oral) to the means that we have used in the past to communicate with the other party. For example, if we have communicated with a party by email but the Internet is unavailable, we will call them on the telephone and follow up where a record is needed with paper copy in the U.S. mail. Communications with clients will be made as soon as possible, but no later than 24 hours from the SBD.

Employees

We now communicate with our employees typically using email, telephone and group SMS text messages. In the event of an SBD, we will assess which means of communication are still available to us, and use the means closest in speed and form (written or oral) to the means that we have used in the past to communicate with the other party. We will also employ a call tree so that senior management can reach all employees quickly during an SBD. The call tree includes all staff cellular, home and office phone numbers. A copy of the current call tree for all office locations is located on the CCMSI "O" Drive in the Business Continuity-Data Center Recovery Plans Directory.

In the event of a Regional SBD (Hurricane Katrina, for example), the CCMSI Human Resources Department will prepare a spreadsheet identifying all employees impacted. Human Resources would then publicize (by telephone, email, text, word of mouth, etc.) an 800 number for impacted employees to utilize to contact Human Resources. The employee spreadsheet would be updated as employees make contact with Human Resources so we can contact and assist our employees through the SBD. Employees would be provided with information on the Employee Assistance Plan, the continuance of payroll and any other available assistance.

X. Critical Business Partners

Business Vendors

We have contacted our critical business vendors (businesses with which we have an ongoing commercial relationship in support of our operating activities,), and determined the extent to which we can continue our business relationships with them in light of the Local or Regional SBD. Our primary, time-sensitive, vendor is StrataCare, LLC (for medical bill processing). Our secondary, time-sensitive, vendor is CDW (for computer hardware). We are satisfied that our relationships would continue uninterrupted in the event of any Local or Regional SBD.

Carriers

Communications with insurance carrier partners, if impacted by the SBD, will be made as soon as possible, but no later than 24 hours from the SBD.

7

Regulatory Reporting/Updates and Annual Review

XI. Regulatory Reporting

CCMSI now files reports (primarily required EDI submissions) with regulatory bodies using paper copies in the U.S. mail, and electronically using fax, email and secure FTP via the Internet. In the event of an SBD, we will check with the regulators to determine which means of filing are still available to us, and use the means closest in speed and form (written or oral) to our previous filing method. In the event that we cannot contact our regulators, we will continue to file required reports using the communication means available to us.

XII. Updates and Annual Review

CCMSI will update this BCP whenever we have a material change to our operations, structure, business or locations. At a minimum, CCMSI will review this BCP annually, during the first quarter of our fiscal year, to modify it for any changes in our operations, structure, business or locations.

CCMSI

Exhibit 7 – Internal Auditing Guidelines & Worksheets

CCMSI INTERNAL AUDIT OVERVIEW

CCMSI Audit Team Mission Statement

The CCMSI audit team will serve our clients, claim professionals, and organization as a whole. We will accomplish this by conducting regular claim file audits in each office to assess compliance with CCMSI Best Practices. The audits we perform will be objective and provide constructive feedback to both the individual office as well as CCMSI's executive management. We will assist each office by identifying opportunities for employee development and assessing internal management controls.

Ultimately, our aim is to assist CCMSI in ensuring that we consistently deliver what matters most—a high level of claim service to our clients. Our audit process is reflective of this goal by maintaining a corporate-level quality control program. We believe that our commitment to quality claim service will position CCMSI to take advantage of new business opportunities in the future.

Strategy and Objectives

We plan to annually audit a sample of claims handled by each adjuster, which will be done through a standard method understood by all claims staff. After each review, feedback will be provided to the individual office. If needed, the management of that office will implement Corrective Plans of Action to address any areas identified as needing improvement.

This continuous evaluation of the claims staff, as well as the processes and systems, will be communicated to executive management. This ongoing communication will foster growth and development in the claims staff and management, and will encourage continuous improvement in CCMSI's quality handling of claims.

Goals of the Audit Team

- Ensure compliance with Best Practices, Client Handling Instructions and Carrier Requirements
- Provide an objective audit with constructive feedback;
- Help management and claims staff proactively identify areas for improvement;
- Work with our claims staff to provide solutions to any areas that were identified as needing improvement;
- Foster understanding of our mission with all claims staff;
- Streamline processes to ensure timely delivery of services to our clients; and
- Ensure quality service and value to our clients.

Confidentiality

Audit results are confidential and should not be shared externally without approval of your Regional Vice-President (RVP).

Internal Audit Process

- Each office will be audited annually and advised that this is a continual process.
- The lead auditor will contact the point person in advance to confirm the audit date is appropriate.
- The lead auditor will obtain a current employee list from Human Resources and determine all appropriate staff to audit based on whether they carry a claims load and their date of hire.
- The lead auditor will ask the point person to instruct all adjusters to complete a Pre-Audit Survey.
- The lead auditor will request the point person to complete/update the State-Specific Fact Sheet.
- The audit will include eight to ten files for each adjuster unless additional information is needed. If clear trends are evident after reviewing eight claims, the auditor may elect not to review further files.
- For staff who earned 93% or higher on their last two audits, the auditor will audit four claims and review the score at that point. If the score is 93% or higher, the score on these four claims will be used as the final score. If the score is below 93%, an additional four to six claims will be reviewed for a full audit.
- The claims selected will include those assigned to the adjuster during the time period since the last internal audit. Typically, this will be a date range of the prior eight to nine months in order to finalize the prior audit, and then not within the last one to two months.
- For indemnity adjusters, it is preferred they are assigned the claim from the start or receive the transfer from a medical only adjuster; avoiding transfers from another indemnity adjuster, if at all possible.
- The audit will include a review of all adjusters handling files, including supervisors with significant caseloads, P&C adjusters, indemnity adjusters, and medical only adjusters.
- It is not mandatory for adjusters employed fewer than six months to be included in the audit, but may be spot-checked, if appropriate. Typically, they will have recently had a new-employee spot-check.
- LevelUp adjusters will not be included in the annual audit, as this is a training program with an audit performed at the local level.
- Audit Worksheets will be completed for each reviewed claim, as well as an Audit Tally Sheet for each audited adjuster.
- Comments are provided on the Audit Worksheets to help support the marks and should provide constructive feedback.
- Audits will be conducted primarily online, but may include some on-site audits, which will include meeting with the appropriate staff (manager, point person, and/or supervisors) and a brief review of the audit findings.
- The lead auditor will provide a draft copy of the Audit Report to the point person in a timely manner and provide a due date for any reconsiderations to be returned.
- If no response is received, the draft copy will be posted as the final report in ten business days.
- Local management will disseminate and communicate audit results to claims staff in a timely manner.
- All Pre-Audit Surveys, Audit Worksheets, and Final Audit Reports generated for each audit will be posted to the O: drive as a resource for future audits.

QC Incentive Program for Rewarding Excellence by Office

When an office achieves 90% or higher on the overall office audit score:

- Office will receive $15 per claim professional, including clerical staff or any others who work on claims, to go toward an office luncheon or in-house celebration for the claims staff. Betsy McConkey will provide a budget to the point person and cc Suzi Wear to look for the receipts on the point person's expense report.

When an office achieves 90% or higher for two consecutive years:

- Office is not formally audited by the QC team for **two years**.
- Office is allowed to carry over their score from the previous year or the average of the past two years, whichever is higher.
- In lieu of a formal audit:
  - *Year one:* a spot-check is required to be completed by local management for any adjusters who scored less than 87% in the formal audit.
  - *Year two:* a spot-check is required to be completed by the audit team for any adjusters who scored less than 87% in the year-one skip.
- In year three (when re-audited after a two-year skip):
  - If the office earns 90% or higher, they will again be skipped for two years and retain the year-three score.
  - If the office earns 87-89%, they will be skipped for one year, as outlined below.

When an office achieves 87% or above for two consecutive years:

- Office is not formally audited by the QC team for **one year**.
- Office is allowed to carry over their score from the previous year or the average of the past two years, whichever is higher.
- In lieu of a formal audit:
  - *Year one:* a spot-check is required to be completed by local management for any adjusters who scored less than 87% in the formal audit.
- In year two (when re-audited after a one-year skip):
  - If the office earns 90% or higher, they will be skipped for two years and retain the year-two score.
  - If the office earns 87-89%, they will be skipped again for one year.
- The audit team has the discretion to audit an office earlier if there are significant changes in the office (turnover, significant new hires, large accounts, etc.).

QC Incentive Program for Rewarding Excellence by Claim Professional

- All claim professionals who earn a score of 90% or higher on their individual score will be provided a Certificate of Claims Excellence signed by Rod Golden, COO; Carrie Milholland, Vice President-Corporate Claims; and Betsy McConkey, Senior QC Manager.
- Any claim professional who scores 93-95% on their individual scores will be provided a certificate entitling them to a half day off to be used within three months, of which their direct supervisor

or manager must approve and keep record. The individual receiving this reward shall NOT make notation of the half day in e-time sheets.

- Any claim professional who scores 96-100% on their individual scores will be provided a certificate entitling them to a full day off to be used within three months, of which their direct supervisor or manager must approve and keep record. The individual receiving this reward shall NOT make notation of the day off in e-time sheets.

QC Corrective Plan of Action

When an office receives 86% or lower:

- Local management is required to complete a Corrective Plan of Action, signed off by the RVP, within ten days of the lead auditor's request.
- Video or on-site training may be provided by the QC team, if appropriate.
- The lead auditor will follow up within ninety days to confirm completion of all action steps in the Corrective Plan of Action.
- The QC team will pull claims for local management to perform required spot-checks six months after the audit results are finalized for all adjusters/supervisors who scored 86% or lower in the formal audit.
- Six months later, the QC team will perform the regularly scheduled annual audit.
- Overall audit scores remain the same until the next formal audit (spot-check scores do not change the official score).

QC Spot-Checks

How the spot-check process will work:

- The lead auditor will confirm who will be audited with the point person.
- The lead auditor will pick claims and run audit reports, if needed.
- The lead auditor will provide forms (worksheets/tally sheet) to the point person to complete the audit.
- Point person will return all audit material in thirty days.
- Local management will disseminate and communicate audit results to claims staff in a timely manner.
- All Audit Worksheets and Spot-Check Summaries generated for each audit will be posted to the O: drive as a resource for future audits.

A spot-check consists of:

- Completed Audit Worksheets in Excel of three to five claims;
- Completed Audit Tally Sheet; and
- Brief summary of the findings for each adjuster, including any ongoing deficiencies that need work.

New-Hire Spot-Checks

- Ninety days after the adjuster/supervisor's date of hire, the lead auditor will reach out to the point person to confirm they have been handling claims.
- The lead auditor will pick claims since the date of hire and audit three to five claims.
- The lead auditor will provide forms (worksheets/tally sheet) to the point person.
- Local management will disseminate and communicate audit results to claims staff in a timely manner.
- All Audit Worksheets for each audit will be posted to the O: drive as a resource for future audits.

Last Name - Claim # (1)

Date/Day of Loss		**Carrier Name**		**Claim Office**	
Date/Day of Entry		**Policy Type**		**Coverage**	
Date/Day Adj Assigned		**Reporting Level**		**Jurisdiction**	
File Status (O/C)		**Adjuster Name**		**Client Name**	
Date Closed		**Supervisor Name**		**Claimant Name**	
Date Audited		**Auditor Name**		**Claim Number**	
				Adj | Supv Claim Score	#DIV/0! n/a

COVERAGE		YES	NO	N/A
Was coverage promptly documented in the log notes as a part of the initial coverage review? **Required on deductible policies. For excess policies: score as Y if documented promptly, N if documented after 30 days, N/A if no mention.	1			
Was the coverage correctly documented in the log notes with the coverage type, insurance carrier/company, policy number, policy period, deductible or retention amount, and reporting level? **Required on deductible policies. For excess policies: score as Y if documented correctly, N if documented incorrectly, N/A if no mention.	2			
Were potential coverage issues identified and documented in the log notes within 10 business days?	3			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

INITIAL CONTACT		YES	NO	N/A
Client Contact				
Was verbal or written **client** contact made or attempted within 2 business days, or within the carrier or client service commitments, whichever is stricter? (day 1 is the day the claim is received by CCMSI, day 2 is the very next business day; generic acknowledgement not sufficient)	4			
If the client was not reached on the first attempt, was client contact attempted at least every 3 business days thereafter until the client was reached?	5			
Was the client contact meaningful and thorough?	6			
If attempts to contact the client were discontinued, was the rationale stated in the log notes?	7			
Claimant Contact				
Was verbal **claimant** contact made or attempted within 2 business days of receipt, or within the carrier or client service commitments, whichever is stricter? (day 1 is the day the claim is received by CCMSI, day 2 is the very next business day)	8			
If the claimant was not reached on the first attempt, was claimant contact attempted at least every 3 business days thereafter until the claimant was reached?	9			
If verbal contact was unsuccessful, was a written follow-up sent promptly to the claimant requesting contact?	10			
Was claimant contact meaningful and thorough?	11			
If attempts to contact the claimant were discontinued, was the rationale stated in the log notes?	12			
Medical Contact				
Were the initial medical records logged? If not, was verbal or written **health provider** contact made or attempted within 2 business days, or within the carrier or client service commitments, whichever is stricter? (day 1 is the day the claim is received by CCMSI, day 2 is the very next business day)	13			
If the medical records were needed to determine compensability, were attempts to obtain these evident in the log notes?	14			
Witness Contact				
Were witnesses contacted/interviewed, if appropriate?	15			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

Last Name - Claim # (1)

Claim Number	0	Date Audited	1/0/1900

INVESTIGATION / CLAIM RISK ASSESSMENT		YES	NO	N/A
Was a brief description of the accident input early in the claim log notes?	16			
Were red-flag fraud indicators recognized and addressed in the investigation?	17			
ISO/Index				
Was the initial ISO/Index Report generated as part of the initial investigation of the claim?	18			
Was a diary established to re-index the claim after 18 months, then every 6 months?	19			
Was the claim re-indexed after 18 months, then every 6 months?	20			
Was the ISO/Index results reviewed in the log notes, with comments of whether or not any follow up was needed?	21			
If there were any relevant hits found on the ISO report, any prior injuries or prior claims, were these fully investigated?	22			
CRA				
Was the CRA form sufficiently completed for a valid profile scoring?	23			
Was the CRA form completed within 10 business days from receipt of the first notice of injury? If not, were continued efforts to gather the information evident?	24			
Subrogation/Recovery				
Was sufficient subrogation, recovery or SIF investigation completed within 10 business days to rule out or identify recovery potential? If not, were continued efforts to gather the information evident?	25			
Was a claim-specific subro, recovery or SIF exposure rationale documented once this was ruled out or identified?	26			
Were all potentially responsible parties put on notice immediately, if applicable?	27			
Was a request for written acknowledgement from the insurance carrier(s) requested & pursued until obtained from all potentially responsible parties, if applicable?	28			
If notice of representation was received on a claim with subrogation potential, was our lien notice sent to the claimant's attorney requesting acknowledgement of our lien?	29			
If the claimant's attorney did not acknowledge our subro lien, was follow up made every 30-90 days until acknowledged?	30			
Was follow-up on subrogation, recovery or SIF completed at a maximum every 90 days?	31			
Was the carrier and/or client consulted prior to waiving or compromising any recoveries?	32			
Compensability				
Was a sufficient investigation completed timely to determine compensability? (within 10 business days)	33			
If the investigation was incomplete, were continued efforts to gather the information evident? (unresolved contacts, witness statements, subro follow up, prior medical records, etc.)	34			
Was the compensability statement strong? (stated after investigation complete, specific to the claim, and reflect the adjuster's review of all important issues unique to the claim)	35			
Were denials clearly documented in the notes, discussed with the client (if required), and reported to the state (if applicable)?	36			
COMMENTS	**n/a** **PERCENTAGE / TOTALS**	0	0	0

RESERVES & WAGE INFORMATION		YES	NO	N/A
Reserves				
Were the initial reserves established timely? (w/in 10 business days, or within the carrier or client service commitments, whichever is stricter)	37			
Were the initial reserves adequate and specific to the claim, based on the facts known at that time?	38			
Were subsequent reserves adjusted timely as developments occurred? (w/in 10 business days)	39			
Were meaningful reserve rationales regularly documented for reserve changes within the reserve worksheet? (including calculations for TTD, permanency or impairment)	40			
Were reserves established in compliance with corporate philosophy? (no stair stepping)	41			
Were the reserves sufficient to bring the claim to a conclusion, based on the facts of the claim at the time of review?	42			
Wage Information				
Was the wage statement/wage information promptly requested?	43			
Was the wage statement/wage information regularly pursued until received?	44			
Was an appropriate explanation of the wage rates with all calculations documented in the log notes?	45			
COMMENTS	**n/a** **PERCENTAGE / TOTALS**	0	0	0

307

Last Name - Claim # (1)

Claim Number 0 **Date Audited** 1/0/1900

MEDICAL & DISABILITY MANAGEMENT		YES	NO	N/A
Was a medical authorization form requested? (Yes if documented, N/A if no mention)	46			
Were pertinent medical records requested, with appropriate follow up if not received?	47			
Were the medical records regularly summarized in the log notes?	48			
Was the medical treatment plan proactively managed? (RTW & MMI targets tracked, IME/2nd opinion requests, prompt authorization of treatment, DME, Rx requests/approvals, etc.)	49			
Was light duty work aggressively pursued and coordinated, if available?	50			
If applicable, was UR/Pre-Cert appropriately used?	51			
If relevant in a particular state, was a PPD rating timely requested?	52			
Nurse CM/Voc Rehab				
Did the assignment to NCM or Voc Rehab include clear instructions/expectations?	53			
Was regular collaboration with the NCM/Voc Rehab Specialist evident, showing the adjuster was overseeing the medical/voc management?	54			
Was a brief summary/description regularly provided for NCM/Voc Rehab correspondence/e-mails/attachments? (including date, CM/Voc Rehab name, summary)	55			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

LITIGATION MANAGEMENT/SETTLEMENT EVALUATION		YES	NO	N/A
Claimant's Attorney				
Was the claimant's attorney letter of representation acknowledged in writing within 10 business days?	56			
Defense Attorney				
Was the file referred to a defense attorney timely? (In states where counsel files an answer, 10 business days)	57			
Did the assignment to the defense attorney include clear instructions and expectations? (including an overview of the claim facts, investigation to date, as well as the issuing carrier name, as applicable)	58			
Was there prompt follow up for the defense attorney's initial litigation review/evaluation if not received within 30 calendar days from referral?	59			
Was a brief summary/description regularly provided for legal correspondence/e-mails/attachments? (including date, attorney name, summary)	60			
Was regular collaboration with the defense attorney evident (or claimant's attorney if no defense on file), showing adjuster was managing the litigation plan?	61			
Budget/Approved Atty				
Was a legal budget requested? (Required for deductible claims; do not mark down for non-deductible claims)	62			
Was there continued follow up for a budget from the DA until received? (Required for deductible claims, do not mark down for non-deductible claims)	63			
Was a carrier-approved defense attorney used, if applicable? (Required for deductible claims, do not mark down for non-deductible claims)	64			
Exposure/Settlement				
Was the claim exposure, settlement values and plans for disposition evident in the notes?	65			
If settling out future medical, was consideration shown in the claim for MMSEA/SCHIP submission & eligibility based on age or SSDI status, if applicable?	66			
Was appropriate settlement authority/concurrence obtained from the client contact and/or supervisor, if applicable?	67			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

Last Name - Claim # (1)

Claim Number	0	Date Audited	1/0/1900

CARRIER REPORTING		YES	NO	N/A
If the claim meets carrier reporting requirements, was prompt notice given and documented in the log notes? (when, why and to whom the claim was reported)	68			
Was the notice sent in such a manner in which proof of receipt was provided? (certified, fax, e-mail)	69			
Was a diary established for follow up every 15 calendar days until the proof of receipt was returned and acknowledgement was received from the carrier?	70			
Were timely follow-up reports provided to the carrier once the initial report was made? If the carrier decontrolled the file, this should be clearly shown in the log notes.	71			
Was reserve authority or settlement authority obtained timely from the carrier in conjunction with their reporting requirements?	72			
COMMENTS	**n/a** **PERCENTAGE / TOTALS**	0	0	0

DOCUMENTATION & ONGOING MGMT		YES	NO	N/A
Action Plans/File Mgmt				
Was a meaningful/proactive initial action plan developed/documented within 30 calendar days, or within the carrier or client service commitments, whichever is stricter?	73			
Was a meaningful/proactive action plan updated every 30-90 calendar days thereafter with appropriate follow up? (Should be able to follow the current treatment status and estimated return to work date, expected MMI date, plans for disposition, current legal status, etc.)	74			
Did the adjuster regularly complete their diaries no later than 15 calendar days?	75			
Were directions and recommendations from supervisors acknowledged or acted upon?	76			
Did the log notes contain appropriate information and read smoothly? (current, clear and complete?)	77			
All claims: SCHIP coding required for Medicare Eligible claims. Were the compensable body parts properly coded? ***Deductible claims:*** Were the loss type/body part/cause codes accurate for the current status of the claim?	78			
Benefits/State Forms				
Were indemnity benefits paid timely? (print date regular and near the period paid)	79			
Were indemnity benefits properly calculated?	80			
If applicable, were adjustments to benefits clearly documented, showing the amount and reason? Were underpayments issued promptly or recovery attempted? If recovery is not allowed in the jurisdiction, was this clearly stated?	81			
Was a brief summary/description provided for state filings, TPD pays, etc.	82			
Surveillance				
If surveillance was used, did the assignment to the surveillance company include clear instructions/expectations?	83			
Was surveillance managed and used appropriately, if applicable?	84			
Was a brief summary/description provided for surveillance reports/e-mails/attachments? (including date, company name, summary)	85			
Ongoing Contact/Mgmt				
Was follow up contact made with the claimant, when appropriate, or as issues arose?	86			
Were the carrier/client instructions followed? (concurrence with denials, reserves or assignment to: CM, surveillance, attorney, etc.) ***Deductible claims:*** Was the correct UW company included on all correspondence and settlement documents and State forms?	87			
Was the claim progressing appropriately and/or concluded effectively and timely?	88			
COMMENTS	**n/a**	0	0	0

Last Name - Claim # (1)

Claim Number	0	Date Audited	1/0/1900

MINIMUM SYSTEM REQUIREMENTS		YES	NO	N/A
Were the 3-point contact fields on the Miscellaneous screen completed?	89			
Was the recovery tab on the Miscellaneous screen completed appropriately?	90			
Was the lien box on the Miscellaneous screen completed, if applicable?	91			
Was the "Claim Denied" box checked on the Claim Edit screen, if applicable?	92			
Were the Claimant and Defendant tabs on the Legal screen completed, if applicable? ***Deductible claims with budgets obtained after 2/1/21***: Was the litigation budget amount properly entered on the Legal Screen/Defendant tab?	93			
Were the Carrier fields completed, if applicable?	94			
Did the claim summary provide a good overview of the claim? (current, concise and complete)	95			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

SUPERVISION		YES	NO	N/A
Did the supervisor document a ***meaningful*** initial review within 30 calendar days?	96			
Was the supervisory follow up frequency in line with the severity of the claim? (maximum of every 90 days)	97			
Was the reserve adequacy regularly reviewed by the supervisor throughout the life of the claim?	98			
Was the supervisor direction appropriate in addressing any claims handling deficiencies in any of the core competencies?	99			
Did the supervisor follow up to ensure the claims professional executed on the direction provided?	100			
Was the supervisor mindful of potential leakage/E&O risks? (subro, overpayments, carrier reporting, etc.)	101			
If the supervisor diary was removed, was a meaningful explanation provided?	102			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

Last Name-Claim # (1)

Date/Day of Loss		**Carrier Name**		**Claim Office**	
Date/Day of Entry		**Policy Type**		**Coverage**	
Date/Day Adj Assigned		**Reporting Level**		**Jurisdiction**	
File Status (O/C)		**Adjuster Name**		**Client Name**	
Date Closed		**Supervisor Name**		**Claimant Name**	
Date Audited		**Auditor Name**		**Claim Number**	
				Adj | Supv Claim Score	#DIV/0! n/a

INVESTIGATION/FNOL		YES	NO	N/A
Was the claim input and the claims management initiated within 2 business days of the first notice of injury?	1			
Was a brief description of the accident input early in the claim log notes?	2			
If a coverage note was documented in the log notes, was the coverage correctly documented with the coverage type, insurance carrier/company, policy number, policy period, deductible or retention amount, and reporting level? (Score as Y if documented correctly, N if documented incorrectly, N/A if no mention)	3			
Was the compensability statement appropriate and clear? (stated after investigation complete; specific to the claim)	4			
Initial Contacts				
If 2-pt or 3-pt contact was required per the Carrier or Client Service Instructions, was this completed timely?	5			
If 2-pt or 3-pt contact was required per the Carrier or Client Service Instructions, was this completed appropriately? (meaningful, specific questions asked, R/S, etc.)	6			
ISO/Index				
If an initial ISO/index was required per the Carrier or Client Service Instructions, was this report generated as part of the initial setup of the claim?	7			
If the ISO/Index report was ran, were the results reviewed in the log notes, with comments of whether or not any follow up was needed?	8			
If there were any relevant hits found on the ISO report, were these fully investigated?	9			
Subrogation/Recovery				
Was sufficient subrogation, recovery or SIF investigation completed within 10 business days to rule out or identify recovery potential? If not, were continued efforts to gather the information evident?	10			
Was a claim-specific subro, recovery or SIF exposure rationale documented once this was ruled out or identified?	11			
Were all potentially responsible parties put on notice immediately, if applicable?	12			
Was a request for written acknowledgement from the insurance carrier(s) requested & pursued until obtained from all potentially responsible parties, if applicable?	13			
Was follow-up on subrogation, recovery or SIF completed at a maximum every 90 days?	14			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

RESERVES		YES	NO	N/A
Were the initial reserves adequate and specific to the claim, based on the facts known at that time?	15			
Were the initial reserves established timely? (w/in 10 business days, or within the carrier or client service commitments, whichever is stricter)	16			
Were subsequent reserves adjusted timely as developments occurred? (w/in 10 business days)	17			
Were the reserves sufficient to bring the claim to a conclusion, based on the facts of the claim at the time of review?	18			
Were meaningful reserve rationales documented for all reserve changes within the reserve worksheet?	19			
Were reserves established in compliance with corporate philosophy? (no stair stepping)	20			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

Last Name-Claim # (1)

Claim Number	0	Date Audited	1/0/1900

MEDICAL & DISABILITY MANAGEMENT		YES	NO	N/A
Were pertinent medical records timely requested and reviewed/attached to the log notes?	21			
Were the medical records appropriately summarized in the log notes?	22			
Was the medical treatment plan proactively managed? (prompt authorization of treatment, DME, Rx requests/approvals, etc.)	23			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

DOCUMENTATION & ONGOING MGMT		YES	NO	N/A
Action Plans/File Mgmt				
Was a meaningful/proactive initial action plan developed/documented within 30 calendar days, or within the carrier or client service commitments, whichever is stricter?	24			
Was a meaningful/proactive action plan updated every 30-90 calendar days thereafter with appropriate follow up? (Should be able to follow the current treatment status and estimated return to work date, expected MMI date, etc.)	25			
Did the adjuster regularly complete their diaries no later than 15 calendar days?	26			
Were directions and recommendations from supervisors acknowledged or acted upon?	27			
Did the log notes contain appropriate information and read smoothly? (current, clear and complete?)	28			
Was a brief summary/description regularly provided for any other non-medical attachments?	29			
Was input sought from the supervisor/indemnity adjuster on complex or questionable issues?	30			
Was the claim converted from Medical Only to Indemnity timely?	31			
Were the carrier/client instructions followed? (concurrence with denials, reserves or assignment to: CM, surveillance, attorney, etc.) ***Deductible claims: Was the correct UW company included on all correspondence and State forms?***	32			
Was the claim progressing appropriately and/or concluded effectively and timely?	33			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

SUPERVISION	YES	NO	N/A

Last Name-Claim # (1)

Date/Day of Loss		**Carrier Name**		**Claim Office**	
Date/Day of Entry		**Policy Type**		**Coverage**	
Date/Day Adj Assigned		**Reporting Level**		**Jurisdiction**	
File Status (O/C)		**Adjuster Name**		**Client Name**	
Date Closed		**Supervisor Name**		**Claimant Name**	
Date Audited		**Auditor Name**		**Claim Number**	
				Adj | Supv Claim Score	#DIV/0! n/a

COVERAGE		YES	NO	N/A
Was coverage promptly documented in the log notes as a part of the initial coverage review? (within 10 business days)	1			
Did the coverage analysis include the carrier name, policy number, reporting level, policy effective dates, limits of coverage, deductibles, replacement cost vs. actual cost value, sub limits, SIR limit, and any applicable endorcements? (limits of coverage above the SIR limit must be included)	2			
Were potential coverage issues identified and documented in the log notes within 10 business days?	3			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

INITIAL CONTACT		YES	NO	N/A
Client Contact				
Was verbal or written **client** contact made or attempted within 2 business days, or within the carrier or client service commitments, whichever is stricter? (day 1 is the day the claim is received by CCMSI, day 2 is the very next business day; generic acknow not appropriate)	4			
If client not reached on first attempt, was client contact attempted at least every 3 business days thereafter until the client was reached?	5			
Was client contact meaningful and thorough?	6			
If attempts to contact client were discontinued, was a sufficient note provided in the log notes?	7			
Claimant Contact				
Was verbal **claimant** contact made or attempted within 2 business days, or within the carrier or client service commitments, whichever is stricter? (day 1 is the day the claim is received by CCMSI, day 2 is the very next business day)	8			
If claimant not reached on first attempt, was claimant contact attempted at least every 3 business days thereafter until the claimant was reached?	9			
If verbal contact was unsuccessful, was a written follow-up sent promptly to the claimant requesting contact?	10			
Was claimant contact meaningful and thorough?	11			
If attempts to contact claimant were discontinued, was a sufficient note provided in the log notes?	12			
Witness Contact				
Were witnesses contacted/interviewed, if appropriate?	13			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

Last Name-Claim # (1)

Claim Number 0 **Date Audited** 1/0/1900

INVESTIGATION		YES	NO	N/A
Was a brief description of the accident input early in the claim log notes?	14			
Were red-flag fraud indicators recognized and addressed in the investigation?	15			
ISO/Index				
Was the initial ISO/Index Report generated as part of the initial investigation of the claim?	16			
Was a diary established to re-index the claim after 18 months, then every 6 months?	17			
Was the claim re-indexed after 18 months, then every 6 months?	18			
Was the ISO/Index results reviewed in the log notes, with comments of whether or not any follow up was needed?	19			
If there were any relevant hits found on the ISO report, any prior injuries or prior claims, were these fully investigated?	20			
Subrogation/Recovery				
Was sufficient subrogation, recovery, including potential third party contribution and/or risk transfers, or salvage investigation completed within 10 business days to rule out or identify recovery potential? If not, were continued efforts to gather the information evident?	21			
Was a claim-specific subro, recovery, potential third party contribution and/or risk transfers, or salvage exposure rationale documented once this was ruled out or identified?	22			
Were all potentially responsible parties put on notice immediately, if applicable?	23			
Was a request for written acknowledgement from the insurance carrier(s) requested & pursued until obtained from all potentially responsible parties, if applicable?	24			
Was follow-up on subrogation, recovery or salvage completed at a maximum every 90 days?	25			
Were potential third party tortfeasors identified, investigated and pursued for third party contribution?	26			
Were contractual risk transfers identified, investigated and evaluated?	27			
If a potential contractual risk transfer existed, was a tender appropriately pursued?	28			
Was the carrier and/or client consulted prior to waiving or compromising any recoveries?	29			
Liability Determination				
Was a sufficient investigation completed timely to determine liability? (within 30 days)	30			
If the investigation was incomplete, were continued efforts to gather the information evident? (unresolved contacts, witness statements, subro follow up, prior medical records, etc.)	31			
Was the liability statement strong? (stated after investigation complete, specific to the claim, include the alleged cause of action and appropriate liability analysis against the client or the standard of care, when applicable)	32			
Did the adjuster document comparative or contributory negligence in the liability statement, if applicable?	33			
Did the adjuster obtain, document and evaluate investigative documents to support the liability statement? ex: police report, photos, scene investigation, use of experts, etc.	34			
Were denials clearly documented in the notes, including State Specific denial language in the denial letter?	35			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

RESERVES		YES	NO	N/A
Were the initial reserves established timely? (w/in 10 business days, or within the carrier or client service commitments, whichever is stricter)	36			
Were the initial reserves adequate and specific to the claim, based on the facts known at that time?	37			
Were subsequent reserves adjusted timely as developments occurred? (w/in 10 business days)	38			
Were meaningful reserve rationales regularly documented for reserve changes within the reserve worksheet?	39			
Were reserves established in compliance with corporate philosophy? (no stair stepping)	40			
Were the reserves sufficient to bring the claim to a conclusion, based on the facts of the claim at the time of review?	41			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

Last Name-Claim # (1)

Claim Number	0	Date Audited	1/0/1900

DAMAGES EVALUATION		YES	NO	N/A
Was the claimant or claimant's attorney questioned about prior injuries and/or claims?	42			
If there were prior injuries, pre-existing medical conditions and/or claims noted by the claimant and/or attorney, were these fully investigated?	43			
Was a medical authorization form requested? (Yes if documented, N/A if no mention)	44			
Were pertinent medical records requested, with appropriate follow up if not received?	45			
Were the medical records regularly summarized in the log notes?	46			
Was the adjuster proactive in obtaining/documenting the claimant's injury and treatment information?	47			
If lost wages were claimed, were pertinent proofs requested, received, documented and evaluated in the log notes?	48			
Were proofs of all other applicable damages requested, received, documented and evaluated in the log notes? (general damages, special damages, property damages, auto damages, loss of use, etc.)	49			
Did the adjuster identify and evaluate unrelated and/or mitigation of damages? (unrelated medical treatment, unrelated property damages, depreciation, etc.)	50			
Were collateral sources appropriately identified, investigated, documented and evaluated in the log notes?	51			
COMMENTS	**n/a** **PERCENTAGE / TOTALS**	0	0	0

LITIGATION MANAGEMENT/SETTLEMENT EVALUATION		YES	NO	N/A
Claimant's Attorney				
Was the claimant's attorney letter of representation acknowledged timely? (within 10 business days)	52			
Defense Attorney				
Was the file referred to a defense attorney timely? (within 3 business days)	53			
Did the assignment to a defense attorney include clear instructions and expectations? (including an overview of the claim facts, investigation to date, as well as the issuing carrier name, as applicable)	54			
Was there prompt follow up for the defense attorney's initial litigation review/evaluation if not received within 30 calendar days from referral?	55			
Was a brief summary/description regularly provided for legal correspondence/e-mails/attachments? (including date, attorney name, summary)	56			
Was regular collaboration with the defense attorney evident, showing adjuster was managing the litigation plan?	57			
Did the adjuster perform all duties that could be accomplished by the adjuster rather than allowing the defense attorney to handle?	58			
Budget/Approved Atty				
Was a legal budget requested? (Required for deductible claims; do not mark down for non-deductible claims)	59			
Was there continued follow up for a budget from the defense attorney until received? (Required for deductible claims, do not mark down for non-deductible claims)	60			
Was a carrier-approved defense attorney used, if applicable? (Required for deductible claims, do not mark down for non-deductible claims)	61			
Exposure/Settlement				
Was the settlement and/or damage exposure and plans for disposition evident in the notes?	62			
If settling out future medical, was consideration shown in the claim for MMSEA/SCHIP submission & eligibility based on age or SSDI status, if applicable?	63			
Was appropriate settlement authority/concurrence obtained from the client contact and/or supervisor, if applicable?	64			
COMMENTS	**n/a** **PERCENTAGE / TOTALS**	0	0	0

Last Name-Claim # (1)

Claim Number 0 **Date Audited** 1/0/1900

CARRIER REPORTING		YES	NO	N/A
If the claim meets carrier reporting requirements, was prompt notice given and documented in the log notes? (when, why and to whom the claim was reported)	65			
Was the notice sent in such a manner in which proof of receipt was provided? (certified, fax, e-mail)	66			
Was a diary established for follow up every 15 calendar days until the proof of receipt was returned and acknowledgement was received from the carrier?	67			
Were timely follow-up reports provided to the carrier once the initial report was made? If the carrier decontrolled the file, this should be clearly shown in the log notes.	68			
Was reserve authority or settlement authority obtained timely from the carrier in conjunction with their reporting requirements?	69			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

DOCUMENTATION & ONGOING MGMT		YES	NO	N/A
Action Plans/File Mgmt				
Was a meaningful/proactive initial action plan developed/documented within 30 calendar days, or within the carrier or client service commitments, whichever is stricter?	70			
Was a meaningful/proactive action plan updated every 30-90 calendar days thereafter with appropriate follow up? (Should be able to follow the plans for disposition, current legal status, etc.)	71			
Did the adjuster regularly complete their diaries no later than 15 calendar days?	72			
Were directions and recommendations from supervisors acknowledged or acted upon?	73			
Did the log notes contain appropriate information and read smoothly? (current, clear and complete?)	74			
All claims: SCHIP coding required for Medicare Eligible claims. Were the compensable body parts properly coded? ***Deductible claims:*** Were the loss type/body part/cause codes accurate for the current status of the claim?	75			
Surveillance				
If surveillance was used, did the assignment to the surveillance company include clear instructions/expectations?	76			
Was surveillance managed and used appropriately, if applicable?	77			
Was a brief summary/description provided for surveillance reports/e-mails/attachments? (including date, company name, summary)	78			
Ongoing Contact/Mgmt				
Was follow up contact made with the claimant, when appropriate, or as issues arose?	79			
Were the carrier/client instructions followed? (concurrence with denials, reserves or assignment to: surveillance, attorney, etc.) ***Deductible claims:*** Was the correct UW company included on all correspondence and settlement documents?	80			
Was the claim progressing appropriately and/or concluded effectively and timely?	81			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

Last Name-Claim # (1)

Claim Number 0 **Date Audited** 1/0/1900

MINIMUM SYSTEM REQUIREMENTS		YES	NO	N/A
Were the 3-point contact fields on the Miscellaneous screen completed?	82			
Was the recovery tab on the Miscellaneous screen completed appropriately?	83			
Was the lien box on the Miscellaneous screen completed, if applicable?	84			
Was the "Claim Denied" box checked on the Claim Edit screen, if applicable?	85			
Were the Claimant and Defendant tabs on the Legal screen completed, if applicable? ***Deductible claims with budgets obtained after 2/1/21*** *:* Was the litigation budget amount properly entered on the Legal Screen/Defendant tab?	86			
Were the Carrier fields completed, if applicable?	87			
Did the claim summary provide a good overview of the claim? (current, concise and complete)	88			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

SUPERVISION		YES	NO	N/A
Did the supervisor document a ***meaningful*** initial review within 30 calendar days?	89			
Was the supervisory follow up frequency in line with the severity of the claim? (maximum of every 90 days)	90			
Was the reserve adequacy regularly reviewed by the supervisor throughout the life of the claim?	91			
Was the supervisor direction appropriate in addressing any claims handling deficiencies in any of the core competencies?	92			
Did the supervisor follow up to ensure the claims professional executed on the direction provided?	93			
Was the supervisor mindful of potential leakage/E&O risks? (subro, overpayments, carrier reporting, etc.)	94			
If the supervisor diary was removed, was a meaningful explanation provided?	95			
COMMENTS **n/a** **PERCENTAGE / TOTALS**		0	0	0

CCMSI

Exhibits 8 – Insurance Coverage Certificates

CCMSHOL-01 LCOZAD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 7/29/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # 0808309 Mesirow Insurance Services, Inc. 353 N Clark St 11th Floor Chicago, IL 60654	CONTACT NAME: PHONE (A/C, No, Ext): (312) 595-6200 FAX (A/C, No): E-MAIL ADDRESS:
INSURED Cannon Cochran Management Services Inc. 2 East Main Street, Suite 208 Towne Centre Building Danville, IL 61832	INSURER A : Continental Casualty Company 20443 INSURER B : National Fire Insurance Company of Hartford 20478 INSURER C : American Casualty Company of Reading, Pennsylvania 20427 INSURER D : Travelers Casualty and Surety Company of America 31194 INSURER E : Great American E & S Insurance Company 37532 INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:			6079556217	11/17/2021	11/17/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 15,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY SCHEDULED AUTOS X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY			6079556220	11/17/2021	11/17/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000			6079556248	11/17/2021	11/17/2022	EACH OCCURRENCE AGGREGATE	$ 10,000,000 $ 10,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		6079556234	11/17/2021	11/17/2022	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
D	Empl Dishonesty			105973793	7/31/2022	7/31/2023	$50K Ded	5,000,000
E	Err & Omissions			TER2861781	7/31/2022	7/31/2023	$150K SIR	10,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Certificate issued as evidence of coverage.

CERTIFICATE HOLDER

Cannon Cochran Management Services, Inc.
2 E. Main Street Towne Centre,
Suite 208
Danville, IL 61832-0000

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

319

CCMSHOL-01 LCOZAD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 7/29/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # 0808309 Mesirow Insurance Services, Inc. 353 N Clark St 11th Floor Chicago, IL 60654	CONTACT NAME: PHONE (A/C, No, Ext): (312) 595-6200 FAX (A/C, No): E-MAIL ADDRESS:
INSURED CCMSI Holdings, Inc. 2 East Main Street, Suite 208 Towne Centre Building Danville, IL 61832	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Accredited Specialty Insurance Company — 16835 INSURER B : Princeton Excess & Surplus Lines Insurance Company — 10786 INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Primary Cyber Liab			2-CIA-IL-17-SO104464-00	11/17/2021	11/17/2022	Limit	5,000,000
B	Excess Cyber Liab			5DA3FF0000194-00	11/17/2021	11/17/2022	Over primary Cyber	5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Job CYBER
EVIDENCE OF COVERAGE

CERTIFICATE HOLDER

CCMSI Holdings, Inc.
2 East Main Street, Suite 208
Towne Centre Building
Danville, IL 61832

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

320