Exhibit E

Adopted: December 6, 1985
Amended: March 4, 1988
Amended: October 7, 1988
Amended: October 6, 1995
Amended: October 1, 1999
Amended: June 6, 2003
Amended: March 2, 2007
Amended: July 1, 2009
Amended: July 1, 2011
Amended: March 2, 2012
Amended: October 4, 2013

ADDENDUM A
WORKERS' COMPENSATION
CLAIMS ADMINISTRATION GUIDELINES

The following Guidelines have been adopted by the CSAC Excess Insurance Authority (hereinafter The Authority or the EIA) in accordance with Article 18(b) of the CSAC Excess Insurance Authority Joint Powers Agreement. It is the intent of these Guidelines to ensure compliance with all applicable Labor Code and California Code of Regulations Sections. In the event that there exists a conflict between the Guidelines, the Labor Code or the Code of Regulations, the most stringent requirement shall apply.

I. CLAIM HANDLING - ADMINISTRATIVE

A. Case Load

1. Each claims examiner assigned to the Member should handle a targeted caseload of 150 but not to exceed 165 claims. In situations where caseloads include future medical and medical only claims, these claims shall be counted as 2:1 in the caseload limit.

2. Supervisory personnel should not handle a caseload, although they may handle specific issues.

B. Case Review and Documentation

1. Documentation should reflect any significant developments in the file and include a plan of action. Plan of action statements should be updated at the time of examiner diary review.

2. The examiner should review the file at intervals not to exceed 45 calendar days. Future medical files should be reviewed at intervals

not to exceed 90 calendar days. An accomplishment level of 95% shall be considered acceptable.

3. The supervisor shall monitor activity on indemnity files at intervals not to exceed 120 calendar days. Future medical files shall be reviewed by the supervisor at intervals not to exceed 180 calendar days. An accomplishment level of 95% shall be considered acceptable.

4. File contents shall comply with Code of Regulations Sections 10101, 10101.1 and 15400, and be kept in a neat and orderly fashion. If claims are maintained in a paperless system, documents shall be clearly identified (e.g., medical report, WCAB Orders, legal, etc.). An accomplishment level of 95% shall be considered acceptable.

5. All medical-only cases shall be reviewed for potential closure or transfer to an indemnity examiner within 90 calendar days following claim file creation. An accomplishment level of 95% shall be considered acceptable.

C. Communication

1. Telephone Inquiries

Return calls shall be made within 1 working day of the original telephone inquiry. All documentation shall reflect these efforts. An accomplishment level of 95% shall be considered acceptable.

2. Incoming Correspondence

All correspondence received shall be clearly stamped with the date of receipt. An accomplishment level of 95% shall be considered acceptable.

3. Return Correspondence

All correspondence requiring a written response shall have such response completed and transmitted within 5 working days of receipt. An accomplishment level of 95% shall be considered acceptable.

4. Ongoing Claimant Contact

On cases involving unrepresented injured workers who are off work, telephone contact shall be made at a minimum of once every 45 days and within 3 working days after a scheduled surgical procedure. This is in addition to nurse case management involvement on claims where nurse case managers are assigned. An accomplishment level of 95% shall be considered acceptable.

D. Fiscal Handling

1. Fiscal handling for indemnity benefits on active cases shall be balanced with appropriate file documentation on a semi-annual basis to verify that statutory benefits are paid appropriately. Balancing is defined as, "an accounting of the periods and amounts due in comparison with what was actually paid". An accomplishment level of 95% shall be considered acceptable.

2. In cases of multiple losses with the same person, payments shall be made on the appropriate claim file. An accomplishment of 95% shall be considered acceptable.

E. Medicare Reporting

Proper verification of a claimant's status as to Medicare eligibility shall be completed and documented in the claim file. In those cases where the claimant does meet the eligibility requirements, mandatory reporting to the Center for Medicaid Services (CMS) must be completed directly or through a reporting agent in compliance with Section 111of the Medicare Medicaid and SCHIP Extension Act of 2007 ("MMSEA"). An accomplishment of 100% shall be considered acceptable.

II. CLAIM CREATION

A. Three Point Contact

Three point contact shall be conducted with the non-represented injured worker, employer representative and treating physician within 3 working days of receipt of the claim by the third party administrator or self administered entity. If a nurse case manager is assigned to the claim, initial physician contact may be conducted by either the claims examiner or the nurse case manager. This initial contact should be substantive and clearly documented in the claim file. In the event a party is non-responsive, there should be evidence of at least three documented attempts to reach the individual. Medical-only claims shall have this three

point contact requirement as well. An accomplishment level of 95% shall be considered acceptable.

B. Compensability

1. The initial compensability determination (accept claim, deny claim or delay acceptance pending the results of additional investigation) and the reasons for such a determination shall be made and documented in the file within 14 calendar days of the filing of the claim with the employer. In the event the claim is not received by the third party administrator or self administered entity within 14 calendar days of the filing of the claim with the employer, the third party administrator or self administered entity shall make the initial compensability determination within 7 calendar days of receipt of the claim. An accomplishment level of 100% shall be considered acceptable.

2. Delay of benefit letters shall be mailed in compliance with the Division of Workers' Compensation (DWC) guidelines. In the event the employer does not provide notice of lost time to the third party administrator or self administered entity timely to comply with DWC guidelines, the third party administrator or self administered entity shall mail the benefit letters within 7 calendar days of notification. An accomplishment level of 100% shall be considered acceptable.

3. The final compensability determination shall be made by the claims examiner or supervisor within 90 calendar days of employer receipt of the claim form. An accomplishment level of 100% shall be considered acceptable.

C. AOE/COE Investigation

If a decision is made to delay benefits on a claim, an AOE/COE investigation shall be initiated within 3 working days of the decision to delay. This may include, but is not limited to, assigning out for witness/injured worker statements, initiating the QME/AME process, requesting medical records, etc. An accomplishment level of 95% shall be considered acceptable.

D. Reserves

1. Using the information available at claim file set up, an initial reserve shall be established for the most probable case value. An accomplishment level of 95% shall be considered acceptable.

2. The initial reserve shall be electronically posted to the claim within 14 calendar days of receipt of the claim. An accomplishment level of 95% shall be considered acceptable.

E. Indexing

All claims shall be reported to the Index Bureau at time of initial set up and re-indexed on an as needed basis thereafter. An accomplishment level of 95% shall be considered acceptable.

The EIA maintains membership with the Index Bureau that members can access.

III. CLAIM HANDLING – TECHNICAL

A. Payments

1. Initial Temporary and Permanent Disability Indemnity Payment

a. The initial indemnity payment shall be issued to the injured worker within 14 calendar days of knowledge of the injury and disability. In the event the third party administrator or self administered entity is not notified of the injury and disability within 14 calendar days of the employer's knowledge, the third party administrator or self administered entity shall make payment within 7 calendar days of notification. Initial permanent disability payments shall be issued within 14 calendar days after the date of last payment of temporary disability. Effective 1/1/2013, permanent disability payments shall be issued upon approval of an Award pursuant to Labor Code Section 4650(b)(2). Prior to a PD Award, advances may be due if the employer has not offered the employee a position paying at least 85% of their wages and compensation at time of injury or the employee is not employed in a position paying at least 100% of their wages and compensation at time of injury. This shall not apply with salary continuation. An accomplishment level of 100% shall be considered acceptable.

b. The properly completed DWC Benefit Notice shall be mailed to the employee within 14 calendar days of the first day of disability. In the event the third party administrator or self administered entity is not notified of the first day of disability until after 14 calendar days, the DWC Benefit Notice shall be mailed within 7 calendar days of notification. An

accomplishment level of 100% shall be considered acceptable.

c. Self imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document. An accomplishment level of 100% shall be considered acceptable.

d. Overpayments shall be identified and reimbursed timely where appropriate. The third party administrator or self administered entity shall request reimbursement of overpaid funds from the party that received the funds. If necessary, a credit shall be sought as part of any resolution of the claim. An accomplishment level of 95% shall be considered acceptable.

2. Subsequent Temporary and Permanent Disability Payments

a. Eligibility for indemnity payments subsequent to the first payment shall be verified, except for established long-term disability. An accomplishment level of 100% shall be considered acceptable.

b. Self imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document. An accomplishment level of 100% shall be considered acceptable.

3. Final Temporary and Permanent Disability Payments

a. All final indemnity payments shall be issued timely and the appropriate DWC benefit notices sent. An accomplishment level of 100% shall be considered acceptable.

b. Self imposed penalty shall be paid on late payments in accordance with Section III. A.7. of this document. An accomplishment level of 100% shall be considered acceptable.

4. Award Payments

a. Payments on undisputed Awards, Commutations, or Compromise and Releases shall be issued within 10 calendar days following receipt of the appropriate document.

An accomplishment level of 95% shall be considered acceptable.

b. For all claims in the primary workers' compensation program (PWC) and/or excess reportable claims, copies of all Awards shall be provided to the Authority at time of payment. An accomplishment level of 95% shall be considered acceptable.

5. Medical Payments

a. Medical treatment billings (physician, pharmacy, hospital, physiotherapist, etc.) shall be reviewed for correctness, approved for payment and paid within 60 days of receipt. An accomplishment level of 100% shall be considered acceptable.

b. The medical provider must be notified in writing within 30 days of receipt of an itemized bill if a medical bill is contested, denied or incomplete. An accomplishment level of 100% shall be considered acceptable.

c. A bill review process should be utilized whenever possible. There should be participation in a PPO and/or MPN whenever possible.

6. Injured Worker Reimbursement Expense

a. Reimbursements to injured workers shall be issued within 15 working days of the receipt of the claim for reimbursement. An accomplishment level of 95% shall be considered acceptable.

b. Advance travel expense payments shall be issued to the injured worker 10 working days prior to the anticipated date of travel. An accomplishment level of 95% shall be considered acceptable.

7. Penalties

a. Penalties shall be coded so as to be identified as a penalty payment. An accomplishment level of 95% shall be considered acceptable

b. If the Member utilizes a third party administrator, the Member shall be advised of the assessment of any penalty for delayed payment and the reason thereof, and the administrator's plans for payment of such penalty, on a monthly basis. An accomplishment level of 95% shall be considered acceptable.

c. If the Member utilizes a third party administrator, the Member, in their contract with the administrator, shall specify who is responsible for specific penalties.

B. Medical Treatment

1. Each Member shall have in place a Utilization Review process as set forth in Labor Code Section 4610. An accomplishment level of 100% shall be considered acceptable.

2. Disputes regarding utilization review determinations shall be resolved using the Independent Medical Review process set forth in Labor Code Section 4610.5 An accomplishment level of 100% shall be considered acceptable.

3. Nurse case managers shall be utilized where appropriate. An accomplishment level of 95% shall be considered acceptable.

4. If enrolled in a Medical Provider Network, the network shall be utilized whenever appropriate.

C. Apportionment

1. Investigation into the existence of apportionment shall be documented. An accomplishment level of 95% shall be considered acceptable.

2. If potential apportionment is identified, all efforts to reduce exposure shall be pursued. An accomplishment level of 95% shall be considered acceptable.

D. Disability Management

1. The third party administrator or self administered entity shall work proactively to obtain work restrictions and/or a release to full duty on all cases. The TPA or self-administered entity shall notify a designated Member representative immediately upon receipt of

temporary work restrictions or a release to full duty, and work closely with the Member to establish a return to work as soon as possible. An accomplishment level of 95% shall be considered acceptable.

2. The third party administrator or self administered entity shall notify a designated Member representative immediately upon receipt of an employee's permanent work restrictions so that the Member can determine the availability of alternative, modified or regular work. An accomplishment level of 95% shall be considered acceptable.

3. If there is no response within 20 calendar days, the third party administrator or self administered entity shall follow up with the designated Member representative. An accomplishment level of 95% shall be considered acceptable.

4. Members shall have in place a process for complying with laws preventing disability discrimination, including Government Code Section 12926.1 which requires an interactive process with the injured worker when addressing a return to work particularly with permanent work restrictions.

5. Third party administrators or self administered claims professional shall cooperate with members to the fullest extent, in providing medical and other information the member deems necessary for the member to meet its obligations under federal and state disability laws.

E. Supplemental Job Displacement Benefits

1. Supplemental Job Displacement Benefits – Dates of injury on or after 1/1/04 and before 1/1/13: Benefits pursuant to Labor Code Section 4658.5 shall be timely provided. Dates of injury on or after 1/1/13: Benefits pursuant to Labor Code 4658.7 shall be timely provided. An accomplishment level of 100% shall be considered acceptable.

2. The third party administrator or self administered entity shall secure the prompt conclusion of vocational rehabilitation/SJDB.. An accomplishment level of 95% shall be considered acceptable.

F. Reserving

1. Reserves shall be reviewed at regular diary and at time of any significant event, e.g., surgery, P&S/MMI, return to work, etc., and adjusted accordingly. This review shall be documented in the file regardless of whether a reserve change was made. A reserve worksheet shall be utilized and/or detailed rationale substantiating reserve levels shall be documented within the claim file. Where the SIP model does not apply, claims should be reserved for the most probable value. An accomplishment level of 100% shall be considered acceptable.

2. Indemnity reserves shall reflect actual temporary disability indemnity exposure with 4850 differential listed separately. An accomplishment level of 95% shall be considered acceptable.

3. Permanent disability indemnity exposure shall include life pension reserve if appropriate. An accomplishment level of 100% shall be considered acceptable.

4. Future medical claims shall be reserved in compliance with SIP regulation 15300 allowing adjustment for reductions in the approved medical fee schedule, undisputed utilization review, medically documented non-recurring treatment costs and medically documented reductions in life expectancy. Detailed rationale and/or reserve worksheet shall be documented within the claim file. An accomplishment level of 100% shall be considered acceptable.

5. Allocated expense reserves shall include medical cost containment, legal, investigation, copy service and other related fees. An accomplishment level of 100% shall be considered acceptable.

G. Resolution of Claim

1. Within 10 working days of receiving medical information indicating that a claim can be finalized, the claims examiner shall begin appropriate action to finalize the claim. An accomplishment level of 95% shall be considered acceptable.

2. Settlement value shall be documented appropriately utilizing all relevant information. An accomplishment level of 95% shall be considered acceptable.

3. Where settlement includes resolution of future medical for a medicare beneficiary or an expected medicare beneficiary, the settlement must document the strategy to protect medicare's

secondary payor status. An accomplishment level of 95% shall be considered acceptable.

4. Pursuant to CCR15400.2, claim files with awards for future benefits may be administratively closed two years after the last provision of benefits.

H. Settlement Authority

1. No agreement shall be authorized involving liability, or potential liability, of the Authority without the advance written consent of the Authority. The member shall be notified of any settlement request submitted to the EIA. An accomplishment level of 95% shall be considered acceptable.

2. The third party administrator shall obtain the Member's authorization on all settlements or stipulations in excess of the settlement authority provided in any provision of the individual contract between the Member and the claims administrator. An accomplishment level of 95% shall be considered acceptable.

3. Proof of settlement authorization(s) shall be maintained in the claim file. An accomplishment level of 95% shall be considered acceptable.

IV. LITIGATED CASES

The third party administrator or self administered entity shall establish written guidelines for the handling of litigated cases. The guidelines should, at a minimum, include the points below, which may be adopted and incorporated by reference as "the guidelines".

1. The third party administrator or self administered entity shall promptly initiate investigation of issues identified as material to potential litigation. The Member shall be alerted to the need for in-house investigation, or the need for a contract investigator who is acceptable to the Member. The Member shall be kept informed on the scope and results of investigations. An accomplishment level of 95% shall be considered acceptable.

2. The third party administrator or self administered entity shall, in consultation with the Member, assign defense counsel from a list approved by the Member. Initial referral and ongoing litigation management shall be timely and appropriate. The third party

administrator or self-administered entity shall maintain control of the ongoing claim activities. An accomplishment level of 95% shall be considered acceptable.

3. Settlement proposals directed to the Member shall be forwarded by the third party administrator, self administered entity or defense counsel in a concise and clear written form with a reasoned recommendation. Settlement proposals shall be presented to the Member as directed so as to insure receipt in sufficient time to process the proposal. An accomplishment level of 95% shall be considered acceptable.

4. Knowledgeable Member personnel shall be involved in the preparation for medical examinations and trial, when appropriate or deemed necessary by the Member so that all material evidence and witnesses are utilized to obtain a favorable result for the defense. An accomplishment level of 95% shall be considered acceptable.

5. The third party administrator or self administered entity shall comply with any reporting requirement of the Member. An accomplishment level of 95% shall be considered acceptable.

V. SUBROGATION

1. In all cases where a third party (other than a Member employee or agent) is responsible for the injury to the employee, attempts to obtain information regarding the identity of the responsible party shall be made within 14 calendar days of recognition of subrogation potential. Once identified, the third party shall be contacted within 14 calendar days with notification of the Member's right to subrogation and the recovery of certain claim expenses. If the third party is a governmental entity, a claim shall be filed with the governing board (or State Board of Control as to State entities) within 6 months of the injury or notice of the injury. An accomplishment level of 95% shall be considered acceptable.
2. Periodic contact shall be made with the responsible party and/or insurer to provide notification of the amount of the estimated recovery to which the Member shall be entitled. An accomplishment level of 95% shall be considered acceptable.

3. The file shall be monitored to determine the need to file a complaint in civil court in order to preserve the statute of limitations. An accomplishment level of 95% shall be considered acceptable.

4. If the injured worker brings a civil action against the party responsible for the injury, the claims administrator shall consult with the Member about the value of the subrogation claim and other considerations. Upon Member authorization, subrogation counsel shall be assigned to file a Lien or a Complaint in Intervention in the civil action. An accomplishment level of 95% shall be considered acceptable.

5. Whenever practical, the claims administrator shall aggressively pursue recovery in any subrogation claim. They should attempt to maximize the recovery for benefits paid, and assert a credit against the injured worker's net recovery for future benefit payments. An accomplishment level of 95% shall be considered acceptable.

6. Member (and EIA if applicable) approval is required to waive pursuit of subrogation or agree to a settlement of a third party recovery. This approval shall be documented in the claim file. In cases of self-administered entities, a process should be documented noting the authority levels within the member organization to waive pursuit of subrogation or agree to a settlement of a third party recovery. An accomplishment level of 95% shall be considered acceptable.

VI. EXCESS COVERAGE

A. Claims meeting the definition of reportable excess workers' compensation claims as defined by the Memorandum of Coverage Conditions Section shall be reported to the Authority within 5 working days of the day on which it is known the criterion is met. Utilize the Excess Workers' Compensation First Report Form available through the EIA website. An accomplishment level of 95% shall be considered acceptable.

B. Subsequent reports shall be transmitted to the Authority on a quarterly basis on all indemnity claims and on a semi-annual basis on all future medical claims or sooner if claim activity warrants, or at such other intervals as requested by the Authority, in accordance with Underwriting and Claims Administration Standards. Utilize the Excess Workers' Compensation Status Report Form available through the EIA website, or a comparable form to be approved by the Authority. An accomplishment level of 95% shall be considered acceptable.

C. Reimbursement requests should be submitted in accordance with the Authority's reporting and reimbursement procedures on a quarterly or semi-annual basis depending on claims payment activity. Utilize the Excess Workers' Compensation Claim Reporting and Reimbursement

Procedures available through the EIA website. An accomplishment level of 95% shall be considered acceptable.

D. A closing report with a copy of any settlement documents not previously sent shall be sent to the Authority. An accomplishment level of 95% shall be considered acceptable.

LAWCX PERFORMANCE STANDARDS FOR CLAIMS ADMINISTRATORS

1. Case load

Each adjustor shall have a caseload not to exceed one hundred seventy-five (175) open indemnity claims, which includes future medical cases. Each claims assistant, future medical clerk, or junior adjustor shall have a caseload not to exceed two hundred (200) open claims. The supervisor shall have a caseload not to exceed thirty (30) open indemnity claims.

2. Compensability

The compensability determination (accept claim, deny claim, or delay acceptance pending the results of additional investigation) and the reasons for such determination will be made and documented in the file within three (3) business days of the receipt of the notification of the loss. Delay and denial of benefit letters shall be mailed in compliance with the Division of Industrial Relations' guidelines.

In no case shall a final compensability decision be extended beyond ninety (90) calendar days from receipt of the Employee Claim Form.

3. Employee Contact

In all non-litigated, lost time cases, where the employee has not returned to work, telephone or personal contact will be established with the injured employee within three (3) business days of receipt of notice of claim. Such contact will continue as often as necessary, but at least monthly. Such contact with the employee shall be clearly documented in the computer notepad.

Return phone calls to employees will be accomplished within one (1) business day.

All correspondence from employees will be responded to within five (5) business days of receipt.

4. Employer Contact

The claims administrator shall contact the employer within three (3) business days of receipt of notice of a claim by any source to conduct an initial and meaningful investigation. Such contact with the employer shall be clearly documented in the computer notepad.

Return phone calls to employers shall be made within one (1) business day.

5. Initial Indemnity Payment

The initial indemnity payment or voucher will be issued and mailed to the injured employee together with a properly completed DWC notices within fourteen (14) calendar days of the first day of disability.

Late payments must include the self-imposed 10% penalty in accordance with Labor Code Section 4650.

6. Subsequent Indemnity Payments

All indemnity payments or vouchers subsequent to the first payment will be verified, except for obvious long-term disability, and issued in compliance with Labor Code Section 4651.

Late payments must include the self-imposed 10% penalty in accordance with Labor Code Section 4650.

7. Permanent Disability

The claims administrator shall determine the nature and extent of permanent disability and arrange for an informal disability rating whenever possible to avoid Workers' Compensation Appeals Board (WCAB) litigation. The claims administrator shall take advantage of any potential apportionment to prior claims, disabilities, and impairments. The claims administrator shall also advise the employer of potential credits and penalties to permanent disability benefits should the employer accommodate permanent/alternative work for at least twelve (12) months.

8. Diary Review

All claim files shall be reviewed at least every forty-five (45) calendar days for active claims and at least every six (6) months for claims that have settled but are open to monitor future medical care. The adjustor shall distinguish the regular diary review from routine file documentation in the computer notepad. A plan of action will be included and separately labeled in the file notes during a diary review. The plan of action shall include, but not limited to, the employee's current work status, medical status, review of reserves, and future activity to move the claim towards resolution.

The supervisor shall monitor the diary reviews by printing a "No Activity" report each month to identify any files that have fallen off the diary system.

9. Plan of Action

Each claim file shall contain the adjustor's plan of action for the future handling of that claim. The plan of action on new claims will be clearly documented in the computer notepad within fourteen (14) calendar days of initial claim set up. Such plan of action shall be clearly stated including the reasoning for the plan. The plan of action will be updated at least every forty-five (45) calendar days on active claims and at least every six (6) months on claims that have settled but are open to monitor future medical care. Each plan of action will be clearly identified in the computer notepad.

10. Claim Supervision

The claims administrator shall provide supervisory staff that will regularly review the work product of the adjustors. Supervisors handling claims for LAWCX members with SIR's of $500,000 or less shall review 20% of the adjustors' caseloads monthly and conduct quarterly reviews on claims with reserves in excess of $50,000. Supervisors handling claims for members with SIRs in excess of $500,000 shall review 10% of the adjustors' caseloads monthly and conduct quarterly reviews on claims with reserves in excess of $100,000. Supervisors shall conduct the reviews to ensure each adjustor is following the performance standards. Such reviews shall be labeled as "Supervisor Review" and clearly documented in the computer notepad.

The supervisor must review all medical only claims open beyond ninety (90) calendar days from the date of entry by the claims administrator for potential closure or conversion to indemnity claim status. Claims with $3,000 or more paid-to-date on any claim open beyond one hundred eighty (180) calendar days from date of entry shall be converted to indemnity status and a reasonable, precautionary indemnity reserve placed on the claim.

11. Transportation Expense

Transportation reimbursement will be mailed within five (5) calendar days of the receipt of the claim for reimbursement. Advance travel expense payments will be mailed to the injured employee at least ten (10) calendar days prior to the anticipated date of travel.

12. Medical Payments

Medical bills will be reviewed for correctness, approved for payment, and paid within the time limits established by Labor Code Section 4603.2. If all or part of the bill is being disputed, the claims administrator will notify the medical provider, on the appropriate form letter, within time limits established by Labor Code Section 4603.2.

Complete medical management services will be provided to the employer.

13. Physician Contact

Physician's office will be contacted within three (3) business days of notice of all new claims to conduct an initial investigation of the medical aspects of the claim and discuss the member entity's return-to-work goals. Contact with the physician's office shall be maintained to ensure injured workers receive proper medical treatment and are returned to full or modified employment at the earliest possible date. Such contact will continue as needed during the continuation of temporary disability to assure that treatment is related to a compensable injury or illness.

14. Litigated Cases

The claims administrator shall promptly initiate investigation of issues identified as material to potential litigation. The employer shall be alerted to the need for an outside investigation as soon as possible and shall appoint an outside investigator who is acceptable to the employer. Such referrals will be documented in the claims administrator's computer notepad. The employer shall be kept informed on the scope and results of all investigations.

All assignments to outside counsel will be done with the employer's authorization and consent. Such referrals will be documented in the claims administrator's computer notepad. In conjunction with the employer, the claims administrator shall monitor the outside counsel's progress. The claims administrator shall audit all bills before payment.

Settlement proposals directed to the employer shall be forwarded by the claims administrator or defense counsel in a concise and clear written form with a reasoned recommendation.

All preparation for a trial shall involve the employer so that all material evidence and witnesses are utilized to obtain a favorable result for the defense.

15. Settlements

The claims administrator shall obtain the employer's authorization on all settlement or stipulations.

Should the total incurred amount exceed the member's self insured retention, the claims adjustor shall obtain written settlement authority from the applicable excess carrier.

16. Future Medical Claims

Claims that remain open to monitor future medical care shall remain open for two (2) years from the last payment of benefit. Reviews shall be documented in the claim notes to include settlement information, outline future medical care, last date and type of treatment, name of excess carrier, excess carrier reporting level, and excess carrier reporting history. Reserves for future medical treatment will be reviewed every six (6) months and adjusted for use over a three (3) year average and the injured employee's life expectancy based on the current version of the U.S. Life Table. The reason(s) and calculation(s) for the adjustment(s) shall be clearly documented in the computer notepad.

The claims administrator shall evaluate the claim at least once a year to determine a reasonable amount for settlement of future medical benefits and any remaining benefits due. The reason(s) and calculation(s) for the recommended settlement amount shall be clearly documented in the computer notepad. The claims administrator shall clearly document the computer notepad with the outcome of the settlement negotiations with the employee or applicant's attorney.

17. Subrogation

In all cases where a third party is responsible for the injury to the employee, the third party shall be contacted within ten (10) business days with notification of the employer's right to subrogation and the recovery of certain claim expenses. Such contact will be documented in the claims administrator's computer notepad. If the third party is a governmental entity, a claim shall be filed with the governing board within six (6) months of the injury or notice of injury.

Periodic contact shall be made with the responsible party and/or insurer to provide notification of the amount of the estimated recovery to which the employer will be entitled. Such contact will be documented in the claims administrator's computer notepad.

If the injured worker brings a civil action against the party responsible for the injury, the claims administrator shall consult with the employer about the value of the subrogation claim and other considerations. Upon employer authorization, subrogation counsel shall be assigned to file a Lien or a Complaint in Intervention in the civil action.

Whenever practical, the claims administrator should take advantage of any settlement in a civil action by attempting to settle the workers' compensation claim by means of a Third Party Compromise and Release. If the parties are unable to agree on a reasonable Third Party Compromise and Release, then every effort should be made through the WCAB to offset claim expenses through a credit against the proceeds from the injured worker's civil action.

18. Vocational Rehabilitation (VR)/Supplemental Job Displacement Benefits (SJDB)

In accordance with all applicable California laws in place at the date of injury, the claims administrator shall:

A. Determine the Qualified Injured Worker/Non-Qualified Injured Worker status;
B. Advise the injured worker of his/her right to VR/SJDB;
C. Provide appropriate VR/SJDB;
D. Control rehabilitation costs;
E. Attempt to secure the prompt conclusion of VR/SJDB; and
F. Provide notification to the employer should work restrictions require permanent or modified alternative accommodations.

19. Excess Insurance

Potential Workers' Compensation excess cases shall be reported in accordance with the reporting criteria established by the Bylaws of the Local Agency Workers' Compensation Excess Joint Powers Authority (LAWCX).

All cases that meet the established reporting criteria are to be reported within ten (10) business days of the day on which it is known the criterion is met.

20. Award Payment

Payments on Awards, Computations, or Compromise and Releases will be issued within ten (10) business days following receipt of the appropriate document.

21. Penalties

Late payment of all benefits must include the self-imposed penalty in accordance with California law. The claims administrator will provide the member a quarterly listing of any administrative penalties paid the quarters ending March 31, June 30, September 30, and December 31, which were the responsibility of the claims administrator, and a check from the claims administrator payable to the member for reimbursement. The check and report shall be submitted to the member within thirty (30) calendar days after the quarter ends.

22. Reserves

Reserves shall be established based on the facts of the claim and the ultimate probable cost of each claim. All reserve categories shall be reviewed on a regular basis but not less than at least every ninety (90) calendar days on active claims and every six (6) months on claims that have settled but are open to monitor future medical care. Such reviews shall be clearly documented in the computer notepad. Any changes to reserves shall include an explanation for the change.

23. Case Closure

All indemnity cases, where permanent disability is not an issue, will be closed within sixty (60) calendar days of the final financial transaction or final correspondence to the injured worker as required by law. All indemnity claims, where permanent disability is an issue, will remain open for two (2) years from the last payment of benefits and then closed within sixty (60) calendar days from that date.

24. Right to Audit or Review

The member or its designated representative is authorized to visit the claim administrator's processing and/or storage premises, for purpose of performing a claims audit or review, and have access to all data, including paper documents, microfilm, microfiche, and magnetically stored data which relate to payments or non-payments made by the employer. Any assistance or service provided in response to a claims audit described above will be rendered at no additional cost to the member or employer.

25. Loss Runs

The loss run shall be issued by the 15th calendar day of the month following the closing date. Corrections to the loss run made by the 20th calendar day of the month shall be reflected in the following month's loss run.

Requests for status of claims generated by the employer shall be provided within thirty (30) calendar days.

26. Loss Data Specification Submissions

The claims administrator shall provide loss data information to the excess carrier on a monthly basis in the format outlined in Attachment I, "Request for Detail Information". The submissions shall be submitted to the excess carrier's secure File Transfer Protocols (FTP) server by the 15th of the following month. The submission shall include the 65 required fields outlined in Attachment 3. The submissions will be made to the FTP server in addition to the loss runs provided to the members and will be made at no additional costs to the member, employer, or excess carrier.

27. Compliance with Labor Code

The claims administrator shall comply with all provisions of the Labor Code and Rules and Regulations in effect at the applicable date of injury.

Request for Detail Information – Universal Electronic Loss Data Submission
Workers' Compensation Claims Information Specifications

The data outlined in this request will be utilized for the member's and excess carrier's underwriting process, loss analysis, benchmarking, and actuarial study. **Please provide an electronic data file in Microsoft Excel format**. If you are submitting data for more than one member, please combine the data into one Excel file. The requested file is a data file only, and should not contain any formatting, macros, formulas, hidden columns or rows, report headers, blank rows, or any other Excel "features". Files will be accepted in Excel 1997-2003, 2007-2009, and 2010 formats.

If you need any help generating the loss data file in the required format, please contact the Bickmore IS team at (916) 244-1100.

When compiling your data, please pay careful attention to the following:

- Data must be evaluated as of the last day of the month being reported.
- If the data is being provided for a Joint Powers Authority (JPA), please use the member/entity's name in the Entity Name Field (described below) and not just the JPA's name.
- Workers' compensation claims data should be provided for the entire claim history – all the years you maintain in your risk management/claims information system.
- Workers' compensation claims data transferred from any prior third party administrators (TPA) shall be incorporated into the data submission.
- Loss amounts should include the full amount of the claim and not be limited to any excess insurance recovery (please do not cap payment, reserve, or recovery amounts).
- Losses should be detailed on a per claim basis.
- The file should include all open and closed workers' compensation claims including "Incident Only" (also known as "Information Only", "Record Only", or "Notice Only") and "First Aid" claims. Incident Only and First Aid claims must be identified using the "Claim Type" field (described below.)
- Medical Management, Bill Review, and/or Cost Containment fees incurred prior to July 1, 2012 should be included in the individual claim paid and reserved medical loss amounts rather than as a separate claim record. Claims coded as "Bill Review", "Cost Containment", "Dummy", or "Ouch" will not be accepted.
- Medical Management, Bill Review, and/or Cost Containment fees incurred after July 1, 2012 should be included in the individual claim paid and reserved ALAE loss amounts rather than as a separate claim record. Claims coded as "Bill Review", "Cost Containment", "Dummy", or "Ouch" will not be accepted.
- For claims involving Labor Code (LC) 4850 and LC 4856 benefits, please be sure to include the claim information and show separately any payments and reserves specifically designated for LC 4850 and LC 4856 ("Paid 4850" and "Reserve 4850"). Do not include

these amounts in the "Paid Indemnity" or "Reserve Indemnity" columns.

- Closed claims cannot have reserve amounts included. By definition, a closed claim cannot have case reserves. Therefore, closed claims with reserve amounts will not be accepted.
- All paid, reserve, and incurred amounts must be "positive" numbers. A negative amount may be listed only if it pertains to a subrogation or excess recovery ("Subro Recovery Amount" and "Excess Recovery Amount").
- Per the group's governing documents, members are required to submit loss data. If the data is not submitted in a timely fashion, the member may be penalized. Please note that if the data is not submitted in the proper format or the record layout does not match the following criteria the submission will not be accepted. Should the submission be rejected, the member may be penalized.

ELECTRONIC DATA FILE LAYOUT

This information will only be accepted via the LAWCX web site (http://www.lawcx.org) or via our Secure Insurance data transfer web site accessible at https://si.brsrisk.com. Please do not send files through the e-mail system. You may use whichever site you prefer.

To upload the files using the LAWCX site, go to "Data Submission" on the main menu (http://www.lawcx.org/DataSubmission.aspx) and click on "Enter". Follow the instructions listed to upload the loss data file(s). To use the LAWCX site you must already have site login credentials which should have been previously provided to you. If you do not have credentials, or have forgotten your user ID or password, please contact the Bickmore Information Services Team at (916) 244-1100 for assistance.

To upload the files using Secure Insurance (https://si.brsrisk.com) (*note that this is an SSL (secure) site and the prefix is https and not http*), login to the site using your e-mail address and password. If you have not previously used the site, you can easily register by clicking on the registration link (https://si.brsrisk.com/secureinsurance/UserRegister.do) on the home page and following the registration instructions. LAWCX files sent using Secure Insurance should be delivered to lawcxdata@bickmore.net. If you need any assistance registering or submitting the data, please contact Bickmore at (916) 244-1100.

If for any reason you are unable to use either of the data transfer sites, please contact us for alternative electronic transfer solutions, or you can send the data via CD or DVD media through overnight shipping or the U.S. mail.

Please utilize the following specifications when submitting your information to us. Each record must consist of the 65 data fields described below. If there is no data for a specific field, please indicate by leaving blank (null); do not use spaces, "NULL", "UNKNOWN", or " / / " as placeholders. Note that only fields 3 (Location Name), 7 (Claimant First Name), 11 (Occupation Code), and 39 (Date Closed) can be left blank, and only under specific circumstances. All numeric (amount) fields must be coded as a dollar amount. If there is no amount, code as "$0.00"; do

not leave blank. If using dollar signs ("$") and/or commas (",") in a loss amount field causes problems with your submission process, they can be omitted. The first row of the file must contain a header identifying the columns ***exactly*** as specified below. If using spaces (" ") in column names causes problems with your submission process, you may substitute underscores ("_") instead.

A template of the file with the correct header and a sample claim row is attached for your use/information. These specifications and the sample template are also available for download at the secure data transfer site.

SPECIFICATIONS:

No.	Field Name	Format	Description
1	**Evaluation Date**	mm/dd/yyyy	The date the loss data was evaluated, which should always be the last day of the month being reported
2	**Entity Name**	text (80)	Name of the member entity, district, or employer. For members of a JPA or group, this field should contain the member/entity name, not the name of the JPA or group. The individual employer/entity name will be used to determine the group
3	**Location Name**	text (80)	Name of the claimant's assigned location, building, facility, school, or division (if the same as Department Name, then leave blank). Do not include location numbers
4	**Department Name**	text (80)	Name of the claimant's department. Do not include department numbers
5	**Claim Number**	text (40)	Claim or file number
6	**Original Claim Number**	text (40)	If the claim has been transferred from another TPA or entity, or is the excess or pool layer loss amount on another claim, include the original claim or file number. Otherwise code the same as 5 (Claim Number) above
7	**Claimant First Name**	text (40)	First name of the claimant. Must be mixed case and only include the claimant's first name
8	**Claimant Last Name**	text (40)	Last name of the claimant. Must be mixed case and not include the claimant's first name

9	**Date of Birth**	mm/dd/yyyy	Claimant's date of birth
10	**Gender**	text (1)	Claimant's gender. Code F for female or M for male
11	**Occupation**	text (40)	Job title of claimant at time of injury/illness
12	**Safety Flag**	text (1)	Code "Y" if the claimant is eligible for full salary benefits under Labor Codes (LC) 4850 and 4856 or "N" if not
13	**Class Code**	text (4)	NCCI standard class code based on claimant's occupation at time of injury/illness. (If the code is not captured, then leave blank.)
14	**Date of Hire**	mm/dd/yyyy	Claimant's hire date
15	**Avg. Weekly Wages**	$#,###.##	Average weekly wages at time of injury/illness. If unknown, code $0.00
16	**Claim Type**	text (2)	Code as IO = Incident (or Record or Notice) Only, FA = First Aide, MO = Medical Only, TD = Temporary Disability, PP = Permanent Partial Disability, PT = Permanent Total Disability (100%), DC = Death Claim, or FM = Future Medical. No other codes will be accepted
17	**PD Rating**	###.##	Percentage of rating established by the TPA, State, or independent rater
18	**PD Amount**	$#,###.##	Amount of PD associated with percentage of rating established by the TPA, State, or independent rater
19	**Settlement Type**	text (2)	Code as CR = Compromise and Release, FA = Findings and Award, ST = Stipulated Award, OS = Other Settlement Type, NS = Not Settled. No other codes will be accepted
20	**Settlement Amount**	$#,###.##	Amount of settlement agreed by all parties and approved by a WCAB judge
21	**Settlement Date**	mm/dd/yyyy	Date judge approved settlement

22	**FM Award Flag**	text (1)	Code "Y" if the claim will remain open to monitor future medical care or "N" if the claimant is not entitled to future medical care
23	**Cause of Loss Code**	text (3)	Alphanumeric Cause of Loss code
24	**Cause Description**	text (80)	Ex.: Fall. Only include description (no codes accepted)
25	**Nature of Injury Code**	text (3)	Alphanumeric Nature of Injury code
26	**Injury Description**	text (80)	Ex.: Sprain. Only include description (no codes accepted)
27	**Body Part Code**	text (3)	Alphanumeric Body Part code
28	**Body Part Description**	text (80)	Ex.: Foot. Only include description (no codes accepted)
29	**Text Description**	text (255)	Free form text description of the claim. This field should list the actual description of the injury or event as listed by the employer. Do not include quotes (‘), double quotes (“), or carriage return or end-of-line characters (CRLF)
30	**Fatality Flag**	text (1)	Code "Y" if the injury or illness caused or allegedly caused the claimant's death or "N" if it did not
31	**Litigated Flag**	text (1)	Code "Y" if the claimant is or was represented by an attorney or the employer retained legal representation at any time or "N" if there are no attorneys involved
32	**Accepted Date**	mm/dd/yyyy	Date the claim or a portion of the claim is accepted
33	**Delayed Date**	mm/dd/yyyy	Date the claim or a portion of the claim was once or is currently delayed
34	**Denied Date**	mm/dd/yyyy	Date the claim or a portion of the claim is denied

35	**Date of Loss**	mm/dd/yyyy	Date the incident, injury, or illness occurred or was alleged. If cumulative trauma is alleged, the date of injury shall be listed as the last date of the injurious exposure
36	**Date Reported**	mm/dd/yyyy	Date claim was reported by the claimant to his or her employer. Also known as date of knowledge
37	**Date Received**	mm/dd/yyyy	Date claim was received/reported to the claims administrator/adjuster
38	**Date Entered**	mm/dd/yyyy	Date claim was entered into the risk management/claims information system. Also known as system date, open date, or registration date
39	**Date Closed**	mm/dd/yyyy	Date this claim was closed (if not closed then leave blank)
40	**Status**	text (2)	Code as follows: OP = Open, CL = Closed, RO = Re-opened, RC = Re-closed. No other codes will be accepted
41	**Paid TD**	$#,###.##	Amount paid to date on the claim for temporary benefits (does not include amount paid per LC 4850 and 4856 or Vocational Rehabilitation (VR)/supplemental job displacement benefits (SJDB)
42	**Paid PD**	$#,###.##	Amount paid to date on the claim for permanent benefits
43	**Paid 4850**	$#,###.##	Amount paid to date for losses/injuries to public safety officers per LC 4850 and 4856. Do not include amount in field 41 (Paid TD)
44	**Paid Other Indemnity**	$#,###.##	Amount paid to date for other indemnity benefits not including TD, PD, or LC 4850 benefits. This includes death benefits and/or penalties
45	**Paid Medical**	$#,###.##	Amount paid to date for medical benefits and medical management fees (bill review, nurse case management, utilization review incurred prior to 07/01/12)

46	**Paid VR/SJDB**	$#,###.##	Amount paid to date for VR/SJDB
47	**Paid ALAE**	$#,###.##	Amount paid to date for all non-legal expenses (fees for copy service, surveillance/sub rosa, interpreters, indexing, witnesses, investigations, and expenses incurred after 06/30/12 for bill review, nurse case management, and utilization review services)
48	**Paid Legal Expenses**	$#,###.##	Amount paid to date for legal expenses (fees for defense attorney and depositions)
49	**Total Paid**	$#,###.##	Total paid on this claim to date. Must total the sum of fields 41+42+43+44+45+46+47+48
50	**Reserved TD**	$#,###.##	Current case reserve for only temporary benefits (does not include amount reserved per LC 4850 and 4856 or VR/SJDB)
51	**Reserved PD**	$#,###.##	Current case reserve for only permanent benefits (does not include amount reserved per LC 4850 and 4856 or VR/SJDB)
52	**Reserved 4850**	$#,###.##	Current case reserves for losses/injuries to public safety officers per LC 4850 and 4856. Do not include this amount in field 50 (Reserved TD)
53	**Reserved Other Indemnity**	$#,###.##	Current case reserves for other indemnity benefits not including TD, PD, or LC 4850 and 4856 benefits. This includes death benefits and/or penalties
54	**Reserved Medical**	$#,###.##	Current case reserve for medical benefits and medical management fees (bill review, nurse case management, utilization review incurred prior to 07/01/12)
55	**Reserved VR/SJDB**	$#,###.##	Current case reserve amount for VR/SJDB
56	**Reserved ALAE**	$#,###.##	Current case reserves for non-legal expenses (fees for copy service, surveillance/sub rosa, interpreters, indexing, witnesses, investigations, and expenses incurred after 06/30/12 for bill review, nurse case management, and utilization review services)

57	**Reserved Legal Expense**	$#,###.##	Current case reserves for legal expenses (fees for depositions and defense attorney)
58	**Total Reserved**	$#,###.##	Total current case reserves on this claim. Must total the sum of fields 50+51+52+53+54+55+56+57
59	**Total Incurred**	$#,###.##	Total Incurred losses for this claim. This amount shall be exclusive of any subro or excess recovery amounts. Must total the sum of fields 49 (Total Paid) and 58 (Total Reserved)
60	**Subrogation Recovery**	$#,###.##	Amount recovered for subrogation recovery on this claim file. This amount shall not be deducted from the paid to date, reserve, or total incurred amounts
61	**Excess Recovery**	$#,###.##	Amount recovered from excess carrier on this claim file. This amount shall not be deducted from the paid to date, reserve, or total incurred amounts
62	**4850 Days Paid**	#,###	Number of LC 4850/4856 days paid. Code as "0" if none has been paid. This field will contain the number of days and not the amount of benefits paid to the claimant per LC 4850 and 4856
63	**Mod. Duty Days Worked**	#,###	Number of modified duty days claimant worked. Code as "0" if none worked. This field will contain the number of days and not the amount of salary paid to the claimant
64	**OSHA Days Paid**	#,###	Number of OSHA days paid. Code as "0" if none paid. This field will contain the number of days and not the amount of temporary disability benefits paid to the claimant
65	**TD Days Paid**	#,###	Number of temporary disability days paid. Code as "0" if none paid. This field will contain the number of days and not the amount of TD benefits paid

Paper loss runs and/or Adobe Acrobat files are not acceptable.