ITEM RES 00-04527

VILLAGE OF DOWNERS GROVE
REPORT FOR THE VILLAGE COUNCIL MEETING
JUNE 14, 2011 AGENDA

SUBJECT:	TYPE:	SUBMITTED BY:
Resolution Authorizing Execution of an Agreement with Underwriters Safety & Claims	✓ Resolution Ordinance Motion Discussion Only	Dennis E. Burke Interim-Human Resources Director

SYNOPSIS
A resolution has been prepared authorizing a three-year agreement between the Village and Underwriters Safety & Claims, Inc. to serve as the Village's Third Party Claims Administrator (TPA) and manage General/Auto and Workers Compensation Claims against the Village.

STRATEGIC PLAN ALIGNMENT
The goals for 2011-2018 identify *Exceptional Municipal Organization*.

FISCAL IMPACT
The FY11 budget includes $49,000 in the Risk Management Fund. The cost for this service will be $46,000 in the first year and $41,000 for each of the following years.

UPDATE & RECOMMENDATION
This item was discussed at the June 7, 2011 Village Council meeting. Staff recommends approval on the June 14, 2011 Consent Agenda.

BACKGROUND
The Village is self-insured for Risk Management and uses a Third Party Claims Administrator (TPA) to manage General and Auto Liability Claims and Workers Compensation Claims. The Village's existing agreement with Claims Management Consultants expired on April 30, 2011. In April, Council awarded a four-month extension to the contract to allow staff sufficient time to review the proposals received from the RFP process. The Village received four proposals. Each vendor was interviewed by a team of Village staff.

Staff recommends Underwriters Safety & Claims for a three-year agreement. Underwriters' programs and approach to claims administration are anticipated to bring greater savings to the Village than those of other vendors. Underwriters has a solid record of client retention and also provides an online reporting system that allows the Village instant access to records. The contract requires Underwriters to take on all open claims that are pending against the Village.

ATTACHMENTS
Resolution
Agreement

RESOLUTION NO. ____

A RESOLUTION AUTHORIZING EXECUTION OF A CLAIMS ADMINISTRATION AGREEMENT BETWEEN THE VILLAGE OF DOWNERS GROVE AND UNDERWRITERS SAFETY & CLAIMS, INC.

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of a certain Agreement (the "Agreement"), between the Village of Downers Grove (the "Village") and Underwriters Safety & Claims, Inc. (the "Consultant"), for third party workers' compensation, auto and general liability claims and administrative services, as set forth in the form of the Agreement submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Agreement, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Agreement.

4. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

5. That this Resolution shall be in full force and effect from and after its passage as provided by law.

_____
Mayor

Passed:
Attest: _____
Village Clerk

1\wp8\res.11\3rdPartyClaimsAdmin-Underwriters

AGREEMENT

This Agreement is made this _____ day of _____, 2011 by and between Underwriters Safety & Claims, Inc. (the "Consultant") and the Village of Downers Grove (the "Village").

WHEREAS, the Village wishes to retain the services of the Consultant to provide services related to third party workers' compensation, auto and general liability claims and administrative services; and

WHEREAS, the Consultant is willing to perform these services for compensation and in accordance with the terms and conditions described in this Agreement.

NOW, THEREFORE, in consideration of the mutual benefits that will result to the parties in carrying out the terms of this Agreement, it is agreed as follows:

I. Scope of Services

The scope of services shall be that set forth in the proposal dated March 7, 2011 attached hereto and made a part hereof as Exhibit B. It is expressly understood that if any terms or conditions contained in Exhibit B conflict with the terms and conditions contained in this Agreement, the terms and conditions contained in this Agreement shall control.

II. Term of Agreement

A. This Agreement shall be for a three (3) year term commencing August 1, 2011.

III. Compensation

A. Basic Fees:

Fees for this service shall be as described in Exhibit C attached hereto and incorporated herein by reference. Any additional work performed that will in increase the agreement price in excess of that amount must be approved in writing by both parties.

B. Consultant Invoices:

The Consultant shall prepare invoices that contain a total reimbursable amount for the billing period, amounts billed to date, and amounts received to date.

C. Prompt Payment Act:

The Village will comply with the Local Government Prompt Payment Act, 50 ILCS 505/1 et seq., in that any bill approved for payment must be paid or the payment issued to the Consultant within 60 days of receipt of a proper bill or invoice. If payment is not issued to the Consultant within this 60 day period, an interest penalty of 1.0% of any amount approved and unpaid shall be added for each month or fraction thereof after the end of this 60 day period, until final payment is made.

The Village shall review in a timely manner each bill or invoice after its receipt. If the Village determines that the bill or invoice contains a defect making it unable to process the payment request, the Village shall notify the Consultant requesting payment as soon as possible after discovering the defect pursuant to rules promulgated under 50 ILCS 505/1 et

seq. The notice shall identify the defect and any additional information necessary to correct the defect.

IV. General Terms and Conditions

A. Relationship Between the Consultant and the Village

The relationship between the Village and the Consultant is that of a buyer and seller of professional services and it is understood that the parties have not entered into any joint venture or partnership with the other.

B. Equal Employment Opportunity

In the event of the Consultant's non-compliance with the provisions of this Equal Employment Opportunity Clause, the Illinois Human Rights Act or the Rules and Regulations of the Illinois Department of Human Rights ("Department"), the Consultant may be declared ineligible for future contracts or subcontracts with the State of Illinois or any of its political subdivisions or municipal corporations, and the contract may be canceled or voided in whole or in part, and such other sanctions or penalties may be imposed or remedies invoked as provided by statute or regulation. During the performance of this contract, the Consultant agrees as follows:

1. That it will not discriminate against any employee or applicant for employment because of race, color religion, sex, marital status, national origin or ancestry, age, physical or mental handicap unrelated to ability, or an unfavorable discharge from military service; and further that it will examine all job classifications to determine if minority persons or women are underutilized and will take appropriate affirmative action to rectify any such underutilization.

2. That, if it hires additional employees in order to perform this contract or any portion thereof, it will determine the availability (in accordance with the Department's Rules and Regulations) of minorities and women in the area(s) from which it may reasonably recruit and it will hire for each job classification for which employees are hired in such a way that minorities and women are not underutilized.

3. That, in all solicitations or advertisements for employees placed by it or on its behalf, it will state that all applicants will be afforded equal opportunity without discrimination because of race, color, religion, sex, marital status, national origin or ancestry, age, physical or mental handicap unrelated to ability, or an unfavorable discharge from military service.

4. That it will send to each labor organization or representative of workers with which it has or is bound by a collective bargaining or other agreement or understanding, a notice advising such labor organization or representative of the Consultant's obligations under the Illinois Human Rights Act and the Department's Rules and Regulations. If any such labor organization or representative fails or refuses to cooperate with the Consultant in its efforts to comply with such Act and Rules and Regulations, the Consultant will promptly so notify the Department and the contracting agency and will recruit employees from other sources when necessary to fulfill its obligations thereunder.

5. That it will submit reports as required by the Department's Rules and Regulations, furnish all relevant information as may from time to time be requested by the Department or the contracting agency, and in all respects comply with the Illinois Human Rights Act and the

Department's Rules and Regulations.

6. That it will permit access to and provide specific relevant documentation from books, records, accounts and work sites by personnel of the contracting agency and the Department for purposes of investigation to ascertain compliance with the Illinois Human Rights Act and the Department's Rules and Regulations.

7. That it will include verbatim or by reference the provisions of this clause in every subcontract it awards under which any portion of the contract obligations are undertaken or assumed, so that such provisions will be binding upon such subconsultant. In the same manner as with other provisions of this contract, the Consultant will be liable for compliance with applicable provisions of this clause by such subconsultants; and further it will promptly notify the contracting agency and the Department in the event any subconsultant fails or refuses to comply therewith. In addition, the Consultant will not utilize any subconsultant declared by the Illinois Human Rights Commission to be ineligible for contracts or subcontracts with the State of Illinois or any of its political subdivision or municipal corporations.

C. Sexual Harassment

Consultant, as a party to a public contract, has a project specific written sexual harassment policy amended so that it:

1. Notes the illegality of sexual harassment;
2. Sets forth the State law definition of sexual harassment;
3. Describes sexual harassment utilizing examples;
4. Describes the Consultant or supplier's internal complaint process including penalties;
5. Describes the legal recourse, investigative and complaint process available through the Illinois Department of Human Rights and the Human Rights Commission and how to contact these entities, and;
6. Describes the protection against retaliation afforded under the Illinois Human Rights Act.

D. Drug Free Work Place

Consultant, as party to a public contract, certifies and agrees that it will provide a drug free workplace by:

1. Publishing a statement: (1) Notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance, including cannabis, is prohibited in the grantee's or Consultant's workplace. (2) Specifying the actions that will be taken against employees for violations of such prohibition. (3) Notifying the employee that, as a condition of employment on such contract or grant, the employee will: abide by the terms of the statement; and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

2. Establishing a drug free awareness program to inform employees about: (1) the dangers of drug abuse in the workplace; (2) the grantee's or Consultant's policy of maintaining a drug free workplace; (3) any available drug counseling, rehabilitation, and employee assistance programs; (4) the penalties that may be imposed upon employees for drug violations.

3. Providing a copy of the statement required by subparagraph (a) to each employee engaged in the performance of the contract or grant and to post the statement in a prominent place in the

workplace.

4. Notifying the contracting or granting agency within ten (10) days after receiving notice under part (B) of paragraph (3) of subsection (a) above from an employee or otherwise receiving actual notice of such conviction.

5. Imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted as required by Section 5 of the Drug Free Workplace Act.

6. Assisting employees in selecting a course of action in the event drug counseling, treatment, and rehabilitation is required and indicating that a trained referral team is in place.

7. Making a good faith effort to continue to maintain a drug free workplace through implementation of the Drug Free Workplace Act.

E. Discrimination

Consultant, its employees and subconsultants, agree not to commit unlawful discrimination and agree to comply with applicable provisions of the Illinois Human Rights Act, the Public Works Employment Discrimination Act, the U.S. Civil Rights Act and Section 504 of the Federal Rehabilitation Act, and rules applicable to each. The equal opportunity clause of the Department of Human Rights rules is specifically incorporated herein.

The Americans with Disabilities Act (42 U.S.C. 12101) and the regulations thereunder (28 CFR 35.130)(ADA) prohibit discrimination against persons with disabilities by the State, whether directly or through contractual arrangements, in the provision of any aid, benefit or service. As a condition of receiving this contract, the undersigned vendor certifies that services, programs and activities provided under this contract are and will continue to be in compliance with the ADA.

V. Insurance and Indemnification of the Village

A. The Consultant shall be required to obtain, from a company or companies lawfully authorized to do business in the jurisdiction in which the project is located, such general liability insurance as will protect the Consultant from claims, at a minimum set forth below which may arise out of or result from the Consultant's operations under this agreement and for which the Consultant may legally liable:

1. Claims under workers compensation, disability benefit and other similar employee benefit acts which are applicable to the operation to be performed;
2. Claims for damages because of bodily injury, occupational sickness or disease, or death of the Consultant's employees;
3. Claims for damages because of bodily injury, sickness or disease, or death of any person other than the Consultant's employees;
4. Claims for damages insured by the usual personal injury liability coverage which are sustained: (1) by a person as a result of an offense directly or indirectly related to employment of such person by the Consultant, or (2) by another person;
5. Claims for damages, other than to the work itself, because of injury to or destruction of tangible property, including loss of use resulting there from;
6. Claims for damages because of bodily injury, death of a person or property damage arising out of ownership, maintenance or use of a motor vehicle:

7. Claims for damages as a result of professional or any other type of negligent action by the Consultant or failure to properly perform services under the scope of the agreement between the Consultant and the Village.

B. The Consultant shall demonstrate having such insurance coverage for a minimum of $2 million for professional liability (errors and omissions).

C. As evidence of said coverages, Consultant shall provide the Village with certificates of insurance naming the Village of Downers Grove as an additional insured and include a provision for cancellation only upon at least 30 days prior notice to the Village. In addition, the Consultant shall indemnify and hold harmless the Village and its officers, employees and agents from any and all liability, losses or damages the Village may suffer as a result of claims, demands, suits, actions or proceedings of any kind or nature in any way resulting from or arising out of negligent action on the part of the Consultant or any sub-Consultant to the Consultant under the Consultant's agreement with the Village.

D. Termination

In the event of the Consultant's nonperformance, breach of the terms of the Agreement, or for any other reason, the Agreement may be canceled, in whole or in part, upon the Village's 30 day written notice to the Consultant. The Village will pay the Consultant's costs actually incurred as of the date of receipt of notice of default. Upon termination, the Consultant will deliver all documents and products of whatever kind, and their reproducible originals related to the project, which have been produced to the date of the notice of default.

E. Governing Law

This Agreement will be governed by and construed in accordance with the laws of the State of Illinois. Venue is proper only in the County of DuPage.

F. Successors and Assigns

The terms of this Agreement will be binding upon and inure to the benefit of the parties and their respective successors and assigns; provided, however, that neither party will assign this Agreement in whole or in part without the prior written approval of the other.

G. Waiver of Contract Breach

The waiver by one party of any breach of this Agreement or the failure of one party to enforce at any time, or for any period of time, any of the provisions hereof will be limited to the particular instance and will not operate or be deemed to waive any future breaches of this Agreement and will not be construed to be a waiver of any provision except for the particular instance.

H. Amendment

This Agreement will not be subject to amendment unless made in writing and signed by all parties.

I. Indemnification

The Consultant will indemnify and hold harmless the Village and its officers, employees and agents from any and all liability, losses or damages the Village may suffer as a result of claims, demands, suits, actions or proceedings of any kind or nature in any way resulting from or arising out of negligent action on the part of the Consultant or any sub-Consultants under this Agreement. This indemnification does not apply to liability caused by the Village's own negligence. This indemnification is further capped at the value of this Contract.

J. Severability of Invalid Provisions

If any provisions of this Agreement are held to contravene or be invalid under the laws of any state, country or jurisdiction, contravention will not invalidate the entire Agreement, but it will be construed as if not containing the invalid provision and the rights or obligations of the parties will be construed and enforced accordingly.

K. Assignment

The Consultant will not assign or subcontract any portion of this Agreement, unless the Village agrees to the assignment or subcontract in writing. Any assignment will not relieve the Consultant from its obligations or change the terms of this Agreement.

The Consultant will provide a list of key staff, titles, responsibilities, and contact information to include all expected sub Consultants.

L. Campaign Disclosure Certificate

The Consultant shall comply with the Campaign Disclosure Certificate attached hereto and incorporated herein by reference as Exhibit B.

M. Notice

Any notice will be in writing and will be deemed to be effectively served when deposited in the mail with sufficient first class postage affixed, and addressed to the party at the party's place of business. Notices shall be addressed to designated representatives of both parties as follows:

Village Manager
Village of Downers Grove
801 Burlington Ave.
Downers Grove, IL 60515

Underwriters Safety & Claims, Inc.
1801 N. Mill St., Suite M
Naperville, Il 60563

N. COOPERATION WITH FOIA COMPLIANCE

Consultant acknowledges that the Freedom of Information Act may apply to public records in possession of the Consultant or a subconsultant. Consultant and all of its subconsultants shall cooperate with the Village in its efforts to comply with the Freedom of Information Act . 5 ILCS 140/1 et.seq.

IN WITNESS WHEREOF, the Parties have executed this Agreement on the date indicated above.

Underwriters Safety & Claims, Inc.

By: George Young

Title: VP-TPA Services

Date: 5/16/2011

Village of Downers Grove

By: _____

Title: Village Manager

Date: _____

Exhibit A.

Campaign Disclosure Certificate

Any consultant, Proposer or vendor who responds by submitting a bid or proposal to the Village of Downers Grove shall be required to submit with its bid submission, an executed Campaign Disclosure Certificate, attached hereto.

The Campaign Disclosure Certificate is required pursuant to the Village of Downers Grove Council Policy on Ethical Standards and is applicable to those campaign contributions made to any member of the Village Council.

Said Campaign Disclosure Certificate requires any individual or entity bidding to disclose campaign contributions, as defined in Section 9-1.4 of the Election Code (10 ILCS 5/9-1.4), made to current members of the Village Council within the five (5) year period preceding the date of the bid or proposal release.

By signing the bid documents, consultant/proposer/Proposer/vendor agrees to refrain from making any campaign contributions as defined in Section 9-1.4 of the Election Code (10 ILCS 5/9-1.4) to any Village Council member and any challengers seeking to serve as a member of the Downers Grove Village Council.

Under penalty of perjury, I declare:

☒ Proposer/vendor has not contributed to any elected Village position within the last five (5) years.

George Young — Signature

George Young — Print Name

☐ Proposer/vendor has contributed a campaign contribution to a current member of the Village Council within the last five (5) years.

Print the following information:

Name of Contributor: _____
(company or individual)

To whom contribution was made: _____

Year contribution made: _____ Amount: $ _____

_____ Signature

_____ Print Name

EXHIBIT B

See Consultant's Response to Proposal dated March 7, 2011

IV. PROPOSER'S RESPONSE TO RFP (Professional Services)

(Proposer must insert response to RFP here DO NOT insert a form contract, the RFP document including detail specs and Proposer's response will become the contract with the Village)

A. Staffing Requirements

Agreed the following staffing requirements scope will be followed except with the respect to the following items:

US&C has an advanced claim system and claim staff operates with paperless files. This enables adjusters to be very efficient. The US&C staffing model will be to provide a designated adjuster and supervisor with the indemnity adjuster assigned no more than 160 lost time claims. Open claims counted in the loss runs provided by the Village total 51. This is less than 50% of an adjuster's workload so the account manager, adjuster and supervisor will be designated to handle all the Village's lost time claims. They will also work with other dedicated accounts to round out their work load.

- A dedicated "Account Manager" must be assigned, who will have the authority to implement servicing specifications, Contract terms and changes in the program on a proactive basis or as required by VILLAGE OF DOWNERS GROVE.
- VILLAGE OF DOWNERS GROVE requires that only claims adjusters with at least three years of workers' compensation experience be assigned to manage its Lost Time cases. The Claims Supervisor must have at least five years workers' compensation experience.
- The maximum caseload of VILLAGE OF DOWNERS GROVE dedicated claims adjusters shall be no more than 125 pending Lost Time files. (Lost Time files are defined according to statute)
- A ratio of the five dedicated adjusters to one dedicated supervisor must be maintained and not exceeded. ("Dedicated" means the person works exclusively for the TPA on the VILLAGE OF DOWNERS GROVE program.)
- Should a change in staff servicing VILLAGE OF DOWNERS GROVE occur, prior written notice to VILLAGE OF DOWNERS GROVE's Risk Manager, or their designee is required, along with a minimum one-week transition-orientation training of the staff person.
- VILLAGE OF DOWNERS GROVE expects its files to be handled by the adjusters dedicated to the VILLAGE OF DOWNERS GROVE Program, who are co-located in one office of the TPA when feasible.

B. Administrative

- **Claim Handling:**

Agreed the following claim handling requirements will be followed. US&C offers the following narrative of the claim handling process for workers' compensation, auto and liability claims:

The following is offered to outline our proposed approach. As you can see, a great deal of activity takes place in the first three days. After this the Claims Adjuster and Nurse are deeply involved in the continuing efforts to return the employee to work, bring the claim to resolution, and resolve any issues.

• **Claim Setup.** An event is reported to the Village. The Village will report the claim by internet, telephone, fax or email. The claim coding is entered on the system the day it is received and a claim record is created. US&C will report the claim electronically to the state as required under the IL regulations.

• **Assign Claim.** Once the claim is input, the claim is received by the Claims Adjuster and diaries are created. The Claim Team Supervisor reviews the information submitted and makes a staff assignment based on general protocol and client specific handling procedures. The system automatically notifies the Claims Adjuster that a new claim has been received. Investigation and medical management begin immediately.

• **Initial Three-Point Contact.** Contact with the employer representative, employee, and physician(s), will take place within 1 business day of receipt of the claim report. These contacts are made by telephone. If after several attempts, we are unsuccessful in reaching the party, we send a fax or letter.

- ***Employer*** – The Claims Adjuster will make immediate contact with the employer to determine the circumstances of the injury, history of the employee, knowledge regarding medical providers and proposed course of treatment, and identify potential transitional work opportunities if the situation presents such an opportunity. Statements will be discussed with the Village and taken as requested

-***Employee*** – The Claims Adjuster will call the employee to obtain information about the accident and the injury/illness, explain the workers' compensation benefits and managed care, receive information indicating the employee's understanding of the treatment plan and prognosis, set expectations for return-to-work, explain our role and discuss the need for their signature for authorization to release medical information. During the course of this conversation, the Claims Adjuster will be evaluating the information and the motivation of the injured employee.

- ***Medical Provider*** – The nurse will contact the treating providers (physician, hospital, or other medical provider) to obtain medical information about the injury/illness and identify restrictions and limitations regarding return to work. The nurse contacts the provider within 1 business day of US&C receiving the claim. The nurse triage's the claim with the adjuster.

• **Begin to contact witnesses.** The Claims Adjuster will start contacting any known witnesses. This is completed within five (5) days or less of receiving the claim assignment.

• **Investigate other related claims.** US&C will file with the Central Index Bureau to report the claim and to determine whether there could be a related injury/illness that would have bearing on this claim. This activity is completed within five (5) or ten (10) days of receipt of the claim.

• **Begin to explore subrogation.** The Claims Adjuster will begin to explore the potential for subrogation. This assessment will be completed within fourteen (14) days of receipt of the claim and updated as new information is made available.

• **Send Letters.** The Claims Adjuster will send a letter to the injured worker to confirm in writing that US&C has received their claim and enclose the medical authorization form and a request for more information about the claim that they need to sign and return in the addressed, stamped envelope. This letter is mailed within the two (2) business days of receipt of the claim.

• **Reserves.** Reserves will be established to best reflect the future prognosis of the claim. Medical only claims will be reserved at $500 per claim until additional information can be obtained, which may reflect a change in status or increase in medical cost. These claims will be closed within sixty (60) days of receipt of the claim unless there is continuing medical activity. If there is continuing medical claim activity in excess of $2,500, these claims will be reviewed by the nurse and/or adjuster for future handling.

After gathering the information listed above, the Claims Adjuster will decide whether to accept or deny the claim and develop an "action plan". US&C strives to make a decision within five (5) working days of receiving the First Report of Injury.

Accepted Claim - Upon accepting the claim, the Claims Adjuster will send a notice to the State (EDI) and begin the temporary total benefits, if applicable, and proceed with the claim management.

Denied Claim - Occasionally, our clients want advance notice of claim denials. If the Village so desires, the Claims Adjuster will contact the Village representative to discuss the claim and provide notice of the planned denial. Upon the Village concurrence with the denial decision, the Claims Adjuster prepares a letter explaining the reason for the denial and sends the letter certified mail return receipt to the claimant.

Medical Only Claims - Our process is very similar … investigation, determining proper relationship to this injury, compensability, with fair and appropriate, and timely payment.

• **Begin the ongoing claim management**. Our Claim Team then proceeds with the ongoing claim management, including obtaining and monitoring medical, communicating with the claimant as appropriate, and maintaining updated action plans and completing the action items. Reserves are adjusted if needed based on significant new developments.

Additional comprehensive services include:

- Paying bills on behalf of the Village
- Scanning of claim documents, medical & legal bills, reports and explanation of benefit reports & providing client access to the scanned documents.
- Facilitating a medical bill review and pharmacy discount program
- Providing a claim and managed care integrated utilization review process.
- Providing client access to adjuster memos, payment detail, scanned file documents and report writing that is easy to use and intuitive.
- Participating in claim review meetings

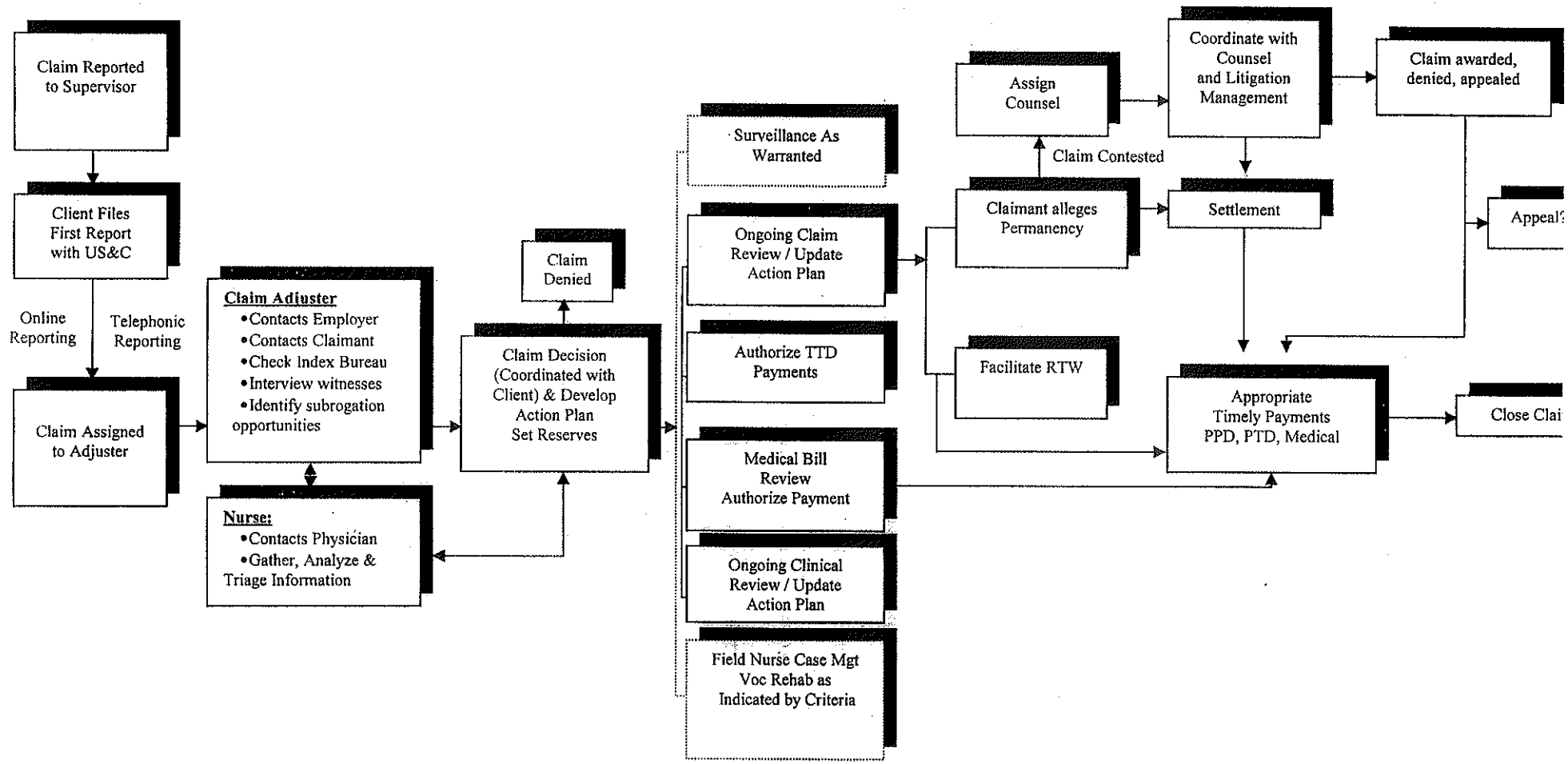
Initial Supervisory Review. As stated earlier, the supervisor will review each file assigned to the Claims Adjuster within two days of the initial report of claim. This will ensure that the initial investigation, contacts, and appropriate reserving have taken place.

Periodic Supervisor Review. After the initial review, the supervisor reviews every lost time and complex medical only claim every sixty (60) days. The supervisor reviews any high dollar claim (exceeds a total of $25,000 paid) every thirty (30) days as long as the file remains open or can be moved back to every sixty (60) days based on the claim status (return to work, litigation, etc.). Simple medical only claims are reviewed every ninety (90) days.

Electronic Notes. All notes by the supervisor are contained within the electronic claim file; the electronic notes are available for online viewing through our web-based service. This ensures that Village representatives can review adjuster notes, supervisor review and comments, as well as the nurse's notes within the claim file. This ensures that all parties are working together to resolve the claim as effectively as

possible.

Claims Flow Chart



US&C will work closely with the Village attorney and with any appointed legal representatives throughout the proceedings.

Assignments to outside counsel if authorized will contain specific instructions as well as a complete recap of the case. The adjuster retains responsibility for the claim and does not abdicate the clams handling to the outside attorney if one is selected. Rather, the attorney will provide us with analysis and review of the claim and possible settlement or resolution suggestions. Mediation or arbitration will be considered when thought to be effective. US&C wants the Village to receive maximum benefit and return on their legal expense. All documentation will be available in our imaging system.

The following will take place.

- Outside legal counsel furnishes budgets on all claims and overages are adequately justified or not approved. This ensures that a review of the monetary advantages and disadvantages to defending the claim are reviewed on a periodic basis.
- An initial defense plan is requested of outside counsel within thirty (30) days of counsel receiving the case. This plan is updated periodically as circumstances change.
- Timely communication with the appropriate Village personnel / legal department.
- All work assignments are reviewed to eliminate duplication of efforts.
- Legal billing will be reviewed to ensure charges are appropriate and in conformity with our understandings of the work performed and budget.
- The case is assigned to one attorney who handles all aspects of the case to conclusion (the case is not passed among members of the firm).
- The attorney performs only value-added legal work and does not perform any adjusting functions. This ensures that the fees for litigating the claim are held in check.
- US&C follows up on each litigated file for re-assessment on a regular basis.
- Scheduled contact is diaried to ensure timely reporting.

US&C ensures that counsel are kept apprised of all developments on the file, discussions are held between counsel, adjuster, and client, regarding settlement opportunities, discovery issues, and potential conflicts which may arise during the claim. Through claim review meetings, the client is kept apprised of any developments and thoughts regarding settlement and claim resolution.

US&C will provide the necessary reports for filings that must be performed by the Village. This included the 2nd injury fund and rate adjustment fund reports. US&C will perform Section 111 MMSEA Medicare query and reporting.

Rehabilitation / Medical treatment

US& C will work with the Village representatives who coordinate the initial treatment and referral to specialists.

Customary protocols for referral for onsite case management follow. These protocols are adjusted to meet the specific needs of each Client.

- Catastrophic injuries: burns, amputation, crush injuries, head/ spinal cord injury
- Noncompliance issues with treatment unsuccessfully addressed by TCM

- Multiple treaters or frequent changes in treating physician
- Problems with social issues more appropriately evaluated in person
- Inability to locate client after multiple phone and mail attempts
- Re-injury of same body part with no RTW plan
- Potential employer or client education may be needed along with job site evaluation
- Case in TCM over 30 days with no RTW date within reasonable timeframe
- Non-cooperative physician; ongoing treatment with no discharge date
- Employer support in creating alternative duty job description to facilitate RTW
- Vocational evaluation indicated

Protocols for assignment for Utilization Review follow:

- Notification of outpatient surgery
- Notification of inpatient admission and continued stay
- Notification of rehab/nursing home stay
- Multiple providers and/or medications
- Request for psychiatric/psychology treatment
- Request for pain management referral
- Request for diagnostic testing, especially lumbar, cervical or shoulder
- Chiropractic treatment
- Request for continued or extended physical therapy
- Request for multiple IME
- Unexpected increase in medical activity

The goal of Utilization Review is to provide a review of proposed or provided medical services to the injured worker to determine the medical necessity and appropriateness of the care rendered and address best evidence-based medical practice to produce positive outcomes.

These goals are accomplished through the following steps:

a. Precertification (prospective) Review.
b. Review of proposed diagnostics, procedures, and inpatient admissions based on nationally recognized criteria and physician peer review.
c. Concurrent Review:
- Review of clinical information, treatment plan and level of service for inpatient hospitalization.
d. Retrospective Review:
- Review of the total continuum of care addressing appropriateness of care, causal relationship to the compensable injury, and recommendations for future care.
e. Appeal:
- Review of medical information by a specialty matched physician following initial denial.

The focus of a UR program is to determine the appropriateness of medical care, the quality of care services provided and necessity of the care based on recognized standards. An injured worker is entitled to efficient, efficacious and necessary treatment provided in the appropriate setting. UR provides a system to make these determinations in a timely manner that does not impede appropriate medical care. UM review provides an avenue to identify unnecessary and frequently over utilized treatment and procedures, identify treatment that does not meet recognized standards and recommend alternative plan of care if indicated. UR can provide a

system to manage costs, improve care and determine if the medical treatment was reasonably required to cure or relieve the effects of the work injury.

US&C's wholly owned subsidiary,BHN is URAC certified and provides Utilization Review services. BHN also provides enhanced medical bill review services utilizing the Coventry workers' compensation network. US&C provides pharmacy program utilizing the services of Preferred Medical.

Electronic data exchange protocols are in place between US&C systems, Coventry's network services and Preferred Medical. This speeds the process and eliminates paper flow.

The BHN "Enhanced Bill Review System" using the Coventry network is much more than an "adjudication to fee schedule" system and contains a number of distinct audit categories designated to detect the following:

Upcoding:
Our bill review system contains a wide variety of clinical review edits including the ability to identify instances of inappropriate upcoding of services. Most edits focus on the upcoding of the most commonly submitted codes such as office visits and physical therapy services.

Unbundling of Outpatient, Surgical, Laboratory, or Diagnostic Procedures
Our system precisely detects unbundled, mutually exclusive and incidental procedures. Our clients routinely receive enhanced savings through the identification of inappropriate treatment intensities for a given diagnosis or treatment that exceeds the needs of an injured person.

Identification of provider billing anomalies is as much a part of the bill review system as is pricing of procedures. Various parts of the system work together to assist the processor in creating the maximum savings possible on any individual bill.

Unbundled procedure codes are identified in our bill review system according to state-specific guidelines and medical policies. Procedure unbundling occurs when two or more procedure codes are used to identify a service when a single, more comprehensive procedure exists to describe the entire service performed. When unbundled services are detected, our bill review system automatically bundles the procedures to the correct procedure code. Occasionally, the correct code is not present on the provider's bill. In these cases, our bill review system will automatically add the correct procedure code and price accordingly.

Incidental procedures that are commonly performed as a part of a larger procedure are edited in the system. For example, if an injection procedure is billed in conjunction with a tendon repair, the system will identify the injection procedure as an incidental procedure and deny the charge.

Mutually exclusive procedures are those procedures that should not be performed during the same visit. The system will automatically identify mutually exclusive procedures and recommend payment only for the most clinically intensive procedure performed.

Fragmented procedures are also identified by our bill review system. A fragmented bill is a bill which the provider submits only a portion of the services. The secondary billing includes additional services on the same or different date of service. Our bill review system performs

edits and audits on a line-by-line basis and uses other service lines on the bill and in the history database to determine appropriate adjudication.

Procedure to diagnosis relationship edits, examines diagnosis codes that are not related to the procedures with which they are billed. A series of edits were created to alert the processor of billing inconsistencies in the areas of radiology and surgeries involving the musculoskeletal system. These edits can be assigned a severity to disallow services or suspend bills for manual review.

Outpatient utilization monitoring is a feature that utilizes a statistical database which contains over 2,000 diagnosis codes and the corresponding number of visits, by percentile, that represent the norm. The client can choose the percentile and the system will identify the number of visits exceeding the parameters. The system can be set to simply print a message on the explanation of review, or can suspend the bill for further review.

Application for state fee schedule: The bill review system offers full bill review capabilities for all state fee schedules. The system offers a high degree of automation for workers' compensation pricing and regulations for medical fee schedules, hospital (inpatient and/or outpatient) fee schedules and implemented schedules for ambulatory surgery centers, dental care, durable medical equipment, etc.
The bill review system has the capability to process the following types of workers' compensation bills:

- Hospital (UB82 and UB92)
- Medical and Ancillary (HCFA-1500 or Other)
- Pharmacy
- Administrative (non-medical bills) including charges for legal services, mileage, and other administrative services such as copy services, etc.

Identification of usual and customary rates: In states that have not adopted an official fee schedule, the bill review system uses usual and customary pricing guidelines from Ingenix (formerly known as Medical Data Research – MDR) which recognizes usual and customary percentiles by provider zip code. Usual and customary pricing is typically loaded at the 80th percentile; however, the pricing percentiles can vary by state, and as well, can be customized by client. In addition, usual and customary pricing is utilized in fee schedule states for those procedures that the state has not yet developed a fee schedule price.

Identification of unnecessary services/procedures: The bill review system includes robust checks to identify unnecessary services. These edits include mutually exclusive, incidental, procedure-to-diagnosis, and injury-related checks. Together, these edits, along with the monitoring or physician utilization patterns of our network providers, provides a high degree of identification and denial of unnecessary procedures.

Identification of PPO Discounts
Our system automatically and accurately applies our negotiated rates to bills generated by providers in the network for workers' compensation. The result is additional savings above and beyond savings from state fee schedules or usual and customary pricing.

Our rehabilitation personnel, including nurses and vocational experts, are well trained in their various areas of expertise. The nursing staff is RN qualified and has multiple years of

experience in nursing as well as case management.

US&C and BHN provide medical management reports to clients and will provide the reports required by the State.

Experts will be obtained when needed and made available to testify.

Pharmacy Services
Preferred Medical Network offers a single source for complete and quality pharmacy solutions that are flexible, easy to implement and offer substantial savings.

Administering workers' compensation medical and pharmacy claims is our specialty and single focus. Our goal is your complete satisfaction through fast, courteous, comprehensive and personal service.

Exclusive Preferred Medical Network benefits:

- Customization of services to fit your work comp needs
- Exceptional service with personal care
- Exclusive Medical Services & Equipment (DME) benefits:
- One of the best hearing aid networks available
- Unique return to independence/return to work rehabilitation program
- Exclusive work comp Rx benefits:
- The largest contracted pharmacy network in the nation including major, national chains, totaling over 64,000 pharmacies
- 98% workers' compensation network utilization rate with the remaining 2% direct billed from member or 3rd party billing agent
- 95% pharmacy network penetration nationwide
- 95% generic prescription utilization
- 100% electronic bill adjudication
- Nationally recognized Pharmacy SmartComp program, which averages $16 savings per prescription from prior systems
- High Utilization Pattern Alert program
- One of the most limited formulary lists in the industry to ensure costs are managed without sacrificing patient care
- Instant patient information to prevent drug interactions in combination with other drugs, allergies or medical conditions/diseases
- No cost card mailings
- No separate fees for drug utilization review (DUR) services

Preferred Medical Network offers workers' compensation cost containment for pharmacy and durable medical equipment.

- Fraud and abuse prevention
- No third party vendors
- Work comp Rx administration:
- Rx savings well below all state fee schedules
- Customized Rx formulary executed by clinical staff
- Program utilization training for claimants and physicians
- Three-tiered drug utilization review (DUR)

- Medical Services & Equipment (DME) administration:
- Savings information on every invoice
- Contracted network with community-based healthcare providers securing the lowest prices available
- Knowledgeable service representatives recommend the most cost effective product or service
- Trained staff that is always looking for more ways to improve savings and effectiveness
- Lowest-cost brand names
- One of the most competitive hearing aid programs available

Preferred Medical Networks offers the following advantages for injured workers:

- No out of pocket expenses
- Personal assistance to ensure complete care and satisfaction
- Access to interpreters in over 100 languages
- Work comp Rx administration:
- Instant Rx benefits for immediate access
- Access to the largest workers' compensation pharmacy network in the industry of more than 61,000 pharmacies
- Pharmacy network utilization via phone, fax, email or web
- Home Mail Order Pharmacy Service
- Medical Services & Equipment (DME) administration:
- Personal assistance in all cases for the claimant and/or physician
- Close monitoring during the entire rehabilitation process to ensure responsible treatment
- Complete management of home medical supplies for the catastrophically injured
- No solicitation of supplies
- Guaranteed nationwide delivery on all products and services
- Overnight shipment upon request
- Quality products and services including many brand names

US&C Workers' Compensation Claim Standards and Technical Claim Handling Guidelines

1. **Employer Contact:**
   Call or meet with Employer (within 1 business days of assignment). Verify that the injury or occupational disease arose out of and in the course and scope of employee's employment. Your investigation should include:
   - A detailed verbal and/or written statement regarding accident facts.
   - Nature and extent of injury.
   - Disability period, expected RTW.
   - When the accident was reported and to whom?
   - Date of hire, pre-employment history.
   - Job description.
   - Employee job disposition (attitude toward work).
   - Prior injuries or claims.
   - Medical history (any related pre-existing conditions).

- Availability of light work.
- Request Wages; Salary Continuation: if yes, does employer wish reimbursement?
- Witness(es) name(s) and address(es).
- Medical treatment -- name(s) and address(es) of physicians.

2. **Employee Contact:**
   Call or meet with Employee (within 24 hours of assignment).
   - Obtain a detailed verbal and/or written statement regarding accident description.
   - Obtain information on Nature and Extent of Injury, Disability, RTW.
   - Witness(es) name(s) and address(es) to whom accident was reported and when.
   - Treating physician(s) name(s) and address(es).
   - Age, DOB.
   - Marital status [dependent(s)].
   - Education.
   - Past medical history (prior injuries).
   - Length of employment.
   - Previous work history.

3. **Physician(s) Contact:**
   Call or meet with the treating physician (within 5 days for assignment).
   - Verify medical history, nature, and the extent of injury and causal relationship.
   - Determine recommended treatment plan
   - Extent of disability, projected RTW.
   - Prior medical history and treatment?
   - Request medical records.

4. **Witness(es) Contact:**
   Call or meet with Witness(es) (within five (5) days of assignment).
   - Verify accident, facts, and nature and extent of claimant's injuries.

5. **Subrogation:**
   - Consider responsible third involvement (within fourteen (14) days of assignment). Determine if there is any potential recovery contribution from third party. Document claim file.

6. **Second Injury Fund:**
   - Consider SIF involvement (within 14 days of assignment). Determine if there is any pre-existing condition(s) that would qualify claim for potential recovery. Document claim file.

7. **Medical Authorization:**
   - Secure/request medical authorization (within 14 days of assignment).

8. **Index Bureau:**
   - Complete the IB request within 5 days of assignment and semiannually thereafter, when required by client.

9. **Rehabilitation:**

- Consider whether the claim qualifies as a referral for Medical Management and/or Vocational Rehabilitation initially at 14 days and thereafter upon receipt of information that indicates an assignment would be in order.

10. Future Plan of Action/Disposition:

- Establish target dates for return to work, medical maximum improvement, partial rating, activity checks, IME, and develop plan for achieving resolution of claim.

US&C Automobile/Liability/Property Claim Standards and Technical Claim Handling Guidelines

1. **Coverage:**
Verify and document the loss is covered under the current policy.

2. **Insured Contact:**
Call or meet with Insured (within 24 hours of assignment) to verify the details of the claim or incident. Your investigation should include:

Automobile
A detailed verbal and/or written statement regarding accident facts, including fault analysis (who is at fault and why).

- Nature and extent of injuries and property damage.
- Location and condition of vehicle. Is it incurring storage fees, is a rental required, (are rental expenses covered under the policy)? Where will the vehicle be repaired? Have estimates been obtained / amounts?
- Witness(es) name(s) and address(es).
- Medical treatment – name(s) and address(es) of physicians and/or hospitals.
- Medical history (any related pre-existing conditions).
- Send PIP applications.
- Request police report.
- Assign appraiser.
- Complete scene investigation if necessary.
- Approve rental if required.
- Follow total loss procedures if totaled.

Property

- A detailed verbal and/or written statement regarding nature and extent of damages.
- Are damages covered (is cause of loss a covered cause of loss).
- Address exclusions.
- Identify location of property and verify that the property is scheduled.
- Mitigation of damages.
- Cause and origin determined.
- Address subrogation and salvage.
- Send Proof of Loss if required.
- Send NICB forms if required.
- Assign appraiser.

General Liability

- A detailed verbal and/or written statement regarding accident facts, including fault analysis (who is at fault and why).
- Were photos taken at the time of the incident
- If injury caused by alleged property defect, was this defect known by insured prior to the incident.
- Nature and extent of injuries or property damage.
- Was an ambulance called? Transport required?
- Witness(es) name(s) and address(es).
- Last known employee in the area prior to the incident occurring
- Medical treatment – name(s) and address(es) of physicians and/or hospitals.
- Complete scene investigation if necessary.

3. **Claimant Contact:**
Call or meet with Insured (within 24 hours of assignment) .Verify the details of the claim or incident. Your investigation should include:

Automobile
A detailed verbal and/or written statement regarding accident facts, including fault analysis (who is at fault and why).

- Nature and extent of injuries or property damage.
- Identify their carrier.
- Location and condition of vehicle. Is it incurring storage fees, is a rental required, (are rental expenses covered under the policy)? Where will the vehicle be repaired? Have estimates been obtained / amounts?
- Follow total loss procedures if totaled.
- Witness(es) name(s) and address(es).
- Medical treatment – name(s) and address(es) of physicians and/or hospitals.
- Medical history (any related pre-existing conditions).
- Send Medical / Wage authorizations.
- Request police report.
- Assign appraiser.
- Approve rental if required.

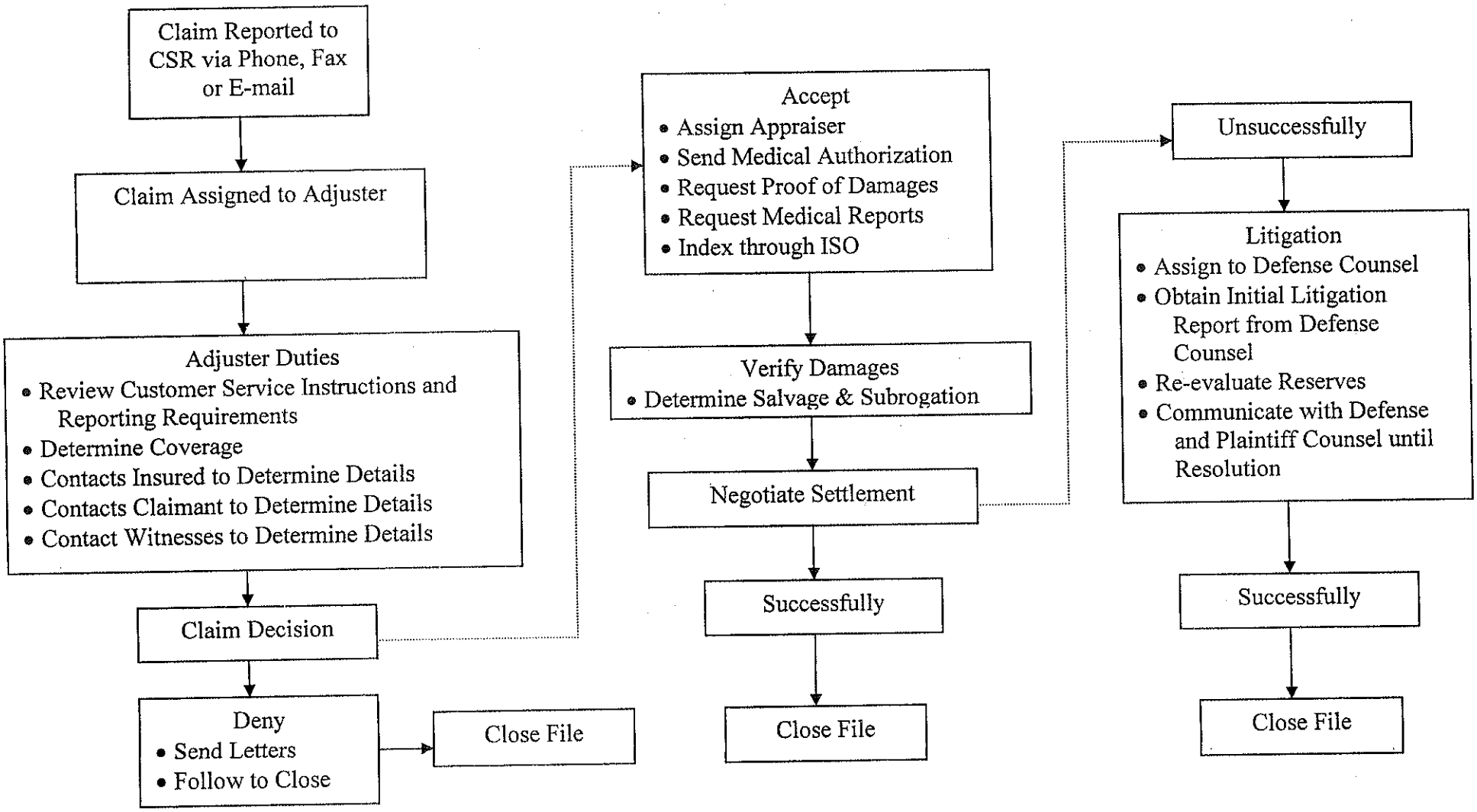
General Liability
- A detailed verbal and/or written statement regarding accident facts, including fault analysis (who is at fault and why).
- Nature and extent of injuries or property damage.
  Witness(es) name(s) and address(es).
- Medical treatment – name(s) and address(es) of physicians and/or hospitals.
- Medical history (any related pre-existing conditions).
- Send Medical / Wage authorizations.

4. **Physician(s) Contact:**
Verify medical history, nature, and the extent of injury and causal relationship.
- Determine recommended treatment plan
- Extent of disability, projected RTW.
- Prior medical history and treatment?

- Request medical records.

5. **Witness(es) Contact:**
   Call or meet with Witness(es) (within 5 days of assignment).
   - Verify accident, facts, and nature and extent of damages and injuries.
6. **Subrogation:**
   - Consider responsible third party involvement (within 14 days of assignment). Determine if there is any potential recovery contribution from third party. Document claim file.
7. **Medical Authorization:**
   - Secure/request medical authorization (within 14 days of assignment).
8. **Index Bureau:**
   - Complete the IB request within 5 days of assignment and semiannually thereafter, when required by client.
9. **Future Plan of Action/Disposition:**
   - Outline future activity to bring this claim to a resolution.
10. **Claim Payments/Resolution**

Document and authorize payment request within 48 hours of settlement


Claim Reported to CSR via Phone, Fax or E-mail
Claim Assigned to Adjuster
Adjuster Duties
• Review Customer Service Instructions and Reporting Requirements
• Determine Coverage
• Contacts Insured to Determine Details
• Contacts Claimant to Determine Details
• Contact Witnesses to Determine Details
Claim Decision
Deny
• Send Letters
• Follow to Close
Close File
Accept
• Assign Appraiser
• Send Medical Authorization
• Request Proof of Damages
• Request Medical Reports
• Index through ISO
Verify Damages
• Determine Salvage & Subrogation
Negotiate Settlement
Successfully
Close File
Unsuccessfully
Litigation
• Assign to Defense Counsel
• Obtain Initial Litigation Report from Defense Counsel
• Re-evaluate Reserves
• Communicate with Defense and Plaintiff Counsel until Resolution
Successfully
Close File

US&C provides comprehensive services including:

- Enhanced bill review with Coventry medical bill review discounting.
- Scanning of claim documents, medical bills, reports and explanation of benefit reports with client access to the scanned documents.
- Pharmacy Discount Program
- A claim and managed care integrated utilization review process.
- Client access to adjuster memos, payment detail, scanned file documents and report writing that is easy to use and intuitive.
- Experienced adjusters.
- A client service contact assigned to coordinate delivery of service.
- A client service person assigned to assist with reporting needs.
- A client service person assigned to provide special request cost and analysis reports.
- A person designated to secure loss reimbursement from underwriters
- An excess reimbursement report available on line for client viewing
- Statement of Audit Standards, SAS70 Type II audit by US&C's Certified Public Accountant to assist clients with their financial audit.
- Electronic transfer of data from the prior TPA system to maintain claim records on one system and enable client access to all data
- Standard financial reporting of data for use by the Village, broker and underwriters.
- Escrow funds management.
- Client internet access to claim data for management of the Village to view adjuster notes, payment detail and to run standard loss runs and check register reports.
- Monitoring of the excess reimbursement status of claims, excess claim reporting to underwriters and the requesting of excess reimbursement from the excess insurance company.
- Claim review meetings
- CMS Mandatory Medicare Claim Reporting
- Notification and training so that the Village will be kept up to date with changes in the State's workers' compensation law and self-insurance regulations.
- Assistance with maintaining the status of self-insurance.

US&C will tailor the claim programs to meet the unique needs of the Village.

- ✓ Medical invoices must be processed for payment with statutory time frame.
- ✓ Indemnity payments must be made within statutory time frame, any deviation must be clearly documented and the claimant and the Workers' Compensation Specialist must be advised.
- ✓ Compensability and coverage positions are required as soon as possible, but no more than 14 days from receipt of claim, unless statutory timeframes are shorter.
- ✓ Perform investigations as necessary to determine compensability under applicable Workers' Compensation Law.
- ✓ Identify and effectively pursue all claims with Second Injury Fund potential recovery. Reimbursement for Second Injury Fund cases must be requested quarterly by the end of the second week following the close of the quarter with copies to VILLAGE OF DOWNERS GROVE's Risk Manager.

- ✓ Report to VILLAGE OF DOWNERS GROVE's Risk Manager on all claims with a reserve value of $5,000 or more. Promptly advise VILLAGE OF DOWNERS GROVE's Risk Manager of any fines, penalties, court judgments, decisions, settlements, proposed appeals and other significant developments on each case.
- ✓ Make no settlements on claims where the total value exceeds $10,000, unless approved in advance by VILLAGE OF DOWNERS GROVE Risk Manager.
- ✓ File all necessary forms, contract for the payment of all medical, legal, utilization review, rehabilitation, support expenses, and claimant compensation payments in a timely fashion as prescribed by the workers compensation law.
- ✓ Verbally notify claimants or their attorneys of decisions to deny or terminate benefits on the same day. Written notification should be immediately sent to the claimant, attorney and pertinent medical providers stating the reason(s) for denial or termination of benefits.
- ✓ Review all claims for subrogation potential. File timely liens and aggressively pursue recovery using all available remedies, including filing suit.
- ✓ Make no compromise of a lien unless approved by the VILLAGE OF DOWNERS GROVE's Risk Manager.
- ✓ Claim files must reflect prompt and fair handling of claims and how such is accomplished throughout the life of the claim.
- ✓ A current posting of payments, reserve analysis, and claim progress notes are required to be electronically maintained.

- **Medical / Vocational Case Management:** Agreed
  - ✓ Contract for and professionally manage all rehabilitation, surveillance, medical, utilization review, and other services as required.
  - ✓ Use an effective medical utilization and fee audit program in accordance with VILLAGE OF DOWNERS GROVE's requirements and the law.
  - ✓ Submit to the Risk Manager for the VILLAGE OF DOWNERS GROVE within 24 hours of receipt, copies of Independent Medical Examinations (IME's).

- **Program Communication**: Agreed, if the activity is desired by the Village.
  - ✓ VILLAGE OF DOWNERS GROVE expects to have considerable ongoing communication and interaction with the TPA claim handler. VILLAGE OF DOWNERS GROVE believes constructive interaction is the most effective means to control its workers' compensation costs.
  - ✓ Informal reviews and/or meetings will be arranged on an ad hoc basis

- ✓ Claims adjusters may be requested to tour facilities to become familiar with position requirements, operations and physical layout as part of the orientation, before the start of the program.
- ✓ Chronic problems of delayed reporting or other critical information must be reported to the Risk Manager for the VILLAGE OF DOWNERS GROVE or its designee.

- ✓ Quarterly Claim Summary Reports are to be provided with specific detail and claim level to be developed jointly by VILLAGE OF DOWNERS GROVE and the TPA.
- ✓ Communication to VILLAGE OF DOWNERS GROVE- Action plans, important, relevant information, at risk issues, and case closure and settlement strategies must be documented and updated as case progresses and communicated to VILLAGE OF DOWNERS GROVE on a timely basis.
- ✓ Visit all work reporting locations on a regular (semi-annual) basis to discuss any reporting problem, ensure notices of compliance with respective Workers Compensation laws are conspicuously posted, provide forms, listings of recommended or approved medical providers.
- ✓ Prepare and submit, on a quarterly basis, a management analysis report evaluating present programs, operating problems and recommend program changes.
- ✓ A "stewardship" report should be done at least annually that summarizes program developments over the year and recommendations for program changes or enhancements.
- ✓ Conduct two (2) seminars per year on changes to workers compensation act(s) and developments in the industry to update VILLAGE OF DOWNERS GROVE staff.

- **File Audits:** All files are electronic and US&C provides clients with access to the claim data 24 hours a day. The Village auditor will be able to audit the files from their office without the need to travel and they will be able to complete the audit at any time and from any location with common internet explorer software. US&C proposes that the electronic documents and files be used for the file and that the file documents not be printed unless absolutely needed. US&C agrees with the audit process.
  - ✓ VILLAGE OF DOWNERS GROVE will conduct the reviews to ensure that VILLAGE OF DOWNERS GROVE employees are receiving the workers' compensation benefits owed to them, the claim handling is cost effective and managed in a technically competent and proactive manner.
  - ✓ VILLAGE OF DOWNERS GROVE will identify the files to be reviewed and provide the list to the TPA at least two weeks in advance of the audit.
  - ✓ Prior to a VILLAGE OF DOWNERS GROVE's review, the TPA must print the computer file notes, pay records and reserve calculations or easy on-line access to the information that supports the file handling.
    - ➢ A wrap up meeting will be held with management staff to identify areas requiring immediate attention.
    - ➢ A written report will summarize the findings and issues within 30 business days of the audit.
    - ➢ The TPA must respond within 30 business days with answers to questions and a plan of action where indicated.
  - ✓ File evaluations or "audits" may be conducted at least twice per year by VILLAGE OF DOWNERS GROVE staff and/or their designated representative and will address the following issues:
    - ➢ **Investigation**
      - o 3-point contact
      - o Initial investigation

- Recorded Statement
- Jurisdiction Filings
- Second Injury Fund/Subrogation

➢ **Medical Management**

- Ongoing contact with Physician or Case Manager
- IME/Expert addressed
- Light / Modified Duty Pursued

➢ **Data Management**

- Standard Data
- Special Coding
- Wages

➢ **Litigation Management**

- Referral Document
- Support of Defense Attorney

➢ **Reserves**

- 14 Day Reserve
- Current Reserves (at the time of the Audit)
- **Claims Management**
- Stated Diary Date/Compliance
- First Status Report
- Ongoing Status Report
- Proactive Handling

➢ **Supervision**

- Initial Review
- 14 Day Review
- Ongoing Review

➢ **General Comments**

- **Miscellaneous:**

US&C recently assumed the claim files and went through a transition with the Village's current administrator. US&C was handling the open run off claims and the new claims as of the effective date of the transfer. The Villages TPA uses a data service provider that operates by their own schedule so the data transfer was delayed. The US&C claim staff was able to

administer the claims during the delay without complaints for claimants. We would suggest the following transition program that worked well on many occasions. US&C would suggest that closed claim files be delivered to the Village for retention and destruction according to the Village's destruction schedule.

Proposed file and data transfer plan

Transfer of claim files to Underwriters Safety & Claims:

The effective date of the transition is 4/30/2011. To accomplish the transition the following steps should be followed:

Open Claim Files

1. Open indemnity files with ongoing TTD payments should be identified as such and grouped together in a shipping box. TTD payments should be issued through 5/27/2011 and the checks should be placed in an envelope marked to the attention of George Young. The envelope should be provided to George at the time of file pick up on Wednesday 4/28/2011
2. All other open claims should be identified as open claims and grouped together in a shipping box. Please identify the box as a box of open claims and mark the box 1 of 5, 2 of 5, etc.
3. Claim system memos and payment details should be printed and placed with each file.
4. The open claim files along with memo and payment detail and any unpaid bills and mail should be available for pickup planned for after pm on April 28th. A final loss run showing all open claims and a separate final loss run showing all claims should be included in the box.
5. Mail & bills received after the files are shipped should be forwarded to George Young's attention on at least a weekly basis. George's contact information follows:

George Young
Underwriters Safety & Claims
1801 North Mill St., Suite M
Naperville, IL 60563
630 357-7680 x223 tel
630 357-7682 fax
gyoung@uscky.com

Closed Claim Files

Closed claim files should be available for pickup on April 28th. The location of pickup is planned to be 3325 N. Arlington Heights Rd. Suite 500-A Arlington Heights, IL 60004. Boxes should be labeled closed and marked 1 of 15, 2 of 15, etc.

Data Conversion

6. A final extract of data should be prepared as of 4/30/2011 before all claim reserves are closed and the extract FTP'd or emailed to:

April Hawes
aprilh@uscky.com
Underwriters Safety & Claims
1700 Eastpoint Parkway
PO Box 23790
Louisville, KY 40223
800 928-1340 x4209

7. Prior to 4/1/2011, provide the name, telephone number and email address of the data department person who will be working with April to provide the data extract so the appropriate communication can take place to facilitate the extract.

EXHIBIT C

New Claims incurred after the contract inception:

US&C proposes a flat annual service fee of $$37,300. The service fee will remain the same for each of the first 3 years of the service agreement.

Should the agreement extend beyond three years, a charge of $30 per open claim per month will be charged for any claims open 3 years after the inception of each annual service term.

Open Run in claims incurred prior to the contract inception:

US&C proposes the following fee for handling open run in claims incurred prior to the contract inception:

Year One	A flat annual fee of $9,000
Year Two	A flat annual fee of $4,000
Year Three	A flat annual fee of $4,000
Thereafter	$30 per open workers compensation indemnity claim, professional liability claimant and bodily injury claimant per month

US&C will handle open run in claims only during the period that US&C has an agreement in place to handle new claims.

Medical bills - will be reduced by fee schedule or usual & customary, applicable PPO and other discounts, at a charge of $7.50/bill + 30% of savings below fee schedule or usual & customary rates.

US&C will serve as the Client's Account Manager on files that US&C administers for the Client, to assist with **Section 111 MMSEA queries and reporting**. Queries will be completed by US&C as required by the MMSEA at $7 each, and will be charged to the claim files as an allocated expense. An additional allocated expense of $25 will be charged when file reporting of confirmed Medicare eligible claimants is required and accomplished.