Introduction

At Intercare we are dedicated to providing prompt, fair, and professional claim handling service. The Intercare claim staff is expected to handle claims in accordance with any applicable state law, and in accordance with the guidelines outlined below. Please note that these are guidelines. The management of any claim is unique, and common sense and good judgment applies.

Unfair Claims Settlement Practices Model Regulation

Most states have adopted some form of the Unfair Claims Settlement Practices Model Regulation. The regulation requires that prompt action and good communication be documented in the claim file. Some states imply into the insurance contract a duty of good faith and fair dealing. Intercare expects its employees to comply with the Unfair Claims Settlement Practices Model Regulation as a general business practice. A copy of the Unfair Claims Settlement Practices shall be provided to each claim professional.

Liability Claim Handling Standards

I. File Record and Documentation
- All claim files shall contain all file notes and work papers pertaining to the claim in such detail that the pertinent events and dates of such events can be reconstructed.
- Notes shall be entered in iVOS to reflect all substantial claim activity with a goal of documenting claim handling progress from file opening until final disposition of the claim.

II. Assignment
- The supervisor shall review the claim notification on the same day it is received in the office, and assignment it to the claim professional in accordance with experience, expertise and licenses held.

III. Client Contact
- Contact the client within 24 hours of receipt of the assignment to the claim professional and document the claim file accordingly.
- Send written acknowledgement by email or regular mail to the client within 48 hours of the claim professional receiving the claim assignment.
- Maintain contact with the client throughout the life of the claim.
  - Keep the insured advised of the progress of the investigation as significant new information is developed within the first 90 days of claim administration.
  - A general guideline is to provide a written report on the progress of the investigation monthly during the first 90 days.
  - Thereafter, written reports should be submitted to the client every 90 days at a minimum, but promptly after new information is developed or significant claim activity occurs, and the file should be documented accordingly.

IV. Claimant Contact

- Contact the claimant or claimant representative, as warranted, within 24 hours of the assignment to the claim professional and document the claim file accordingly.
- Send a written acknowledgement letter to the claimant within 3 business days, or to the claimant representative within 10 business days of receipt of the claim by the claim professional.
- Initial contact should include obtaining/requesting necessary information, files, records & other pertinent documents pertaining to the claim.
- Respond within 10 business days to all pertinent communications from a claimant which reasonably suggests that a response is expected.

V. Coverage

- The claims handler has access to any applicable insurance policies/profiles.
- This documentation is either in the form of actual policies or in some instances, in the form of system coverage profiles.
- Coverage determinations are made within 30 days of receipt of a claim.
  - If a determination cannot be made by that time, the file reflects the status of the coverage investigation and the reason for any delay.
- The claims handler reviews and analyzes the coverage information to determine appropriate application of all terms, conditions, limits, insuring agreements, exclusions and endorsements to the claim. This review includes, but is not limited to, the following:
  - Does the claim fall within the period of coverage?
  - Is the loss location covered by the policy?
  - Are there any additional/other-insured issues?
  - Are deductibles or retentions involved, and if so, the applicability of the same to indemnity and defense costs?
  - Are there any exclusions or limitations that may apply?
  - Are there timing of notice issues involved?
  - Is there any other applicable insurance which may give rise to other insurance /co-insurance issues?
- Following a review of the loss and an analysis of any applicable coverage, the claims handler either:
  - Determines that there are no questions as to coverage.
  - Determines that coverage most likely exists subject with some reservations.
  - Determines that there is no applicable insurance coverage for the loss.
- Regardless of the determination of the applicability of coverage, the file adequately reflects the claims handler's evaluation of coverage and the actions taken as regarding any coverage issues.
- If necessary, the claim handler drafts a reservation of rights or coverage denial letter. The claims handler obtains client and/or supervisory approval for the issuance of any coverage position as appropriate.
- If a claim has realistic potential beyond the deductible/retention or the policy, the insured is advised and if required by the client's claim handling instructions, excess carriers are placed on notice of the claim.

VI. Investigation

Detailed information about the circumstances of an incident is obtained from all parties with knowledge of the incident in a timely manner to assist in proper evaluation of any claim. The involvement of the client in the loss events is confirmed.

- When beginning an investigation, the claim professional starts with the information that is known and builds on it to uncover as much as possible about the involved parties, the location of the incident, circumstances surrounding the incident, and the date and time of the incident; truly the who, what, where, when and how of the occurrence.
- Involved parties are contacted promptly and interviewed. A determination is made as to whether or not to attempt a recorded statement. Under certain circumstances a local claim professional is engaged to visit and interview certain persons, including claimants. When a local claim professional is hired, specific instructions are given to guide activities.
- Personal information about the claimant is obtained, including:
  - date of birth
  - sex
  - marital status and name of spouse
  - social security number
  - home address and phone number
  - age
  - name(s) and number of dependents
  - occupation
  - employer and salary
  - education
  - injury information
  - identification of treating physicians
  - existence/description of any prior injury(s).
- For accidents involving operation of equipment:
  - the position of the operator at the time of the incident
  - the exact manner in which claimant utilized the equipment
  - claimant's prior experience with the equipment
  - any training claimant received related to use of equipment
  - any accessories utilized with the equipment.
- Accident scene investigations are conducted when appropriate, including obtaining a diagram of the site, area measurements and photos of the site to help determine the cause of the accident. The services of a field claim professional may be obtained; however, specific instructions guiding the investigation are given. An agreement on fees is arranged in advance.
- The date, time, weather conditions (when appropriate), names and telephone numbers of any witnesses to the incident, description of the incident scene and a detailed description of the claimant's activities are obtained promptly. Alleged injury and property damage are identified, as well.
- Witnesses are contacted to obtain their version of the incident. The date, time, weather conditions (if appropriate), incident circumstances, the identity of other witnesses, alleged injury, etc. are confirmed.

- Any official records and photographs related to the incident that may exist are obtained. These may include:
  - Police reports
  - Fire Reports
  - Weather Reports
  - Death Certificates
  - Autopsy Reports
  - Emergency Service Records
  - OSHA investigation
  - Workers compensation records, if the claimant was working when the incident occurred.
- Local newspaper articles are obtained when available, or information is obtained on the Internet.
- Information necessary to address possible contractual indemnification and third party contribution is obtained. Any potential subrogation possibilities are identified and supported.
- All damages are documented and verified. A medical authorization form is used to obtain medical records directly from the care providers, including pre-incident records when appropriate. Invoices for all claimed medical care are obtained. These may include bills from ambulance services, the emergency room, treating physicians, chiropractors, radiologists, prescription medication and medical devices, physical therapy, rehabilitation expenses, etc.
- When the true nature of the alleged injury(s), disability, permanency or scarring is either questionable or unknown, an IME (independent medical exam) is considered to assist in proper evaluation of the injury(s).
- When lost wages are claimed, verification of lost wages, salary information and amount of lost time are obtained in writing from the claimant's employer.
- Subrosa investigation is conducted, if warranted. Such investigation is tightly controlled if utilized, with specific instructions provided to the investigator as to the scope of the investigation, and a budget for the investigation is set.
- Property damage claims are supported by the appropriate documentation such as purchase receipts, information about the age of the property, repair estimates and photographs. In cases where the damaged property is replaced, salvage value is considered.

VII. Reserves

- Reserving is not an exact science.
- The claims handler, however, must establish as soon as possible an assessment of the client's exposure, the likelihood of a successful defense, the ability to reach a settlement if necessary and the anticipated settlement value of the claim.
- Within one week of receipt of a claim, the handler establishes reserves, both loss and expense, based on the information gathered from the investigation completed to date.
- The file documents the rationale behind the reserve.

- If required, the client and/or their insurer are advised of the reserve and the file reflects such notice.
- If the client requires that the claims handler obtain approval to establish a reserve, the request to establish reserves is documented in the file.
- The file reflects any subsequent reserve recommendations and the client's approval/modification of such requests.
- An accurate probable ultimate cost reserve is established within 90 days of file creation.
- Reserves are reexamined every time the file is handled, and a review of reserves is completed on at least a quarterly basis.
- Ultimately, the probable ultimate cost of the claim is determined and a reserve is established in that amount.
- If the claim professional is uncertain about the validity of the reserves, the claim should be reviewed with a supervisor or other claim professional in an effort to establish realistic reserves.
- It is appropriate to change reserves upon receipt of information or documentation that significantly modifies the claim evaluation, but the claim professional should avoid "step ladder reserving".

VIII. File Documentation

- Thoroughly investigate, identify and document all applicable coverage.
- Document all communications pertaining to the claim.
  - Note the date, and parties involved as well as the content of all communications.
- Document any direction given pertaining to your investigation or the discovery being conducted on the claim.
- Document your evaluation and analysis.
- Document your action plan and update it as needed.
- Document your analysis of discovery.
- Maintain active claims on a 45 to 60 day diary.
  - Document any reason for extending the diary beyond 60 days.
- Maintain accurate data in our claim system.
  - Update all screens as information changes.
- Print and store a copy of all pertinent E-mails pertaining to the claim in the claim file.
- Reporting is tailored to each client's needs.
- The following outlines the Divisions standard procedures in the absence of any account instructions to the contrary:
  - Narrative reporting to the client is completed as required by the client.
  - The file is documented as to the claim handler's activities either via notes in the physical file or on the claims system.
  - Reporting to insurance carriers complies with any notice provisions of any applicable policy(s).

IX. Litigation Management

While client specific instructions are followed, the following steps are basic Intercare guidelines. The first step in litigation management is the initial review of the suit documents to:

- Determine the answer date
- Determine if service appears proper
- Evaluate whether suit has been brought in the proper jurisdiction/venue
- Determine if proper parties/entities named
- Note the Ad Damnum to determine if any excess issues are involved
- Evaluate whether there are any potential cross claims, counter claims and/or third party claims.

Following the initial review of the suit documents, the client is contacted to discuss the suit and the claims handler's initial recommendations as to handling. In the absence of any client wishes to the contrary, the claim handler contacts the plaintiff attorney and attempts to solicit additional information regarding the accident facts and the claimant's damages.

An initial evaluation of the suit is made to determine if an early resolution is appropriate and possible. Extensions of time are obtained if case is a candidate for early resolution or if there is insufficient time to get an answer on file. All extensions are confirmed with plaintiff counsel in writing.

Defense counsel is assigned in accordance with any special handling instructions for the account. In the absence of any specific instructions, the claims handler determines the appropriate law firm, considering:

- geographical proximity to the venue
- cost factors
- special expertise/experience

All assignments to counsel are accompanied by an in depth narrative assignment letter. This letter includes:

- Copies of the Summons and Complaint
- Copies of any pertinent investigative materials
- Accident facts developed to date
- Specific instructions to counsel regarding reporting:
    - Counsel's initial report is completed within 30 days of assignment.
    - This report outlines defense counsel's preliminary evaluation of the case, discusses any unique jurisdictional issues and makes recommendations as to a course of action.
    - This report also includes a projection as to litigation expenses.

- An explanation of the authority extended to counsel to conduct investigation, discovery, retain experts, etc.
- Billing instructions
- Discussion of the roles of the client, the claims handler and counsel in the litigation process, emphasizing ownership of the file by the claims handler

X. Litigated Cases

On litigated cases, the resolution plan is expanded to a Litigation plan. This plan includes all of the elements of a resolution plan, with the addition of a discussion of specific steps in the litigation process required to bring the case to conclusion and the timing of those steps. The plan also discusses a consideration as to whether alternative methods of dispute resolution (ADR) should be considered. While not appropriate for all cases, the concept is considered in every case and a decision as to whether to pursue ADR is made.

Strategy meetings and/or conference calls between client, the claim handler and defense counsel are held at key points of the development of a case. At these conferences the litigation plan is discussed and altered as needed. Unless unique situations warrant, these meetings are held at the following key times:

- At the completion of written discovery and document production and before depositions begin.
- After the completion of key depositions.
- After the completion of discovery but before trial.

As the case approaches trial, the case is reviewed and discussed with the unit manager. If at all possible, the claim handler attends trial in order to observe first hand any developments. If attendance is impossible, defense counsel reports to the claim handler on at least a daily basis. Unless the client has other requirements, the claim handler reports to the client on a daily basis during trial.

Attorney and other vendor invoices are examined for reasonableness and to make certain that the work performed was authorized. In the absence of any client instructions to the contrary, attorney invoices are submitted quarterly All legal bills are itemized detailed to $1/10^{th}$ of an hour. The claim handler reviews the invoice for accuracy. The claim handler clarifies any questions regarding the invoice and makes/negotiates any adjustments as necessary.

For accidents involving the operation of equipment, the position of the operator at the time of the incident is determined, along with the exact manner in which the claimant utilized the equipment. The claimant's prior experience with the equipment, any training the claimant received related to use of equipment and any accessories utilized with the equipment are also identified.

XI. Evaluation

- Our liability and damage evaluation should be completed within 90 days of receipt of the claim by the claim professional.
- Promptly and continuously consider and document the analysis of liability, defenses and damages in the claim file.
- Determine and apply proportionate liability to all parties involved, documenting the impact to the probable ultimate cost.
- Our liability analysis should include a discussion of the following:

- Coverage issues, if applicable.
- The facts giving rise to the occurrence.
- Credibility of prospective witnesses.
- Damages and supporting documentation.
- Our discussion of damages should include verification of claimed damages including but not limited to the claimed medical damages, the claimed wage loss damages and any other claimed damages, offsets, statutory limits and sources of contribution.
- Liability exposure of all parties involved.
  - Our discussion of liability should include:
    - identification of central issues,
    - analysis of the alleged fault on the part of our client,
    - analysis of the full liability value,
    - mitigating factors in liability assessment,
    - an estimation of our chances of a successful defense,
    - and the probable ultimate claim cost.
- Reserve recommendation.
- Litigation considerations.
- Plan of action going forward.

XII. Resolution Plan/Claim Management

A resolution plan is developed for all cases. This plan reflects the thought process of the claim handler and at a minimum discusses:

- The incident facts
- Confirmation that the client was involved in the occurrence.
- Injuries and damages.
- Evaluation as to liability
- Evaluation as to claim potential and potential settlement value.
- If information is insufficient to make a preliminary evaluation of the claim, an outline of the information required and a strategy for obtaining these materials.
- Strategy for bringing the claim to conclusion.

The resolution plan is not a static document. As developments warrant, it is revised and the claim handler's thoughts as to these changes are documented.

Settlement authority is obtained from the client as specified in the account service instructions. All discussions regarding settlement authority are documented.

Structured settlements are considered where appropriate

XIII. Key Time Frames

- Claimant and insured contact – 24 hour from receipt of the claim.
- Coverage Analysis and Final Position – within 30 days of receipt of the claim if possible, or document reasons for delay, what is needed and when positions will be stated.

- Written Evaluation and Analysis – 90 days unless otherwise specified in client service agreement.
- Coverage Letters- as soon as possible, but no later than 30 days
- Ultimate Reserve- 90 days.