

FILING MEMORANDUM

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

PURPOSE

This item establishes NCCI's Workers Compensation Insurance Plan documents and rules (Plan Documents) in Tennessee. NCCI's Workers Compensation Insurance Plan (WCIP or Plan) is established by state insurance regulatory authorities to make workers compensation insurance available to employers that are unable to secure such coverage in the voluntary market. The Plan rules appear as Rule 4—Workers Compensation Insurance Plan Rules in NCCI's **Basic Manual for Workers Compensation and Employers Liability Insurance (Basic Manual)**.

Also included in this item is the following information related to the establishment of NCCI's Plan Documents in Tennessee:

- Tennessee state rule exceptions to NCCI's **Basic Manual** Rule 4.
- Tennessee miscellaneous rules in NCCI's **Basic Manual**.
- Statistical code information for certain Tennessee premium elements in NCCI's **Statistical Plan for Workers Compensation and Employers Liability Insurance (Statistical Plan)**. Specifically, Deductible Insurance, the Cost Reduction Seminar Incentive Plan, and certain increased limits of employers liability insurance will no longer apply to assigned risk policies in Tennessee; therefore, NCCI's **Statistical Plan** must be revised to provide the discontinuation dates for the statistical codes associated with these programs or coverages.
- National and Tennessee state-specific endorsements in NCCI's **Forms Manual of Workers Compensation and Employers Liability Insurance (Forms Manual)**.
- Bylaws of the National Workers Compensation Reinsurance Association NFP (NWCRA or Association).

Additionally, national Rule 3-A-22—Waiver of Right to Recover From Others (Subrogation) in NCCI's **Basic Manual** will become applicable in Tennessee for both the voluntary and residual markets; therefore, the current Tennessee state rule exception to national Rule 3-A-22 must be eliminated and the Tennessee workers compensation premium algorithm must be revised. NCCI's **Statistical Plan** must also be revised to provide the effective dates for the statistical code applicable to reporting the premium charge for providing a waiver of subrogation.

BACKGROUND

The Tennessee Department of Commerce and Insurance (TDCI) has chosen NCCI as the new Plan Administrator for Tennessee's Workers Compensation Insurance Plan (WCIP). For more than 80 years, NCCI has managed residual market services across the country and looks forward to serving as the Tennessee Plan Administrator.

Beginning with policies effective at 12:01 a.m. on July 1, 2015, the current assigned risk plan will be replaced with NCCI's WCIP and is applicable for new and renewal assigned risk business only effective on or after this date. As a result of this change in the residual market mechanism, NCCI, as the Plan Administrator, is filing all appropriate plans, programs, rules, rates, and forms necessary to implement NCCI's WCIP.

A summary of NCCI's **Basic Manual** Rule 4—Workers Compensation Insurance Plan Rules and additional supporting documents and rules related to the establishment of NCCI's WCIP in Tennessee follows:

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NCCI's *Basic Manual* Rule 4

The following rules applicable to assigned risk policies only must be established in NCCI's *Basic Manual* for use in Tennessee:

- **Rule 4-A—Workers Compensation Insurance Plan (WCIP)**—Establishes the authority for the Plan, provides for the equitable apportionment of employers who are in good faith entitled to workers compensation insurance and are unable to procure such insurance in a regular manner, and details rules related to:
 - WCIP definitions
 - Employer eligibility and assignment
 - Assigned carrier responsibilities
 - Carrier participation options
 - Plan Administrator duties and responsibilities
 - Servicing carrier eligibility requirements
 - Interstate assignments
 - Assignment formula determination
 - Dispute resolution procedures
 - Self-funded Plan
- **Rule 4-B—Professional Employer Organization (PEO) Arrangements**—Provides rules for the issuance of workers compensation insurance for employers involved in professional employer organizations (PEO) arrangements.
- **Rule 4-C—Loss Sensitive Rating Plan (LSRP)**—Provides a mandatory assigned risk retrospective rating plan for those employers that have a qualifying policy. LSRP reflects the actual experience of the employer by using the losses incurred during the term of the policy to establish the cost of insurance, including provisions for all expenses and taxes on premium.
- **Rule 4-D—Voluntary Coverage Assistance Program (VCAP[®] Service)**—Operates as a supplemental program for all employers applying for coverage through the WCIP. VCAP[®] Service is designed to provide an additional source for producers and employers to secure workers compensation coverage in the voluntary market and operates in conjunction with NCCI's RMAPS[®] Online Application Service.
- **Rule 4-F—Take-Out Credit Program**—Operates as a supplemental program by providing carriers with financial incentives for writing residual market employers on a voluntary market basis. The take-out credit is applied against the premium used to calculate the voluntary market carrier's Plan participation base.
- **Rule 4-G—Available Coverages**—Provides rules for additional coverages that are available at the employer's request. This includes increased limits of employers liability insurance, limited other states insurance, waiver of subrogation, alternate employer endorsement, federal coverages, and coverage for volunteers.
- **Rule 4-H—Producer Fees**—Provides rules for producer fee procedures and percentage scales.
- **Rule 4-I—Initial or Deposit Premium and Premium Installments**—Establishes the deposit premium amounts and provides comprehensive tables that include each state's premium installment basis and minimum deposit percentage.

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NCCI's *Basic Manual* Rule 4-E—Assigned Risk Adjustment Program (ARAP) will not apply in Tennessee.

Tennessee Miscellaneous Rules

The following Tennessee miscellaneous rules in NCCI's *Basic Manual* must be revised:

- **Dispute Resolution Process**—Provides a mechanism by which employers may obtain review by NCCI of the application by an insurance carrier of NCCI classifications, manual rules, and rating plans. The rule must be revised to apply to disputes involving policies written in both the Tennessee voluntary and residual markets.
- **Drug-Free Workplace Premium Credit Program**—Provides a 5% premium credit for an employer that has certified to the Division of Workers Compensation of the Tennessee Department of Labor that a qualifying drug-free workplace program has been established. The rule must be revised to remove a footnote that is no longer applicable.
- **Deductible Insurance**—Provides the deductible options available for employers. The rule must be revised to specify that deductibles must not be applied to Tennessee assigned risk policies.
- **Tennessee Workers Compensation Premium Algorithm**—Provides the framework for premium charges and credits. The rule must be revised to add a line item for the waiver of subrogation premium charge.

The above Tennessee miscellaneous rules are also being updated for minor formatting and language revisions.

The following Tennessee miscellaneous rules must be established in NCCI's *Basic Manual* to be applicable to assigned risk policies only:

- **Tennessee Small Employer Plan**—Any employer insured in the Tennessee WCIP that is not eligible for an experience rating modification is considered to be eligible for the Tennessee Small Employer Plan. Subject to meeting the requirements of the Tennessee Small Employer Plan, an employer that has no losses and is otherwise eligible at the end of its policy term will receive a 10% premium credit from the assigned carrier at the time of final audit.
- **Tennessee Special Risk Plan**—Any employer insured in the Tennessee WCIP that has an experience rating modification of 1.10 or less as of the policy effective date is considered to be in the Tennessee Special Risk Plan. Subject to meeting the requirements of the Tennessee Special Risk Plan, an employer that has no losses and is otherwise eligible at the end of the policy term will receive a 5% premium credit from the assigned carrier at the time of final audit.
- **Tennessee Tabular Surcharge**—Any employer insured in the Tennessee WCIP that has an experience rating modification of 1.11 or higher as of the policy effective date is subject to a surcharge. The surcharge amount ranges from 5% to 15% based on the experience rating modification.
- **Tennessee Assigned Risk Workers Compensation Premium Algorithm**—Provides the framework for premium charges and credits.

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National and Tennessee State-Specific Endorsements

The following residual market national and state-specific endorsements must be established for use in Tennessee in NCCI's *Forms Manual*:

- Professional Employer Organization (PEO) Extension Endorsement (WC 00 03 20 B)
- Professional Employer Organization (PEO) Exclusion Endorsement (WC 00 03 21 A)
- Professional Employer Organization (PEO) Client Exclusion Endorsement (WC 00 03 22 A)
- Multiple Coordinated Policy Endorsement (WC 00 03 23 A)
- Residual Market Limited Other States Insurance Endorsement (WC 00 03 26 A)
- Assigned Risk Loss Sensitive Rating Plan Notification Endorsement (WC 00 04 17 B)
- Assigned Risk Loss Sensitive Rating Plan Endorsement (WC 00 04 18 F)
- Tennessee Small Employer Plan Endorsement (WC 41 04 05)
- Tennessee Special Risk Plan Endorsement (WC 41 04 06)
- Tennessee Tabular Surcharge Endorsement (WC 41 04 07)

As a result of the establishment of the PEO endorsements and the Multiple Coordinated Policy Endorsement referenced above, the following endorsements must be withdrawn for assigned risk policies only:

- Labor Contractor Endorsement (WC 00 03 20 A)
- Labor Contractor Exclusion Endorsement (WC 00 03 21)
- Employee Leasing Client Exclusion Endorsement (WC 00 03 22)
- Multiple Coordinated Policy Endorsement (WC 00 03 23)

Bylaws of the National Workers Compensation Reinsurance Association NFP (NWCRA)

Member carriers participate in the Reinsurance Agreement(s) authorized under NCCI's Plan to provide reinsurance to the servicing carriers on employers assigned to them under the Plan. The Bylaws of the NWCRA are the agreement subscribed to by carriers selecting Option 2—Subscription to Association Bylaws as their means of satisfying their participation in the Plan. The Bylaws are attached, incorporated into, and made a part of NCCI's WCIP.

Assigned Carrier Performance Standards

NCCI's *Assigned Carrier Performance Standards (ACPS)* is included with this item for informational purposes only and is not being filed for approval. The *ACPS* provides policy issuance and service level requirements that assigned carriers must adhere to, in order to provide residual market employers with uniform quality service while containing residual market system costs. Performance Standard 8—Billing and Collection for Deductibles will not apply in Tennessee.

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PROPOSAL

This item proposes the following for Tennessee:

1. Establishment of national Rule 4—Workers Compensation Insurance Plan Rules in NCCI's **Basic Manual**
2. Establishment of national Rule 3-A-22—Waiver of Right to Recover From Others (Subrogation) in NCCI's **Basic Manual**
3. Elimination, establishment, or revision of Tennessee state rule exceptions and Tennessee miscellaneous rules in NCCI's **Basic Manual**
4. Revisions to reporting requirements in NCCI's **Statistical Plan**
5. Establishment or withdrawal of national and state-specific endorsements in NCCI's **Forms Manual**
6. Establishment of the NWCRA Bylaws in Tennessee, which will be available on **ncci.com**
7. Minor formatting and language revisions in various NCCI manuals

IMPACT

There will be no premium impact as a result of the establishment of NCCI's Plan Documents. It is anticipated that NCCI's WCIP will enhance the understanding of the rules and procedures pertaining to assigned risk policies.

EXHIBIT COMMENTS AND IMPLEMENTATION SUMMARY

Exhibit	Exhibit Comments	Implementation Summary
1-A	Displays the establishment of national Rule 4—Workers Compensation Insurance Plan Rules in NCCI's Basic Manual .	To become effective for new and renewal assigned risk policies only effective at 12:01 a.m. on and after July 1, 2015.
1-B	Displays the establishment of national Rule 3-A-22—Waiver of Right to Recover From Others (Subrogation) in NCCI's Basic Manual .	To become effective for new and renewal policies effective at 12:01 a.m. on and after July 1, 2015.

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Exhibit	Exhibit Comments	Implementation Summary
2-A	Displays the elimination or establishment of the following Tennessee state rule exceptions in NCCI's Basic Manual : <ul style="list-style-type: none"> • Rule 4—Workers Compensation Insurance Plan Rules • Rule 4-A—Workers Compensation Insurance Plan (WCIP) <ul style="list-style-type: none"> • Rule 4-A-4-a(5) • Rule 4-A-5-a(5) • Rule 4-A-6-a • Rule 4-B—Professional Employer Organization (PEO) Arrangements <ul style="list-style-type: none"> • Rule 4-B-2-c • Rule 4-B-4-e • Rule 4-B-4-o(1) • Rule 4-C-1—Introduction to the Loss Sensitive Rating Plan • Rule 4-E—Assigned Risk Adjustment Program (ARAP) • Rule 4-H-6—Producer Fee Tables 	To become effective for new and renewal assigned risk policies only effective at 12:01 a.m. on and after July 1, 2015.
2-B	Displays the elimination of Tennessee State Rule Exception Rule 3-A-22—Waiver of Right to Recover From Others (Subrogation) in NCCI's Basic Manual .	To become effective for new and renewal policies effective at 12:01 a.m. on and after July 1, 2015.
3-A	Displays the revisions to the following Tennessee miscellaneous rules in NCCI's Basic Manual : <ul style="list-style-type: none"> • Tennessee Dispute Resolution Process • Tennessee Drug-Free Workplace Premium Credit Program 	To become effective for new and renewal policies effective at 12:01 a.m. on and after July 1, 2015.
	Displays the revisions to the following Tennessee miscellaneous rules in NCCI's Basic Manual : <ul style="list-style-type: none"> • Tennessee Deductible Insurance • Tennessee Workers Compensation Premium Algorithm 	To become effective for new and renewal voluntary policies only effective at 12:01 a.m. on and after July 1, 2015.

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Exhibit	Exhibit Comments	Implementation Summary
3-B	Displays the establishment of the following Tennessee miscellaneous rules in NCCI's Basic Manual : <ul style="list-style-type: none"> • Tennessee Small Employer Plan • Tennessee Special Risk Plan • Tennessee Tabular Surcharge • Tennessee Assigned Risk Workers Compensation Premium Algorithm Displays the establishment of the LSRP factors in the Tennessee Miscellaneous Values in NCCI's Basic Manual . Future updates to the LSRP factors will be provided in the Tennessee assigned risk rate filings.	To become effective for new and renewal assigned risk policies only effective at 12:01 a.m. on and after July 1, 2015.
4	Displays the revisions to the following rules in NCCI's Statistical Plan : <ul style="list-style-type: none"> • Part 6-H-1—Premium Amount <i>Subject</i> to Experience Modification Factor • Part 6-H-2—Premium Amount <i>Not Subject</i> to Experience Modification Factor • Part 6-H-3—Premium Amount <i>Not Part</i> of Standard Premium 	To become effective for new and renewal policies effective at 12:01 a.m. on and after July 1, 2015.

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Exhibit	Exhibit Comments	Implementation Summary
5-A	Displays the establishment of the following national and state-specific endorsements in NCCI's Forms Manual : <ul style="list-style-type: none"> • Professional Employer Organization (PEO) Extension Endorsement (WC 00 03 20 B) • Professional Employer Organization (PEO) Exclusion Endorsement (WC 00 03 21 A) • Professional Employer Organization (PEO) Client Exclusion Endorsement (WC 00 03 22 A) • Multiple Coordinated Policy Endorsement (WC 00 03 23 A) • Residual Market Limited Other States Insurance Endorsement (WC 00 03 26 A) • Assigned Risk Loss Sensitive Rating Plan Notification Endorsement (WC 00 04 17 B) • Assigned Risk Loss Sensitive Rating Plan Endorsement (WC 00 04 18 F) • Tennessee Small Employer Plan Endorsement (WC 41 04 05) • Tennessee Special Risk Plan Endorsement (WC 41 04 06) • Tennessee Tabular Surcharge Endorsement (WC 41 04 07) 	To become effective for new and renewal assigned risk policies only effective at 12:01 a.m. on and after July 1, 2015.
5-B	Displays the withdrawal of the following national endorsements in NCCI's Forms Manual : <ul style="list-style-type: none"> • Labor Contractor Endorsement (WC 00 03 20 A) • Labor Contractor Exclusion Endorsement (WC 00 03 21) • Employee Leasing Client Exclusion Endorsement (WC 00 03 22) • Multiple Coordinated Policy Endorsement (WC 00 03 23) 	To become effective for new and renewal assigned risk policies only effective at 12:01 a.m. on and after July 1, 2015.
6	Displays the NWCRA Bylaws, which will be available on ncci.com .	

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ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

EXHIBIT 1-A**BASIC MANUAL—2001 EDITION****RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES****(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)****A. WORKERS COMPENSATION INSURANCE PLAN (WCIP)****1. Preface to the Workers Compensation Insurance Plan**

Pursuant to the Insurance Code or Regulation, there is hereby established a Workers Compensation Insurance Plan ("Plan" or "WCIP"), which provides for the equitable apportionment of employers who are in good faith entitled to workers compensation insurance as defined herein, but who are unable to procure such insurance in a regular manner. This Plan and any future modification thereof is subject to the approval of the appropriate insurance regulatory authority and pursuant to any state law, regulation, and/or rule.

2. WCIP Definitions

The definitions in Rule 4-A—Workers Compensation Insurance Plan (WCIP) apply to all national and state-specific rules and programs under Rule 4—Workers Compensation Insurance Plan Rules unless specified otherwise in a rule or program.

a. Affiliated Insurer

An insurer that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, another insurer specified. The term "control" means possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an insurer, whether through the ownership of voting securities, by contract, or otherwise. Control will be deemed to exist if any person or business enterprise, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies, representing ten (10) percent or more of the voting securities of any other insurer.

b. Application

Form(s) approved for use in the residual market by the Plan Administrator for the purpose of securing workers compensation insurance under the Plan, which contains the required information as described in NCCI's ***Assigned Risk Supplement to the Basic Manual for Workers Compensation and Employers Liability Insurance***. The forms currently used in the residual market are the ACORD® 130 and 133 applications.

c. Application Submission Methods

The methods approved by the Plan Administrator, in which good faith eligible employers may submit completed and signed current editions of the ACORD® 130 and 133 applications that have been approved for use by the Plan Administrator, for coverage through the WCIP are as follows:

- Online—Through **ncci.com** and NCCI's ***RMAPS® Online Application Service***
- Mail—The US Postal Service or private overnight delivery service
- Telephone—By contacting the Plan Administrator

For the rules regarding the treatment of incomplete applications or outdated editions of the applications received by the Plan Administrator, *refer to Rule 4-A-3-e*.

d. Association Bylaws

The Bylaws of the National Workers Compensation Reinsurance Association NFP (NWCRA), whose member insurers participate in the Reinsurance Agreement(s) authorized under this Plan to provide reinsurance to the servicing carriers on employers assigned to them under this Plan.

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**EXHIBIT 1-A (CONT'D)
BASIC MANUAL—2001 EDITION****RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES****(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)**

The Bylaws are the agreement subscribed to by insurers selecting Option 2—Subscription to Association Bylaws as their means of satisfying their participation in the Plan. The Bylaws are attached hereto and by this reference are incorporated into and made a part of this Plan.

e. Assigned Carrier

An insurer assigned to provide coverage to an employer who has applied for and is good faith eligible for workers compensation insurance under the Plan. An assigned carrier can either be defined as one of the following:

- **Servicing Carrier**—An insurer authorized by the regulatory authority to receive Plan assignments and provide coverage to eligible employers on behalf of those participating companies subscribing to the Association Bylaws incorporated as part of this Plan, or
- **Direct Assignment Carrier**—An insurer that has elected and has been authorized by the regulatory authority to receive assignments under Option 1 of Rule 4-A-5 of this Plan, directly from the Plan Administrator without reinsurance through the Reinsurance Agreement(s). Insurers selecting the direct assignment option will be solely responsible for the financial results of the assignments they receive.

Assigned carrier references throughout the Plan mean direct assignment carriers and servicing carriers. If a carrier is specifically referenced as either direct assignment carrier or servicing carrier, the language is exclusive of that carrier's status.

f. Assigned Carrier Performance Standards

The minimum level of performance for assigned carriers writing coverage on behalf of the WCIP. The purpose of the **Assigned Carrier Performance Standards** is to provide policy issuance and service level requirements that assigned carriers must adhere to in order to provide residual market policyholders with uniform service while reducing the overall loss ratio for the reinsurance mechanism.

g. Bona Fide Premium Dispute

A bona fide premium dispute for a workers compensation insurance premium obligation exists when the employer or its representative has provided:

- (1) Written notice to the Plan Administrator that includes:
 - All documentation relevant to the dispute, including written notice to the insurer or the assigned carrier detailing the specific areas of dispute
 - Description of the attempts to reconcile the differences with the insurer
 - A specific request for a review of all documentation, appropriate action to resolve the areas of dispute, and if necessary, a hearing before the appropriate administrative or regulatory body having jurisdiction over assigned risk related appeals
- (2) An estimate of the premium the employer believes to be correct, with an explanation of the premium calculation
- (3) Verification of payment of the undisputed portion of the premium provided to the assigned carrier or insurer, and the Plan Administrator

Note: If the premium in dispute is in litigation, documentation (i.e., legal complaint, order and/or any legal notice providing the status of the case) must be provided to the Plan Administrator.

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**EXHIBIT 1-A (CONT'D)
BASIC MANUAL—2001 EDITION****RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES****(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)**

The Plan Administrator will notify the assigned carrier when a bona fide premium dispute is confirmed. Upon notification, the assigned carrier will act according to the Plan Administrator's direction pending the resolution of the dispute, which may include:

- Suspension of collection activity
- Suspension of cancellation if a dispute exists prior to the effective date of cancellation
- Reinstatement of a policy after the effective date of cancellation in accordance with the reinstatement provisions for cancelled policies in Rule 4-A-4-a(4)
- Verification of receipt of payment of the undisputed portion of the premium

h. Common Managing (or Management) Interest

Where referred to a policyholder or applicant within a state's WCIP, "common managing (or management) interest" exists when one or more individuals are or were owners or officers of, or perform management functions for, two or more entities, or for a succession of entities.

i. Employer

Any business organization or enterprise that is required by state law, regulation and/or rule to maintain workers compensation insurance in this state or state(s). The term includes any business organization or enterprise that are or were affiliated at any time as a result of common management or common ownership.

j. Governing State

The state that generates the largest amount of payroll.

k. Insured

The assigned risk employer designated in the Information Page of the policy or policies to which this Plan is applied and issued by an assigned carrier.

l. National Council on Compensation Insurance, Inc. or NCCI

The rating/advisory organization and/or statistical agent licensed in this state to make and file rates, loss costs, rating values, classifications, and rating plans for workers compensation insurance.

m. National Workers Compensation Reinsurance Association NFP (NWCRA or Association)

A not-for-profit corporation whose members provide for contractual quota share reinsurance through Reinsurance Agreement(s) among themselves as workers compensation insurers, which affords such insurers an option for complying with state workers compensation insurance plan requirements by sharing in the experience arising of certain policies written pursuant to such insurance plans.

n. Net Premiums Written

The gross direct premiums charged less all premiums (except dividends and savings refunded under participating policies) returned to insureds for all workers compensation and occupational disease insurance, exclusive of premiums for:

- (1) Employers subject to this Plan

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INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 1-A (CONT'D)
BASIC MANUAL—2001 EDITION****RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES
(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)**

- (2) Employers written under the National Defense Projects Rating Plan, and
- (3) Under excess policies

o. Payment Methods—Initial or Deposit Premium

The payment methods currently approved by the Plan Administrator for the required initial or deposit premium on application submissions are:

- Electronic Funds Transfer (EFT)
- Credit Card
- Check

The employer or its representative may submit the required initial or deposit premium using these payment methods based on the availability of these methods.

Note: If an application is submitted via overnight delivery service or U.S. mail, a check for the required estimated annual or initial deposit premium must accompany the application to establish the effective date in accordance with Rule 4-A-3-d.

For more information regarding deposit premium, *refer to Rule 4-I.*

p. Plan Administrator

The organization designated to administer the affairs of this Plan as approved by the regulatory authority in a state.

q. Producer

A licensed insurance agent, broker, producer, or insurance representative, as defined in the state insurance law, regulation, and/or rule, whose privileges under this Plan have not been suspended or revoked, designated by the employer or applicant applying under this Plan to secure and maintain workers compensation and employers liability insurance on behalf of the employer. For purposes of this Plan, the producer is considered to be acting on behalf of the insured or employer applying for coverage under this Plan and not as an agent of the Plan Administrator or of any assigned carrier for Plan business.

r. Reasonable Offer of Voluntary Coverage

Any offer for voluntary coverage where the total estimated annual premium is less than or equal to the assigned risk total estimated annual premium including any applicable assigned risk surcharges and/or pricing programs for all comparable coverages.

Subject to the Plan Administrator's discretion and without limitation, the following are not considered a reasonable offer of voluntary coverage:

- Offer does not provide all of the required coverage (i.e., carrier cannot provide federal coverage or limits of liability)
- A deductible or deposit that is a financial burden to the employer as determined by the producer and/or employer
- Carrier's A.M. Best financial rating status is below that required by the producer and/or employer

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s. Reasonable Rating Plan

Any rating program approved for use in a state by the regulatory authority.

t. Regulatory Authority

The commissioner, director, or superintendent of the state's Department of Insurance or their properly appointed designee.

Regulatory authority references throughout the Plan mean the commissioner, director, or superintendent or their properly appointed designee.

u. Residual Market

State insurance plans that provide employers unable to secure coverage in the voluntary market with a means for insuring their operations through a designated insurance carrier. The residual market is also known as "involuntary market," "assigned risk market," or "market of last resort."

v. State

Any state of the United States of America, and the District of Columbia.

w. Undisputed Premium

A workers compensation insurance premium obligation that is not a bona fide premium dispute as defined in Rule 4-A-2-g.

x. Workers Compensation Insurance

- (1) Insurance for liability under statutory workers compensation and occupational disease liability insurance including insurance for liability under the Longshore and Harbor Workers' Compensation Act, as amended, and the Federal Mine Safety and Health Act, as amended
- (2) Employers Liability Insurance written in connection with a workers compensation insurance policy
- (3) Such other coverages as determined by the Plan Administrator and approved by the regulatory authority

y. Workers Compensation Insurance Plan (WCIP or Plan)

A program established by state insurance regulatory authorities whereby eligible employers unable to secure coverage in the voluntary market may secure workers compensation insurance.

z. Board of Directors

The Board of Directors for the National Workers Compensation Reinsurance Association NFP.

aa. Reinsurance Agreement

A contractual arrangement among Association members providing a quota share reinsurance facility for workers compensation insurance in a number of states and for which administrative services are provided by the National Council on Compensation Insurance, Inc. in its capacity as Administrator as designated under the Association Bylaws.

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(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)****3. Eligibility and Assignment****a. Purpose**

The following rules will govern the insuring of employers who are *in good faith entitled to workers compensation insurance* as defined herein, but who are unable to procure such insurance in a regular manner.

For purposes of this Plan, the offer of any reasonable rating plan approved by the regulatory authority is deemed an offer of insurance in a regular manner. Any dispute arising from the application or interpretation of this Plan is subject to the dispute resolution procedure provided in Rule 4-A-10.

b. Good Faith Rules of Eligibility

Good faith will be presumed in the absence of clear and convincing evidence to the contrary. An employer is not in good faith entitled to insurance if any of the following circumstances exist at the time of application or thereafter, or other evidence exists that such employer is not in good faith entitled to insurance:

(1) A self-insured employer knows or is aware of pending bankruptcy proceedings, insolvency, cessation of operations, or conditions that would probably result in occupational disease or cumulative injury claims from exposure incurred while the employer was self-insured.

(2) On a current or previous workers compensation policy, the employer:

- Knowingly refuses to meet reasonable health, safety, premium audit, or loss prevention requirements
- Does not allow any insurer or assigned carrier reasonable access to its records for audit or inspection under the policy
- Does not comply with any other policy obligations

The employer will remain ineligible for coverage through the WCIP until such time the employer has complied with the policy provisions and is deemed by the Plan Administrator to be in good faith entitled to insurance.

(3) The employer has any outstanding workers compensation insurance premium obligation or other monetary policy obligation, (e.g., deductible program) on a current workers compensation insurance policy or on any previous or other workers compensation insurance policy, that is not subject to a bona fide premium dispute as defined in Rule 4-A-2-g. The employer will remain ineligible for coverage through the WCIP until such time the employer has satisfied the outstanding workers compensation insurance premium obligation or other monetary policy obligation and is deemed by the Plan Administrator to be in good faith entitled to insurance.

(4) The employer, its representative, or the producer knowingly fails to comply with Plan procedures, or knowingly makes a material misrepresentation on the application by express statement, omission or otherwise, including, but not limited to, the following:

- Estimated payroll
- Offers of workers compensation insurance
- Nature of business
- Name of business
- Management or ownership of business

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- Previous insurance history
- Avoidance of an experience rating modification
- An outstanding workers compensation insurance premium obligation or other monetary policy obligation of the employer
- Noncompliance with any applicable state licensing or registration requirements

The employer will remain ineligible for coverage through the WCIP until such time the employer has remedied the above-referenced instances of noncompliance and is deemed by the Plan Administrator to be in good faith entitled to insurance.

- (5) The employer, its representative, or the producer does not accept any reasonable offer of voluntary coverage through NCCI's **VCAP[®] Service**.

c. Declinations

Within sixty (60) days preceding the date of application, the employer must apply for workers compensation insurance and have received declinations from at least two (2) nonaffiliated insurers that are licensed to write and are actively writing workers compensation insurance within the state.

Specifically, one of the declinations must be from the insurer providing workers compensation insurance to the employer at the time of application, if any. Proof of cancellation or nonrenewal from such insurer will be considered as one of the required declinations.

The employer or its representative must maintain a record of all carrier declinations for the policy period that is in force. This information must be provided upon request to the Plan Administrator or assigned carrier and must include:

- Carrier name
- Person contacted at carrier
- Mailing address and phone number of carrier contact
- Date of declination

d. Securing a Requested Effective Date

The employer or its representative may request an effective date no later than sixty (60) days from the date of application; however, such requested effective date must be the later of the following:

- (1) The established effective date as outlined in the following tables
- (2) The date of expiration of existing coverage
- (3) A date the employer requested

To secure a requested effective date, the employer or its representative must:

- (1) Submit to the Plan Administrator signed and completed current editions of the ACORD[®] 130 and 133 applications, that have been approved for use by the Plan Administrator, using one of the submission methods as defined in Rule 4-A-2-c.
- (2) For applications submitted by US Postal Service or private overnight delivery service, at a minimum, include in the application submission the required critical threshold elements as defined in NCCI's **Assigned Risk Supplement to the Basic Manual**. For the rules regarding the treatment of incomplete applications or outdated editions of the applications received by the Plan Administrator, refer to Rule 4-A-3-e.

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(3) If submitting an application via mail or an overnight delivery service, send the application to the appropriate lockbox and include the appropriate initial or deposit premium. Note: Receipt of the application at the appropriate lockbox will be considered receipt by the Plan Administrator.

Depending on the application submission method, the earliest effective date for coverage will be established in the following manner:

Application Submission Table 1

If the application is submitted by regular mail and the envelope containing the application has . . .	Then the earliest eligible effective date will be 12:01 a.m. on the day after . . .
A legible US postmark	Postmark
An illegible US postmark	Receipt of the application by the Plan Administrator
A meter mark only	Receipt of the application by the Plan Administrator
Internet postage with a legible cancellation stamp	The date on the cancellation stamp
Internet postage without a cancellation stamp or an illegible cancellation stamp	Receipt of the application by the Plan Administrator

Application Submission Table 2

If the application is submitted by overnight mail and . . .	Then the earliest eligible effective date will be 12:01 a.m. on the day after . . .
The package containing the application has proof of mailing that can be verified	The application was sent to the Plan Administrator
The package containing the application does not have proof of mailing or proof of mailing cannot be verified	Receipt of the application by the Plan Administrator
Proof of mailing (i.e., certified mail receipt) can be obtained	Postmark
Proof of mailing cannot be obtained	Receipt of the application by the Plan Administrator

Application Submission Table 3

If all required information and deposit premium is received within the established time frame and the application is submitted by . . .	Then the earliest eligible effective date will be 12:01 a.m. on the day after receipt of the . . .
<i>RMAPS® Online Application Service</i>	Completed online submission
Telephone	Telephone submission

e. Application Review

Upon receipt of the application, the Plan Administrator will review it for eligibility and completeness. The Plan Administrator may request additional information at its discretion to establish eligibility, assign appropriate classification codes, calculate applicable premium, and otherwise appropriately process the application. Such information may include, but is not limited to:

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- Tax documentation
- Ownership information, which may include a request to complete and sign an ERM-14 Form
- Contracts (i.e., PEO Arrangement, temporary employment agency contracts, or franchise agreements)
- Supplemental PEO Arrangement applications
- Additional information regarding short-term policies requests (i.e., verification of annualized payroll)
- Proof of declinations of voluntary coverage
- Proof of bankruptcy and/or settlements
- Any other information that is demonstrated by the Plan Administrator to be necessary to process the application

The employer and/or its representative must provide this information/documentation or provide an acceptable explanation for failure to provide the requested items within the time frame established by the Plan Administrator.

Incomplete applications and/or outdated editions of the applications, received by the Plan Administrator may, at the discretion of the Plan Administrator, be returned to the employer or its representative for completion or, with notice to the employer or its representative, may be retained by the Plan Administrator pending receipt of further information. Failure to comply in a time frame as established by the Plan Administrator may result in the rejection of the application and loss of the previously established effective date.

Complete and signed current editions of the applications may be resubmitted to the Plan Administrator for an application review and establishment of a new effective date in accordance with Rule 4-A-3-d.

f. Additional States Coverage

Any current assigned risk employer desiring insurance for operations in states other than those listed in Item 3.A. of the Policy Information Page may request its assigned carrier to furnish insurance in the additional states in accordance with Rule 4-A-8 of this Plan.

Except as indicated on the binder/verification page, all assignments under this Plan are to be made on an intrastate basis.

Plan policies affording coverage on operations in more than one (1) state must clearly indicate the premium developed for each state separately.

g. Premium Obligations

Assignments under this Plan will not knowingly be made unless all undisputed workers compensation premium obligations on any previous workers compensation insurance have been met by the employer whether the obligation is to any or all of the following, but not limited to:

- An assigned carrier
- A voluntary insurer
- The Plan Administrator

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If, after policy issuance, the employer does not meet all undisputed workers compensation insurance premium obligations under the current policy or previous assigned risk or voluntary market policies, the employer's present assigned carrier retains the right to cancel a policy currently in force under this Plan within the statutory cancellation requirements.

h. Initial or Deposit Premium

The employer or its representative must submit the required initial or deposit premium to the Plan Administrator, using one of the payment methods defined in Rule 4-A-2-o. For more information regarding deposit premium, *refer to Rule 4-I*.

i. Binding of Coverage

- (1) The Plan Administrator is authorized under this Plan to issue binders (electronically or hard copy) to eligible employers in accordance with the provisions of this Plan. Coverage under any binder issued by the Plan Administrator shall be provided by the assigned carrier, subject to the provisions of this Plan, any applicable policy terms or conditions, and/or any applicable laws, rules, or regulations. The Plan Administrator will issue a binder to the employer, its representative, if any, the assigned carrier to which the Plan Administrator assigned the employer, and the appropriate state agency if required by law, subject to Plan rules, only when **all** of the following occur:
 - The Plan Administrator is in receipt of complete and signed current editions of the ACORD[®] 130 and 133 applications along with any additional information within the established time frame. The signature must be that of an officer, owner, or other designee with power of attorney. Only the current editions of the ACORD[®] 130 and 133 applications, as determined by the Plan Administrator, will be accepted for binding of coverage.
 - The applicant is deemed eligible by the Plan Administrator.
 - The total initial or deposit premium has been received by the Plan Administrator within the established time frame.
- (2) The Plan Administrator uses a random, equitable assignment system to select the assigned carrier in accordance with Rule 4-A-9. Once coverage is bound, the assigned carrier will electronically receive:
 - A copy of the binder
 - The initial or deposit premium
 - The ACORD[®] 130 and 133 applications
 - Copies of any provided election or rejection forms
 - Other forms submitted during the application review process
 - Any information to assist the assigned carrier in providing the proper coverage and correct rates (e.g., experience rating modification worksheet data, NCCI's Inspection and Classification Report, and change of ownership information (ERM-14), if applicable)

Upon receipt of the assignment package, the assigned carrier will review the documents to ensure that all documentation needed to properly issue the policy is attached. Based on their separate review, the assigned carrier may request additional information and/or premium from the employer. All such requested information and/or premium must be received by the assigned carrier prior to issuing a policy.

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The assigned carrier must issue the policy (electronically or hard copy) in accordance with Plan rules, state law, and the ***Assigned Carrier Performance Standards***. Where these ***Performance Standards*** conflict with Plan rules, state law or regulation, the more stringent applies.

j. Binder Information

The binder/verification page will be sent (electronically or hard copy) to the appropriate parties as required and must remain in effect until cancelled or until a policy has been issued in accordance with the ***Assigned Carrier Performance Standards*** or state law. Coverage will not exist if a binder was not issued by the Plan Administrator.

k. Reassignment

An employer may submit to the Plan Administrator a written request for reassignment to a different assigned carrier, if available. The request for reassignment must be made in writing no less than thirty (30) days or more than sixty (60) days prior to the expiration of the current policy unless otherwise approved by the Plan Administrator or at the request of the regulatory authority.

The employer must provide the Plan Administrator with an acceptable reason(s) for the request along with the appropriate documentation.

Acceptable reasons for reassignment requests from an employer are:

- Documented items pertaining to assigned carrier service—timely issuance of statements, policies, and endorsements, or services not provided under the policy
- Documented refusal of or inability of an assigned carrier to supply a required type of coverage (i.e., longshore, coal mine, maritime, additional state exposures, etc.)
- Documented items pertaining to an assigned carrier's return of premium due to the insured, where there is no valid bona fide premium dispute
- Based on the assigned carrier's A.M. Best Rating or financial size category, if appropriate documentation is provided to and approved by the Plan Administrator
- Other substantial documented reasons are subject to approval in the discretion of the Plan Administrator

Any request for reassignment is subject to approval by the Plan Administrator. If the Plan Administrator approves the reassignment request, the employer must submit a new application along with the appropriate initial or deposit premium to the Plan Administrator and otherwise be eligible for continued coverage through the Plan in accordance with the Rule 4-A-3. All reassignments will be made on a random and equitable basis.

l. Producer Information:

The assigned carrier must pay producer fees in accordance with Rule 4-H. To be paid a fee, a producer and/or agency must be properly licensed in the state(s) for which new and/or renewal policies are issued. It is the assigned carrier's responsibility to determine whether or not the producer and/or agency is properly licensed in the appropriate jurisdictions for payment of fees. Producer fee checks are made payable to the licensed agency of record rather than to the individual licensed producer, unless they are one and the same. Producer of record changes must also be applied in accordance with Rule 4-H.

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Additional coverages may be available to the employer through the assigned carrier. *Refer to Rule 4-G for more information.*

n. Policy Term

The policy must be issued for a term of at least one (1) year, unless insurance for a shorter term has been requested. A short-term policy may be obtained only once within a twelve (12)-month period unless agreed to by the assigned carrier.

4. Assigned Carrier**a. Responsibilities**

The assigned carrier is held accountable to the appropriate **Assigned Carrier Performance Standards**, state laws, regulations, and/or rules, market conduct requirements, or rating/advisory and/or statistical organization reporting requirements (where appropriate) for the following issues including, but not limited to:

(1) Policy Information Page

The Policy Information Page and all endorsements must be submitted electronically to the Plan Administrator or its designee and properly identified as a WCIP or AR (Assigned Risk) policy. This information must include the binder number and be submitted to the Plan Administrator or its designee within the time frame and the format established by the Plan Administrator. If policy information is submitted on hard copy, on an exception basis, it must show the WCIP or AR indicator and the binder number, where approved, by the policy number on the Information Page.

(2) Forms and Rates

All policies issued to employers to which this Plan applies must be written utilizing the classifications, forms (e.g., policy endorsements, ERM-14 forms, supplemental PEO arrangement forms, etc.), rates, and rating plans (including retrospective rating plans) approved by the regulatory authority and authorized for use in the residual market by the Plan Administrator.

(3) Cancellation of the Policy

If, after the issuance of a policy, the assigned carrier determines that an employer is in noncompliance with any of the following policy provisions on a current or previous workers compensation policy by:

- Not being in good faith entitled to workers compensation insurance
- Failing to comply with reasonable health, safety, audit, and/or loss prevention requirements
- Violating any of the terms and conditions under which the insurance was issued
- Refusing to allow the carrier or NCCI reasonable access to its facilities or its files and records for audit or inspection
- Refusing to disclose to the carrier the full nature and scope of the employer's exposure

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The current assigned carrier will initiate cancellation (after providing an opportunity for cure) even if the noncompliance was for a previous policy issued by a different carrier, and inform the Plan Administrator and appropriate state organization of the reason for such cancellation. The policy should be cancelled in accordance with the cancellation provision of NCCI's *Basic Manual* Rule 3-A-3, the *Assigned Carrier Performance Standards*, and state law.

The assigned carrier must keep the Plan Administrator fully informed of any cancellation and of any reestablishment of eligibility or of compliance by the employer in accordance with Rule 4-A-4-a(7). Any employer whose coverage is cancelled must reestablish eligibility or must demonstrate entitlement to coverage under this Plan to the Plan Administrator before any further assignment can be made under this Plan.

(4) Effective Date of Policy

Policies must be issued, renewed, or reinstated without a lapse in coverage when premium, including an interim premium audit or installment payment, is received or contains a legible U.S. postmark **prior** to the policy effective date or cancellation date.

Refer to the following table for information regarding reinstatement provisions for cancelled and renewal policies:

If . . .	Then . . .
An item correcting a deficiency that resulted in cancellation is received on or within 60 days after the effective date of cancellation	The carrier will reinstate insurance with a lapse in coverage, issue a short-term policy, or take other underwriting action consistent with NCCI <i>Basic Manual</i> Rules, one time only during the original policy period. The lapse of coverage must clearly be stated on the reinstatement notice. A copy of the reinstatement notice must be sent to the Plan Administrator. In those instances where a proof of mailing cannot be clearly determined, timely receipt of the deficiency by the assigned carrier will be presumed if received within (5) five days of the expiration date of the policy. Receipt at the assigned carrier's designated lockbox is considered receipt by the assigned carrier. No lapse occurs if such item(s) are U.S. postmarked prior to the effective date of cancellation.
An item correcting a deficiency that resulted in cancellation is received more than sixty (60) days from the effective date of cancellation	If coverage is still required under the Plan, the employer must submit a new application to the Plan Administrator.

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If . . .	Then . . .
An item correcting a deficiency that resulted in cancellation is received on, within, or after sixty (60) days after the effective date of cancellation and the insured had received a previous policy reinstatement during the policy term	If coverage is still required under the Plan, the employer must submit a new application to the Plan Administrator.
Payment for a renewal policy is received on or within sixty (60) days after the renewal effective date	The policy will be issued with a revised new or different effective date (a "gap") in coverage. The determination of the revised effective date will be in accordance with Rule 4-A-3-d—Application Submission Table 1 and 2.
A finance company requests cancellation for non-payment of premium, and subsequently a request for reinstatement is received within sixty (60) days of the date of cancellation	A one-time reinstatement is allowed. However, the assigned carrier is not obligated to reinstate.

The carrier may impose additional requirements, if necessary, to effect the reinstatement.

Effective/reinstatement dates for lapses in coverage will be determined in the same manner as described in Rule 4-A-3-d.

(5) Renewal and Nonrenewal of Coverage

Any assigned carrier must send a renewal or nonrenewal notice of impending expiration of coverage (electronically or hard copy) to the insured, its representative, and the Plan Administrator at least:

- (a) Sixty (60) days in advance of expiration of insurance, or
- (b) The number of days required by state law, regulation, and/or rule if more stringent

Upon receipt of the required premium, the policy must be issued in accordance with the **Assigned Carrier Performance Standards** and a copy of such policy and all endorsements, properly identified as a WCIP or AR (Assigned Risk) policy, must be reported to the Plan Administrator or its designee within the time frame and the format established by the Plan Administrator.

If the assigned carrier is unwilling to renew a policy, they must provide the employer with a reason(s) that is acceptable to the Plan Administrator. Acceptable reasons for nonrenewal are:

- Refusal of or inability of an assigned carrier to supply a required type of coverage (e.g., longshore, coal mine, maritime, additional state exposures, etc.)
- Other substantial and documented reasons subject to approval in the discretion of the Plan Administrator

(6) Cancellation for Voluntary Coverage

Notwithstanding Rule 4-A-4-a(9), any insurer that wishes to insure an employer as voluntary business may do so at any time. If such insurer is not the assigned carrier, the assigned

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carrier must cancel its policy pro rata and the assignment must automatically terminate as of the effective date of the voluntary insurer's policy.

(7) Notification of Undisputed Outstanding Premium and Other Noncompliance Issues

Outstanding premium or other monetary policy obligation information identified by the assigned carrier or its representative must be updated and reported to the Plan Administrator or its designee in accordance with the *Assigned Carrier Performance Standards*. Assigned carriers should immediately report all instances of noncompliance and subsequent compliance information to the Plan Administrator, regardless of whether the impacted policy is currently in force. Additionally, assigned carriers must issue cancellation notices in accordance with Rule 4-A-4-a(3), when appropriate.

(8) Policyholder Services

Policyholders and their designated representative must be provided:

- Access to audit, loss prevention, and safety services
- Prompt, professional handling of claims, including investigation, resolution, and communication
- Fair and prompt responses to complaints and disputes
- Access to appropriate information regarding the classification of the business and the policy premium

Assigned carriers are required to comply with the minimum level of performance standards as defined in the *Assigned Carrier Performance Standards*.

(9) Confidentiality of Information

The assigned carrier must keep in confidence and must not, except as directed by the insured or the producer of record, or as otherwise may be required by law or regulatory authority, disclose to any third party, or use for the benefit of itself or any third party, such detailed information as it may obtain by virtue of its position as the assigned carrier. Such information will be used solely for the evaluation, underwriting, and insuring of coverage under this Plan and not for any other purpose. The assigned carrier must not use any information it obtains in its capacity as the assigned carrier to request, encourage, or solicit employers it insures under this Plan to utilize the services of any specific insurance agent, agency, broker, insurer or group of insurers, including without limitation, direct writers affiliated with the assigned insurer, for purposes of providing voluntary workers compensation insurance or other lines of insurance to such employer.

5. Participation**a. Options**

All insurers licensed to write and/or that are actively writing workers compensation insurance in this state are required to participate in this Plan by selecting one of the following options:

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Option	Participation Type	Description
1	Direct Assignment Carrier	Participating under the Plan by electing, subject to authorization by the regulatory authority, to receive assignments directly from the Plan Administrator.
2	Association Member	Participating under the Plan by electing to participate as a member of the National Workers Compensation Reinsurance Association NFP (NWCRA) by subscribing to the Association Bylaws, which are attached upon initial implementation and subsequent amendment, and are incorporated by reference into and made a part of this Plan, including any amendments, as applicable.

All affiliated insurers must select the same option if allowed by the regulatory authority in a state. If Option 1 is selected, one insurer may be designated to accept direct assignments on behalf of all of the affiliated insurers in that group.

(1) Election Time Frames

An insurer elects its participation option once per year in accordance with the following Insurer Participation Tables.

Insurer Participation Table Option 1—Direct Assignment Carrier

If . . .	Then . . .
An insurer selects Option 1	<ul style="list-style-type: none"> • Application for such approval must be made to the regulatory authority, with notification to the Plan Administrator no later than September 1 of the current calendar year. • The regulatory authority must approve or disapprove selection within 30 days of receipt of the request, but no later than October 1 of the current calendar year, with notification of the approval or disapproval to the Plan Administrator. This ensures that the carrier can begin to receive assignments January 1 of the following calendar year. • If approved, the insurer will become a direct assignment carrier on January 1 of the following calendar year. If previously a subscriber to the Association Bylaws, the insurer must also comply with the withdrawal provision in the Association Bylaws. • If disapproved, the insurer will automatically be deemed to have selected Option 2 for the following calendar year.

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Insurer Participation Table Option 2—Association Member

If . . .	Then . . .
An insurer selects Option 2	The insurer will subscribe to the NWCRA Bylaws no later than September 1 of the current calendar year.
<ul style="list-style-type: none"> • An insurer fails to submit an application to the regulatory authority for approval as a direct assignment carrier by September 1 of the current calendar year, or • The regulatory authority fails to act on a letter of application or disapproves the letter of application for direct assignment carrier status, or • After the Plan has been approved in a state, an insurer applies to be licensed in a state 	The insurer will automatically be deemed to have selected Option 2 until the next Plan membership election, at which time the insurer may then change its participation selection.
A licensed workers compensation insurer has not made an election	Upon verification by the Plan Administrator, the insurer will automatically be deemed to have selected Option 2 until the next Plan membership election, at which time the insurer may then change its participation selection.
An insurer fails to act upon the opportunity to make a new participation selection during the annual election process	The insurer will automatically be deemed to have selected Option 2 for the following calendar year.

(2) Direct Assignment Application Pending Approval or Appeal

While an application is pending or an appeal is pending before the regulatory authority regarding a disapproved letter of application for direct assignment carrier status, an insurer will automatically be deemed to have selected Option 2 for the period during which approval has not been granted. If previously a subscriber to the Association Bylaws, an insurer seeking to become a direct assignment carrier, once approved, must also comply with the withdrawal provision in the Association Bylaws.

The regulatory authority will review all applications for direct assignment carrier status, and at its discretion may approve or disapprove direct assignment carrier status of any individual carrier(s) or all carriers for any reason that is in the best interest of the state or Plan.

(3) State Carrier Participation Status

All licensed insurers in a state whose participation type is an Association Member under Option 2 may have their participation type automatically changed by the state regulatory authority to a direct assignment carrier under Option 1 in accordance with the Participation Status Table. Under this provision, all licensed insurers will automatically be deemed approved as direct assignment carriers and will not need to seek regulatory approval.

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Participation Status Table

If . . .	Then . . .
Participation under Option 2 consists of those insurers cumulatively writing 40% or less of the total net workers compensation insurance premiums written by all insurers in this state as calculated in accordance with the preceding calendar year figures	<ul style="list-style-type: none"> • The Plan Administrator will advise the state regulatory authority. • All insurers that selected Option 2 will, as of January 1 of the following year, automatically be deemed by the state regulatory authority to have selected Option 1 for employers insured effective on or after said January 1. • The regulatory authority will also have the full discretion to approve any, some, or none of the insurers applying for, or currently acting as, a direct assignment carrier under Option 1 in order to ensure continuation of the reinsurance pooling mechanism in the state.
<ul style="list-style-type: none"> • The Plan Administrator determines the capacity of servicing carriers to handle assignments made pursuant to Rule 4-A-3 falls below a level that is adequate to handle all assignments being made, or • The Reinsurance Agreement(s) for the state provided pursuant to the Association Bylaws is terminated 	All insurers that selected Option 2 will, as of January 1 of the following year, automatically be deemed by the state regulatory authority to have selected Option 1 for employers insured effective on or after said January 1.

(4) Servicing Carrier

A servicing carrier is an insurer that participates under Option 2 and has been authorized by the regulatory authority to receive Plan assignments as a result of the servicing carrier selection process. The servicing carrier provides coverage to eligible employers on behalf of those participating companies subscribing to the Association Bylaws incorporated as part of this Plan.

(5) Assigned Carrier Differences

The following tables describe the differences between a direct assignment carrier and a servicing carrier.

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Direct Assignment Carrier Table

Type	Description
Direct Assignment Carrier	<ul style="list-style-type: none"> • Not eligible for reinsurance through the reinsurance agreement among members of the National Workers Compensation Reinsurance Association • Solely responsible for the financial results of the assignments received • Financial strength and levels of performance are monitored and enforced by the regulatory authority or its designee • Required to meet the minimum levels of performance under the Plan in accordance with the Assigned Carrier Performance Standards • Required to write assigned risk policies using filed and approved assigned risk rates, rating plans, and miscellaneous values • Not required to report assigned risk financial results and information to the reinsurance pooling mechanism • Subject to market conduct examinations by the regulatory authority, and not subject to carrier oversight by the Plan Administrator

Servicing Carrier Table

Type	Description
Servicing Carrier	<ul style="list-style-type: none"> • Eligible for reinsurance through the reinsurance agreement among members of the National Workers Compensation Reinsurance Association • Shares in the operating results of the assignments received • Selected through a competitive selection process • Required to meet the minimum levels of performance under the Plan in accordance with the Assigned Carrier Performance Standards • Required to write assigned risk policies using filed and approved assigned risk rates, rating plans, and miscellaneous values • Required to report specific assigned risk financial results and information to the reinsurance pooling mechanism

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 Servicing Carrier Table (Cont'd)**

	<ul style="list-style-type: none"> • Subject to carrier oversight by the Plan Administrator
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b. Direct Assignment Carrier Requirements

Direct assignment carriers are required to adhere to all Plan, regulatory, and statutory requirements that apply to the issuance and servicing of assigned risk policies. An approved direct assignment carrier may receive assignments for any employer eligible for coverage under the Plan. A direct assignment carrier's reinsurance treaty exclusions are not considered when making assignments.

c. Termination of Participation

An insurer may terminate participation in this Plan as of the close of the calendar year in which its authority to write workers compensation is terminated. With respect to all policies in force on the effective date of an insurer's termination, the liability of the terminating insurer will cease on the succeeding anniversary date of each such policy. Termination of participation will not discharge or otherwise affect liabilities incurred prior to the anniversary date of such policies, and the insurer will be charged or credited in due course with its proper share of all expenses, losses, and profits allocable thereof.

d. Basis of Participation

1. All insurers that elect to participate in the Plan through the Reinsurance Agreement(s) provided for in the Association Bylaws collectively share in assignments made pursuant to this Plan. This participation is based on the proportion that the total net premiums of all members participating in the Plan through the Reinsurance Agreement(s) in this state during the preceding calendar year bears to the total net premiums written in this state during the preceding calendar year by all insurers participating in this Plan. Such computations exclude that portion of the premiums attributable to the operation of the Plan.
2. With each such Reinsurance Agreement, each insurer's individual proportionate share of financial results is determined in accordance with the Association Bylaws and Reinsurance Agreement(s). Each insurer's participation in the Plan is determined on the basis of such net premiums written as reported in the annual statements filed with the regulatory authority for the appropriate calendar year.
3. All insurers that have elected to become direct assignments carriers retain all profit, losses, and expenses on business assigned to them. Assignments are made to and among assigned carriers pursuant to procedures developed by the Plan Administrator and provide for the equitable distribution of employers.

6. Plan Administrator

a. Designation

The National Council on Compensation Insurance, Inc. (NCCI) is designated as the Plan Administrator hereunder, unless it resigns by giving ninety (90) days' advance written notice to the regulatory authority.

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In recognition of the interests of the participating companies who have subscribed to the Association Bylaws, the Plan Administrator will carry out its duties and responsibilities with respect to the establishment of servicing carrier eligibility requirements and **Assigned Carrier Performance Standards** subject to the review and acceptance of the Board of Directors.

The Plan Administrator will have the following duties and responsibilities in addition to any others set forth in this Plan:

- (1) Administering, managing, and enforcing the Plan subject to the provisions contained herein.
- (2) Establishing eligibility criteria for servicing carriers and selecting servicing carriers by an objective selection or solicitation process or otherwise, subject to regulatory approval or review where applicable.
- (3) Determining the methodology and formula for making assignments to assigned carriers pursuant to Rule 4-A-9 and securing the necessary information in order to make the assignments.
- (4) Developing and implementing assigned risk procedures and forms to the extent necessary to carry out the purpose of this Plan.
- (5) Processing assigned risk applications pursuant to Rule 4-A-3.
- (6) Establishing written **Assigned Carrier Performance Standards** requirements for assigned carriers, including, but not limited to:
 - Verification of ongoing Plan eligibility of the employer
 - Issuance of policies and endorsements
 - Filings with administrative agencies
 - Maintenance of premiums on policies consistent with manual rules, rates, rating plans, and classifications
 - Completion and billing of final audits
 - Collection of premium
 - Claim services, including investigation, disability management, and medical cost control
 - Loss prevention services and safety information to encourage employers to make safety a part of their business
 - Payment of producer fees
 - Issuance of renewal proposals and nonrenewal notices
 - Assurance of insured and insurer compliance with all terms and conditions of the policy contract
 - Resolution of complaints and response to insured/producer inquiries
 - Reporting financial and statistical data
- (7) Monitoring assigned carrier performance (as required) and enforcing the **Assigned Carrier Performance Standards** requirements and incentives.
- (8) Administering the dispute resolution procedure as provided in Rule 4-A-10.
- (9) Informing the regulatory authority of any insurer not participating in this Plan.
- (10) Monitoring the performance and operation of the Plan and initiating amendments thereto as appropriate.

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- (11) Reporting to the Board of Directors on a regular basis relative to the ongoing operation of the Plan.
- (12) Determining the expenses for the operation of the Plan (including, without limitation, the Plan Administrator's fees or legal expenses associated with Plan matters), and will charge a fee to each insurer participating in the Plan for those expenses on an equitable basis as determined by the Plan Administrator subject to the approval of the regulatory authority, if required. The Plan Administrator will provide, upon written request of the Board of Directors, the regulatory authority, or any direct assignment carrier, the amount of fees and any additional charges billed by the Plan Administrator in such detail as the parties may agree.

7. Servicing Carriers**a. Eligibility to Act as a Servicing Carrier**

With respect to the servicing carriers selected, the following will apply:

The Plan Administrator will establish written requirements that insurers must meet in order to be eligible to act as a servicing carrier. The Plan Administrator will make available such written requirements to the Board of Directors for review and acceptance. An insurer that has been approved as a direct assignment carrier pursuant to Option 1 under Rule 4-A-5 is not eligible to be selected as a servicing carrier under this Plan while they continue to act as a direct assignment carrier. From among those insurers that are eligible and have applied to act as a servicing carrier, and subject to regulatory approval or review where applicable, the Plan Administrator will ensure that there are a sufficient number of servicing carriers to handle the assignments made pursuant to this Plan. The Plan Administrator may confer with the Board of Directors in regard to the number of servicing carriers needed to handle the assignments made pursuant to this Plan. The Plan Administrator may terminate the servicing carrier status of any insurer that fails to meet the servicing carrier requirements on a continuing basis.

b. Servicing Carrier Minimum Eligibility Requirements

In order to serve as a servicing carrier, the insurer must meet all of the following eligibility criteria:

- Be licensed to write workers compensation and employers liability insurance in the state
- Be writing or be an affiliated insurer of a carrier that is currently licensed and actively writing voluntary workers compensation and employers liability insurance premium in the state and has been licensed and writing in such state for each of the most recent five (5) calendar years immediately preceding the first effective year of the proposed contract; or be licensed and actively writing workers compensation and employers liability insurance in the state for a minimum of the most recent three (3) calendar years immediately preceding the first effective year of the proposed contract and active as a workers compensation servicing carrier in any other NWCRP or NWCRA, as applicable, reinsurance state for a minimum of five (5) calendar years immediately preceding the first effective year of the proposed contract
- Be assigned and maintain at a minimum, a financial strength rating of "A—" as published by A.M. Best
- Maintain the necessary staff and facilities to comply with the procedures, **Assigned Carrier Performance Standards**, financial reporting requirements, and Plan requirements

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- Comply with all applicable statutory and/or regulatory requirements, including but not limited to, statutes, regulations, codes, rules, acts, directives, bulletins, announcements, and/or circulars
- Must be either precertified in writing by the Plan Administrator or have achieved and maintained and not be subject to a revocation of precertification or certification status as determined by the Plan Administrator under the applicable precertification and/or certification program established by the Plan Administrator
- Comply with all mandatory electronic processing and reporting requirements of NCCI that are currently in effect and that may be amended from time to time
- Comply with all federal and state laws and regulations, which relate to the policies applicable to the servicing carrier
- For purposes of Rule 4-A-7-b, the National Workers Compensation Reinsurance Pool (NWCRP) shall mean a contractual reinsurance mechanism among participating workers compensation insurers, which affords such insurers in certain states an option for complying with state insurance plan requirements by sharing in the experience arising out of certain policies written pursuant to such insurance plans
- Accept multistate assignments as directed by the Plan Administrator in accordance with the signed Association Bylaws

c. Servicing Carrier Report

Servicing carriers must provide a report to the Plan Administrator in such format and time as determined by the Plan Administrator if they have not acted as a servicing carrier in this state or any other NCCI Plan-administered state. This report, among other things, must provide information on the servicing carrier's operations related to Plan business in the following areas: underwriting, auditing, claims, loss prevention, premium collection, and customer service. Upon request, the Plan Administrator must submit such reports to the regulatory authority for review.

d. Standards for Servicing Carrier Performance, Compensation, and Incentives

The Plan Administrator, subject to regulatory authority approval if required, must establish written procedures for measuring servicing carrier performance. In recognition of the interests of the participating companies who have subscribed to the Association Bylaws, the Plan Administrator must provide a copy of such written **Assigned Carrier Performance Standards** to the Board of Directors for review and acceptance. Servicing carriers must manage losses in compliance with the **Assigned Carrier Performance Standards** established hereunder. The Plan Administrator, with the approval of the regulatory authority, must also establish the compensation for servicing carriers in accordance with the selection or solicitation process, which will take into consideration, among other things, provisions for:

- (1) Rewarding servicing carriers for positive action targeted at reducing losses and costs
- (2) Disincentives for inefficiencies and service below the minimum **Assigned Carrier Performance Standards**
- (3) Servicing carrier capacity

e. Monitoring and Enforcement

The Plan Administrator will monitor and review servicing carrier performance by:

- (1) Reviewing the operations reports

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- (2) Requiring and reviewing self-audits
- (3) Conducting on-site audits
- (4) Reviewing any other information available that relates to the servicing carrier

The Plan Administrator will require servicing carriers to maintain desired performance levels and will take appropriate remedial action where necessary including, but not limited to, establishment and administration of a progressive discipline program, which may lead to terminating an insurer's servicing carrier status. Any formal action taken by the Plan Administrator under this provision will be the exclusive remedy and in lieu of any other penalty or sanction that may apply under this Plan. Any action taken by the Plan Administrator under this provision is subject to review under the Rule 4-A-10. In order to fulfill its responsibilities under this Plan, the Plan Administrator will have the right, itself or through authorized representatives, at all reasonable times during regular business hours, to audit and inspect the books and records of any servicing carrier with respect to any policies, claims, or related documents coming within the purview of this Plan, the Association Bylaws, or the Reinsurance Agreement(s). Upon request, the Plan Administrator will make available to the regulatory authority and the Board of Directors a formal written report on the Plan Administrator's monitoring and enforcement activities related to servicing carriers.

8. Interstate Assignments

Note: This section applies to known or anticipated operations for physical locations in which coverages may be requested under Part 3.A. of the Workers Compensation and Employers Liability Policy. This section is not applicable for unknown or unanticipated operations and/or exposures for which coverage may be available under the Residual Market Limited Other States Coverage Endorsement (WC 00 03 26 A).

a. Additional States Requested During the Policy Period

Any eligible employer assigned under this Plan and desiring workers compensation insurance for operations for physical locations in states other than those covered by this Plan may request its assigned carrier to furnish insurance in the additional states under Part 3.A.

In instances in which the assigned carrier is licensed in those additional states and will write workers compensation insurance on a voluntary basis, it must do so in accordance with the law, rates, rules, classifications, and regulations applicable to the voluntary workers compensation market in those states.

If the assigned carrier does not wish to provide the insurance on a voluntary basis, they may provide assigned risk coverage in such additional states subject to the following:

- (1) Workers compensation insurance may only be provided in accordance with Rule 4-A-3 in those states that have a Workers Compensation Insurance Plan that is similar to this Plan and that allows employers applying for coverage under those Plans to obtain coverage for operations in this state.
- (2) Assigned carriers providing workers compensation insurance must collect all premiums based on the exposures for those other states' physical operations.

The effective date of such insurance in the additional states must be the day after premium is received; however, in the event coverage in the additional states is on an "if any" basis, the effective date of the coverage will be the day following receipt of an acceptable request for the insurance by the assigned carrier. A copy of the Policy Information Page and

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all endorsements, properly identified as a WCIP or AR (Assigned Risk) policy, must be submitted to the appropriate Plan Administrator having jurisdiction in states where the coverage is effected.

(3) The rates, rating plans, classifications, and policy forms used to provide coverage in such additional states are:

- Those that are applicable to the residual market
- On file and have been approved by the regulatory authority in those additional states
- Authorized for use in the residual market by the Plan Administrator

(4) In order to combine multiple states on a single policy, the following conditions apply:

- If the assigned carrier is a servicing carrier, it must also be a signatory to an agreement providing reinsurance for workers compensation insurance policies issued to residual market employers under the Association Bylaws in each state where the coverage must be provided. If the servicing carrier is licensed and writing in another WCIP NCCI Plan-administered state, the carrier must extend coverage unless otherwise directed by the Plan Administrator.
- If the assigned carrier is a direct assignment carrier pursuant to Option 1 under Rule 4-A-5, in order to combine multiple states on a single policy, it must also be authorized to act as a direct assignment carrier or servicing carrier in each state where the coverage must be provided.
- Separate policies must be issued for states in which the insurer is a direct assignment carrier and for states in which the insurer is a servicing carrier.

If the assigned carrier is unwilling or unable to add additional states to the employer's policy, it will instruct the employer to contact the Plan Administrator or appropriate administrative organization handling the states where coverage is needed for instructions and applications.

b. Multistate Policy Procedure at Time of Application

Employers who make application for workers compensation insurance under another state's Workers Compensation Insurance Plan may purchase coverage for physical operations in this state without meeting the application requirements of this Plan, provided:

- The employer qualifies for such insurance under the other state's Plan
- The employer is in good faith entitled to insurance under this Plan
- The other state's Plan is similar to this Plan
- The other state's Plan also provides for interstate assignments
- The payroll for the employer's operations in this state is not greater than the payroll in the other state

The rates, rating plans, classifications, and policy forms used to provide coverage in this state must be those which are applicable to the residual market in this state, and are on file and have been approved by the regulatory authority and authorized for use in the residual market by the Plan Administrator.

The Plan Administrator of the other Plan is authorized to assign employers with operations in this state to the other Plan's assigned carriers subject to the following conditions:

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- (1) If the assigned carrier is a direct assignment carrier, it must also be a direct assignment carrier in this state pursuant to Option 1 of Rule 4-A-5—Participation.
- (2) If the assigned carrier is a signatory to an agreement providing reinsurance for workers compensation insurance policies issued to residual market employers under this other state's Association Bylaws, it must also be a signatory to the Association Bylaws in this state. In addition, if the payroll for the employer's operation in this state is greater than \$250,000, and if the assigned carrier is a signatory to the Association Bylaws or a similar document in the other state, it must also be a servicing carrier in this state. If there is no eligible assigned carrier in this state that is also an insurer in the state of assignment, then the above payroll limitation may be removed at the discretion of the Plan Administrator or the employer may be required to submit a separate application for coverage in this state.
- (3) The other state's Plan must give the Plan Administrator in this state similar authority to make interstate assignments.

With regard to interstate assignments and policies, this Plan will have jurisdiction over all disputes resulting from the application of rules, programs, and procedures in accordance with Rule 4-A-10. Disputes regarding application requirements will be under the jurisdiction of the state's Plan where the application was submitted.

9. Assignment Formula Determination**a. Procedures**

The following describes the mechanism used to provide for the random and equitable distribution of employers under this Plan to assigned carriers. The Plan Administrator may override the random assignment process to ensure the availability of the requested Plan coverages for the employer.

b. Assignment Distribution

- (1) The percentage of Plan premium assigned to carriers is based on the following distribution:

(a) Direct Assignment Carriers

The distribution of assignments to a direct assignment carrier will be equal to its net voluntary premiums written in a state as compared to the total net premiums written in that state by all members of the Plan. A direct assignment carrier's reinsurance treaty exclusions are not considered when making assignments.

(b) Servicing Carriers

A servicing carrier is responsible for providing services on behalf of those insurers that have elected to meet their Plan participation requirements by subscribing to the Association Bylaws pursuant to Option 2 of Rule 4-A-5—Participation. Its allocable percentage will be determined by the Plan Administrator through an objective selection process. However, the combined allocable percentages for all servicing carriers must be equal to the combined net voluntary premiums written for all signatories to the Association Bylaws as compared to the total net premiums of all insurers participating in the Plan in this state.

This distribution is based on each direct assignment carrier's allocable percentage and the combined allocable percentage of all servicing carriers, and the amount of estimated premium in the Plan, so far as practicable.

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An approved assigned carrier may receive assignments for any risk eligible for coverage under the Plan.

- (2) When assigning an employer to an insurer, the assignment mechanism considers the employer's prior Plan coverage, special requirements (i.e., additional states or federal coverage) and premium size.
- (3) Any carrier authorized by the US Department of Labor to provide coverage under the US Longshore and Harbor Workers Compensation (USL&HW) Act and extension acts is eligible to receive assignments requesting the same coverages in the assigned risk market. Carriers with USL&HW authorization will also be eligible for assignments requesting Maritime (Admiralty), Program I or II. Assignments requesting USL&HW, Maritime, and/or extension acts coverage will be made as determined by the Plan Administrator in accordance with the assignment methodology established by the Plan Administrator.
- (4) An assigned carrier that, in any state, has previously reported voluntary or assigned risk premium writing that is subject to the Federal Mine Safety and Health Act or has previously accepted assignments in any state for operations that are subject to the Federal Mine Safety and Health Act, will receive assignments requesting such coverage in accordance with the assignment methodology as established by the Plan Administrator.

c. Reassignment

If an employer had prior assigned risk coverage, the system will reassign the employer to the original assigned carrier as long as the carrier can provide authorized coverages requested by the employer. Circumstances occasionally require the suspension of this criterion, such as when the suspension is warranted in order to ensure that all assigned carriers achieve their allocable percentage of Plan business. The Plan Administrator will provide a report of such suspensions to the regulatory authority, upon request.

d. Carrier Eligibility

The assignment system identifies those assigned carriers eligible to receive an assignment based on the following requirements of the employer and the capabilities of carriers:

(1) Additional States Coverage

The system will select an assigned carrier that is able to provide coverage in the additional states requested by the employer in accordance with Rule 4-A-8—Interstate Assignments.

(2) Available Coverages

The system will select an assigned carrier that is able to provide authorized available coverages requested by the employer (*Refer to Rule 4-G*). The following coverages require assignment to an assigned carrier with special capabilities as indicated:

- United States Longshore and Harbor Workers (USL&HW) Compensation Act and its extension acts (Outer Continental Shelf Lands Act, Defense Base Act, and Nonappropriated Fund Instrumentalities Act): the system will select a carrier that has been authorized by the U.S. Department of Labor to provide these coverages.
- Maritime (Admiralty Law) coverage: the system will select a carrier that has been authorized by the Department of Labor to provide USL&HW coverage.

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- Coal mine risks: the system will select a carrier that is experienced in servicing coal mine risks, usually through writing coal mine policies in the voluntary market or through prior servicing of residual market coal mine risks.

(3) Size of Risk

If the carrier is a direct assignment carrier, the system will select a carrier that is eligible for the size of the risk being assigned, based on previously determined premium size ranges. The Plan Administrator is responsible for establishing these ranges based on each assigned carrier's allocable percentage of Plan premium. A direct assignment carrier may voluntarily request an increase to its established range but may not decrease it. A direct assignment carrier that wishes to increase the upper limit of its range must submit a written request to the Plan Administrator. This request is subject to the review and approval of the Plan Administrator. The Plan Administrator will provide a report, upon request, of deviations from established ranges to the regulatory authority. Premium size ranges are as follows:

Allocable Percentage of Market	Premium Range
less than .5%	\$0–49,999
.5% to .99%	\$0–99,999
1% and greater	unlimited

(4) Number of Risks

The Plan Administrator, under special circumstances, may establish a minimum or maximum number of assignments or premium in order to ensure equitable assignments. These are variable numbers generally based on the amount of business remaining to be assigned and the number of weeks remaining in the calendar year. An assigned carrier that has met or exceeded its maximum weekly number of risks will not be considered eligible.

(5) Random Carrier Assignment Process

Each employer is assigned to an eligible assigned carrier according to the following algorithm, considering each direct assignment carrier and all servicing carriers in the aggregate:

- Each carrier's expected quota premium is calculated by multiplying total premium in the Plan at the time of the assignment by the carrier's quota percent. An assigned carrier's quota percent may be adjusted to allow for a more even distribution of assignments over a period of time.
- Each assigned carrier's remaining business to be assigned is calculated by subtracting its premium in force at the time of the assignment from its adjusted quota premium. In order to allow the flexibility of slightly larger assignments in the carrier assignment process, an adjustment is made to each carrier's quota premium. This adjustment consists of applying an "over-quota limit" of 5% or \$5,000, whichever is greater, up to a maximum of \$200,000. The Plan Administrator may lower this limit if circumstances warrant, such as when required to ensure that all assigned carriers achieve their allocable percentage of Plan business.
- Based on the difference between the percentage of an assigned carrier's premium in force and its quota premium, a range of numbers proportional in size to the percentage difference is assigned to each carrier. A random number is generated, and the

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assignment is made to the assigned carrier whose range encompasses the random number.

10. Dispute Resolution Procedure**a. Procedure**

The dispute resolution procedure can be categorized as either Assigned Risk Employer/Producer related disputes or WCIP related disputes.

b. Assigned Risk Employer/Producer Disputes

Any assigned risk policyholders and their producers affected by the actions of their assigned carrier or NCCI are provided with a process in which grievances can be reviewed, resolved, or heard by the mechanism that has been established and approved in the state for such grievances.

(1) Employer Disputes

The conditions outlined in Rule 4-A-2-g must be met in order for the employer to have a bona fide premium dispute. The Plan Administrator's intervention in disputes is generally limited to matters involving:

- Experience rating modification factors
- Application of rules contained in NCCI manuals
- Eligibility and assignment under the Workers Compensation Insurance Plan (WCIP)
- Classification assignment
- Assigned risk pricing programs

The Plan Administrator may intervene in disputes involving other matters arising under this Plan as determined by the Plan Administrator in its discretion.

The Plan Administrator (upon receipt of all necessary information regarding the dispute), will review the matter and provide a written response within thirty (30) days.

(a) Interstate Appeals

When an employer dispute concerns any of the above matters, (other than the application of NCCI's *Experience Rating Plan Manual* rules), in more than one state, the Plan Administrator will determine the appropriate jurisdiction in which the dispute will be heard, based upon the following factors:

- Governing state (state generating the greatest payroll)
- The state covered by the assigned carrier with the greatest exposure
- The state where the operations are best represented

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Interstate Employer-Related Dispute Jurisdiction Table

If . . .	Then . . .
As determined by the Plan Administrator, the governing state is an NCCI Plan administered state that best represents the operations of the business	The governing state's dispute resolution process will apply
The governing state is an NCCI Plan administered state, but the Plan Administrator determines that the governing state does not best represent the operations of the business	The Plan Administrator will review the dispute and determine the appropriate jurisdiction in which the dispute will be heard
The dispute involves NCCI Plan administered states and non-NCCI Plan administered states	The jurisdiction selected and resulting decision will apply only to the NCCI Plan administered states
The governing state is not an NCCI Plan administered state	The employer must follow the appropriate dispute resolution process for the governing state

When a dispute concerns the application of NCCI's *Experience Rating Plan Manual* rules for interstate rated risks, the Plan Administrator will determine the appropriate jurisdiction for the dispute to be heard.

Unless state-specific rules apply, the ruling of the state appeals mechanism (as determined by the Plan Administrator to have jurisdiction over the dispute) will apply to all assigned risk policies whether written by one or more assigned carriers.

For a general overview of the employer dispute resolution process, refer to NCCI's *Assigned Risk Supplement*.

(2) Producer Disputes

For disputes relating to the calculation and/or payment of producer fees and producer of record changes, the Plan Administrator (upon receipt of all necessary information regarding the dispute), will review the matter and provide a written decision within thirty (30) days.

c. WCIP Disputes

Any Plan participants (Association members and/or assigned carriers) who have a dispute with respect to any aspect of the Plan or Reinsurance Agreement(s) (including any dispute arising out of the Association Bylaws) must first seek a review of the matter under this section by providing the following to Plan Administrator:

- Written documentation detailing specific areas of the dispute
- Specific request for a review of all documentation
- Appropriate actions of areas to resolve the dispute

The Plan Administrator may request additional information, as it deems necessary to make a decision. All disputes submitted to the Plan Administrator will be governed as follows:

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For disputes relating to the general operation of the Plan, including but not limited to, standards for assigned carrier performance, compensation and incentives and application assignment determination, the Plan Administrator (upon receipt of all necessary information regarding the dispute), will review the matter and provide a written decision within thirty (30) days.

Any party affected by the decision of the Plan Administrator may seek binding arbitration for such purpose; or in the alternative, the party may seek a *de novo* review by the regulatory authority, by requesting such binding arbitration or *de novo* review in writing and at its own expense, within thirty (30) days after the date of such decision.

For any such *de novo* review, the regulatory authority will:

- Follow those procedures applicable to administrative hearings in the state
- Decide the dispute in accordance with the state law, regulation, and policy and in the interests of the efficient, cost-effective, reasonable, and proper administration of the Plan

The regulatory authority's decision will be final, subject to court review under the applicable state law, regulation, and/or rule.

For disputes relating to the servicing carrier selection process, refer to the Bid Protest Procedures contained in the applicable Servicing Carrier Request for Proposal (RFP).

(2) Reinsurance Agreement-Related Disputes

If the dispute arises under the Association Bylaws or Reinsurance Agreement(s), the Administrator designated under the Association Bylaws will, after receipt of all necessary information regarding the dispute, review the matter and provide a written decision within thirty (30) days. Any party affected by the decision may seek a review by the Board of Directors established under the Association Bylaws by requesting such review, in writing, within thirty (30) days of the date of the decision by the Administrator under the Association Bylaws. The Board of Directors may (a) consider the matter and render its written decision pursuant to the procedures set forth in the Association Bylaws, or (b) waive its decision and offer the aggrieved party the option of appealing directly to the regulatory authority or submitting the dispute to arbitration in accordance with the terms and conditions established by the Board of Directors. Any party affected by a decision of the Board of Directors may seek a *de novo* review by the regulatory authority by requesting such a review, in writing, within thirty (30) days of the date of the Board of Directors decision.

If the dispute relates to the expulsion of a participating company under the Association Bylaws by the Board of Directors or the noncontinuation of the reinsurance afforded under the Association Bylaws, any appeal may be taken directly to the regulatory authority without first complying with the procedures contained herein. The regulatory authority will have exclusive jurisdiction over all such disputes.

For any such *de novo* review, the regulatory authority will:

- Follow those procedures applicable to administrative hearings in the state
- Decide the dispute in accordance with the state law, regulation, and policy and in the interests of the efficient, cost-effective, reasonable, and proper administration of the Association Bylaws

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The regulatory authority's decision will be final, subject to court review under the applicable state law, regulation, and/or rule.

11. Self-Funded Plan

It is essential for maintaining the viability of the Plan to establish and maintain rates at a level that must permit the Plan to operate as a self-funded mechanism. NCCI will maintain necessary ratemaking data in order to permit the actuarial determination of rates and rating plans appropriate for the business insured through the Plan. All assigned carriers are required to report their experience on business written under the Plan to NCCI in a format prescribed by NCCI. It is the responsibility of NCCI to monitor both rate adequacy and Plan results. NCCI will notify the regulatory authority if excessive losses are indicated to enable the regulatory authority to take corrective action.

12. Approval

I have reviewed the foregoing Plan and all matters incorporated therein and have determined that it is reasonable, complies with the laws and regulations of this state, and provides for the equitable apportionment of employers who are in good faith entitled to workers compensation insurance and are unable to procure such insurance in a regular manner. I hereby approve this Plan for use in this state as indicated by the signature below or any other acceptance method authorized for use by the regulatory authority.

Date _____

Regulatory Authority

B. PROFESSIONAL EMPLOYER ORGANIZATION (PEO) ARRANGEMENTS

1. Definitions

a. Assigned Carrier

An insurer assigned to provide coverage to an employer who has applied for and is good faith eligible for workers compensation insurance under the Plan. An assigned carrier can either be defined as one of the following:

- Servicing Carrier—An insurer authorized by the regulatory authority to receive Plan assignments and provide coverage to eligible employers on behalf of those participating companies subscribing to the Association Bylaws incorporated as part of the WCIP or
- Direct Assignment Carrier—An insurer that has elected and has been authorized by the regulatory authority to receive assignments under Option 1 of NCCI's *Basic Manual* Rule 4-A-5, directly from the Plan Administrator without reinsurance through the Reinsurance Agreement(s). Insurers selecting the direct assignment option will be solely responsible for the financial results of the assignments they receive.

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An entity that obtains all or part of its workforce for a fee, pursuant to an agreement, written or otherwise, from another entity through a professional employer organization (PEO) arrangement or that employs the services of an entity through a PEO arrangement. Without limitation, a client may also be referred to as a lessee.

c. Direct Worker

An employee, executive officer, LLC member, partner, or owner of a client or PEO that is not a leased worker obtained through a PEO arrangement as defined in 4-B-1-k. For purposes of this rule, the employer of the direct worker(s) is responsible for securing workers compensation insurance for the direct worker(s), unless otherwise determined by state law or regulation.

d. Employer

Any business organization or enterprise that is required by state law, regulation, and/or rule to maintain workers compensation insurance in this state or state(s). The term “employer” includes any business organization or enterprise that are or were affiliated at any time as a result of common management or common ownership.

e. Entity

Without limitation, an individual, partnership, corporation, LLC, unincorporated association, trust, fiduciary, or any other legal structure that acts as an employer or otherwise is considered to be or represents itself to others as an employer.

f. Leased Worker

An employee performing services for a client under a PEO arrangement. The term “leased worker” does not include a person working on a temporary basis as defined in Rule 4-B-1-m.

If an employee was previously employed by the client prior to working for that PEO, it must be presumed that the employee is a leased worker and not a temporary worker.

g. Long-Term Temporary Arrangement

An arrangement where one company leases all or a portion of workers from another entity for a period in excess of six (6) months or consecutive periods equal to or greater than one (1) year.

h. Multiple Coordinated Policies (MCP) Basis

A form of policy issuance used to provide workers compensation and employers liability insurance for the leased workers of a PEO. Under the MCP basis, policy issuance must be as follows:

- The PEO has its own standard policy covering only its direct workers
- Each client has its own standard policy covering its leased workers
- Endorsements are used to coordinate coverage between the client and PEO in accordance with Rule 4-B-4-g

For further details, *refer to Rule 4-B-4.*

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A licensed insurance agent, broker, producer, or insurance representative, as defined in the state insurance law, regulation, and/or rule, whose privileges under the WCIP have not been suspended or revoked, designated by the employer or applicant applying under the WCIP to secure and maintain workers compensation and employers liability insurance on behalf of the employer. For purposes of this rule, the producer is considered to be acting on behalf of the insured or employer applying for coverage under the WCIP and not as an agent of the Plan Administrator or of any assigned carrier for Plan business.

j. Professional Employer Organization (PEO)

An entity or group of entities who are or were formerly related by common management or ownership that provides workers to its client(s) through a PEO arrangement for a fee pursuant to an agreement, written or otherwise. Without limitation a PEO may also be referred to as a labor contractor, employee leasing company, lessor, or other similarly administered arrangement.

If an entity provides workers, by contract and for a fee, to a client and any such workers are not provided on a temporary basis as defined in NCCI's *Basic Manual* Rule 4-B-1-m, that entity will be considered a PEO.

k. Professional Employer Organization (PEO) Arrangement

An arrangement under contract or agreement, written or otherwise, whereby one entity obtains or leases any or all of its workers from another entity. PEO arrangements include, but are not limited to:

- Full service PEO arrangements
- Long-term temporary arrangements
- Any other arrangement that involves the allocation of employment responsibilities among two or more entities (i.e., co-employment relationship)
- An arrangement whereby a PEO contractually agrees to perform specified employer responsibilities as to leased workers, including the securing of workers compensation insurance
- Any arrangement whereby one entity pays wages for workers on behalf of another entity for a fee including, but not limited to:
 - A relationship in which the contract, or other agreement with a client requires that the entity (i.e. Administrative Services Organization (ASO) or other similarly established entity) obtains the workers compensation coverage and
 - Completes the withholding and reporting of payroll related taxes for the leased workers (i.e. W-2 forms)

For purposes of this rule, a PEO arrangement does not include arrangements to provide temporary help service as defined in Rule 4-B-1-m.

l. Standard Policy

A residual market standard workers compensation and employers liability insurance policy.

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An arrangement whereby an organization hires its own employees and such workers are provided to work for a client on a temporary basis. A temporary basis is considered to exist when there is a written contract or agreement that states the finite period of time the service will be provided and/or the service is provided under one or more of the following work situations, including but not limited to:

- Replace an absent worker who will return, such as during an authorized leave of absence, vacation, jury duty, or illness
- Fill a short-term or temporary professional skill shortage
- Staff a seasonal workload
- Staff a special assignment or project where the worker will be terminated or assigned to another temporary project upon completion
- Satisfy the requirements of the employer's overall employment program, such as a probationary period before new workers are granted permanent employee status

2. Coverage

- a. Statutory workers compensation coverage for leased workers under the WCIP must be secured on a MCP basis.
- b. All of the PEO's leased workers to clients under the approved state's WCIP must be secured on a MCP basis.
- c. For additional coverages, which may be available upon request by the employer, *refer to the WCIP Supplement—Additional Coverages Under the WCIP*.
- d. If an employer operates a PEO and a separate temporary arrangement, a separate policy of workers compensation insurance is required and must be maintained for each type of business in that state. If the payroll records do not specify which workers are provided on a temporary basis, all workers are deemed to be leased workers and will be included under the MCP. The Plan Administrator will assign both the PEO and the separate temporary arrangement to the same assigned carrier for issuance of the separate policies, where practicable.
- e. Only one PEO can be written on a single MCP policy, even if combinable with other PEO's in accordance with NCCI's ***Experience Rating Plan Manual for Workers Compensation and Employers Liability Insurance***.

3. Premium for Leased Workers

Premium for leased workers must be charged on the client policy issued under a PEO arrangement on a MCP basis. Premium will be determined on each client's policy based on the applicable classification, rates, payroll, and rating programs for each client for whom coverage is being requested and/or exposure exists as determined by the assigned carrier, with payment made by the PEO.

The PEO must provide a complete payroll record of the leased workers. If the payroll records of the leased workers are not provided, 100% of the full PEO arrangement fee must be established as the payroll of the leased workers. The premium must be charged on that amount as payroll. If research on a specific PEO arrangement discloses that a specific amount of the PEO arrangement fee represents payroll, such amount—if deemed reasonable in the discretion of the Plan Administrator—must be the payroll for the premium computation.

Refer to Rule 4-B-4-c and 4-I for Deposit Premium rules.

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4. Multiple Coordinated Policies (MCP)**a. Eligibility**

- (1) A PEO must meet and maintain each of the following requirements at the time of application to qualify for securing coverage for their direct employees and clients on a MCP basis:
- (a) It is in good faith entitled to insurance required under the applicable state and federal workers compensation laws and has been unable to secure such insurance in a regular manner in accordance with NCCI's **Basic Manual** Rule 4-A-3.
 - (b) The officers, partners, LLC members, owners, directors, or other parties with a common management or ownership interest in the PEO do not have any outstanding workers compensation insurance premium obligation or other monetary policy obligation (e.g. deductible program) on any previous workers compensation insurance that is not subject to a bona fide premium dispute as defined in NCCI's **Basic Manual** Rule 4-A-2-g.
 - (c) It provides all information required under each policy's terms and conditions in accordance with this rule and with NCCI's **Basic Manual** Rule 4-A-3-e.
Each PEO must comply with the assigned carrier's requests for pertinent information, including without limitations a copy of a signed contract with each client, each client's name, federal identification number, classification codes, payrolls, loss data, and states with exposure, and must submit timely to audits of its operations. Failure to comply with the assigned carrier's requests, after a reasonable opportunity to cure any deficiency, will be grounds for cancellation of the standard policy.
 - (d) It is in compliance with all state laws or regulations applicable to PEO arrangements, including without limitations registration/licensing with the appropriate regulatory authority where applicable.
- (2) In order for the PEO to secure coverage for the workers leased to a client, the client must be in good faith eligible for workers compensation insurance in accordance with NCCI's **Basic Manual** Rule 4-A-3. The client is not in good faith entitled to insurance if any of the following circumstances exist, at the time of application or thereafter:
- (a) A self-insured client must not be aware of pending bankruptcy proceedings, insolvency, cessation of operations, or conditions that would probably result in occupational disease or cumulative injury claims from exposures incurred while the client was self-insured.
 - (b) The client:
 - Knowingly refuses to meet reasonable health, safety, audit, or loss prevention requirements
 - Does not allow the assigned carrier reasonable access to its records for audit or inspection under the policy
 - Does not comply with any other policy obligations
 - (c) The client, or an entity with a common management or ownership interest with the client, must not have any outstanding workers compensation insurance premium obligation or other monetary policy obligation (e.g. deductible program) on any previous workers compensation insurance that is not the subject of a bona fide premium dispute as defined in NCCI's **Basic Manual** Rule 4-A-2-g.

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- (d) The client, its representative (e.g. PEO), or producer knowingly fails to comply with Plan procedures, or knowingly makes a material misrepresentation on the application by express statement, omission or otherwise, including, but not limited to, the following:
- Estimated payroll
 - Offers of workers compensation insurance
 - Nature of business
 - Name of business
 - Management or ownership of business
 - Previous insurance history
 - Application of an experience rating modification
 - Any outstanding workers compensation insurance premium obligation or other monetary policy obligation of the client
- (3) If a PEO is determined to be ineligible for coverage by the Plan Administrator, the entire MCP (PEO and each client) is ineligible for coverage. The PEO will not be able to secure coverage for its direct and leased workers under the WCIP until the Plan Administrator has determined the PEO to be eligible for coverage or evidence that a bona fide premium dispute exists as defined in NCCI's *Basic Manual* Rule 4-A-2-g.
- (4) If a client is determined to be ineligible for coverage by the Plan Administrator, that client will not be able to obtain coverage under the MCP or for a new policy outside of a PEO Arrangement, until the Plan Administrator has deemed the client to be eligible for coverage or evidence that a bona fide premium dispute exists as defined in NCCI's *Basic Manual* Rule 4-A-2-g.

b. Policy Issuance

- (1) Each client will have its own standard policy covering its leased workers pursuant to the workers compensation laws of the state and in accordance with the WCIP.
- (a) The client's policy covering its leased workers will be issued in the name and FEIN of the client in accordance with this rule and all other rules governing the issuance of a standard policy for assigned risk business.
 - (b) Direct workers of a client will not be included on the client's policy for its leased workers, unless otherwise required by state law or regulation.
 - (c) If a client leases workers from more than one PEO, there must be a separate MCP policy for the leased workers of each PEO.
- (2) Each PEO must have its own standard policy covering the direct workers of the PEO.
- (a) A policy issued to cover the direct workers of the PEO under a MCP basis will be issued in the name and FEIN of the PEO in accordance with this rule and all other rules governing the issuance of a standard policy for assigned risk business under the WCIP.
 - (b) If the PEO has no direct workers in the state where its clients' coverage is being obtained, the PEO's policy will be issued with premium based on the use of Code 8810—Clerical Office Employees NOC on an "if any" basis.
 - (c) All policies of any PEO related by common management or ownership must be assigned to one assigned carrier in the state, where practicable.

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- (d) All policies for clients of the same PEO will be assigned to one assigned carrier in the state, where practicable.
 - (e) The assigned carrier will arrange to have the same renewal/nonrenewal dates for all policies in a MCP arrangement, including any new client exposure added midterm to the PEO's MCP.
 - (f) For information regarding the anniversary rating date, *refer to NCCI's Basic Manual*.
- (3) Appropriate endorsements will be used to restrict the coverage to named leased workers and to manage coverage between all clients and the PEO(s).

c. Deposit Premium

- (1) An MCP issued for a single PEO may be combined for the purpose of computing deposit premiums but not for the application of rating programs, including, but not limited to, experience rating modification and premium discount.
- (2) The total estimated annual premium of the clients should be calculated individually, including all rating programs, and then combined with the premium of the PEO's policy for its direct workers to determine the deposit premium.
- (3) A deposit premium is payable at the time of application and/or at renewal by the PEO, unless otherwise directed by contract.
- (4) The deposit premium due is based on the deposit premium rules for the governing state (state with the highest payroll) on the application and/or policy in accordance with Rule 4-I.
- (5) For Loss Sensitive Rating Plan (LSRP) policies, the deposit premium is paid in addition to the LSRP contingency deposit, as detailed in Rules 4-C-5-b(2) and 4-C-6-c.

d. Billing

- (1) The assigned carrier will arrange to have all policy notices sent to the PEO and to have a single itemized master invoice sent to the PEO for all policies covering the clients of the PEO.
- (2) If the PEO fails to pay the master invoice, the second notice of premium due will be an itemized bill for each client. The assigned carrier will send the second notice of premium due to the PEO and each client (including notice of cancellation and nonrenewal, if applicable).
- (3) The client company is jointly liable with the PEO for the contributions, premiums, forfeits, or interest attributable to the wages of the workers leased to it by the PEO.
- (4) Failure of the client to pay its invoice will result in the cancellation of its policy.

e. Application of Rating Elements

All rating elements apply individually to each client's standard policy and PEO's standard policy issued under a MCP basis. Such elements include, but are not limited to:

- Expense constant
- Premium discount
- Experience rating modification
- ARAP
- Merit rating
- Loss Sensitive Rating Plan

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- Catastrophe provisions

f. Cancellation

(1) PEO Cancellation Table 1 and Client Cancellation Table 2 provide scenarios for the cancellation treatment of a PEO or client policy under a MCP in accordance with NCCI's *Basic Manual* Rule 3-A-3.

PEO Cancellation Table 1

If . . .	And . . .	Then, the PEO policy cancellation will be on a . . .
The PEO leaves the residual market	Has secured coverage in the voluntary market	Pro rata basis
A PEO ceases to exist	Is part of an MCP arrangement	Pro rata basis
A PEO is cancelled due to ineligibility under the WCIP	Is part of an MCP arrangement	Pro rata basis
A PEO fails to pay the master invoice	The assigned carrier provides second notice of premium due to the PEO and each client (including notice of cancellation and nonrenewal, if applicable)	Pro rata basis
A PEO fails to pay the second notice of premium due	The second notice of premium due was also sent to the client, which has failed to pay the notice of premium	Pro rata basis

Client Cancellation Table 2

If . . .	And . . .	Then . . .
The client leaves the residual market	Has secured coverage in the voluntary market	The client policy cancellation will be on a pro rata basis
An employer in the residual market requests cancellation	Becomes a client under a MCP secured in the residual market	The employer policy cancellation will be on a short-rate basis
A PEO ceases to exist	A client is part of that PEO's MCP arrangement	<ul style="list-style-type: none"> • The client policy will be maintained to policy expiration and nonrenewed as part of the MCP. The assigned carrier must provide a notice to the client regarding the status of its coverage. • The client must reestablish eligibility in the WCIP to secure coverage in a new MCP arrangement or for a new policy outside of a PEO arrangement.

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Client Cancellation Table 2 (Cont'd)**

If . . .	And . . .	Then . . .
A PEO is cancelled due to ineligibility under the WCIP	A client is part of that PEO's MCP arrangement	<ul style="list-style-type: none"> The client policy cancellation will be on a pro rata basis The client must reestablish eligibility in the WCIP to secure coverage in a new MCP arrangement or for a new policy outside of a PEO arrangement
A client is cancelled due to ineligibility under the WCIP	Is part of an MCP arrangement	<ul style="list-style-type: none"> The client policy cancellation will be on a pro rata basis The client must reestablish eligibility in the WCIP to secure coverage under the MCP arrangement or for a policy outside of a PEO arrangement.
A PEO fails to pay the master invoice	The assigned carrier provides second notice of premium due to each client and PEO (including notice of cancellation and nonrenewal, if applicable)	The client policy cancellation will be on a pro rata basis
A PEO fails to pay the second notice of premium due	The second notice of premium due was also sent to the client, which has failed to pay the notice of premium	The client policy cancellation will be on a pro rata basis

g. Endorsements

(1) The following endorsements are applied to the PEO or client policy under the MCP:

Type of Policy	Endorsement	Purpose
PEO policy	Professional Employer Organization (PEO) Exclusion Endorsement (WC 00 03 21 A)	Excludes coverage for workers leased to specified clients from the PEO policy that covers its direct workers
Client Policy (leased workers)	Multiple Coordinated Policy Endorsement (WC 00 03 23 A)	Provides coverage for workers leased from the specified PEO
	Professional Employer Organization (PEO) Extension Endorsement (WC 00 03 20 B)	Extends coverage to the PEO
Client Policy (direct workers)	Professional Employer Organization (PEO) Client Exclusion Endorsement (WC 00 03 22 A)	Excludes coverage for the client's leased workers from the specified PEO

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- (2) The Alternate Employer Endorsement (WC 00 03 01 A) is not applicable for PEO arrangements written on a MCP basis in the residual market.

h. Treatment of Executive Officers, Sole Proprietors, Partners, and LLC Members

- (1) Executive officers, sole proprietors, partners, and LLC members of a client who are leased workers from a PEO under a PEO arrangement will be:
- (a) Treated as leased workers of the client for the purposes of classification assignment and premium determination.
 - (b) Charged for payroll under the client policy as an employee and not subject to executive officer, sole proprietor, partner, or LLC member payroll limitations in accordance with Rule 2-E of NCCI's **Basic Manual**.
- (2) Executive officers, sole proprietors, partners, and LLC members of a client who are not leased workers from a PEO under a PEO arrangement will be:
- (a) Treated as non-leased workers of the client for the purposes of classification assignment and premium determination.
 - (b) Charged for payroll under a separate policy that provides coverage for the client's direct workers as permitted under state regulation or law, and subject to the executive officer, sole proprietor, partner, or LLC member payroll limitations in accordance with Rule 2-E of NCCI's **Basic Manual**, unless the applicable exclusion/inclusion documentation is provided.

i. Application of Loss Sensitive Rating Plan

*Refer to NCCI's **Basic Manual** for the treatment of professional employer organizations (PEOs) and temporary arrangements who qualify for the Loss Sensitive Rating Plan.*

j. Audits

- (1) The assigned carrier must conduct a preliminary physical and final physical audit on all new business policies issued under an MCP basis (PEO and client), regardless of premium size, in accordance with the time frame established in NCCI's **Assigned Carrier Performance Standards**.
- (2) The assigned carrier may conduct periodic audits thereafter to determine whether all classifications, rates, rating programs, experience rating modifications, and estimated payrolls used are appropriate.
- (3) A final physical audit must be conducted on all renewal policies issued under a MCP basis (PEO and client), regardless of premium size, in accordance with the time frame established in NCCI's **Assigned Carrier Performance Standards**.

k. Renewals

- (1) Renewal notices for MCPs must be mailed to the PEO and a copy sent to the individual clients.
- (2) The assigned carrier should obtain updated copies of originally submitted documentation, such as supplemental applications, when needed.
- (3) *Refer to NCCI's **Basic Manual** Rule 4-A-4 and NCCI's **Assigned Carrier Performance Standards** for the rules regarding carrier responsibilities for renewals.*

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BASIC MANUAL—2001 EDITION****RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES****(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)****I. Experience Rating**

(1) The PEO's experience rating modification, if any, applies to the policy(ies) covering the PEO's direct workers.

(2) A PEO client's experience rating modification applies to:

- The client's policy covering the leased workers under the MCP; and
- Any other policy(ies) covering the client's direct workers

Note: The client's experience rating modification will include the client's experience, if any, prior to the PEO arrangement.

(3) PEO's will be ruled combinable for experience rating purposes if clients can be transferred among the related PEO's according to the PEO's agreement or contract with the client.

(4) *Refer to Rule 5-A—Employee Leasing/Professional Employer Organizations in NCCI's Experience Rating Plan Manual for the rules regarding treatment of experience rating modifications.*

(5) *Refer to Rule 3-F—Evasion of Experience Rating Modification in NCCI's Experience Rating Plan Manual for the rules regarding evasion of an experience rating modification.*

m. Multistate Operations

(1) A multistate application must be submitted to the governing state.

(2) A PEO or client which has a multistate operation that would normally be combinable on one application will have to complete multiple applications if the states requiring coverage have not approved this rule.

(3) The Plan Administrator will make assignments for multiple applications to the same assigned carrier, where practicable, even if the multiple states do not have the same state PEO arrangement rules.

(4) *Refer to NCCI's Basic Manual Rule 4-A-8 for the rules governing multistate applications.*

Note: The Plan Administrator and/or regulatory authority may determine that a PEO's and/or client's circumstances may warrant assignment exceptions in accordance with this rule.

n. Client Additions to the MCP

(1) New clients may be added to the MCP at any time during the policy period if the client is in good faith eligible for workers compensation insurance in accordance with Rule 4-A-3. New clients must complete and submit the appropriate applications and Professional Employer Organization (PEO) Client Supplemental Application to the Plan Administrator.

(2) Multiple clients that are added to the MCP midterm can be combined for deposit premium determination, if the request for coverage is submitted to the Plan Administrator at the same time.

(3) A client policy, which is added to the MCP, will be required to have the same expiration date as the MCP. For information regarding the anniversary rating date, *refer to Rule 3-A-2.*

(4) For more information regarding deposit premium, *refer to Rule 4-1.*

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o. Reporting Requirements

- (1) Refer to NCCI's **Workers Compensation Policy Data Reporting Manual** for the requirements and guidelines for submitting policy data to NCCI and the **WCIO Workers Compensation Data Specifications Manual** for reporting policy data electronically to NCCI.
- (2) The PEO or client company code, which is the one-character code reported on the Name Record (Record Type 02) found in NCCI's **WCIO Workers Compensation Data Specifications Manual** is not optional for electronic reporting of residual market policies to NCCI written on a MCP basis.

C. LOSS SENSITIVE RATING PLAN

1. Introduction to the Loss Sensitive Rating Plan

- a. Loss Sensitive Rating Plan (LSRP) is a mandatory assigned risk retrospective rating plan for those employers that have a qualifying workers compensation and employers liability insurance policy(ies) through the Workers Compensation Insurance Plans (WCIP).
- b. LSRP adjusts the premium for an employer's WCIP policy(ies) on the basis of losses incurred during a particular policy term. LSRP reflects the actual experience of the employer by using the losses incurred during the term of the policy(ies) to establish the cost of insurance, including provisions for all expenses and taxes on premium. The result of the actual experience may be additional premium, return premium, or no change to the estimated premium.
- c. The LSRP is designed to:
 - Encourage safety and loss prevention
 - Provide incentives for employers with favorable loss experience through lower premiums
 - Provide a disincentive for employers with unfavorable loss experience through higher premiums
 - Depopulate the residual market

2. Eligibility

- a. Eligibility for LSRP is determined in accordance with the Eligibility Tables below. Refer to Rule 4-C-5-c(12) for the definition of LSRP standard premium. Refer to the **User's Guide** for examples.

Eligibility Table 1

If a single-state employer has operations in . . .	Then . . .
<ul style="list-style-type: none"> • One LSRP-approved state, and • Has a single-state WCIP policy covering such operations in the state 	The single-state WCIP policy must meet or exceed LSRP standard premium of \$250,000
<ul style="list-style-type: none"> • One LSRP-approved state, and • Has two or more WCIP policies covering such operations in the state, and • The two or more policies are written by the same assigned carrier 	The combined LSRP standard premium of all policies written by the same assigned carrier must meet or exceed \$250,000

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Eligibility Table 2

If a multistate employer has operations in . . .	Then . . .
<ul style="list-style-type: none"> • Two or more LSRP-approved states, and • Has one multistate WCIP policy covering such operations in those states 	<p>The combined LSRP standard premium of all states on the policy must meet or exceed:</p> <ul style="list-style-type: none"> • \$250,000 • The premium eligibility requirement for the LSRP state generating the largest LSRP standard premium if such state's eligibility requirement is less than \$250,000
<ul style="list-style-type: none"> • Two or more LSRP-approved states, and • Has multiple WCIP policies covering such operations in those states, and • The two or more policies are written by the same assigned carrier 	<p>The combined LSRP standard premium of all policies written by the same assigned carrier must meet or exceed:</p> <ul style="list-style-type: none"> • \$250,000, or • The premium eligibility requirement for the LSRP state generating the largest LSRP standard premium if such state's eligibility requirement is less than \$250,000

- b. It may not always be possible for a single carrier to provide coverage for all requested states; additional policies issued by more than one carrier may be necessary. *Refer to Rule 4-C-5-b(3) for more information about policy issuance and corresponding deposits.*
- c. WCIP policies issued in non-LSRP-approved jurisdictions are not subject to LSRP and are not combinable with WCIP policies in LSRP-approved jurisdictions for eligibility purposes.
- d. LSRP eligibility may be impacted by ownership or combinability status in accordance with NCCI's ***Experience Rating Plan Manual***.

3. Evasion of LSRP

- a. Some employers may take actions for the purpose of avoiding the application of LSRP. Other employers may take actions for otherwise legitimate business reasons that nonetheless result in the improper calculation and/or application of LSRP. Regardless of intent, any action that results in the miscalculation and/or misapplication of LSRP determined in accordance with these LSRP rules is prohibited. These actions include, but are not limited to:
 - Misrepresentation and/or miscalculation of payroll at application, audit, or renewal
 - Failure to report changes in ownership or ownership information according to the WCIP and NCCI's ***Experience Rating Plan Manual***
 - Violation of any of the terms and conditions under the policy for which this insurance was issued
 - Failure to allow the assigned carrier and/or Plan Administrator and/or rating organization reasonable access to facilities or files and records for audit or inspection
 - Failure to disclose to the assigned carrier and/or Plan Administrator and/or rating organization the full nature and scope of the employer's exposure or business operations
- b. In such circumstances, the assigned carrier and/or Plan Administrator and/or rating organization may obtain any information that indicates evasion or improper calculation or application of LSRP

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due to actions included, but not limited to, those listed in Rule 4-C-3-a. The assigned carrier and/or Plan Administrator and/or rating organization will act to ensure the proper calculation and application of LSRP to inception of all current and preceding WCIP policies impacted by these actions.

4. Assigned Carrier Responsibilities

Assigned carrier responsibilities include, but are not limited to:

- a. Administering, managing, and applying LSRP in accordance with these rules to:
 - (1) Individual LSRP policies within an LSRP-approved jurisdiction.
 - (2) Other WCIP policies related through common majority ownership as defined in NCCI's *Experience Rating Plan Manual*.
- b. Providing the employer with a full explanation and potential impact of LSRP at policy issuance, in accordance with Rules 4-C-6-b(2) and (3).
- c. Completing preliminary physical and final physical audits for all new business qualifying for LSRP (and any other audit requirements for renewal business) in accordance with NCCI's *Assigned Carrier Performance Standards*.
- d. Indicating on all renewal quotes to employers that payment of the renewal deposit constitutes knowledge and acceptance of the possible application of LSRP to the policy(ies).
- e. Attaching all appropriate LSRP endorsement(s) to the policy(ies) in accordance with Rule 4-C-6-b(3).
- f. Filing for Proof of Claim when it receives notification that the employer has declared bankruptcy; for information about off-cycle valuations, *refer to Rule 4-C-9-e*.
- g. Performing valuations of losses in accordance with Rule 4-C-9.
- h. Calculating all LSRP premiums.
- i. Collecting or returning any LSRP premium and/or LSRP contingency deposit.

5. LSRP Definitions**a. Assigned Carrier**

Assigned carrier refers to direct assignment carriers and servicing carriers as defined in Rule 4-A-2-e or applicable state workers compensation insurance plan approved for use in a jurisdiction.

b. Deposits**(1) Deposit or Initial Premium**

For purposes of LSRP, deposit or initial premium is paid on all new and renewal WCIP policies, including LSRP policies, in accordance with Rule 4-I. On LSRP policies, it is paid in addition to the LSRP contingency deposit as detailed below and in Rule 4-C-6-c. For more information about all payment methods, *refer to Rule 4-A-2-o or the applicable state workers compensation insurance plan*.

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(2) LSRP Contingency Deposit

- (a) In addition to the WCIP initial or deposit premium, new and renewal LSRP policies are secured with a LSRP contingency deposit.
- (b) The LSRP contingency deposit serves as collateral for premium that may be due to the assigned carrier as a result of losses incurred during the policy term.
- (c) The LSRP contingency deposit must be paid in accordance with Rule 4-C-6-c, as applicable.
- (d) At policy inception, the LSRP contingency deposit is calculated by multiplying the LSRP standard premium by 20%. When WCIP policies are combined for LSRP purposes, the LSRP contingency deposit is calculated by multiplying the combined LSRP standard premium for all policies by 20%.

(3) Deposit/Initial Premium and LSRP Contingency Deposit Submission Requirements

Deposit/initial premium and LSRP contingency deposits are submitted for single and multiple policy employers in accordance with the table below.

Deposit/Initial Premium, LSRP Contingency Deposit, and Policy Issuance Table

Application and Conditions	Application Assignment and Policy Issuance	The employer must submit ...
One application—No other applications or existing policies are in effect that may be combined for LSRP eligibility determination and/or coverage	<ul style="list-style-type: none"> • Individual application assigned to carrier • Assigned carrier issues one policy 	<ol style="list-style-type: none"> 1. Individual WCIP deposit or initial premium for the WCIP policy, and 2. An additional 20% LSRP contingency deposit based on the LSRP standard premium
Multiple applications—To determine LSRP eligibility, review possible combination with any applications and/or policies in effect for an employer with common majority ownership as defined in NCCI's <i>Experience Rating Plan Manual</i>	<ul style="list-style-type: none"> • Multiple applications assigned to same carrier • Assigned carrier issues LSRP policies for those that meet the eligibility requirement • Policy inception dates may vary; however, all policies must have a common expiration date • <i>Refer to Rule 4-C-6-a for anniversary rating date application</i> 	<ol style="list-style-type: none"> 1. Individual WCIP deposit or initial premium for each WCIP policy (e.g., two WCIP policies require two WCIP initial or deposit premiums), and 2. An additional 20% LSRP contingency deposit based on the combined LSRP standard premium

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Deposit/Initial Premium, LSRP Contingency Deposit, and Policy Issuance Table (Cont'd)**

Application and Conditions	Application Assignment and Policy Issuance	The employer must submit ...
Multiple applications—For the rare circumstance when applications and/or policies in effect for an employer with common majority ownership as defined in NCCI's <i>Experience Rating Plan Manual</i> cannot be assigned to an individual carrier	<ul style="list-style-type: none"> • Multiple applications assigned to multiple carriers, including affiliated insurers when possible • Assigned carriers issue LSRP policies for those that meet the eligibility requirement • Policy effective dates may vary • <i>Refer to Rule 4-C-6-a for anniversary rating date application</i> 	<ol style="list-style-type: none"> 1. Individual WCIP deposit or initial premium for each WCIP policy (e.g., two WCIP policies require two WCIP initial or deposit premiums), and 2. Additional 20% LSRP contingency deposits based on individual eligible LSRP standard premium(s)
Assigned carriers must issue a guaranteed cost policy(ies) for a state(s) where LSRP is not approved.		

c. Elements of the LSRP

(1) Basic Premium Factor (BPF)

The basic premium factor (BPF) is a fixed factor of 0.40 used to determine the basic premium.

(2) Basic Premium

- (a) Basic premium is determined by multiplying the total LSRP standard premium by the BPF.
- (b) The basic premium contributes to the recovery of expenses, such as those for servicing the LSRP policy, loss prevention services, premium audit, and general administration of the LSRP policy.
- (c) The basic premium does not include premium taxes or claim adjustment expenses. These elements are provided for in the tax multiplier and the loss conversion factor.

(3) Loss Conversion Factor (LCF)

A loss conversion factor (LCF) is applied to actual incurred losses to determine converted losses. The LCF:

- Includes claim adjustment expenses
- Includes the costs of the assigned carrier's claim services, such as investigation of claims and filing claim reports
- Applies on a state basis, as shown in the individual state assigned risk miscellaneous values pages

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Converted losses are determined by applying an LCF to the actual incurred losses. A converted loss is the loss amount including an approximate load for claim adjustment expenses.

(5) Incurred Losses (ICL)

Losses used in the LSRP calculation are those incurred losses (ICL) reported in accordance with the applicable statistical plan, subject to exclusions in accordance with Rule 4-C-9-f.

(6) Loss Limitations

For purposes of LSRP, losses are not limited.

(7) Loss Development Factor (LDF)

The loss development factor (LDF) is included in all four adjustments of LSRP premium. The LDF:

- Anticipates a pattern of increasing loss valuations during the adjustment periods
- Stabilizes premium adjustments
- Applies on a state basis, as shown in the individual state assigned risk miscellaneous values pages

(8) Maximum Premium Factor (MaxPF)

The maximum premium factor (MaxPF) is a fixed factor of 1.75 used to determine the greatest amount of premium that may be paid.

(9) LSRP Maximum Premium

LSRP maximum premium is determined by multiplying LSRP standard premium by the MaxPF. It limits the impact of incurred losses on LSRP premium. The policyholder will not pay more than the calculated LSRP maximum premium. For combinable policies, the LSRP maximum premium is based on the combined LSRP standard premium for all combinable policies.

(10) Minimum Premium Factor (MinPF)

The minimum premium factor (MinPF) is a fixed factor of 0.75 used to determine the least amount of premium that may be paid.

(11) LSRP Minimum Premium

LSRP minimum premium is determined by multiplying LSRP standard premium by the MinPF. The policyholder will not pay less than the calculated LSRP minimum premium. For combinable policies, the LSRP minimum premium is based on the combined LSRP standard premium for all combinable policies.

(12) LSRP Standard Premium (SP)

- (a) LSRP standard premium (SP) is determined on the basis of authorized rates (including premium developed from payroll assigned to aircraft classifications), and includes any:

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- Increased limits of liability
 - Experience rating modification
 - Deductible credit, if applied
 - ARAP and/or assigned risk surcharge programs and/or other assigned risk pricing programs other than LSRP
 - Minimum premium
- (b) Determination of LSRP standard premium must exclude:
- Premium resulting from non-ratable elements
 - Premium developed by the passenger seat surcharge under Code 7421
 - Premium discount
 - Premium developed by the occupational disease rates for employers subject to the Federal Coal Mine Safety and Health Act
 - Expense constant
 - Premium developed by catastrophe provisions in accordance with Rule 3-A-24
- (c) LSRP standard premium is calculated differently than standard premium as defined in Rule 3-A-20.
- (d) LSRP standard premium may change before, during, and/or after a policy period due to reasons including, but not limited to:
- Premium endorsements
 - Preliminary and/or final audits
 - A change in ownership or combinability status in accordance with NCCI's *Experience Rating Plan Manual*

(13) Tax Multiplier (TM)

The tax multiplier (TM) varies by state and includes licenses, fees, assessments, and taxes that an assigned carrier must pay on the premium it collects. The appropriate factors for these elements are located in the individual state Assigned Risk Miscellaneous Values pages.

d. Total Standard Premium, Estimated Annual Premium, and Final Annual Premium

Premiums developed in accordance with state-specific premium algorithms include premium elements that may be excluded from LSRP standard premium as detailed in Rule 4-C-5-c(12). Although these elements are excluded from LSRP standard premium and the calculation as detailed in Rule 4-C-9-c for LSRP purposes, these elements are still charged as part of a WCIP policy's total standard premium, estimated annual premium, and final annual premium as determined in accordance with the applicable algorithms and *Basic Manual* rules.

6. General Explanations**a. Anniversary Rating Date**

All LSRP rating values are applied on an anniversary rating date (ARD) basis for all single and multiple LSRP policy risks where Rule 3-A-2 applies.

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b. Application of LSRP

(1) Applicable Rating Programs, Pricing Programs, and Premium Elements

Although certain rating and/or pricing programs and corresponding premium elements (if any) may be specifically excluded from LSRP standard premium, the rating and/or pricing programs may still apply to LSRP policies. These include:

- Increased limits of liability
- Wrap-up construction policies, including Owner-Controlled Insurance Programs (OCIPs)
- Premium discount

(2) Assigned Risk Policyholder Notices

(a) ACORD® 133 Application

Notification about LSRP is provided to the employer and its representative when submitting the ACORD® 133 application for coverage in the residual market. By signing the applicant statement on the ACORD® 133, the applicant understands and agrees that they are acknowledging that the LSRP has been explained, and agrees to the terms of LSRP if the employer meets the eligibility requirements. The applicant also agrees to submit an additional LSRP contingency deposit in accordance with Rules 4-C-5-b(2) and 4-C-6-c.

(b) Binder

In states that have approved LSRP, notification about the application of LSRP to an employer's WCIP policy is provided to the employer and its representative on the binder notification pages.

(3) Endorsements

The following endorsements are applied to **all** new and renewal assigned risk policies in accordance with the LSRP rules.

LSRP Endorsements Table

Endorsement	Instructions and Purpose
WC 00 04 17 B—Assigned Risk Loss Sensitive Rating Plan Notification Endorsement	<ul style="list-style-type: none"> • Assigned carriers must attach this endorsement to all new and renewal assigned risk policies regardless of premium size • This endorsement ensures that all assigned risk employers, regardless of premium size, are notified of the intent and details of LSRP as well as possible application of LSRP if the employer meets the eligibility requirements
WC 00 04 18 F—Assigned Risk Loss Sensitive Rating Plan Endorsement	<ul style="list-style-type: none"> • All assigned carriers must attach this endorsement to all new and renewal assigned risk policies meeting the LSRP eligibility requirements

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 LSRP Endorsements Table (Cont'd)**

Endorsement	Instructions and Purpose
	<ul style="list-style-type: none"> This endorsement advises policyholders meeting the eligibility requirements of the applicable LSRP factors and how LSRP premium is calculated

c. LSRP Contingency Deposit Procedures

(1) Mandatory LSRP Contingency Deposit

- (a) In accordance with Rule 4-C-5-b(2), the employer must pay the LSRP contingency deposit as collateral. Nonpayment of the LSRP contingency deposit will result in:
- Cancellation of the WCIP policy according to the Plan rules, state law, or NCCI's **Assigned Carrier Performance Standards**, whichever is more stringent, and
 - Ineligibility in good faith for coverage in the residual market
- (b) Upon receipt, LSRP contingency deposits are treated in accordance with Rules 4-C-7 and 4-C-10.

(2) LSRP Contingency Deposit Submission Methods

The LSRP contingency deposit payment methods below are approved by the Plan Administrator. For details about submission methods, refer to NCCI's **Assigned Risk Supplement**.

(a) Automated Clearing House/Electronic Funds Transfer (ACH/EFT)

Assigned carriers may offer policyholders the ability to pay LSRP contingency deposit by ACH (Automated Clearing House) in the form of an EFT (electronic funds transfer).

(b) Credit Card

Assigned carriers may offer policyholders the ability to pay LSRP contingency deposit by credit card.

(c) Personal or Business Check

A personal or business check may be provided to pay the LSRP contingency deposit. For details on how to tender the check, based on whether submitting a new application or payment for renewal policies, refer to Rules 4-C-6-c(3) and (4) below, respectively.

(d) Irrevocable Letter of Credit (ILOC)

An Irrevocable Letter of Credit (ILOC) may be provided as collateral for the LSRP contingency deposit. The ILOC must:

- (1) Be drawn on a member bank of the U.S. Federal Reserve System.
- (2) Be acceptable, clean, unconditional, and irrevocable.
- (3) Name the insured on the policy as the Applicant.
- (4) Name the assigned carrier as the Beneficiary. The Plan Administrator and/or NCCI and/or the rating organization must **not** be named as the Beneficiary(ies).

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- (5) Contain a provision where the assigned carrier is notified by the issuing bank in advance of any proposed alteration, modification, amendment, or waiver of terms and conditions. No alterations, modifications, amendments, or waivers of terms and conditions are permitted without the advance express written consent of the Beneficiary.
- (6) Not be assignable or transferable.
- (7) Have an initial expiration date no earlier than 10 months following the policy expiration date.
- (8) Have an automatic annual renewal clause for as many as three additional one-year periods.

(3) New Application Submission

- (a) The employer must pay the deposit or initial premium, as defined in Rule 4-C-5-b(1), at time of application submission for a binder to be issued. Additionally, LSRP contingency deposits are treated in accordance with the Deposit/Initial Premium, LSRP Contingency Deposit, and Policy Issuance Table in Rule 4-C-5-b(3) and the New Application LSRP Contingency Deposit Table.

New Application LSRP Contingency Deposit Table

If at the time of application, the employer . . .	Then . . .
Pays the LSRP contingency deposit	The Plan Administrator forwards the LSRP contingency deposit to the assigned carrier with the deposit premium and binder package
Does not pay the LSRP contingency deposit	Within 30 days of the issue date of the binder, the employer must submit the LSRP contingency deposit to the assigned carrier
Indicates that the LSRP contingency deposit will be secured with an ILOC and does not obtain an acceptable ILOC within 30 days of the issue date of the binder	<ul style="list-style-type: none"> • The employer must tender a check to the assigned carrier for the LSRP contingency deposit • The check must be made payable to the assigned carrier • The check must be received by the assigned carrier within 10 days of the employer informing the assigned carrier that an ILOC could not be obtained

- (b) A binder is issued by the Plan Administrator in accordance with Rule 4-A or other applicable state rules when an employer is determined to be eligible for coverage under the WCIP and is eligible for LSRP.
- (c) The binder also specifies the appropriate LSRP contingency deposit, which is determined at the time of application submission.
- (d) The employer may be considered ineligible for coverage under the WCIP, and the binder may be revoked or cancelled in accordance with Plan rules, state law, and NCCI's

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Assigned Carrier Performance Standards, whichever is more stringent, if for any reason:

- The funds provided are insufficient or are not received by the assigned carrier, or
- An ILOC is not secured

(4) Renewal of Coverage

- (a) Assigned carriers must include notice of any new LSRP contingency deposit in its renewal quote.
- (b) The new LSRP contingency deposit must be paid to the assigned carrier in accordance with Rules 4-C-5-b(2) and 4-C-6-c(1) and (2) before the expiration of the current policy for coverage to be renewed without any gap in coverage.
- (c) If the employer is unable to obtain an ILOC for the renewal policy and has notified the assigned carrier, to avoid any gap in coverage, the new LSRP contingency deposit must still be paid for the renewal policy to the assigned carrier before expiration of the current policy.
- (d) Effective dates for renewal LSRP policies are established in accordance with Rule 4-A-4-a(4) or other applicable state rules.

7. Changes in LSRP Standard Premium

- a. For all policies except for professional employer organizations and temporary arrangements, in accordance with the tables below, during a policy term:
 - (1) LSRP may be applied to a policy, or
 - (2) A policy may be converted to a guaranteed cost policy
- b. For treatment of professional employer organizations and temporary arrangements, *refer to Rule 4-C-11.*

Application of LSRP During the Policy Term—Table 1

If during the first 120 days of the policy term . . .	Then . . .
The LSRP standard premium decreases and falls below the LSRP eligibility threshold	<ul style="list-style-type: none"> • The policy is converted to a guaranteed cost policy, retroactively to policy inception • LSRP contingency deposit is returned
The LSRP standard premium increases and meets the LSRP eligibility threshold	<ul style="list-style-type: none"> • LSRP is applied retroactively to policy inception • An LSRP contingency deposit must be paid within 30 days of the assigned carrier issuing notice of the application of LSRP • Valuations are calculated in accordance with Rule 4-C-9 • The assigned carrier must hold the LSRP contingency deposit in accordance with Rule 4-C-10

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 Application of LSRP During the Policy Term—Table 1 (Cont'd)**

If during the first 120 days of the policy term . . .	Then . . .
The employer's LSRP policy is cancelled due to reasons detailed in Rule 3-A-3-b, Cancellation Provisions Tables 1, 2, or 3	<ul style="list-style-type: none"> • The policy is converted to a guaranteed cost policy, retroactively to policy inception • The policy is cancelled pro rata • The LSRP contingency deposit and any unearned premium is returned, subject to final audit
The employer's LSRP policy is cancelled due to reasons detailed in Rule 3-A-3-b, Cancellation Provisions Table 4	<ul style="list-style-type: none"> • The policy is converted to a guaranteed cost policy, retroactively to policy inception • The policy is cancelled short rate • The LSRP contingency deposit and any unearned premium is returned, subject to final audit

Application of LSRP During the Policy Term—Table 2

If after the first 120 days of the policy term . . .	Then . . .
The LSRP standard premium decreases and falls below the LSRP eligibility threshold	<ul style="list-style-type: none"> • LSRP continues to apply to the policy • Valuations are calculated in accordance with Rule 4-C-9
The LSRP standard premium increases and meets the LSRP eligibility threshold	<ul style="list-style-type: none"> • The policy remains a guaranteed cost policy • LSRP is applied at renewal, subject to meeting the eligibility requirements on the renewal policy
The employer's LSRP policy is cancelled due to reasons detailed in Rule 3-A-3-b, Cancellation Provisions Tables 1, 2, or 3	<ul style="list-style-type: none"> • LSRP continues to apply to the policy • The policy is cancelled pro rata in accordance with Rule 4-C-8 • Valuations are calculated in accordance with Rule 4-C-9 • The assigned carrier must hold the LSRP contingency deposit in accordance with Rule 4-C-10
The employer's LSRP policy is cancelled due to reasons detailed in Rule 3-A-3-b, Cancellation Provisions Table 4	<ul style="list-style-type: none"> • LSRP continues to apply to the policy • The policy is cancelled short rate in accordance with Rule 4-C-8 • Valuations are calculated in accordance with Rule 4-C-9 • The assigned carrier must hold the LSRP contingency deposit in accordance with Rule 4-C-10

Refer to Rule 4-C-6-b(3) for further information on the proper application of endorsements.

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- c. Application of LSRP in accordance with Rule 4-C-3 applies retroactively to policy inception, regardless of the 120-day timing requirement detailed in Application of LSRP During the Policy Term—Table 1 and Application of LSRP During the Policy Term—Table 2.

8. Cancellation of LSRP Policies

a. General Information

- (1) Cancellation of LSRP policies must be in accordance with the standard workers compensation and employers liability insurance policy.
- (2) Cancellation of LSRP policies is subject to pro rata or short-rate calculation of LSRP standard premium in accordance with Rule 3-A-3.
- (3) The assigned carrier must report noncompliance and any subsequent compliance to the Plan Administrator.
- (4) Cancelled LSRP policies are subject to all LSRP rules, as applicable.
- (5) Employers with cancelled LSRP policies are responsible for any additional premium due for reasons including, but not limited to:
 - (a) Premium endorsements
 - (b) Audits
 - (c) An ownership change or change in combinability status in accordance with NCCI's *Experience Rating Plan Manual*
 - (d) An employer retiring from business
 - (e) Any applicable and/or remaining LSRP valuations

b. Calculation of Minimum and Maximum Premium

(1) Elements

Based on the type of policy cancellation (pro rata or short rate), minimum and maximum premiums for LSRP policies are adjusted in accordance with the applicable calculation method, using the following elements:

- SP represents LSRP Standard Premium
- PRF represents Pro Rata Factor
- SR represents Short-Rate Factor
- MinPF represents Minimum Premium Factor
- MaxPF represents Maximum Premium Factor

(2) Methods

(a) Pro Rata LSRP Minimum Premium Calculation Method (PMnP)

$$\text{PMnP} = \text{SP} \times \text{PRF} \times \text{MinPF}$$

(b) Pro Rata LSRP Maximum Premium Calculation Method (PMxP)

$$\text{PMxP} = \text{SP} \times \text{PRF} \times \text{MaxPF}$$

(c) Short-Rate LSRP Minimum Premium Calculation Method (SMnP)

$$\text{SMnP} = \text{SP} \times \text{SR} \times \text{MinPF}$$

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(d) Short-Rate LSRP Maximum Premium Calculation Method (SMxP)

$$\text{SMxP} = \text{SP} \times \text{SR} \times \text{MaxPF}$$

9. LSRP Valuation**a. General Information**

LSRP policies are subject to a first valuation with three subsequent valuations for a maximum of four valuations. The valuations adjust LSRP standard premium to reflect the actual experience of the employer. The result of the actual experience may be additional premium, return premium, or no change to the estimated premium. *Refer to the **User's Guide** for examples.*

b. Timing and Reporting of Valuations

- (1) LSRP valuations and resulting premium adjustments must be based on losses valued at 18, 30, 42, and 54 months after the month in which the policy became effective in accordance with the applicable statistical plan.
- (2) For policies in effect for less than 12 months, the first LSRP valuation must be calculated as soon as practical based on losses valued six months after the WCIP policy(ies) expiration. Three additional LSRP valuations must be calculated at 30, 42, and 54 months after the month in which the policy(ies) became effective in accordance with the applicable statistical plan. *Refer to Rule 4-C-9-e for information about off-cycle valuations.*
- (3) Reporting subsequent valuations must occur in accordance with the applicable statistical plan reporting requirements for open, closed, and/or reopened claims.

c. Formula

The LSRP formula is designed to allow for a premium that is not less than the LSRP minimum premium or more than the LSRP maximum premium in accordance with Rules 4-C-5-c(9) and (11). The formula is:

$$\text{LSRP (Additional/Return) Premium} = \{[(\text{SP} \times \text{BPF}) + (\text{ICL} \times \text{LCF}) + (\text{SP} \times \text{LDF} \times \text{LCF})] \times \text{TM}\} - \text{SP}$$

d. Calculation of LSRP (Additional/Return) Premium

- (1) LSRP (additional/return) premium is calculated by the assigned carrier.
- (2) The data used must be reported in accordance with the applicable statistical plan.
- (3) LSRP (additional/return) premium adjustments are calculated as soon as practical.
- (4) A maximum of four valuations are calculated to determine the LSRP (additional/return) premium per policy period.

e. Off-Cycle Valuation of LSRP (Additional/Return) Premium

- (1) In certain circumstances, the assigned carrier may perform an off-cycle (early) valuation to determine LSRP (additional/return) premium. Such cases include, but are not limited to cancellation of the policy; and/or the employer's:
 - Noncompliance with policy terms and conditions
 - Bankruptcy
 - Default on premium

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- Involvement in any liquidation, reorganization, or receivership
 - Disposal of all, or substantially all, of its assets
- (2) The employer or the bankruptcy estate, if applicable, is responsible for any additional premium due as a result of any off-cycle valuations or other applicable remaining valuations.
- (3) Reporting of off-cycle valuations must be in accordance with the applicable statistical plan.

f. Treatment of Incurred Losses in Valuation Calculation

For purposes of calculating LSRP (additional/return) premium, certain losses associated with classifications or rating and/or pricing programs are treated in accordance with the Loss Treatment Table.

Loss Treatment Table

Program or Loss Type	Treatment
Losses associated with aircraft passenger seat surcharge reported under Code 9108	Exclude losses
Deductible programs	Include all losses at the net amount, regardless of net/gross reporting
Federal Coal Mine Safety and Health Act	Exclude the disease-related portion of losses covered under the Act
Catastrophe provisions in accordance with Rule 3-A-24	Exclude losses
Any other losses where premium is non-ratable	Exclude losses

10. Application of LSRP (Additional/Return) Premium

Application of LSRP (additional/return) premium is determined in accordance with the tables below. LSRP contingency deposits are typically held until the fourth or final valuation.

First and/or Subsequent Valuations Table

If the first and/or a subsequent valuation results in . . .	Then . . .
Additional premium due to the assigned carrier	<ul style="list-style-type: none"> • The assigned carrier must: <ul style="list-style-type: none"> • Bill the employer for additional LSRP premium due, and • Hold the LSRP contingency deposit until the fourth or final valuation • Payment must be postmarked or submitted electronically on or before 30 days from the date of billing or earlier, if required by state law • If the employer is noncompliant for nonpayment, any existing WCIP policy may be cancelled; the

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 First and/or Subsequent Valuations Table (Cont'd)**

If the first and/or a subsequent valuation results in . . .	Then . . .
	employer will no longer be eligible in good faith for coverage under the WCIP
Return premium due to the employer	The assigned carrier must: <ul style="list-style-type: none"> • Return the LSRP premium due, and • Hold the LSRP contingency deposit until the fourth or final valuation, subject to earlier return based on sound underwriting judgment except for all professional employer organizations and temporary arrangements policies; the file must be documented with sufficient level of detail when an early return of the contingency deposit is made, and • Provide the employer with a billing statement, including a reason for the return.

Fourth and/or Final Valuation Table

If the fourth and/or final valuation results in . . .	Then . . .
Additional premium due to the assigned carrier	<ul style="list-style-type: none"> • The assigned carrier: <ul style="list-style-type: none"> • Must bill the employer for additional LSRP premium due • May offset the additional LSRP premium with the LSRP contingency deposit if the employer requests that contingency deposit funds or an Irrevocable Letter of Credit originally provided be applied • Payment must be postmarked or submitted electronically on or before 30 days from the date of billing or earlier, if required by state law • If the employer is noncompliant for nonpayment, any existing WCIP policy may be cancelled; the employer will no longer be eligible in good faith for coverage under the WCIP
Return premium due to the employer	Within 10 days after the valuation, the assigned carrier must: <ul style="list-style-type: none"> • Return the LSRP premium due and LSRP contingency deposit, if any • Provide the employer with a billing statement, including a reason for the return
No premium due to the assigned carrier or employer	Within 10 days after the valuation, the assigned carrier must:

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 Fourth and/or Final Valuation Table (Cont'd)**

	<ul style="list-style-type: none"> • Return the LSRP contingency deposit, if any • Provide the employer with a billing statement
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11. Professional Employer Organizations (PEO) and Temporary Arrangements

a. General Information

- (1) LSRP is a mandatory assigned risk retrospective rating plan for those professional employer organizations (PEO) and its individual clients and temporary arrangement employers that have a qualifying workers compensation and employers liability insurance policy(ies) through the Workers Compensation Insurance Plans (WCIP).
- (2) Unless otherwise specified, Rules 4-C-1 through 10 apply to PEO, individual client, and temporary arrangement WCIP policies.

b. Definitions

(1) Client

Client is defined in accordance with Rule 4-B-1-b or other applicable state rules. For purposes of LSRP, clients are referred to as individual clients when used in conjunction with multiple coordinated policies.

(2) Master Policy

A WCIP policy issued to the PEO which covers the leased employees of the client companies that may be listed on the policy. *Refer to applicable state rules and laws for the state-specific definition.*

(3) Multiple Coordinated Policies (MCP) Basis

WCIP policies written in accordance with Rule 4-B-1-h or other applicable state rules.

(4) Professional Employer Organizations (PEO) and PEO Arrangement

PEO is defined in accordance with Rule 4-B-1-j or other applicable state rules; PEO arrangement is defined in accordance with Rule 4-B-1-k or other applicable state rules.

(5) Temporary Arrangement

Temporary arrangement is defined in accordance with Rule 4-B-1-m or other applicable state rules.

c. Eligibility

- (1) Eligibility for LSRP for PEOs, its individual clients, and temporary arrangement employers is determined in accordance with the Eligibility Tables below. *Refer to Rule 4-C-5-c(12) for the definition of LSRP standard premium.*

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Eligibility Table 1

If a single-state employer has operations in . . .	Then . . .
<ul style="list-style-type: none"> • One LSRP-approved state, and • Has a single-state WCIP policy covering such operations in the state 	The single-state WCIP policy must meet or exceed LSRP standard premium of \$250,000
<ul style="list-style-type: none"> • One LSRP-approved state, and • Has two or more WCIP policies covering such operations in the state, and • The two or more policies are written by the same assigned carrier 	The combined LSRP standard premium of all policies written by the same assigned carrier must meet or exceed \$250,000

Eligibility Table 2

If a multistate employer has operations in . . .	Then . . .
<ul style="list-style-type: none"> • Two or more LSRP-approved states, and • Has one multistate WCIP policy covering such operations in those states 	The combined LSRP standard premium of all states on the policy must meet or exceed: <ul style="list-style-type: none"> • \$250,000, or • The premium eligibility requirement for the LSRP state generating the largest LSRP standard premium if such state's eligibility requirement is less than \$250,000
<ul style="list-style-type: none"> • Two or more LSRP-approved states, and • Has multiple WCIP policies covering such operations in those states, and • The two or more policies are written by the same assigned carrier 	The combined LSRP standard premium of all policies written by the same assigned carrier must meet or exceed: <ul style="list-style-type: none"> • \$250,000, or • The premium eligibility requirement for the LSRP state generating the largest LSRP standard premium if such state's eligibility requirement is less than \$250,000

- (2) It may not always be possible for a single carrier to provide coverage for all requested states; additional policies issued by more than one carrier may be necessary. *Refer to Rule 4-C-5-b(3) for more information about policy issuance and corresponding deposits.*
- (3) WCIP policies issued in non-LSRP-approved jurisdictions are not subject to LSRP and are not combinable with WCIP policies in LSRP-approved jurisdictions for eligibility purposes.
- (4) LSRP eligibility may be impacted by ownership or combinability status in accordance with NCCI's ***Experience Rating Plan Manual***.
- (5) LSRP standard premium is determined in accordance with Rule 4-C-5-c(12); however, the policy type/type of arrangement must be considered when determining LSRP standard premium as referenced in the Arrangement Type Eligibility Table below.

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Arrangement Type Eligibility Table

Policy Type/Type of Arrangement	LSRP eligibility is determined . . .
PEO master policy	Using LSRP standard premium for the entire master policy (PEO and clients)
PEO multiple coordinated policy (MCP)	<ul style="list-style-type: none"> • For PEOs (excluding clients), using LSRP standard premium of any PEO policy written in accordance with Rule 4-B-4-b(2) or other applicable state-specific WCIP MCP rule • For individual clients of PEOs, using LSRP standard premium separately for each individual client PEO policy written in accordance with Rule 4-B-4-b(1) or other applicable state-specific WCIP MCP rule
Temporary Arrangement	Using LSRP standard premium for the entire temporary arrangement policy

d. Deposit/Initial Premium and LSRP Contingency Deposits

Deposit and initial premium and LSRP contingency deposits are applied in accordance with Rules 4-C-5-b and 4-C-10.

e. Application of LSRP

PEO arrangement and temporary arrangement policies are subject to Rule 4-C-5-c(12). If the LSRP eligibility threshold **is met at any time** then:

- LSRP is applied retroactively to policy inception
- An LSRP contingency deposit is required to be paid within 30 days of the assigned carrier issuing notice of the application of LSRP
- Valuations are calculated in accordance with Rule 4-C-9
- The assigned carrier **must** hold the LSRP contingency deposit until the fourth or final valuation is completed

D. VOLUNTARY COVERAGE ASSISTANCE PROGRAM (VCAP[®] SERVICE)

1. Introduction

NCCI's **VCAP[®] Service** operates as a supplemental program for all employers applying for assigned risk coverage through the Workers Compensation Insurance Plan (WCIP or Plan). The WCIP is administered by NCCI as Plan Administrator, as defined in NCCI's **Basic Manual for Workers Compensation and Employers Liability Insurance** Rule 4-A-2-p. It is designed to provide an additional source for producers and employers to secure workers compensation coverage in the voluntary market and will operate in conjunction with NCCI's Residual Market Application Processing System (**RMAPS[®] Service**).

VCAP[®] Service promotes depopulation of the residual market by redirecting opportunities for employers' coverage to voluntary market insurers, which generally provide coverage at a lower cost.

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(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)****2. Definitions****a. Application Submission Methods**

The methods approved by the Plan Administrator, in which good faith eligible employers may submit completed ACORD[®] 130 and 133 applications for coverage through the WCIP, are as follows:

- Online—Through **ncci.com** and NCCI's **RMAPS[®] Online Application Service**
- Mail—The U.S. Postal Service or private overnight delivery service
- Telephone—By contacting the Plan Administrator

b. Criteria

Underwriting specifications designated by a participating voluntary coverage provider to identify the types of employers processed through NCCI's **VCAP[®] Service** for underwriting evaluation and potential placement in the voluntary market.

c. Employer

Any business organization or enterprise that is required by state law, regulation, and/or rule to maintain workers compensation insurance in this state or state(s). The term includes any business organization or enterprise that is or was affiliated at any time as a result of common management or common ownership.

d. NCCI's RMAPS[®] Service

Automated application processing system for residual market applications submitted under NCCI's Workers Compensation Insurance Plan.

e. NCCI's VCAP[®] Service

A free Internet-based application designed to provide an additional source for producers and employers to secure workers compensation insurance in the voluntary market.

f. National Workers Compensation Reinsurance Association NFP (NWCRA or Association)

A not-for-profit corporation whose members provide for contractual quota share reinsurance through Reinsurance Agreement(s) among themselves as workers compensation insurers, which affords such insurers an option for complying with state workers compensation insurance plan requirements by sharing in the experience of certain policies written pursuant to such insurance plans.

g. Producer

A licensed insurance agent, broker, or insurance representative, as defined in the state insurance law, regulation, and/or rule, whose privileges under the WCIP have not been suspended or revoked, designated by the employer or applicant applying under the WCIP to secure and maintain workers compensation and employers liability insurance on behalf of the employer. For purposes of this WCIP and/or **VCAP[®] Service**, the producer is considered to be acting on behalf of the insured or employer applying for coverage under the WCIP and not as an agent of the Plan Administrator or of any assigned carrier for Plan business.

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Any offer for voluntary coverage where the total estimated annual premium is less than or equal to the assigned risk total estimated annual premium including any applicable assigned risk surcharges and/or pricing programs for all comparable coverages.

Subject to the Plan Administrator's discretion and without limitation, the following are not considered a reasonable offer of voluntary coverage:

- Offer does not provide all of the required coverage (i.e., carrier cannot provide federal coverage or limits of liability)
- A deductible or deposit that is a financial burden to the employer as determined by the producer and/or employer
- Carrier's A.M. Best financial rating status is below that required by the producer and/or employer

i. VCAP[®] Service User

An employee or other designated representative of a participating voluntary coverage provider that is authorized to access **VCAP[®] Service** on behalf of the participating voluntary coverage provider.

j. Workers Compensation Insurance Plan (WCIP or Plan)

A program established by state insurance regulatory authorities whereby eligible employers unable to secure coverage in the voluntary market may secure workers compensation insurance.

3. General Explanation**a. Voluntary Coverage Provider Eligibility Requirements**

Voluntary coverage providers must meet the following minimum eligibility requirements to participate in NCCI's **VCAP[®] Service**:

- (1) Participate in the Plan as a member of the National Workers Compensation Reinsurance Association or as a residual market assigned carrier
- (2) Be licensed to write workers compensation and employers liability insurance in the state in which NCCI's **VCAP[®] Service** has been approved
- (3) Have a minimum of a B+ financial rating as published by A.M. Best
- (4) Agree to **VCAP[®] Service** contractual arrangements and/or procedures established by NCCI and/or the Plan Administrator

b. Voluntary Coverage Provider Underwriting Criteria

Voluntary coverage providers participating in NCCI's **VCAP[®] Service** will establish certain underwriting criteria that include:

- (1) Participating companies*
- (2) Governing state(s)*
- (3) Governing class code(s)*

* Required Field

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- (4) Estimated premium range*
- (5) Experience rating modification range
- (6) Excluded zip code(s)
- (7) Business Type (existing, new or all)
- (8) Number of employees
- (9) Include/exclude coverage for:
 - Coal Mine
 - USL&H
 - Professional Employer Organization (PEO) Arrangements
 - Temporary Arrangement
- (10) Banking information (for deposit premium transfer)*

c. Application Verification

All assigned risk applications (electronic, phone-in, or mail-in) submitted to NCCI as Plan Administrator are processed through **VCAP® Service** to determine if they match any of the preselected criteria specified by a participating voluntary coverage provider.

d. Procedures

All assigned risk applications (electronic, phone-in, or mail-in) submitted to NCCI as Plan Administrator are processed through **VCAP® Service** to determine if they match the preselected criteria specified by a participating voluntary coverage provider. If an employer matches the preselected criteria specified by a participating voluntary coverage provider, a real-time electronic notification will inform the voluntary coverage provider and the producer and/or employer that the applicant meets the preselected criteria.

- (1) The transactions to develop and accept a voluntary offer will take place directly between the voluntary coverage provider and the producer and/or employer.
- (2) The commission rate is negotiated directly between the producer and voluntary coverage provider. The producer commission should not be less than the amount of the producer fee that would be paid had the policy been written through the residual market. For additional information, *refer to the producer fee percentage scales in NCCI's **Assigned Risk Supplement to the Basic Manual for Workers Compensation and Employers Liability Insurance***. The producer commission should otherwise be based on generally accepted business practices for the payment of commissions in the voluntary market.
- (3) If an employer meets the preselected criteria of multiple voluntary coverage providers, the application information will be sent to all such voluntary coverage providers.
- (4) The voluntary coverage provider must use sound underwriting judgment when determining whether an offer of voluntary coverage will be made, and may, at its discretion, either extend an offer or decline an offer of voluntary coverage to the employer.
- (5) Applications being considered for voluntary coverage will be temporarily suspended from further **RMAPS® Service** processing. The effective date of coverage will be determined based on the date the policy would have been effective in the residual market in accordance with NCCI's **Basic Manual** Rule 4-A-3-d.

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- (6) Voluntary coverage providers will be allotted up to three business days, including the date the match is identified, to review the application and determine whether they want to extend an offer of voluntary coverage. NCCI will provide copies of the ACORD[®] 130, application history, and the residual market premium calculation to assist the voluntary coverage provider in deciding whether to offer coverage.
- (7) The producer and/or employer and the voluntary coverage provider will work together to negotiate a reasonable offer of voluntary coverage. The producer and/or employer or the voluntary coverage provider may request an additional day to review the application which may be granted at the discretion of the Plan Administrator.
- (8) The first voluntary coverage provider to receive an acceptance of an offer from the producer or employer will confirm coverage and issue the policy.
- (9) The voluntary coverage provider, producer, and employer must agree to all of the terms and conditions of the offer, including the acceptance of the employer's producer. Upon renewal, the voluntary coverage provider may renew or nonrenew the policy. Any agreements between the producer and the voluntary coverage provider are exclusively between the two parties, do not include NCCI, and are not part of NCCI's filed and approved Workers Compensation Insurance Plan (WCIP).
- (10) The producer or employer must accept any reasonable offer of voluntary coverage made by a voluntary coverage provider participating in NCCI's **VCAP[®] Service**.
- (11) The voluntary coverage provider will confirm a voluntary offer of coverage through NCCI's **VCAP[®] Service** within one business day of the producer or employer accepting a reasonable offer of voluntary coverage.
- (12) Employers that are not extended an offer of voluntary coverage will be assigned to a residual market assigned carrier through NCCI's **RMAPS[®] Service**, subject to all terms, conditions and/or eligibility requirements of NCCI's Workers Compensation Insurance Plan.

e. Deposit Premium

For the purpose of transferring deposit premium funds between NCCI and a voluntary coverage provider, all voluntary coverage providers wishing to participate in NCCI's **VCAP[®] Service** must provide banking information—Authorization Agreement for Automatic Processing of ACH Credit/Debit Transactions—to the Plan Administrator.

F. TAKE-OUT CREDIT PROGRAM**1. General Information**

- a. The Take-Out Credit Program provides carriers with financial incentives for writing residual market employers on a voluntary market basis.
- b. Each voluntary market carrier participating in the Workers Compensation Insurance Plan (WCIP) that removes an employer insured under the WCIP may be eligible for a take-out credit (TOC). The TOC is applied against the premium used to calculate the voluntary market carrier's Plan participation base as defined in **Basic Manual** Rule 4-A-5-d or applicable state workers compensation insurance plan.
- c. All carriers licensed in a TOC Program-approved jurisdiction and writing workers compensation and employers liability insurance coverage are eligible to participate in the TOC Program.
- d. It is the voluntary market carrier's responsibility to:

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- (1) Enroll with the Plan Administrator as well as update enrollment information on an annual basis as required in accordance with the enrollment procedures established by the Plan Administrator.
 - (2) Submit an annual request for TOC in accordance with Rule 4-F-5 and any procedures established by the Plan Administrator.
 - (3) Provide supporting data as may be required by the Plan Administrator.
- e. TOCs are not issued to carriers that do not enroll in the program.
 - f. TOCs are not issued to enrolled carriers that do not submit an annual request for credit.
 - g. The Plan Administrator determines the applicability of all TOC Program rules.

2. General Terms**a. Direct Premiums Written in the Exhibit of Premiums and Losses (Statutory Page 14)**

Refers to a carrier's Direct Premiums Written in the Exhibit of Premiums and Losses (Statutory Page 14) contained in its Annual Statement.

b. Employer

Employer refers to an insured or a policyholder, in accordance with *Basic Manual* Rule 4-A-2-i or applicable state workers compensation insurance plan.

c. Experience Rating Threshold Average

A specific jurisdiction's experience rating threshold average is located in NCCI's *Experience Rating Plan Manual*. For purposes of TOC, the threshold is used as a parameter. *Refer to the TOC Parameters Table in Rule 4-F-4-e.*

d. Individual Reported Policy Premium

For purposes of TOC, individual reported policy premium is the amount of policy premium included for specific employers in the carrier's Direct Premiums Written in the Exhibit of Premiums and Losses (Statutory Page 14) of the carrier's Annual Statement for the most recent calendar year. This premium is also the basis for carrier participation in the Plan. *Refer to the TOC Parameters Table in Rule 4-F-4-e.*

e. Plan

Plan refers to NCCI's Workers Compensation Insurance Plan (WCIP), as defined in *Basic Manual* Rule 4-A-2-y or applicable state workers compensation insurance plan.

f. Plan Administrator

The organization designated to administer the affairs of the Plan as approved by the regulatory authority in a jurisdiction. For purposes of TOC, the Plan Administrator may also be referred to as the TOC Administrator.

g. Plan Participation Base

Plan participation base refers to the basis of a carrier's participation in the Workers Compensation Insurance Plan in accordance with *Basic Manual* Rule 4-A-5-d or applicable state workers compensation insurance plan.

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Program length refers to the maximum number of consecutive years that a specific employer's initial and renewal voluntary market policies may qualify for a TOC. For instance, a three-year program length means that a voluntary market employer's initial policy and two subsequent renewals may qualify for TOC. *Refer to the TOC Parameters Table in Rule 4-F-4-e.*

i. TOC

TOC refers to the Take-Out Credit Program. The term is also used to refer to the actual credit (e.g., a carrier may qualify for a TOC to be applied to its Plan participation base). TOC is a residual market depopulation incentive program, with state-specific program parameters.

j. Program Year

Program year refers to the individual year that an employer's initial and renewal voluntary market policies may participate in TOC. For instance, an eligible initial voluntary market policy would be Program Year 1. The consecutive renewals would be Program Years 2 and 3, respectively.

k. TOC Ratio

Each jurisdiction has a ratio that is multiplied against the individual reported policy premium. *Refer to the TOC Parameters Table in Rule 4-F-4-e.*

l. Voluntary Market Carrier

For purposes of TOC, a voluntary market carrier removes an employer from a specific jurisdiction's residual market and writes the employer on a voluntary basis. For purposes of TOC, voluntary market carrier(s) will be referred to only as carrier(s).

3. TOC Requirements

- a. Any carrier, other than the last voluntary carrier of record, may remove an employer without any restriction on the length of time that the employer was written in the residual market. For purposes of TOC, these requirements apply to a carrier's group/affiliate as well as the carrier.
- b. A carrier will not receive a TOC for any employer removed from the residual market within 12 months of that carrier, or a member of that carrier's group, writing the employer in the voluntary market.
- c. In no instance may a carrier receive a TOC for employers returned to the residual market within 12 months of being removed from the residual market.
- d. If the enrolled carrier keeps the employer out of the residual market for the full program length, that carrier will receive the TOC for premium relating to each of the program years of voluntary market coverage.
- e. A carrier is not eligible for a TOC for an employer's remaining program years if:
 - (1) A carrier does not enroll in TOC for an employer's first program year, or
 - (2) A carrier does not request a TOC for an employer's first program year, or
 - (3) A carrier requests a TOC for an employer's first program year, but subsequently decides not to accept the TOC, or

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(4) An enrolled carrier accepts a TOC for a specific program year, but not its subsequent program years, in accordance with the specific jurisdiction's program length as detailed in the TOC Parameters Table in Rule 4-F-4-e.

f. Subject to Rule 4-F-3-a through e., if the enrolled carrier does not write the employer for the full program length, it will receive TOC only for that consecutive period of time that it covered the employer in the voluntary market.

4. TOC Calculation

a. Individual reported policy premium is used to determine the Individual Policy TOC and is subject to subsequent adjustments.

$$\text{Individual Policy TOC} = \text{Individual Reported Policy Premium} \times \text{TOC Ratio}$$

b. Total Carrier TOC is calculated by jurisdiction as follows:

$$\text{Total Carrier TOC} = \text{Sum of Individual Policy TOC}$$

c. Subsequent adjustments made to TOC (such as audit premiums, retro adjustments, etc.) are developed and reported in the calendar year in which they are made.

d. Regardless of when a policy adjustment is made by the carrier, a TOC adjustment is applied if it is related to a policy within the program length.

e. The TOC parameters used in the calculation are as follows:

TOC Parameters Table

		Individual Reported Policy Premium				
		All Policies	Less Than Experience Rating Threshold Average	Equal to or Greater Than Experience Rating Threshold Average	Less Than \$5,000	Equal to or Greater Than \$5,000
Jurisdiction	(Years) Program Length	TOC Ratio	TOC Ratio	TOC Ratio	TOC Ratio	TOC Ratio
Alabama	3	N/A	2:1	1:1	N/A	N/A
Alaska	3	N/A	N/A	N/A	2:1	1:1
Arizona	3	N/A	N/A	N/A	2:1	1:1
Arkansas	3	1.5:1	N/A	N/A	N/A	N/A
Connecticut	3	1:1	N/A	N/A	N/A	N/A

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TOC Parameters Table (Cont'd)**

		Individual Reported Policy Premium				
		All Policies	Less Than Experience Rating Threshold Average	Equal to or Greater Than Experience Rating Threshold Average	Less Than \$5,000	Equal to or Greater Than \$5,000
Jurisdiction	(Years) Program Length	TOC Ratio	TOC Ratio	TOC Ratio	TOC Ratio	TOC Ratio
District of Columbia	3	1:1	N/A	N/A	N/A	N/A
Georgia	2	Refer to State Pages				
Illinois	3	N/A	2:1	1:1	N/A	N/A
Indiana	3	1:1	N/A	N/A	N/A	N/A
Iowa	3	1:1	N/A	N/A	N/A	N/A
Kansas	3	N/A	2:1	1:1	N/A	N/A
Mississippi	3	N/A	2:1	1:1	N/A	N/A
New Hampshire	3	N/A	N/A	N/A	2:1	1:1
North Carolina	3	1:1	N/A	N/A	N/A	N/A
South Carolina	3	1:1	N/A	N/A	N/A	N/A
South Dakota	3	N/A	3:1	2:1	N/A	N/A
Tennessee	3	N/A	2:1	1:1	N/A	N/A
Vermont	3	N/A	N/A	N/A	2:1	1:1
Virginia	3	N/A	2:1	1:1	N/A	N/A
West Virginia	3	N/A	N/A	N/A	2:1	1:1

5. Carrier Submission of Request for Take-Out Credit

If a carrier wishes to have a TOC applied to its Plan participation base, it must request the TOC in accordance with the following:

- a. Carriers must enroll in the TOC Program in accordance with the enrollment procedures established by the Plan Administrator.
- b. In order to receive a TOC for the entire program length, policies of employers taken out of the residual market must be identified as voluntary and accurately reported every year to the appropriate rating/advisory/statistical organization.
- c. The Plan Administrator performs a systematic review and provides enrolled carriers with an electronic detailed report of eligible policies by program year. The report includes only voluntary market policies as reported by the enrolled carrier for employers that were previously written in the residual market.

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- d. Enrolled carriers must review and change the report (if change is necessary) to ensure that only eligible policies are included in the calculation of the TOC. The report changes must be provided in accordance with the procedures established by the Plan Administrator.
- e. Enrolled carriers must ensure that the individual reported policy premium is the amount included in the Direct Premiums Written in the Exhibit of Premiums and Losses (Statutory Page 14) of the carrier's Annual Statement for the most recent calendar year.
- f. If no changes are necessary, *refer to Rule 4-F-5-h*.
- g. Upon receipt of a modified report, the Plan Administrator reviews the submitted changes to ensure agreement. The Plan Administrator has the discretion to eliminate policies from the report that were inaccurately reported or whose changes cannot be confirmed.
- h. The enrolled carrier must review and provide final approval of the policies on the report. The approval and corresponding official request to receive a TOC must be sent electronically to the Plan Administrator for final processing.

6. Total Carrier TOC Application to Plan Participation Base

- a. A total carrier TOC will be given only to enrolled carriers that provide electronic acceptance by the authorized TOC contact as provided in accordance with the established enrollment procedures.
- b. The developed total carrier TOC is applied to the carrier's Plan participation base.
- c. There is no maximum limit on the total carrier TOC amount, but a carrier's Plan participation base will not be reduced below zero as a result of the TOC.
- d. Total carrier TOCs are applied to each individual carrier's Plan participation base, and are not rolled up to an aggregate TOC for the carrier's group.
- e. If a carrier disagrees with the final total carrier TOC, it may dispute the TOC in accordance with *Basic Manual* Rule 4-A-10-c or applicable state workers compensation insurance plan.

G. AVAILABLE COVERAGES**1. General Information**

- a. In accordance with Rule 4-A-2-x(3) or applicable state workers compensation insurance plan, additional coverage(s) may be secured, at the employer's request, on a WCIP standard workers compensation and employers liability insurance policy.
- b. Additional coverage(s) availability is subject to the assigned carrier's ability and agreement to provide the requested coverage.
- c. If federal coverage is requested and the assigned carrier is able and agrees to provide the requested federal coverage, it can only be provided as an adjunct to state act workers compensation coverage.

2. Limits of Employers Liability Insurance**a. Standard Limits of Liability**

- (1) Employers liability insurance can only be secured in the residual market in conjunction with workers compensation insurance. Employers liability insurance without workers compensation insurance is not available.
- (2) Standard limits of liability apply to employers liability insurance, as detailed in Rule 3-A-14.

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b. Increased Limits of Liability

- (1) Increased limits of liability are available under Part Two—Employers Liability of the policy. In the residual market, the standard limits may be increased up to the maximum limits provided in the following table:

Increased Limits of Liability Availability Table

Coverage	Maximum Increased Limits Available
Employers Liability Insurance	<ul style="list-style-type: none"> • \$1,000,000—Bodily Injury by Accident, Each Accident • \$1,000,000—Bodily Injury by Disease, Policy Limit • \$1,000,000—Bodily Injury by Disease, Each Employee

- (2) Increased limits, their corresponding factors, and minimum premiums are applied in accordance with Rule 3-A-14-b, Appendix C, and applicable state rules and algorithms.

c. Limits of Liability for Specific Coverages

If endorsed onto the policy, Voluntary Compensation and Employers Liability Coverage and USL&HW Act and its extensions are included in the limits of Employers Liability Insurance requested under Part Two—Employers Liability.

3. Limited Other States Insurance

Limited Other States Insurance coverage is provided under the WCIP through the Residual Market Limited Other States Insurance Endorsement. This endorsement is attached to all residual market policies.

4. Waiver of Our Right to Recover From Others (Subrogation)

- a. The Waiver of Our Right to Recover From Others Endorsement is available if required of the employer by contract. The employer must provide the portion of the contract with such requirement to the assigned carrier.
- b. Blanket waivers are **not** available in the residual market.
- c. Additional premium charged for a waiver of subrogation is applied in accordance with Rule 3-A-22.

5. Alternate Employer Endorsement

- a. The Alternate Employer Endorsement is available if required of the employer by contract and only when the state of operations of the alternate employer is listed in Item 3.A. of the policy.
- b. The Alternate Employer Endorsement is **not** available for Professional Employer Organization (PEO) and/or temporary arrangement policies.

6. Federal Coverages

a. USL&HW Act and Extensions

- (1) **USL&HW Act**

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Coverage for the United States Longshore and Harbor Workers' Compensation (USL&HW) Act is available by endorsement in the residual market written only as an adjunct to state workers compensation act coverage.

(2) USL&HW Act Extensions

Coverage for USL&HW Act's extensions are available in the residual market only when the Longshore and Harbor Workers' Compensation Act Endorsement is attached, as well as the other appropriate endorsements, and is available when written only as an adjunct to state workers compensation act coverage.

(3) Endorsements

The available endorsements are:

- Longshore and Harbor Workers' Compensation Act Coverage Endorsement
- Defense Base Act Coverage Endorsement
- Nonappropriated Fund Instrumentalities Act Coverage Endorsement
- Outer Continental Shelf Lands Act Coverage Endorsement

For more information about federal coverages, refer to *Rules 3-A-4 and 3-A-14, NCCI's Basic Manual User's Guide, and the Assigned Risk Supplement.*

b. Coverage for Maritime (Admiralty), Program I or Program II**(1) General Information**

Coverage for Maritime (Admiralty), Program I or Program II, is available by endorsement only at the standard limit of liability in accordance with Rule 3-A-14-b(4), written only as an adjunct to state workers compensation act coverage. Increased limits are not available for this coverage in the residual market.

(2) Additional Maritime (Admiralty) Options

Coverage for the following may be included at an additional charge, subject to certain requirements.

(a) Transportation, Wages, Maintenance, and Cure (TWMC)

- 1) In conjunction with Maritime coverage, the assigned carrier may provide coverage for TWMC on the Maritime Coverage Endorsement.
- 2) The TWMC premium charge for the exposure is determined by the assigned carrier based on its evaluation of the exposure presented by the risk.

(b) Voluntary Compensation Maritime Coverage

In conjunction with Maritime coverage, the assigned carrier may provide coverage for voluntary compensation maritime exposure only under Program II for masters and members of the crews of vessels and only when the Maritime Coverage Endorsement is attached.

(c) Endorsements

The available endorsements are:

- Maritime Coverage Endorsement

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- Voluntary Compensation Maritime Coverage Endorsement

c. Federal Mine Safety & Health Act

Coverage for Federal Mine Safety & Health Act is available by endorsement, written only as an adjunct to state workers compensation act coverage. For more information about how to provide this coverage, *refer to Rule 3-A-12.*

7. Coverage for Volunteer Workers

In the residual market, coverage for volunteer workers is available by endorsement when state law specifically states that such coverage is permissible. The coverage is not available if specifically prohibited by state law. *Refer to Rule 2-J and NCCI's **Assigned Risk Supplement** for more information.*

H. PRODUCER FEES**1. General Explanation and Requirements**

- a. For purposes of this rule, producer means a licensed insurance agent, broker, or insurance representative, as defined in the state insurance law, regulation, and/or rule, whose privileges under this Workers Compensation Insurance Plan (Plan) have not been suspended or revoked, designated by the employer or applicant applying under this Plan to secure and maintain workers compensation and employers liability insurance on behalf of the employer applying for coverage under this plan and not as an agent of the Plan Administrator or of any assigned carrier for Plan business. Also, for purposes of this rule:
 - (1) Producer fees may be referred to as producer fees, fees, or commissions.
 - (2) Proper producer licenses and producer licensing refer to resident or nonresident producer and/or agency licenses as applicable.
 - (3) Plan Administrator is defined in accordance with Rule 4-A-2-p or applicable state workers compensation insurance plan approved for use in a state.
 - (4) WCIP is defined in accordance with Rule 4-A-2-y or applicable state workers compensation insurance plan approved for use in a state.
 - (5) Anniversary rating date does not apply.
- b. Rule 4-A-3-l, or applicable state workers compensation insurance plan approved for use in a state, provides the authority for the fees that must be paid by an assigned carrier to a licensed agency for all new and renewal assigned risk policies for which the agency is the agency of record.
- c. Assigned carriers must have and adhere to internally documented state producer and agency licensing requirements for payment of producer fees.
- d. To be paid a fee, a producer and/or agency must be properly licensed in the state(s) for which new and/or renewal policies are issued. It is the assigned carrier's responsibility to determine whether or not the producer and/or agency is properly licensed in the appropriate jurisdictions for payment of fees. Producer fee checks are made payable to the licensed agency of record rather than to the individual licensed producer, unless they are one and the same.
- e. Only one producer and agency can be recognized by the assigned carrier at any one time for a single policy. The producer of record and agency of record are the producer and agency designated on the application unless the producer and/or agency changes during the policy period in accordance with Rule 4-H-3-a.

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- (1) Subject to Rule 4-H-2-a(4) below, when an assigned risk ACORD® 133 application is submitted to the Plan Administrator, the producer must include the proper producer license number and agency license number (resident or nonresident, depending on state law, regulation, and/or rule) in the Producer's Certification section of the application.
- (2) If the producer is **not** properly licensed (e.g., expired licenses, lack of an applicable nonresident license) the assigned carrier will accept the assignment, but the producer fee will **not** be paid to the producer listed on the application. However, for all other purposes, the unlicensed representative is treated as the producer of record.
- (3) If the employer has designated a representative (e.g., attorney) that is not a licensed producer, the assigned carrier will accept the assignment, but the producer fee will **not** be paid to the designated representative on the application. For all other purposes, the unlicensed representative is treated as the producer of record.
- (4) When the assigned carrier receives the WCIP binder package from the Plan Administrator, it must confirm proper producer and/or agency licensing in the appropriate state(s).

b. Continuing License Verification—During Policy Term and Renewals

- (1) At renewal, the assigned carrier must confirm proper producer and/or agency licensing in the appropriate states.
- (2) If, during the policy period, an assigned carrier obtains written documentation that a producer's and/or agency's license has been suspended or revoked by a particular state(s), the producer and/or agency will be terminated as the producer of record, will no longer be eligible for producer fees, and will no longer be treated as the producer of record. If the producer and/or agency appeals the suspension or revocation of their license and subsequently wins their appeal, the producer and/or agency will not be paid producer fees retroactively.
- (3) Subject to Rule 4-H-1-c, if the agency of record is still properly licensed even though the producer is not licensed, the agency will continue to be paid producer fees and will continue as the agency of record.

c. Multistate Policies

On a multistate policy, a fee is paid only in the state(s) in which the producer and/or agency is properly licensed. If a policy covers two or more states, and the producer and/or agency is properly licensed in:

- (1) Only one of the states, the fee is paid only on the premium and premium basis for the state in which the producer and/or agency is licensed.
- (2) Two or more of the states, the fee is paid on all premiums for all states in which the producer and/or agency is licensed, based on each state's premium basis in accordance with Rule 4-H-4-a, and percentage in accordance with Rule 4-H-6. A fee is not paid on any premium for a state in which a producer and/or agency is not licensed.

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3. Producer Changes

- a. A policyholder may change its producer and/or agency of record by providing written notice to the assigned carrier. Such written notice is generally, in the form of a “producer of record” letter, indicating the new producer and/or agency information and the requested effective date of the change.
- b. Such requests must be made before the renewal policy effective date or with the consent of the assigned carrier at another agreed upon time. The assigned carrier is not required to make such a change before renewal, but changes typically become effective as of the date of renewal. The policyholder must contact the assigned carrier for its requirements.

4. Premium Basis

a. General Information

Producer fees are paid in accordance with the following Premium Basis Table. Refer to the applicable state assigned risk workers compensation premium algorithm for the premium elements included in each premium basis. Premium may be adjusted due to endorsements and preliminary, interim, and final audits, which may result in an adjustment to the producer fee.

Premium Basis Table

State	Premium Basis
AL, AR, AZ, CT, DC, IA, ID, IN, KS, MS, NH, NV, OR, SC, SD, VA, VT, WV	Total Standard Premium charged and collected
AK, GA, IL, NC, <u>TN</u>	Total Annual Premium charged and collected
All states	If the minimum premium becomes the total policy premium, the producer fee is paid on the entire minimum premium

b. LSRP Policies

In states in which LSRP applies:

- (1) Producer fees are paid based on premium in accordance with Rule 4-H-4-a, **not** LSRP Standard Premium as defined in Rule 4-C-5-c(12).
- (2) Producer fees are **not** paid on the LSRP contingency deposit.
- (3) No additional producer fee is payable or return commission chargeable as a result of LSRP valuation activity.

5. Payment Information

- a. The assigned carrier pays fees in accordance with Table 1—Collected Premium and Table 2—Exceptions below:

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Table 1—Collected Premium

If premium is charged and collected from the policyholder and the . . .	Then the assigned carrier must process and mail fee payments within 30 days of the . . .
<ul style="list-style-type: none"> • Producer fee meets or exceeds \$25, or • The policy is a minimum premium policy 	<ul style="list-style-type: none"> • Date that the assigned carrier issues the policy in accordance with the applicable Performance Standard, or • Receipt of premium
<p>Producer fee is less than \$25</p>	<ul style="list-style-type: none"> • Date of reaching a cumulative total of \$25 per agency, or • Date the withholding time period exceeds six months, or • Request for payment, or • Whichever is earlier

Table 2—Exceptions

If premium is not collected and the account . . .	Then producer fees are . . .
<p>Has not yet been referred to an outside collection agency</p>	<p>Not paid on any uncollected premium until the premium is collected and the fees meet the requirements in Table 1—Collected Premium</p>
<p>Has been referred to an outside collection agency</p>	<p>Never paid on any balance that is referred to the outside collection agency, even if the balance is subsequently collected</p>

- b. Producers and/or agencies must return fees to the assigned carrier in a timely manner when return premiums are generated. The fee payment may also be applied to return fees that the producer and/or agency may owe to the carrier from other assigned risk policies for that agency. The assigned carrier may be required to report the producer and/or agency to the appropriate regulatory authority(ies) if return fees are not paid as billed by the assigned carrier.
- c. Except where allowed by state law, the producer may **not** deduct the producer fee when sending in the deposit or a payment. The assigned carrier will forward the fee as appropriate.

6. Producer Fee Tables

The fee paid by the assigned carrier for all policies must be in accordance with the Graduated Table or Graduated Interval Table.

Graduated Table

Premium Dollar Amount (\$)	Producer Fee Percentage (%)
First 1,000	8.0
Next 4,000	5.0

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Graduated Table (Cont'd)**

Premium Dollar Amount (\$)	Producer Fee Percentage (%)
Next 95,000	3.0
Over 100,000	2.0

Graduated Interval Table

Premium Interval (\$)	Producer Fee Percentage (%)	Premium Interval (\$)	Producer Fee Percentage (%)
0–1,017	8.0	6,668–7,027	4.9
1,018–1,053	7.9	7,028–7,429	4.8
1,054–1,091	7.8	7,430–7,879	4.7
1,092–1,132	7.7	7,880–8,387	4.6
1,133–1,176	7.6	8,388–8,966	4.5
1,177–1,224	7.5	8,967–9,630	4.4
1,225–1,277	7.4	9,631–10,400	4.3
1,278–1,333	7.3	10,401–11,304	4.2
1,334–1,395	7.2	11,305–12,381	4.1
1,396–1,463	7.1	12,382–13,684	4.0
1,464–1,538	7.0	13,685–15,294	3.9
1,539–1,622	6.9	15,295–17,333	3.8
1,623–1,714	6.8	17,334–20,000	3.7
1,715–1,818	6.7	20,001–23,636	3.6
1,819–1,935	6.6	23,637–28,889	3.5
1,936–2,069	6.5	28,890–37,143	3.4
2,070–2,222	6.4	37,144–52,000	3.3
2,223–2,400	6.3	52,001–86,667	3.2
2,401–2,609	6.2	86,668–107,619	3.1
2,610–2,857	6.1	107,620–118,947	3.0
2,858–3,158	6.0	118,948–132,941	2.9
3,159–3,529	5.9	132,942–150,667	2.8
3,530–4,000	5.8	150,668–173,846	2.7
4,001–4,615	5.7	173,847–205,455	2.6

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(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)
Graduated Interval Table (Cont'd)**

Premium Interval (\$)	Producer Fee Percentage (%)	Premium Interval (\$)	Producer Fee Percentage(%)
4,616–5,098	5.6	205,456–251,111	2.5
5,099–5,306	5.5	251,112–322,857	2.4
5,307–5,532	5.4	322,858–452,000	2.3
5,533–5,778	5.3	452,001–753,333	2.2
5,779–6,047	5.2	753,334–2,260,000	2.1
6,048–6,341	5.1	2,260,001 and over	2.0
6,342–6,667	5.0		

7. Producer Disputes

For information about disputes relating to the calculation and/or payment of producer fees and producer of record changes, refer to Rule 4-A-10-b(2) or the applicable state workers compensation insurance plan approved for use in a state.

I. INITIAL OR DEPOSIT PREMIUM AND PREMIUM INSTALLMENTS

1. General Information

- a. The Plan Administrator establishes the deposit premium amount in accordance with Rule 4-A-6-b or the applicable state workers compensation insurance plan.
- b. For purposes of this rule, initial or deposit premium is referred to as deposit premium.
- c. Deposit premium is the initial payment submitted by either the employer and/or its representative, as required by the Plan Administrator and/or insurance carrier, before coverage is assigned or a policy renews.
- d. Deposit premium is required to be submitted at the time of application and at policy renewal. At the time of application, failure to submit the required deposit premium in the time frame established by the Plan Administrator may prevent coverage from being bound. For more information regarding binding of coverage, refer to Rule 4-A-3-i(1) or the applicable state workers compensation insurance plan. For impact on renewal policies, refer to Rule 4-A-4-a(4) or the applicable state workers compensation insurance plan.
- e. For more information regarding the payment methods available for the total required deposit premium on application submissions, refer to Rule 4-A-2-o or the applicable state workers compensation insurance plan.
- f. Premium installments must be made in equal amounts, the sum of which, when added to the deposit premium, must equal 100% of the estimated annual premium.
- g. Estimated annual premium is developed in accordance with **Basic Manual** rules and state-specific assigned risk workers compensation premium algorithms. For more information regarding estimated annual premium, refer to Rule 3-A-9.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 1-A (CONT'D)
BASIC MANUAL—2001 EDITION****RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES****(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)****2. Minimum Premium Policies**

The deposit premium for a minimum premium policy is 100% of the estimated annual premium. A minimum premium policy must be paid in full and is not eligible for premium installment payments.

3. Short-Term Policies

At the time of application, the deposit premium for short-term policies with a duration of six months or less is 100% of the estimated premium. The estimated premium is based on the estimated payroll for the policy period, unless otherwise approved by the Plan Administrator.

For renewal policies, the required deposit premium for short-term policies with a duration of six months or less is also 100% of the estimated premium, subject to the discretion of the assigned carrier.

4. Loss Sensitive Rating Plan (LSRP) Policies

For an employer that meets the eligibility criteria for LSRP, the contingency deposit for LSRP, which is not part of the premium, must be submitted to the Plan Administrator in addition to the deposit premium. For the LSRP contingency deposit requirements, *refer to Rule 4-C-5-b(2) and Rule 4-C-6-c, where applicable.*

5. Professional Employer Organization (PEO) Arrangements

For PEO arrangements, Rule 4-I applies in addition to Rule 4-B-4-c or the applicable state PEO rules.

6. Deposit and Premium Installment Basis**a. Deposit and Premium Installment (DPI) Tables**

- (1) The DPI Tables are followed by all assigned carriers. However, the assigned carrier, based on sound underwriting practices, may make appropriate changes to the governing state's premium installment basis that the employer selected from the DPI Tables. The assigned carrier must provide the reason(s) for such change(s) to the employer and will appropriately document the file.
- (2) At policy inception, the employer may request a higher minimum deposit percentage, but may not select a deposit percentage lower than the otherwise applicable minimum stated in the DPI Tables. For each state's minimum deposit percentages, *refer to Rule 4-I-6-a(4).*
- (3) Estimated annual premium is used to determine the number of additional payments during the policy period. An employer may elect to have a different installment plan with fewer installments. However, an employer may not elect to have more installments. *Refer to NCCI's Assigned Risk Supplement (ARS) for an example.*
- (4) The premium installment basis and deposit premium is determined in accordance with DPI Tables 1 and 2.

DPI Table 1 displays jurisdictions that share the same requirements and does not include those states listed in DPI Table 2.

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**EXHIBIT 1-A (CONT'D)
BASIC MANUAL—2001 EDITION
RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES
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DPI Table 1

Jurisdictions	Estimated Annual Premium (EAP)	Premium Installment Basis	Minimum Deposit Percentage of EAP	Additional Payments During Year	Other
<ul style="list-style-type: none"> • Alabama • Connecticut 	Under \$5,000	Annual	100%	None	N/A
	At least \$5,000	Semiannual	75%	One	
	At least \$10,000	Quarterly	50%	Three	
	At least \$50,000	Monthly	25%	Nine	
<ul style="list-style-type: none"> • District of Columbia • Georgia • North Carolina • South Carolina • West Virginia 	Under \$5,000	Annual	100%	None	N/A
	At least \$5,000	Semiannual	75%	One	
	At least \$10,000	Quarterly	50%	Three	
<ul style="list-style-type: none"> • Indiana • Iowa 	Under \$2,500	Annual	100%	None	N/A
	At least \$2,500	Semiannual	75%	One	
	At least \$5,000	Quarterly	50%	Three	
	At least \$25,000	Monthly	25%	Eight	
<ul style="list-style-type: none"> • New Hampshire • Vermont 	Under \$1,000	Annual	100%	None	Service Fee: None
	At least \$1,000	Deposit + 2	50%	Two equal installments due at the beginning of months four and seven	Service Fee: \$5 each
	Above \$5,000	Deposit + 8	30%	Eight equal installments due at the beginning of months two through nine	Service Fee: \$5 each

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

**EXHIBIT 1-A (CONT'D)
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DPI Table 2 displays jurisdictions that do not share the same requirements and does not include those states listed in DPI Table 1.

DPI Table 2

Jurisdictions	Estimated Annual Premium (EAP)	Premium Installment Basis	Minimum Deposit Percentage of EAP	Additional Payments During Year	Other
Alaska	Under \$2,000	Annual	100%	None	N/A
	At least \$2,000	Deposit + 1	50%	The balance is due 90 days after policy inception.	N/A
	At least \$5,000	Deposit + 2	30%	Two installments due at the beginning of months three and six.	N/A
		Deposit + 7	30%	Seven installments due at the beginning of months two through eight.	N/A
		Deposit + 11	30%	Installments are calculated using the insured's monthly report of actual payroll to the carrier as specified in 3 AAC 30.130(2).	N/A
Arizona	Under \$2,500	Annual	100%	N/A	N/A
	At least \$2,500	Semiannual	75%		
	At least \$10,000	Quarterly	50%		
	At least \$25,000	Monthly	25%		
Arkansas	Less than \$2,500	Annual	100%	None	N/A
	At least \$2,500	Semiannual	50%	One	
	At least \$10,000	Quarterly	50%	Three	
	\$50,000 or more	Monthly	25%	Eight	

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**EXHIBIT 1-A (CONT'D)
BASIC MANUAL—2001 EDITION
RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES
(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)
DPI Table 2 (Cont'd)**

Jurisdictions	Estimated Annual Premium (EAP)	Premium Installment Basis	Minimum Deposit Percentage of EAP	Additional Payments During Year	Other
Idaho	Under \$2,000	Annual	100%	N/A	N/A
	At least \$2,000	Semiannual	75%		
	At least \$5,000	Quarterly	50%		
	At least \$25,000	Monthly	25%		
Illinois	\$1,000 or less	Annual	100%	None	N/A
	At least \$1,001	Quarterly	40%	Three	
	At least \$10,000	Monthly	25%	Eleven	
Kansas	Under \$1,001	Annual	100%	None	N/A
	At least \$1,001	Quarterly	40%	Three	
	At least \$10,000	Monthly	25%	Eight	
Mississippi	Under \$5,000	Annual	100%	None	For premium financed policies, refer to Rule 4-1-6-d.
	At least \$5,000	Semiannual	75%	One	
	At least \$10,000	Quarterly	50%	Three	
	At least \$25,000	Monthly	25%	Nine	
Nevada	Under \$1,000	Annual	100%	None	N/A
	At least \$1,000	Semiannual	65%	One	
	At least \$5,000	Quarterly	40%	Three	
	At least \$10,000	Monthly	20%	Nine	
Oregon	Under \$1,000	Annual	100%	N/A	Policies paid on an annual basis are not subject to the audit adjustment program. Refer to Rule 4-1-9.
	At least \$1,000	Semiannual	66.67%	N/A	Employers are billed according to the results of their payroll records. This program results in the billing and collection of greater than estimated annual
	At least \$7,500	Quarterly	41.67%		
	At least \$25,000	Monthly	25%		

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

**EXHIBIT 1-A (CONT'D)
BASIC MANUAL—2001 EDITION
RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES
(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)
DPI Table 2 (Cont'd)**

Jurisdictions	Estimated Annual Premium (EAP)	Premium Installment Basis	Minimum Deposit Percentage of EAP	Additional Payments During Year	Other
					premium. Refer to Rule 4-1-9.
South Dakota	Under \$1,000	Annual	100%	None	N/A
	At least \$1,000	Semiannual	50%	Two due in months four and seven	
	Above \$5,000	Monthly	30%	Eight due in months two through nine	
Tennessee	<u>\$1,000 or less</u>	<u>Annual</u>	<u>100%</u>	<u>None</u>	N/A
	<u>\$1,001–\$10,000</u>	<u>Quarterly</u>	<u>40%</u>	<u>Three</u>	
	<u>At least \$10,001</u>	<u>Monthly</u>	<u>25%</u>	<u>Ten</u>	
Virginia	Under \$5,000	The balance due must be paid within 90 days of the policy effective date	50%	One	N/A
	At least \$5,000	An additional 25% must be paid within 90 days of the effective date and the remaining 25% paid within 180 days of the effective date	50%	Two	
	At least \$10,000	Quarterly	50%	Three	N/A
	At least \$25,000	Monthly	25%	Nine	N/A

b. Premium Installment Basis

- (1) Premium installments may be on an annual, semiannual, quarterly, or monthly basis. For the appropriate state-specific premium installment basis, refer to Rule 4-1-6-a(4).
- (2) Billing statements for remaining premium installments may be issued at any time after the deposit premium is received but cannot be due any earlier than the payment due date in accordance with NCCI's **Assigned Carrier Performance Standards (ACPS)**. For more information regarding the payment due date, refer to Rule 4-1-6-b(3).
- (3) For purposes of this rule and subject to any state-specific details as shown in DPI Tables 1 and 2:

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**EXHIBIT 1-A (CONT'D)
BASIC MANUAL—2001 EDITION**

RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES

(National Rules to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)

- (a) Annual means the employer pays the total premium due prior to the policy inception date
- (b) Semiannual means the employer pays the remaining premium, due in month six
- (c) Quarterly means the employer pays the remaining premium in three equal installments, due in months three, six, and nine
- (d) Monthly means the employer pays the remaining premium in equal installments, due every month based on the policy effective date

c. Multistate Policy Premium Payment and Adjustment Basis

For multistate policies, the employer must submit the required deposit and premium installments based on the deposit premium rules for the governing state (state with the highest payroll) on the application and/or policy. The governing state minimum deposit percentage is applied to the estimated annual premium for all states combined. For more information regarding governing state, *refer to Rule 4-A-2-j or the applicable state workers compensation insurance plan.*

Refer to NCCI's ARS for an example.

7. Audits and Endorsements

The estimated annual premium is subject to adjustment at preliminary, interim, and/or final audit(s) or when an endorsement is issued. Any adjustments to the total estimated premium at any time during the policy term may impact the installment basis and deposit premium amount.

8. Dispute Resolution

For any dispute concerning a change of an employer's premium installment basis, *refer to Rule 4-A-10 or the applicable state workers compensation insurance plan.*

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**EXHIBIT 1-B
BASIC MANUAL—2001 EDITION
RULE 3—RATING DEFINITIONS AND APPLICATION OF PREMIUM ELEMENTS
A. EXPLANATION AND APPLICATION
(National Rule to Be Established in Tennessee)**

22. Waiver of Right to Recover From Others (Subrogation)

- a. The premium for this endorsement (WC 00 03 13) is based on a charge determined by the carrier from its evaluation of the exposures.
- b. In jurisdictions where NCCI is the Plan Administrator, an additional premium charge is required for the use of this endorsement (WC 00 03 13) on assigned risk policies. The additional premium charge for assigned risk policies is 5% of the manual premium developed in conjunction with the work for which that waiver is provided, subject to a \$250 minimum premium charge per waiver.
- c. The minimum premium, if applicable, for this coverage is in addition to the policy minimum premium and applies although coverage may have been added during the policy term.

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**EXHIBIT 2-A
BASIC MANUAL—2001 EDITION
TENNESSEE STATE RULE EXCEPTIONS—APPLICABLE TO ASSIGNED RISK POLICIES
ONLY
RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES**

Rule 4 does not apply in Tennessee. Please refer to AON Risk Services as the contract carrier in Tennessee for Plan rules and procedures at 800-471-6767 or visit www.twcip.com.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 2-A (CONT'D)
BASIC MANUAL—2001 EDITION
TENNESSEE STATE RULE EXCEPTIONS—APPLICABLE TO ASSIGNED RISK POLICIES
ONLY
RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES**

A. WORKERS COMPENSATION INSURANCE PLAN (WCIP)**4. Assigned Carrier****a. Responsibilities****(5) Renewal and Nonrenewal of Coverage**

Change Rule 4-A-4-a(5) as follows:

For any employer that has had a Tennessee assigned risk policy for three consecutive years, the assigned carrier must notify the employer and the Plan Administrator that the policy will not be renewed. The nonrenewal notice of impending expiration of coverage must be sent (electronically or hard copy) to the employer, its representative, and the Plan Administrator at least:

- Sixty days in advance of expiration of insurance, and will advise the employer to seek coverage, if needed, through the voluntary market, or
- Within the number of days required by state law, regulation, and/or rule if more stringent

Where the employer is unable to secure coverage through the voluntary market, the employer may reapply for coverage through the Plan in accordance with the requirements under these rules. Nothing in this paragraph will be deemed to preclude assignment of the employer to its previous assigned carrier.

Upon receipt of the required premium, the policy must be issued in accordance with the **Assigned Carrier Performance Standards**, and a copy of such policy and all endorsements, properly identified as a WCIP or AR (Assigned Risk) policy, must be reported to the Plan Administrator or its designee within the time frame and the format established by the Plan Administrator.

Except in the case of any employer that has had a Tennessee assigned risk policy for three consecutive years, if the assigned carrier is unwilling to renew a policy, it must provide the employer with a reason(s) that is acceptable to the Plan Administrator. Acceptable reasons for nonrenewal are:

- Refusal of or inability of an assigned carrier to supply a required type of coverage (e.g., USL&HW Act, Federal Mine Safety & Health Act, Maritime, additional state exposures, etc.)
- Substantial and documented reasons subject to approval by the Plan Administrator

5. Participation**a. Options****(5) Assigned Carrier Differences**

Change Direct Assignment Carrier Table in Rule 4-A-5-a(5) as follows:

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**EXHIBIT 2-A (CONT'D)
 BASIC MANUAL—2001 EDITION
 TENNESSEE STATE RULE EXCEPTIONS—APPLICABLE TO ASSIGNED RISK POLICIES ONLY
 RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES**

Direct Assignment Carrier Table

<u>Type</u>	<u>Description</u>
<u>Direct Assignment Carrier</u>	<ul style="list-style-type: none"> • <u>Not eligible for reinsurance through the reinsurance agreement among members of the National Workers Compensation Reinsurance Association</u> • <u>Solely responsible for the financial results of the assignments received</u> • <u>Financial strength and levels of performance are monitored and enforced by the regulatory authority or its designee</u> • <u>Required to meet the minimum levels of performance under the Plan in accordance with the <i>Assigned Carrier Performance Standards</i></u> • <u>Required to write assigned risk policies using filed and approved assigned risk rates, rating plans, and miscellaneous values</u> • <u>Not required to report assigned risk financial results and information to the reinsurance pooling mechanism</u> • <u>Subject to market conduct examinations by the regulatory authority and subject to carrier oversight by the Plan Administrator</u>

6. Plan Administrator

a. Designation

Change Rule 4-A-6-a as follows:

NCCI is designated as the Plan Administrator hereunder unless it resigns by giving 120 days' advance written notice to the regulatory authority or as provided by contract with the regulatory authority.

B. PROFESSIONAL EMPLOYER ORGANIZATION (PEO) ARRANGEMENTS

2. Coverage

Change Rule 4-B-2-c as follows:

- c. Additional coverages may be available, at the employer's request, through the assigned carrier. For more information, refer to Rule 4-G.

4. Multiple Coordinated Policies (MCP)

e. Application of Rating Elements

Change Rule 4-B-4-e as follows:

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EXHIBIT 2-A (CONT'D)
BASIC MANUAL—2001 EDITION
TENNESSEE STATE RULE EXCEPTIONS—APPLICABLE TO ASSIGNED RISK POLICIES ONLY
RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES

All rating elements apply individually to each client's standard policy and PEO's standard policy issued under an MCP basis. Such elements include, but are not limited to:

- Expense constant
- Premium discount
- Experience rating modification
- Drug-Free Workplace Premium Credit Program
- Tennessee Small Employer Plan
- Tennessee Special Risk Plan
- Tennessee Tabular Surcharge
- Loss Sensitive Rating Plan
- Catastrophe provisions

o. Reporting Requirements

Change Rule 4-B-4-o(1) as follows:

- (1) For the requirements and guidelines for submitting policy data to NCCI, refer to NCCI's *Policy and Proof of Coverage Guidebook* and the *WCIO Workers Compensation Data Specifications Manual*.

C. LOSS SENSITIVE RATING PLAN (LSRP)

1. Introduction to the Loss Sensitive Rating Plan

Add the following to Rule 4-C-1:

- d. LSRP does not apply to nonprofit organizations. A nonprofit organization means any corporation, trust, community chest fund or foundation that is:
- Exempt from United States federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or corresponding provisions of any subsequent federal tax laws (Code); and
 - Described in Section 170(c)(2) of the Code.

E. ASSIGNED RISK ADJUSTMENT PROGRAM (ARAP)

Change Rule 4-E as follows:

Rule 4-E does not apply in Tennessee.

H. PRODUCER FEES

6. Producer Fee Tables

Add the following to Rule 4-H-6:

In addition to the producer fee paid in accordance with the Graduated Table or Graduated Interval Table, the producer fee for policies with **occupational disease coverage** subject to the Federal Mine Safety and Health Act is a 1% flat fee applied to the total standard premium charged and collected specifically for that coverage.

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

**EXHIBIT 2-A (CONT'D)
BASIC MANUAL—2001 EDITION
TENNESSEE STATE RULE EXCEPTIONS—APPLICABLE TO ASSIGNED RISK POLICIES ONLY
RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES**

If occupational disease coverage for the Federal Mine Safety and Health Act is **not** provided on the policy, the 1% flat fee is **not applicable** even if a policy provides traumatic coverage for operations subject to the Federal Mine Safety and Health Act.

Change Graduated Table in Rule 4-H-6 as follows:

Graduated Table

Total Annual Premium Dollar Amount (\$)	Producer Fee Percentage (%)
First 1,000	8.0
Next 4,000	6.0
Next 95,000	5.0
Over 100,000	3.0

Change Graduated Interval Table in Rule 4-H-6 as follows:

Graduated Interval Table

Premium Interval (\$)	Producer Fee Percentage (%)	Premium Interval (\$)	Producer Fee Percentage (%)
0–1,025	8.0	15,556–20,000	5.4
1,026–1,081	7.9	20,001–28,000	5.3
1,082–1,142	7.8	28,001–46,666	5.2
1,143–1,212	7.7	46,667–100,975	5.1
1,213–1,290	7.6	100,976–106,153	5.0
1,291–1,379	7.5	106,154–111,891	4.9
1,380–1,481	7.4	111,892–118,285	4.8
1,482–1,600	7.3	118,286–125,454	4.7
1,601–1,739	7.2	125,455–133,548	4.6
1,740–1,904	7.1	133,549–142,758	4.5
1,905–2,105	7.0	142,759–153,333	4.4
2,106–2,352	6.9	153,334–165,600	4.3
2,353–2,666	6.8	165,601–180,000	4.2
2,667–3,076	6.7	180,001–197,142	4.1
3,077–3,636	6.6	197,143–217,894	4.0
3,637–4,444	6.5	217,895–243,529	3.9

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**EXHIBIT 2-A (CONT'D)
 BASIC MANUAL—2001 EDITION
 TENNESSEE STATE RULE EXCEPTIONS—APPLICABLE TO ASSIGNED RISK POLICIES ONLY
 RULE 4—WORKERS COMPENSATION INSURANCE PLAN RULES
 Graduated Interval Table (Cont'd)**

Premium Interval (\$)	Producer Fee Percentage (%)	Premium Interval (\$)	Producer Fee Percentage (%)
<u>4,445–5,185</u>	<u>6.4</u>	<u>243,530–276,000</u>	<u>3.8</u>
<u>5,186–5,600</u>	<u>6.3</u>	<u>276,001–318,461</u>	<u>3.7</u>
<u>5,601–6,086</u>	<u>6.2</u>	<u>318,462–376,363</u>	<u>3.6</u>
<u>6,087–6,666</u>	<u>6.1</u>	<u>376,364–460,000</u>	<u>3.5</u>
<u>6,667–7,368</u>	<u>6.0</u>	<u>460,001–591,428</u>	<u>3.4</u>
<u>7,369–8,235</u>	<u>5.9</u>	<u>591,429–828,000</u>	<u>3.3</u>
<u>8,236–9,333</u>	<u>5.8</u>	<u>828,001–1,380,000</u>	<u>3.2</u>
<u>9,334–10,769</u>	<u>5.7</u>	<u>1,380,001–4,140,000</u>	<u>3.1</u>
<u>10,770–12,727</u>	<u>5.6</u>	<u>4,140,001 and over</u>	<u>3.0</u>
<u>12,728–15,555</u>	<u>5.5</u>		

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
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**EXHIBIT 2-B
BASIC MANUAL—2001 EDITION
TENNESSEE STATE RULE EXCEPTIONS
RULE 3—RATING DEFINITIONS AND APPLICATION OF PREMIUM ELEMENTS
A. EXPLANATION AND APPLICATION**

22. Waiver of Right to Recover From Others

This rule does not apply in Tennessee. However, the nonavailability of this rule does not preclude the availability of the Waiver of Our Right to Recover From Others Endorsement (WG 00 03 13) to waive right of recovery where permitted.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 3-A
BASIC MANUAL—2001 EDITION
TENNESSEE MISCELLANEOUS RULES****DISPUTE RESOLUTION PROCESS****A. Authority, Purpose, and Scope of the Dispute Resolution Process (Process)**

Pursuant to the authority granted under Tenn. Code Ann. § 56-5-309(b), an Internal Review Panel (Panel) is hereby established to provide a mechanism by which policyholders may obtain review by the National Council on Compensation Insurance, Inc. (NCCI) of the application by an insurance carrier of NCCI classifications, manual rules, and rating plans.

- ~~1. This item replaces the "Appeals Board Objectives and Rules," approved and effective as of June 22, 1992, which are withdrawn effective upon the approval of this filing.~~
2. 1. The Panel will have authority only to hear requests by policyholders for dispute resolution services relating to experience modification factors, payroll classification code assignments, and NCCI manual rules, unless otherwise directed by the regulatory authority.
- ~~3. 2. The Panel will not have the authority to interpret, apply, or opine on state or federal laws, rules, or regulations, or decisions of courts or administrative proceedings; or to hear disputes brought by carriers.~~
4. 3. The rules of the Process apply to disputes involving policies written in both the voluntary and residual markets. However, additional rules found in NCCI's **Basic Manual** Rule 4-A apply regarding the resolution of disputes involving policies written in the residual market. Policyholders must first seek resolution of disputes with regard to policies written in the residual market through NCCI's **Basic Manual** Rule 4-A before the rules of this Process apply. The Review Panel will not have the authority to hear or to issue a decision with regard to disputes arising from a policy or policies in the Tennessee residual market. NCCI will provide assistance as reasonably as possible to the Tennessee Workers Compensation Residual Market Plan Administrator (Plan Administrator) in accordance with the procedures for dispute resolution in the Tennessee residual market as filed by the Plan Administrator and approved by the Tennessee Department of Commerce and Insurance.
- ~~5. 4. Carriers are encouraged to consult with NCCI about any question regarding the application or interpretation of NCCI's rules. If a carrier, after consulting with NCCI, wants to formally dispute any action by NCCI regarding a policy written in the voluntary market, the carrier is directed to the appropriate regulatory authority (and not the Panel). Disputes by carriers about any aspect of the Plan or Pool are governed by the rules found in NCCI's **Basic Manual** Rule 4-A.~~

B. Members of the Panel

The Panel will consist of three ~~(3)~~ employees of NCCI who will each have one vote. Each Panel member will be knowledgeable on the class codes, rules, and rating programs that are in dispute. Panel members will be appointed by NCCI. Members of the Panel are deemed not to have a conflict of interest with respect to any dispute brought before the Panel, based solely on the Panel member's affiliation with NCCI. The carrier or the employer involved in a dispute may submit a request to NCCI that a Panel member be replaced at any time prior to a review by the Panel. A Panel member will be replaced if NCCI determines, in its sole discretion, that the Panel member in question is related to any party to the dispute, or has any material interest in the outcome of any issue in dispute. The Panel is not an NCCI committee and does not report to the NCCI Board of Directors or any committee of NCCI.

C. Requesting Dispute Resolution Services

- ~~(1)~~ 1. A policyholder may obtain dispute resolution services of the Panel only after the policyholder has made a reasonable attempt to first resolve their dispute directly with the carrier.
- ~~(2)~~ 2. A policyholder may obtain dispute resolution services of the Panel by sending a written request for review to NCCI. Any request for review submitted under this ~~Dispute Resolution~~ Process must be in writing and must contain:

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- (a) a. The name, address, daytime telephone number, and (if the policyholder has one), the Federal Employer Identification Number (FEIN) of the policyholder;
- (b) b. An explanation of what the policyholder is disputing;
- (c) c. A statement of the relief sought by the policyholder;
- (d) d. A statement that the policyholder has attempted to resolve their dispute directly with the carrier, but has not been able to do so;
- (e) e. A statement that the policyholder has furnished a copy of the request for review to the carrier with which the policyholder has a dispute;
- (f) f. A statement of how the policyholder wishes to appear before the Panel (by mail, by telephone, or by video conference);
- (g) g. The signature of the policyholder; and
- (h) h. A legible copy of any relevant policy of insurance, workers compensation experience rating worksheet, or audit information and any other correspondence the policyholder has received from the carrier with regard to the matters in dispute.
- (3) 3. The policyholder may also include any other information or copies of any other documentation in support of ~~their~~ its position.
- (4) 4. This ~~Dispute Resolution~~ Process applies to any dispute arising out of a policy issued either before or after the approval of this item; however, policyholders seeking dispute resolution under this ~~Dispute Resolution~~ Process must file a request for review with NCCI within three years of the expiration date of the policy in question. Any extension of time to file a request for review will be granted at the sole discretion of NCCI, and only in the interest of fairness to the policyholder or carrier as determined by NCCI. An extension of time to file a request for review will be granted only once.
- (5) 5. Within ~~fifteen (15)~~ business days of receipt by NCCI of a request for review, NCCI will grant or deny the request and if granted, NCCI will promptly give written notice to all parties of the date, time, and manner in which the Panel will consider the dispute; otherwise, NCCI will give written notice to the policyholder and the carrier that the request for review is not granted and will state the reasons the request is not granted, and will state the deadline for filing by the policyholder of an amended request for review, if applicable.
- (6) 6. "Receipt" by NCCI means the date a document is stamped as received by NCCI's ~~Department of Regulatory Assurance~~ Department.
- (7) 7. A request for review will be denied if:
- (a) a. ~~The~~ the request for review fails to state an issue in dispute that is within the authority of the Panel to hear; or
- (b) b. ~~The~~ the request for review has been untimely submitted
and a Any denial by the Panel of a request for review under this paragraph is final, and the policyholder will not be given an opportunity to amend the request for review or resubmit it to NCCI.
- (8) 8. A request for review may be denied if the policyholder fails to provide adequate information for NCCI to evaluate the merits of the dispute. NCCI will notify the policyholder and the carrier in writing, if a request for review is denied pursuant to this paragraph, that the policyholder is allowed to file an amended request for review. The policyholder will be allowed to amend the request for review only one time. A denial pursuant to this paragraph is final and the policyholder will not be given an opportunity to amend the request for review or resubmit it to NCCI if an amended request for review is not received by NCCI within ~~ten (10)~~ business days of the date a denial pursuant to this paragraph is issued.
- (9) 9. Once a carrier is notified by NCCI that a policyholder's request for review has been granted, the carrier will have ~~fifteen (15)~~ business days to file with NCCI a written answer to the policyholder's request for

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review. The carrier is not required to file an answer; however, if the policyholder has chosen to appear before the Panel by mail, the Panel will only consider what is submitted to NCCI by the policyholder with his/her request for review; and by the carrier with its answer.

D. Appearances by Policyholder, Carrier, and Others

(+) 1. Dispute resolution services under this ~~Dispute Resolution~~ Process are meant to be informal in nature, and legal representation by either the employer or the carrier is not required. However, either the policyholder or the carrier may, at their own expense, be represented by legal counsel properly licensed to practice law in any state or the policyholder's current agent of record.

(2) 2. Policyholders must choose to appear before the Panel in one of two ways:

(a) a. In Writing—The Panel will only consider information contained in or attached to the policyholder's request for review, or provided by the carrier in writing as an answer to the policyholder's request for review. Either the policyholder or the carrier may submit statements by others for the Panel's consideration. All statements made by the policyholder or carrier or any other person must be in writing and signed by the person making the statement. No personal appearance before the Panel by either the policyholder or the carrier or by any other person will be allowed, and no oral communications by any person will be considered by the Panel in making its decisions.

(b) b. By Telephone or Video Conference—The Panel will notify the policyholder and the carrier in writing of a date, time, and telephone number through which both will appear before the Panel by telephone or video conference. The Panel, in making its decisions, will consider information contained in or attached to the policyholder's request for review, and provided in writing to the Panel by the carrier in its answer to the policyholder's request for review, and any oral testimony given at the time of the dispute resolution review. Legal counsel or the current agent of record may appear for the carrier or the employer.

The carrier will appear by the same method that is chosen by the policyholder. Each person will be responsible for their own costs associated with their participation in the dispute resolution review, except that NCCI will absorb the cost of long-distance telephone charges if the employer chooses to appear by telephone.

E. Where to Send Documents

Every request for review, answer, and every other paper submitted to NCCI under this ~~Dispute Resolution~~ Process will be mailed or delivered by hand by the person making such a filing to the following address:

~~National Council on Compensation Insurance, Inc.~~ NCCI
Regulatory Assurance Department—Internal Review Panel
901 Peninsula Corporate Circle
Boca Raton, Florida 33487-1362

That person must also provide a copy simultaneously by mail or hand delivery to all other parties to the dispute, or their legal counsel.

Facsimile transmission (faxes) of documents, and electronically transmitted documents, will not be accepted by NCCI.

F. Date and Time of Dispute Resolution Review

NCCI will set a date and time for all dispute resolution reviews and will send written notice to the policyholder and the carrier at their last address of record. No less than ~~fifteen~~ (15) business days' notice will be given

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for a review unless otherwise agreed to in writing by NCCI, the policyholder, and the carrier. The Panel will review and decide each request for review within ~~forty-five (45)~~ 30 business days of the date the request for review is accepted by NCCI as complete, unless:

- ~~(4)~~ 1. The policyholder and the carrier agree, ~~to~~ in writing, to an extension of time; or
- ~~(2)~~ 2. NCCI, in its sole discretion, determines that an inspection of the policyholder's business is necessary, in which case the Panel will conduct a dispute resolution review within ~~fifteen (15)~~ business days of the issuance by NCCI of a final inspection report.

G. Conferences Prior to Review

Mandatory Participation—At any time after a dispute has been submitted to NCCI, the Panel may direct the policyholder and the carrier to confer for the purpose of clarifying and simplifying issues, and attempting to resolve issues in dispute. Failure by a policyholder to comply with a reasonable request by NCCI to confer may result in the dismissal of the policyholder's request for review. Failure by a carrier to comply with a reasonable request by NCCI to confer may result in a decision by the Panel in favor of the policyholder.

Interstate Appeals—This section applies where the resolution of the issue(s) disputed by the policyholder affect the business operations of the policyholder in Tennessee and at least one other state. In such cases, the Panel will hold a conference with the policyholder and all carriers that could potentially be affected by the disputed issue(s) raised by the policyholder. One purpose of the conference will be to determine if the policyholder and all potentially affected carriers can agree in writing that a resolution by the Internal Review Panel of the issue(s) in dispute will apply to all business operations of the policyholder regardless of the state in which the business operations are domiciled or otherwise located. The Panel decision will be in accordance with all applicable NCCI manual rules for any state in which the decision will apply. If the policyholder and all potentially affected carriers cannot come to such a written agreement, the dispute will be heard by the Tennessee Internal Review Panel, but the Panel's decision will only apply to the employer's business operations that are domiciled or located in Tennessee.

H. Continuances

The Panel may grant a request by either the employer or the carrier for a continuance of a dispute resolution review, but only one continuance per party will be granted. Except in cases of emergency, requests for continuances must be made in writing to NCCI at least three ~~(3)~~ business days prior to the date noticed for the dispute resolution review, or the request may be denied.

I. Decision of the Panel

- ~~(4)~~ 1. Proceedings under this ~~Dispute Resolution~~ Process will not be videotaped or audio recorded in any manner by NCCI or by any person, or witness or observer. The sole record of the proceedings will be created by NCCI in the form of a Summary of Proceedings ~~attached to~~ incorporated within the Panel's decision.
- ~~(2)~~ 2. The decision of the Panel will be by majority vote of those Panel members present at the dispute resolution review, either in person or by telephone or video conference.
- ~~(3)~~ 3. The Panel will issue its decision in writing ~~within twenty (20) business days of a dispute resolution review,~~ and will issue that decision to all parties and the Tennessee Commissioner of Insurance by US Mail. The votes of the individual Panel members will not be recorded or noted in the Panel's decision or otherwise disclosed in any manner to any person. The Panel's decision will include a summary of the dispute resolution review proceedings including a copy of the policyholder's request for review, the carrier's answer, all attachments submitted with either the request for review or the answer, and a summary of any oral testimony given at the review if it was conducted via telephone or video conference. The Panel decision will state the facts in dispute (if any), the representations the Panel considered to

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be most credible, the NCCI classification code assignments, manual rules, and/or rating plans that are applicable to the dispute, and the Panel will provide a resolution to all disputed matters through the issuance of a Panel decision that will apply or interpret NCCI classification code assignments, manual rules, and/or rating plans.

J. Appeal of Panel Decisions

Either the employer or the carrier may appeal a decision of the Panel to the Tennessee Commissioner of Insurance pursuant to Tenn. Code Ann. § 56-5-309(b) by sending a written request for an appeal to:

State of Tennessee
Department of Commerce and Insurance
Actuarial Services Section
500 James Robertson Parkway, 4th Floor
Nashville, TN 37243-0574

A request for an appeal under this section must be made within ~~thirty (30)~~ days after the date of the issuance of the Panel's decision or the decision of the Panel will become final and the parties will have waived their right for further review by the Tennessee Department of Commerce and Insurance.

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**EXHIBIT 3-A (CONT'D)
BASIC MANUAL—2001 EDITION
TENNESSEE MISCELLANEOUS RULES****DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM***

The premium for a risk shall be reduced by 5% for an employer who has Employers that have certified to the Tennessee Division of Workers' Compensation (DWC) of the Tennessee Department of Labor & Workforce Development that a qualifying drug-free workplace program (DFWP) has been established will receive a premium credit of 5%.

The 5% premium credit is ~~shall be~~ applied to the employer's insured's policy pro rata as of the date of certification by the Tennessee DWC Tennessee Department of Labor, but no earlier than April 11, 1998.

The employer may obtain certification by completing and submitting a Tennessee Drug-Free Workplace Premium Credit Application (LB-0393) issued by the Tennessee DWC. The form should be mailed to the Tennessee DWC. Certification may be accomplished by completing the DFWP employer application form (LB-0393) promulgated by the Tennessee Department of Labor and filing it with the Workers' Compensation Division of the Department of Labor.

~~Anytime~~ When an employer who that is currently receiving the premium credit changes carriers for their its workers compensation coverage, a new application for certification must be resubmitted to the Tennessee DWC Tennessee Department of Labor.

~~In order to~~ To continue to receive the premium credit for each subsequent policy, the certification must be renewed annually on the policy anniversary effective date. To accomplish this, a new copy of the application form must be completed by the employer and submitted to the Tennessee DWC Department of Labor prior to before the inception of their its new or renewal workers compensation insurance policy.

~~Anytime~~ When an employer wishes wants to terminate its participation in the Tennessee Drug-Free Workplace Premium Credit Program, a new copy of the application form must be completed and mailed to the Tennessee DWC Tennessee Department of Labor.

Before granting any premium credit to an employer, an insurance carrier ~~must shall~~ obtain a true copy of the filed certification application form. Upon granting such credit to the employer, the ~~insurer carrier~~ must shall notify the Workers' Compensation Division of the Department of Labor of such action by filing the form created by the Commissioner for that purpose in a DFWP processing report to be filed with the Department. If an employer misrepresents compliance with its certified drug-free workplace program, the employer will be subject to an additional premium charge for purposes of reimbursement of the previously granted premium credit.

~~If an employer misrepresents compliance with its certified drug-free workplace program, the employer shall be subject to an additional premium for purposes of reimbursement of the previously granted premium credit.~~

The premium credit is ~~shall be~~ applied to a qualifying policy risk in a multiplicative manner to subject premium, after increased limits factors and deductible credits, if applicable, but before application of the experience modification, any other premium surcharge, premium discounts, and expense constants.

~~Standard earned premium figures reported to the National Council on Compensation Insurance, Inc. on the aggregate calls for experience (e.g., policy year, calendar/accident year, etc.) must be net of the effects of the credit (i.e., be after). The net standard premium will then be the basis of any adjustment (i.e., guaranteed cost or retro).~~

~~The d~~ Drug-free workplace premium credits must be reported in accordance with NCCI's **Statistical Plan for Workers Compensation and Employers Liability Insurance** under Statistical Code 9844 on unit statistical reports submitted to the National Council on Compensation Insurance, Inc.

* ~~Applicable under the Tennessee Workers Compensation Insurance Plan (TWGIP) effective 01/01/2009.~~

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**EXHIBIT 3-A (CONT'D)
BASIC MANUAL—2001 EDITION
TENNESSEE MISCELLANEOUS RULES**

Rules, guidelines, and application forms regarding participation and certification can be obtained by calling or writing to:

Tennessee Department of Labor & Workforce Development
Division of Workers' Compensation
Drug-Free Workplace Program
740 ~~James Robertson Parkway~~ 220 French Landing Drive
Nashville, TN 37243-~~0664~~ 1002
1-800-332-2667
www.tn.gov/labor-wfd/wcomp/dfwp.shtml

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**EXHIBIT 3-A (CONT'D)
BASIC MANUAL—2001 EDITION
TENNESSEE MISCELLANEOUS RULES****DEDUCTIBLE INSURANCE**

Each ~~carrier insurer~~ transacting or offering to transact workers compensation insurance in Tennessee may offer deductibles to employers in the voluntary market. Deductibles are not available for assigned risk policies in Tennessee. Deductible coverage is effected by attaching the Benefits Deductible Endorsement (WC 00 06 03) to the policy.

Deductibles may be available for total combined indemnity and medical benefits in the amounts of \$100, \$200, \$300, \$400, \$500, \$1,000, \$1,500, \$2,000 and \$2,500. A selected deductible ~~shall~~ applies ~~γ~~ on a per claim basis and applies ~~γ~~ to a claim's total indemnity and medical loss, excluding any adjustment expenses.

The claim ~~shall~~ must be paid by the ~~carrier insurer~~, which ~~shall~~ is then be reimbursed by the employer for any deductible amounts paid by the ~~carrier insurer~~. The employer ~~shall~~ be is liable for reimbursement up to the limit of the deductible chosen. The payment or nonpayment of deductible amounts by the ~~insured~~ employer to the ~~carrier is insurer~~ shall be treated under the policy insuring the liability for workers compensation in the same manner as payment or nonpayment of premiums.

Other deductible programs may be offered at the discretion of the individual carrier and should be filed by the carrier with the Tennessee Department of Commerce and Insurance.

A ~~n insurer shall~~ carrier is not be required to offer a deductible to an employer.

The applicable advisory loss elimination ratio (LER) represents the percentage of losses removed when an employer is responsible for losses up to the deductible amount. LERs vary by deductible amount and hazard group.

The policy premium credit is calculated using the deductible-specific LER on the Tennessee Advisory Miscellaneous Values in combination with the applicable carrier expenses. The carrier will determine the policy premium credit for the deductible amount and apply that credit to the policy manual premium, which is determined before the application of any experience or schedule rating modification, pricing programs, premium discounts, or any retrospective rating plan.

The applicable premium reduction percentage is that percentage corresponding to the appropriate hazard group and desired deductible amount. The premium reduction for deductible coverage is obtained by the application of the appropriate premium reduction percentage to the premium determined before application of any experience or schedule modification, premium surcharges, premium discounts or any retrospective rating plan.

The applicable hazard group is determined from the Table of Classifications by Hazard Group. Refer to Appendix E for the Table of Classifications by Hazard Group. The hazard group assignments are based on the classification, subject to any deductible amount, that produces the largest amount of estimated workers compensation standard premium for Tennessee.

For the applicable statistical code and reporting requirements for deductible insurance, refer to NCCI's **Statistical Plan for Workers Compensation and Employers Liability Insurance**.

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**EXHIBIT 3-A (CONT'D)
BASIC MANUAL—2001 EDITION
TENNESSEE MISCELLANEOUS RULES**

TENNESSEE WORKERS COMPENSATION PREMIUM ALGORITHM

The following algorithm provides the framework for premium charges and credits. Where not specified, the premium base would be the result from the prior line.*

	PREMIUM ELEMENTS	EXPLANATORY NOTES
	MANUAL PREMIUM	[(PAYROLL / 100) * RATE]
+	Supplementary Disease (foundry, abrasive, sandblasting)	[(SUBJECT PAYROLL / 100) * DISEASE RATE]
+	USL&H Exposure for non-F classification codes	[(SUBJECT PAYROLL / 100) * (RATE * USL&H FACTOR)]
	TOTAL MANUAL PREMIUM	
±	Waiver of Subrogation factor**	[% applied to the portion of Total Manual Premium where waiver is applicable]
+	Employers Liability (E/L) increased limits factor	[% applied to Total Manual Premium]
+	Employers Liability increased limits charge	[Balance to E/L increased limits minimum premium]
+	Employers Liability increased limits factor (Admiralty, FELA)	[Factor applied to the portion of Manual Premium where Admiralty/FELA coverage is applicable]
-	Small Deductible credit	[% applied to Total Manual Premium]
+	Employers Liability/Voluntary Compensation flat charge	[Coverage in Monopolistic State Funds]
	SUBJECT PREMIUM	
x	Drug-Free Workplace Premium factor (1 - DFW credit %)	
	TOTAL SUBJECT PREMIUM	
x	Experience Modification (Exp Mod)	
	TOTAL MODIFIED PREMIUM	
x	Schedule Rating factor (1 - SR credit %) or (1 + SR debit %)	
+	Supplemental Disease Exposure (Asbestos, ^{NOC} †)	
+	Atomic Energy Radiation Exposure ^{NOC} †	
+	Charge for nonratable catastrophe loading †	
+	Balance to Minimum Premium (State Act)	[Balance to minimum premium at Standard Limits]
+	Balance to Minimum Premium (Admiralty, FELA)	
	TOTAL STANDARD PREMIUM	
-	Premium Discount [§]	[% of Standard Premium]
+	Coal Mine Disease Charge	[Underground, surface, surface auger]
+	Expense Constant	
+	Terrorism	[(PAYROLL / 100) * TERRORISM VALUE]
+	Catastrophe (other than Certified Acts of Terrorism)	[(PAYROLL / 100) * CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) VALUE]
	ESTIMATED ANNUAL PREMIUM	

* The above rating method would be used in absence of independent carrier filings.

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**EXHIBIT 3-A (CONT'D)
BASIC MANUAL—2001 EDITION
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**** Premium charges established for Waiver of Subrogation are not filed by NCCI for the voluntary market.**

NOC = Not Otherwise Classified.

† Nonratable Element Premiums generated by nonratable portion of manual rate are subject to all applicable premium elements applied to the policy, however, not subject to experience rating or retrospective rating.

§ For policies subject to premium adjustments under a retrospective rating plan, premium discount does not apply.

Note: For short rate cancellations, short rate percentage/short rate penalty premium factor is subject to experience rating, included in Total Subject Premium, and applied prior to Experience Modification.

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**EXHIBIT 3-B
BASIC MANUAL—2001 EDITION
TENNESSEE MISCELLANEOUS RULES—APPLICABLE TO ASSIGNED RISK POLICIES ONLY
TENNESSEE SMALL EMPLOYER PLAN**

A. Definition

A “small employer” is an employer that is insured in the Tennessee Workers Compensation Insurance Plan (WCIP) that is not eligible for an experience rating modification as of the policy effective date.

B. Requirements

To qualify for a premium credit under the Tennessee Small Employer Plan, the policy must be written for a full, one-year continuous policy term and the small employer must:

- Have no losses for the entire policy term;
- Be in compliance with all premium auditing requirements; and
- Not have any unpaid premium, unless there is a formal written dispute on file with the Plan Administrator specifically related to the unpaid premium.

C. Credit

The premium credit is 10%, subject to a maximum amount of \$900.

D. Application

The premium credit is applied at final audit in a multiplicative manner to the Tennessee total modified premium. The application of this premium credit must not reduce the premium below the policy minimum premium. The premium credit is not applicable to a Tennessee minimum premium policy.

E. Endorsement

The Tennessee Small Employer Plan Endorsement (WC 41 04 05) must be attached to all policies considered to be in the Tennessee Small Employer Plan.

F. Reporting of Credits

Premium credits must be reported in accordance with NCCI's ***Statistical Plan for Workers Compensation and Employers Liability Insurance***.

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**EXHIBIT 3-B (CONT'D)
BASIC MANUAL—2001 EDITION**

TENNESSEE MISCELLANEOUS RULES—APPLICABLE TO ASSIGNED RISK POLICIES ONLY

TENNESSEE SPECIAL RISK PLAN

A. Definition

A "special risk" is an employer that is insured in the Tennessee Workers Compensation Insurance Plan (WCIP) that has a current experience rating modification of 1.10 or less as of the policy effective date.

B. Requirements

To qualify for a premium credit under the Tennessee Special Risk Plan, the policy must be written for a full, one-year continuous policy term and the special risk must:

- Have no losses for the entire policy term;
- Be in compliance with all premium auditing requirements; and
- Not have any unpaid premium, unless there is a formal written dispute on file with the Plan Administrator specifically related to the unpaid premium.

C. Credit

The premium credit is 5%.

D. Application

The premium credit is applied at final audit in a multiplicative manner to the Tennessee total modified premium. The application of this premium credit must not reduce the premium below the policy minimum premium. The premium credit is not applicable to a Tennessee minimum premium policy.

E. Endorsement

The Tennessee Special Risk Plan Endorsement (WC 41 04 06) must be attached to all policies considered to be in the Tennessee Special Risk Plan.

F. Reporting of Credits

Premium credits must be reported in accordance with NCCI's ***Statistical Plan for Workers Compensation and Employers Liability Insurance***.

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

**EXHIBIT 3-B (CONT'D)
BASIC MANUAL—2001 EDITION**

TENNESSEE MISCELLANEOUS RULE—APPLICABLE TO ASSIGNED RISK POLICIES ONLY

TENNESSEE TABULAR SURCHARGE

A Tennessee Tabular Surcharge is applicable to any employer insured in the Tennessee Workers Compensation Insurance Plan (WCIP) that has a current experience rating modification of 1.11 or higher as of the policy effective date. The Tennessee Tabular Surcharge is applied in a multiplicative manner to the Tennessee total modified premium. The Tennessee Tabular Surcharge percentages are:

<u>Experience Rating Modification Range</u>	<u>Tennessee Tabular Surcharge</u>
<u>1.11 to 1.15</u>	<u>5%</u>
<u>1.16 to 1.20</u>	<u>10%</u>
<u>1.21 to 1.25</u>	<u>13%</u>
<u>1.26 and over</u>	<u>15%</u>

The Tennessee Tabular Surcharge Endorsement (WC 41 04 07) must be attached to all policies receiving this surcharge.

Premium surcharges must be reported in accordance with NCCI's **Statistical Plan for Workers Compensation and Employers Liability Insurance.**

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**EXHIBIT 3-B (CONT'D)
BASIC MANUAL—2001 EDITION**

TENNESSEE MISCELLANEOUS RULES—APPLICABLE TO ASSIGNED RISK POLICIES ONLY

TENNESSEE ASSIGNED RISK WORKERS COMPENSATION PREMIUM ALGORITHM

The following algorithm provides the framework for premium charges and credits. Where not specified, the premium base would be the result from the prior line.

PREMIUM ELEMENTS	EXPLANATORY NOTES
<u>MANUAL PREMIUM</u>	[(PAYROLL / 100) * RATE]
+ Supplementary Disease (foundry, abrasive, sandblasting)	[(SUBJECT PAYROLL / 100) * DISEASE RATE]
+ USL&H Exposure for non-F classification codes	[(SUBJECT PAYROLL / 100) * (RATE * USL&H FACTOR)]
<u>TOTAL MANUAL PREMIUM</u>	
+ Waiver of Subrogation factor	[% applied to the portion of Total Manual Premium where waiver is applicable, subject to a minimum charge]
+ Employers Liability (E/L) increased limits factor	[% applied to Total Manual Premium]
+ Employers Liability increased limits charge	[Balance to E/L increased limits Minimum Premium]
+ Employers Liability increased limits factor (Admiralty)	[Factor applied to the portion of Manual Premium where Admiralty coverage is applicable]
<u>SUBJECT PREMIUM</u>	
x Drug-Free Workplace Premium factor (1 – DFW credit %)	[% applied to Subject Premium]
<u>TOTAL SUBJECT PREMIUM</u>	
x Experience Modification (Exp Mod)	
<u>TOTAL MODIFIED PREMIUM</u>	
x Tennessee Small Employer Plan (1 – credit %)	[% applied to Total Modified Premium if nonrated risk; subject to a maximum amount of \$900]
x Tennessee Special Risk Plan (1 – credit %)	[% applied to Total Modified Premium if Exp Mod is 1.10 or less]
x Tennessee Tabular Surcharge (1 + surcharge %)	[% applied to Total Modified Premium if Exp Mod is 1.11 or higher]
+ Supplemental Disease Exposure (Asbestos ^{NOC†})	
+ Atomic Energy Radiation Exposure ^{NOC†}	
+ Charge for nonratable catastrophe loading [†]	
+ Balance to Minimum Premium (State Act)	[Balance to Minimum Premium at Standard Limits]
+ Balance to Minimum Premium (Admiralty)	[Balance to Minimum Premium at Admiralty Standard Limits]
<u>TOTAL STANDARD PREMIUM</u>	
- Premium Discount	[% applied to Standard Premium > \$5,000]
+ Coal Mine Disease Charge	[Underground, surface, surface auger]
+ Expense Constant	
+ Terrorism	[(PAYROLL / 100) * TERRORISM VALUE]
+ Catastrophe (other than Certified Acts of Terrorism)	[(PAYROLL / 100) * CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) VALUE]
<u>ESTIMATED ANNUAL PREMIUM</u>	

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 3-B (CONT'D)
BASIC MANUAL—2001 EDITION**

TENNESSEE MISCELLANEOUS RULES—APPLICABLE TO ASSIGNED RISK POLICIES ONLY

^{NOC} = Not Otherwise Classified.

† Nonratable Element Premiums generated by nonratable portion of manual rate are subject to all applicable premium elements applied to the policy; however, they are not subject to experience rating or NCCI's Loss Sensitive Rating Plan.

Note: For short rate cancellations, short rate percentage/short rate penalty premium factor is subject to experience rating, included in Total Subject Premium, and applied prior to Experience Modification.

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

EXHIBIT 3-B (CONT'D)

BASIC MANUAL—2001 EDITION

TENNESSEE MISCELLANEOUS VALUES

APPLICABLE TO ASSIGNED RISK POLICIES ONLY

Loss Sensitive Rating Plan (LSRP)—The factors which are used in the calculation of the LSRP are as follows:

<u>Basic Premium Factor</u>	<u>0.40</u>
<u>Minimum Premium Factor</u>	<u>0.75</u>
<u>Maximum Premium Factor</u>	<u>1.75</u>
<u>Loss Conversion Factor</u>	<u>1.201</u>
<u>Tax Multiplier</u>	<u>1.046</u>

<u>Loss Development Factors</u>	
<u>1st Adjustment</u>	<u>0.19</u>
<u>2nd Adjustment</u>	<u>0.16</u>
<u>3rd Adjustment</u>	<u>0.14</u>
<u>4th Adjustment</u>	<u>0.11</u>

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

EXHIBIT 4
 STATISTICAL PLAN—2008 EDITION
 PART 6—CODING VALUES
 H. STATISTICAL CODES

1. PREMIUM AMOUNT *SUBJECT* TO EXPERIENCE MODIFICATION FACTOR

Premium Amount *Subject* to Experience Modification Factor

Description	Stat Code	Premium Credit (-) or Debit (+)	Applicable States	Effective Date	Discontinuation Date
Deductible Reporting—Subject to Experience Modification Factor	9664	-	All States Except NV, TN, TX, VA, and WV	01/96	
			TN	01/96 <u>Voluntary</u>	
				01/96 <u>Assigned Risk</u>	06/30/15 <u>Assigned Risk</u>
Increased Limits for Admiralty or FELA Risks (in 000s)—\$50,000	9817	+	TN	04/84 <u>Voluntary</u>	
				04/84 <u>Assigned Risk</u>	06/30/15 <u>Assigned Risk</u>
Increased Limits for Admiralty or FELA Risks (in 000s)— \$200,000 \$300,000 \$400,000 \$500,000 Over \$500,000	9819	+	TN	04/84 <u>Voluntary</u>	
	9820			04/84 <u>Assigned Risk</u>	06/30/15 <u>Assigned Risk</u>
	9821				
	9822				
	9840				
Increased Limits With Workers Compensation Coverage (in 000s)— \$1,000/1,000/2,500 \$1,000/1,000/5,000 \$1,000/1,000/10,000 Over \$1,000/1,000/10,000	9813	+	TN	04/84 <u>Voluntary</u>	
	9814			04/84 <u>Assigned Risk</u>	06/30/15 <u>Assigned Risk</u>
	9815				
	9816				

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

EXHIBIT 4 (CONT'D)
 STATISTICAL PLAN—2008 EDITION
 PART 6—CODING VALUES
 H. STATISTICAL CODES

Premium Amount *Subject* to Experience Modification Factor (Cont'd)

Description	Stat Code	Premium Credit (-) or Debit (+)	Applicable States	Effective Date	Discontinuation Date
Increased Limits Without Workers Compensation Coverage (in 000s)— \$100/100/1,000 \$100/100/2,500 \$100/100/5,000 \$100/100/10,000 \$500/500/500 \$500/500/1,000 \$500/500/2,500 \$500/500/5,000 \$500/500/10,000 \$1,000/1,000/1,000 \$1,000/1,000/2,500 \$1,000/1,000/5,000 \$1,000/1,000/10,000 Over \$1,000/1,000/10,000		+	TN	04/84 <u>Voluntary</u>	
	9823			04/84 <u>Assigned Risk</u>	06/30/15 <u>Assigned Risk</u>
	9824				
	9825				
	9826				
	9827				
	9828				
	9829				
	9830				
	9831				
	9832				
	9833				
	9834				
	9835				
	9836				
Increased Limits—All Other Limits of Liability	9837	+	TN	04/79 <u>Voluntary</u>	
				04/79 <u>Assigned Risk</u>	06/30/15 <u>Assigned Risk</u>
Waiver of Subrogation	0930	+	TN	07/01/15 <u>Voluntary</u> ⁶	
				07/01/15 <u>Assigned Risk</u>	

⁶ TN—Available for use in Tennessee when the Waiver of Subrogation charge has been filed by the carrier and approved by the Tennessee Department of Insurance.

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

EXHIBIT 4 (CONT'D)
 STATISTICAL PLAN—2008 EDITION
 PART 6—CODING VALUES
 H. STATISTICAL CODES

2. PREMIUM AMOUNT *NOT SUBJECT* TO EXPERIENCE MODIFICATION FACTOR

Premium Amount *Not Subject* to Experience Modification Factor

Description	Stat Code	Premium Credit (-) or Debit (+)	Applicable States	Effective Date	Discontinuation Date
Deductible Reporting—Not Subject to Experience Modification Factor	9663	-	All States Except NV, <u>TN</u> , TX, and WV	01/96	
			TN	01/96 <u>Voluntary</u>	
				01/96 <u>Assigned Risk</u>	06/30/15 <u>Assigned Risk</u>

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

**EXHIBIT 4 (CONT'D)
 STATISTICAL PLAN—2008 EDITION
 PART 6—CODING VALUES
 H. STATISTICAL CODES**

3. PREMIUM AMOUNT *NOT* PART OF STANDARD PREMIUM

Premium Amount *Not Part* of Standard Premium

Description	Stat Code	Premium Credit (-) or Debit (+)	Applicable States	Effective Date	Discontinuation Date
Cost Reduction Seminar Incentive Plan	9769	–	TN	01/01/07 Assigned Risk	06/30/15 <u>Assigned Risk</u>
Deductible Reporting—Not Part of Standard Premium	9657	–	All States Except OR, SC, TN, TX, VA, and WV	09/01/08	
			TN	09/01/08 <u>Voluntary</u>	

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-A
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
PROFESSIONAL EMPLOYER ORGANIZATION (PEO) EXTENSION ENDORSEMENT (WC
00 03 20 B)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk
Policies Only)****PROFESSIONAL EMPLOYER ORGANIZATION (PEO) EXTENSION ENDORSEMENT (WC 00 03 20 B)**

This endorsement applies only with respect to bodily injury to your leased workers in the state named in Item 2 of the Schedule when provided by a PEO named in Item 1 of the Schedule. This endorsement does not apply with respect to bodily injury to workers provided to you on a temporary basis.

Certain words and phrases in this endorsement are defined as follows:

Professional Employer Organization (PEO) is an entity or group of entities who are or were formally related by common management or ownership that provides workers to its client(s) through a PEO arrangement for a fee, pursuant to an agreement, written or otherwise. Without limitation, a PEO may also be referred to as a labor contractor, employee leasing company, lessor, or other similarly administered arrangement.

Client is an entity that obtains all or part of its workforce for a fee, pursuant to an agreement, written or otherwise, from another entity through a professional employer organization (PEO) arrangement or that employs the services of an entity through a PEO arrangement. Without limitation, a client may also be referred to as a lessee.

Temporary worker is a worker who is furnished to an entity for a finite period of time, including but not limited to one or more of the following work situations:

- Replace an absent worker who will return, such as during an authorized leave of absence, vacation, jury duty, or illness
- Fill a short-term or temporary professional skill shortage
- Staff a seasonal workload
- Staff a special assignment or project where the worker will be terminated or assigned to another temporary project upon completion
- Satisfy the requirements of the employer's overall employment program, such as a probationary period before new workers are granted permanent employee status

Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) of your policy will apply as though the PEO is an insured. If an entry is shown in Item 3 of the Schedule, the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

Under Part One we will reimburse the PEO named in the Schedule for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the PEO's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the labor contractor PEO with any governmental or regulatory agency.

We will not ask any other insurer of the PEO to share with us a loss covered by this endorsement.

Premium will be charged for your leased workers while provided by the PEO. You must obtain from the labor contractor PEO and furnish to us a complete payroll record of your leased workers provided by the PEO to satisfy your obligations under Part Five (Premium), C.2. You are jointly liable with the PEO for the contributions, premiums, forfeits, or interest attributable to the wages of the workers leased to you by the PEO.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
PROFESSIONAL EMPLOYER ORGANIZATION (PEO) EXTENSION ENDORSEMENT (WC
00 03 20 B)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk
Policies Only)**

The policy may be cancelled according to its terms or for violation of rules applicable to PEO arrangements, provided that the PEO has been provided a reasonable opportunity to cure the violation. If the policy is cancelled, we will send notice of such cancellation to the PEO and provide you with a notice regarding the status of your coverage.

Part Four (Your Duties If Injury Occurs) applies to you and the PEO. The PEO will recognize our right to defend under Parts One and Two and our right to inspect under Part Six (Conditions).

Schedule

- | | PEO | Address |
|----|-----------------------------------|----------------|
| 1. | | |
| 2. | State Where Work Performed | |
| 3. | Contract or Project | |

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
PROFESSIONAL EMPLOYER ORGANIZATION (PEO) EXCLUSION ENDORSEMENT (WC
00 03 21 A)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk
Policies Only)**

PROFESSIONAL EMPLOYER ORGANIZATION (PEO) EXCLUSION ENDORSEMENT (WC 00 03 21 A)

As used in this endorsement, a PEO arrangement is an arrangement under contract or agreement, written or otherwise, whereby one entity obtains or leases any or all of its workers from another entity for a fee or other compensation. The third party providing PEO services will be referred to as a "PEO." The entity receiving the services will be referred to as a "client."

This endorsement is used to exclude workers you lease to specified clients from your policy, which only covers your direct (non-leased) workers. Your policy, to which this endorsement is attached, does not provide coverage for workers you lease to any clients listed below or others added subsequent to policy issuance even if not endorsed on the policy. Any changes to such information must be reported to the carrier immediately.

Schedule

Client

Address

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
PROFESSIONAL EMPLOYER ORGANIZATION (PEO) CLIENT EXCLUSION ENDORSEMENT
(WC 00 03 22 A)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk
Policies Only)**

**PROFESSIONAL EMPLOYER ORGANIZATION (PEO) CLIENT EXCLUSION ENDORSEMENT (WC
00 03 22 A)**

As used in this endorsement, a PEO arrangement is any arrangement under contract or agreement, written or otherwise, whereby one entity obtains or leases any or all of its workers from another entity for a fee or other compensation. The third party providing PEO services will be referred to as a "PEO." The entity receiving the services will be referred to as a "client."

This endorsement is used to exclude leased workers from your policy, which only covers your direct (non-leased) workers. Your policy, to which this endorsement is attached, does not provide coverage for workers you lease from any PEO(s) listed below or others added subsequent to policy issuance even if not endorsed on the policy. Any changes to such information must be reported to the carrier immediately.

Schedule

PEO

Address

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
MULTIPLE COORDINATED POLICY ENDORSEMENT (WC 00 03 23 A)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk
Policies Only)**

MULTIPLE COORDINATED POLICY ENDORSEMENT (WC 00 03 23 A)

Your policy, to which this endorsement is attached, provides coverage for the workers you lease from the professional employer organization (PEO) and in the state listed below on a multiple coordinated policy basis. Your policy does not provide coverage for any other workers, leased or non-leased.

Schedule

- | | Address |
|--------------------------------------|----------------|
| 1. PEO | |
| 2. State Where Work Performed | |
| 3. Contract or Project | |
| 4. PEO Policy Number | |

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
RESIDUAL MARKET LIMITED OTHER STATES INSURANCE ENDORSEMENT (WC 00 03 26 A)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk
Policies Only)**

RESIDUAL MARKET LIMITED OTHER STATES INSURANCE ENDORSEMENT (WC 00 03 26 A)

“Part Three—Other States Insurance” of the policy is replaced by the following:

PART THREE OTHER STATES INSURANCE

A. How This Insurance Applies

1. We will pay promptly when due the benefits required of you by the workers compensation law of any state not listed in Item 3.A. of the Information Page if all of the following conditions are met:
 - a. The employee claiming benefits was either hired under a contract of employment made in a state listed in Item 3.A. of the Information Page or was, at the time of injury, principally employed in a state listed in Item 3.A. of the Information Page; and
 - b. The employee claiming benefits is not claiming benefits in a state where, at the time of injury, (i) you have other workers compensation insurance coverage, or (ii) you were, by virtue of the nature of your operations in that state, required by that state's law to have obtained separate workers compensation insurance coverage, or (iii) you are an authorized self-insurer or participant in a self-insured group plan; and
 - c. The duration of the work being performed by the employee claiming benefits in the state for which that employee is claiming benefits is temporary.
2. If we are not permitted to pay the benefits directly to persons entitled to them and all of the above conditions are met, we will reimburse you for the benefits required to be paid.
3. This insurance does not apply to fines or penalties arising out of your failure to comply with the requirements of the workers compensation law.

IMPORTANT NOTICE !

If you hire any employees outside those states listed in Item 3.A. on the Information Page or begin operations in any such state, you should do whatever may be required under that state's law, as this endorsement does not satisfy the requirements of that state's workers compensation law.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
ASSIGNED RISK LOSS SENSITIVE RATING PLAN NOTIFICATION ENDORSEMENT (WC
00 04 17 B)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk
Policies Only)****ASSIGNED RISK LOSS SENSITIVE RATING PLAN NOTIFICATION ENDORSEMENT (WC 00 04 17 B)****A. LSRP Mandatory Assigned Risk Retrospective Rating Plan**

This endorsement is to advise you that, during the term of this policy or upon renewal, you may become subject to the mandatory assigned risk Loss Sensitive Rating Plan (LSRP), which is a retrospective rating plan that may adjust the cost of your workers compensation and employers liability insurance policy. This endorsement must be attached to all assigned risk policies, including policies for professional employer organization (PEO) and temporary arrangements, regardless of LSRP standard premium size in states that have approved the LSRP. In the event that you meet or exceed the eligibility requirements of LSRP, an LSRP contingent deposit equal to 20% of LSRP standard premium is required.

B. Eligibility

1. Your insurance is written under a Workers Compensation Insurance Plan (WCIP) in a state that has approved LSRP.
2.
 - a. LSRP will apply to an individual assigned risk policy if the standard premium meets or exceeds the amount noted in the Schedule, in accordance with NCCI's *Basic Manual*.
 - b. It may not always be possible for a single carrier to provide coverage for all requested states; additional policies issued by more than one carrier may be necessary.
 - c. WCIP policies issued in non-LSRP-approved jurisdictions are not subject to LSRP and are not combinable with WCIP policies in LSRP-approved jurisdictions for eligibility purposes.
 - d. LSRP eligibility may be impacted by ownership or combinability status in accordance with NCCI's *Experience Rating Plan Manual*.
3. LSRP standard premium is defined in accordance with NCCI's *Basic Manual*.

C. Deposit/Initial Premium and LSRP Contingency Deposit

1. Deposit or initial premium is paid on all new and renewal WCIP policies, including LSRP policies, in accordance with NCCI's *Basic Manual*. It is paid to us in addition to the LSRP contingency deposit, which secures all new and renewal LSRP policies as detailed in the LSRP rules.
2. The LSRP contingency deposit paid to us serves as collateral for premium that may be due to us as a result of losses incurred during the policy term.
3. At policy inception, the LSRP contingency deposit is calculated by multiplying the LSRP standard premium by 20%. If WCIP policies are combined for LSRP purposes, the LSRP contingency deposit is calculated by multiplying the combined LSRP standard premium for all policies by 20%.

D. Impact of Changes in LSRP Standard Premium

1. For all policies except for professional employer organizations (PEOs) and temporary arrangements, LSRP may be applied to a policy, or an LSRP policy may be converted to a guaranteed cost policy:
 - a. If the LSRP standard premium decreases during the first 120 days, and falls below the LSRP eligibility threshold, your policy will be converted to a guaranteed cost policy, retroactive to policy inception, and your LSRP contingency deposit will be returned.

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

EXHIBIT 5-A (CONT'D)

FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE ASSIGNED RISK LOSS SENSITIVE RATING PLAN NOTIFICATION ENDORSEMENT (WC 00 04 17 B)

(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)

- b. If the LSRP standard premium increases during the first 120 days, and meets the LSRP eligibility threshold, LSRP will be applied retroactively to policy inception and the 20% LSRP contingency deposit must be paid to us within 30 days of us issuing notice to you of the application of LSRP.
 - c. If the LSRP standard premium decreases after the first 120 days and falls below the LSRP eligibility threshold, the LSRP continues to be applied to your policy(ies).
 - d. If the LSRP standard premium increases after the first 120 days, and meets the LSRP eligibility threshold, your policy(ies) will remain a guaranteed cost policy(ies) and the LSRP is applied at renewal, subject to meeting the eligibility requirements on the renewal policy(ies).
2. For all PEO and temporary arrangement WCIP policies, if the LSRP standard premium meets or exceeds the eligibility threshold **at any time**, LSRP is applied retroactively to policy inception. The 20% LSRP contingency deposit must be paid to us within 30 days of us issuing notice to you of the application of LSRP.

E. Evasion of LSRP

1. If you take actions for the purpose of avoiding the application of LSRP, or for otherwise legitimate business reasons that nonetheless result in the improper calculation and/or application of LSRP, regardless of intent, any action that results in the miscalculation and/or misapplication of LSRP determined in accordance with the LSRP rules is prohibited. These actions include, but are not limited to:
- Misrepresentation and/or miscalculation of payroll at application, audit, or renewal
 - Failure to report changes in ownership or ownership information according to the WCIP and NCCI's *Experience Rating Plan Manual*
 - Violation of any of the terms and conditions under the policy for which this insurance was issued
 - Failure to allow us and/or the Plan Administrator and/or rating organization reasonable access to your facilities or files and records for audit or inspection
 - Failure to disclose to us and/or the Plan Administrator and/or rating organization the full nature and scope of your exposure or business operations
2. In such circumstances, we and/or the Plan Administrator and/or rating organization may obtain any information that indicates evasion or improper calculation or application of LSRP due to actions including, but not limited to, those listed above. We and/or the Plan Administrator and/or rating organization will act to ensure the proper calculation and application of LSRP to inception of all current and preceding WCIP policies impacted by these actions.

This endorsement applies in the states listed in the Schedule below.

Schedule

State

Premium Eligibility

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
ASSIGNED RISK LOSS SENSITIVE RATING PLAN ENDORSEMENT (WC 00 04 18 F)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)**

ASSIGNED RISK LOSS SENSITIVE RATING PLAN ENDORSEMENT (WC 00 04 18 F)

This endorsement amends and is added to Part Five (Premium) of your Policy to explain how the mandatory assigned risk Loss Sensitive Rating Plan (LSRP) (additional/return) premium is determined.

This endorsement applies in states where the LSRP has been approved. This endorsement is attached to all assigned risk policies, including professional employer organization (PEO) and temporary arrangements that meet or exceed the LSRP eligibility requirements. A 20% LSRP contingency deposit is required.

A. LSRP Premium Elements

LSRP uses specific elements to determine premium. The elements are listed below and are determined in accordance with *Basic Manual* Rule 4-C and applicable state rating values.

1. **LSRP Standard Premium**
2. **Basic Premium Factor**
3. **Loss Conversion Factor**
4. **Converted Losses**
5. **Incurred Losses**
6. **Loss Development Factor**
7. **Maximum Premium Factor**
8. **Minimum Premium Factor**
9. **Tax Multiplier**

B. LSRP Formula

1. Calculating LSRP (Additional/Return) Premium Under This Plan

The first LSRP valuation to determine the (additional/return) premium is to be calculated as soon as practical based on losses valued six months after the WCIP policy(ies) expiration. The data used in the LSRP calculation must be the same data that is reported under the rules of the applicable statistical plan. In accordance with Section C-7 of this endorsement and *Basic Manual* Rule 4-C, in certain cases, we may perform an early calculation of LSRP premium.

2. LSRP Formula

The LSRP formula is designed to allow for premium that is not less than the LSRP minimum premium or more than the LSRP maximum premium in accordance with *Basic Manual* Rule 4-C. The formula is:

$$LSRP \text{ (Additional/Return) Premium} = \{[(SP \times BPF) + (ICL \times LCF) + (SP \times LDF \times LCF)] \times TM\} - SP$$

Where ...	Equals ...
SP	LSRP Standard Premium
BPF	Basic Premium Factor
ICL	Incurred Losses

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
ASSIGNED RISK LOSS SENSITIVE RATING PLAN ENDORSEMENT (WC 00 04 18 F)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)**

Where ...	Equals ...
LCF	Loss Conversion Factor
LDF	Loss Development Factor
TM	Tax Multiplier

3. LSRP Minimum and Maximum Premium

You will not pay less than the LSRP minimum premium or more than the LSRP maximum premium. The LSRP minimum premium is determined by multiplying the LSRP standard premium by the applicable minimum premium factor. The LSRP maximum premium is determined by multiplying LSRP standard premium by the applicable maximum premium factor. The minimum premium factor and the maximum premium factor are shown in the Schedule. If this policy is combinable with another LSRP policy, the LSRP minimum and maximum premiums are based on the combined LSRP standard premium for all combinable policies.

C. Premium Calculation and Payments

1. You will pay a premium in accordance with the approved Workers Compensation Insurance Plan (WCIP) rules, rates, and rating values.
2. You will pay an LSRP contingency deposit that will equal 20% of the LSRP standard premium.
3. Your LSRP (additional/return) premium is determined after the policy period ends.
4. The first valuation of LSRP premium is determined using all loss information valued as of six months after policy expiration or as soon as practical. Three additional annual premium adjustment calculations shall be made based on losses valued at 30, 42, and 54 months after the month in which the policy became effective.
5. We must value the policy annually after the first valuation and subsequent valuations as needed (up to four valuations). We will not need to do subsequent valuations if there are no open losses.
6. If we are notified that the employer has declared bankruptcy, we must file for Proof of Claim.
7. We may make a special adjustment for the purpose of calculating LSRP premium to determine if additional or return premium is due when the policy is cancelled and/or you:
 - Are in noncompliance with policy terms and conditions
 - Have declared bankruptcy
 - Have defaulted on your premium
 - Are involved in any liquidation, reorganization, or receivership
 - Disposed of all, or substantially all, of your assets

You or the bankruptcy estate, if applicable, is responsible for any additional premium due as a result of any special valuations or other applicable remaining valuations.

8. After each valuation, you will pay to us the amount due within 30 days. If you fail to pay all LSRP premium due, your current policy will be cancelled in accordance with the WCIP rules, state law, or NCCI's **Assigned Carrier Performance Standards**, whichever is more restrictive. You will no longer be in good faith eligible for coverage under the applicable WCIP.

D. Evasion of LSRP

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
ASSIGNED RISK LOSS SENSITIVE RATING PLAN ENDORSEMENT (WC 00 04 18 F)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)**

1. If you take actions for the purpose of avoiding the application of LSRP, or for otherwise legitimate business reasons that nonetheless result in the improper calculation and/or application of LSRP, regardless of intent, any action that results in the miscalculation and/or misapplication of LSRP determined in accordance with the LSRP rules is prohibited. These actions include, but are not limited to:
 - Misrepresentation and/or miscalculation of payroll at application, audit, or renewal
 - Failure to report changes in ownership or ownership information according to the WCIP and NCCI's *Experience Rating Plan Manual*
 - Violation of any of the terms and conditions under the policy(ies) for which the WCIP policy(ies) was issued
 - Failure to allow us and/or the Plan Administrator and/or rating organization reasonable access to your facilities or files and records for audit or inspection
 - Failure to disclose to us and/or the Plan Administrator and/or rating organization the full nature and scope of your exposure or business operations
2. In such circumstances, we and/or the Plan Administrator and/or rating organization may obtain any information that indicates evasion or improper calculation or application of LSRP due to actions including, but not limited to, those listed above. We and/or the Plan Administrator and/or rating organization will act to ensure the proper calculation and application of LSRP to inception of all current and preceding WCIP policies impacted by these actions.

E. Cancellation

1. If your policy is cancelled, LSRP is applied in accordance with Part Five (Premium), E. of your workers compensation and employers liability insurance policy.
2. Cancellation of LSRP policies are subject to pro rata or short rate calculation of LSRP standard premium in accordance with LSRP rules located in NCCI's *Basic Manual*.
3. We must report noncompliance and any subsequent compliance to the Plan Administrator.
4. Cancelled LSRP policies are subject to all LSRP rules, as applicable.
5. If your LSRP policy is cancelled by you or us, you are responsible for any LSRP additional premium due for reasons including, but not limited to:
 - a. Premium endorsements
 - b. Audits
 - c. An ownership change or change in combinability status in accordance with NCCI's *Experience Rating Plan Manual*
 - d. Your retirement from business
 - e. Any applicable and/or remaining LSRP valuations

Schedule

1. Basic Premium Factor _____
2. Loss Conversion Factor _____
3. Tax Multiplier _____

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

EXHIBIT 5-A (CONT'D)

**FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
ASSIGNED RISK LOSS SENSITIVE RATING PLAN ENDORSEMENT (WC 00 04 18 F)
(National Endorsement to Be Established in Tennessee—Applicable to Assigned Risk
Policies Only)**

- 4. Minimum Premium Factor _____
- 5. Maximum Premium Factor _____
- 6. Loss Development Factor:
 - 1st Adjustment _____
 - 2nd Adjustment _____
 - 3rd Adjustment _____
 - Subsequent Adjustments _____

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
TENNESSEE SMALL EMPLOYER PLAN ENDORSEMENT (WC 41 04 05)
(Applicable to Assigned Risk Policies Only)**

TENNESSEE SMALL EMPLOYER PLAN ENDORSEMENT (WC 41 04 05)

This endorsement provides notice that the final earned premium for your policy may be affected by the Tennessee Small Employer Plan.

You may receive a 10% premium credit on the Tennessee premium, subject to a \$900 maximum. To be eligible for the Tennessee Small Employer Plan premium credit, you must:

- Not be experience rated
- Have no losses for the entire term covered by this policy
- Be insured for the full, one-year continuous policy term
- Comply with all premium auditing requirements
- Not have any unpaid premium, unless there is a formal written dispute on file with the Plan Administrator specifically related to the unpaid premium

The premium credit is not applicable to a Tennessee minimum premium policy.

We will determine your eligibility for this premium credit at the time your final audit is processed. The application of this premium credit will not reduce your premium below the minimum premium applicable to your policy.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
TENNESSEE SPECIAL RISK PLAN ENDORSEMENT (WC 41 04 06)
(Applicable to Assigned Risk Policies Only)**

TENNESSEE SPECIAL RISK PLAN ENDORSEMENT (WC 41 04 06)

This endorsement provides notice that the final earned premium for your policy may be affected by the Tennessee Special Risk Plan.

You may receive 5% premium credit on the Tennessee premium. To be eligible for the Tennessee Special Risk Plan premium credit, you must:

- Have a current experience rating modification of 1.10 or less as of the policy effective date
- Have no losses for the entire term covered by this policy
- Be insured for the full, one-year continuous policy term
- Comply with all premium auditing requirements
- Not have any unpaid premium, unless there is a formal written dispute on file with the Plan Administrator specifically related to the unpaid premium

We will determine your eligibility for this premium credit at the time your final audit is processed. The application of this premium credit will not reduce your premium below the minimum premium applicable to your policy.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-A (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
TENNESSEE TABULAR SURCHARGE ENDORSEMENT (WC 41 04 07)
(Applicable to Assigned Risk Policies Only)**

TENNESSEE TABULAR SURCHARGE ENDORSEMENT (WC 41 04 07)

This endorsement applies only to the insurance provided by the policy because Tennessee is shown in Item 3.A. of the Information Page.

Add the following to Part Five—Premium of the policy:

If the premium for this policy is subject to an experience rating modification of 1.11 or higher as of the policy effective date, the total modified premium for Tennessee is subject to the Tennessee Tabular Surcharge. The surcharge percentage is shown in Item 4 of the Information Page.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-B
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
LABOR CONTRACTOR ENDORSEMENT (WC 00 03 20 A)
(National Endorsement to Be Withdrawn in Tennessee—Withdrawal Is Applicable to
Assigned Risk Policies Only)**

LABOR CONTRACTOR ENDORSEMENT (WC 00 03 20 A)

This endorsement applies only with respect to bodily injury to your leased employees in the state named in Item 2 of the Schedule when provided by a labor contractor named in Item 4 of the Schedule. This endorsement does not apply with respect to bodily injury to workers provided to you on a temporary basis.

Certain words and phrases in this endorsement are defined as follows:

Labor contractor means the entity furnishing some or all of the workers to another entity.

Client means the entity using the services of a labor contractor to obtain some or all of its workers.

Temporary worker means a worker who is furnished to an entity to substitute for a permanent employee on leave or to meet seasonal or short-term workload conditions.

Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the labor contractor is an insured. If an entry is shown in Item 3 of the Schedule, the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

Under Part One we will reimburse the labor contractor named in the Schedule for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the labor contractor's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the labor contractor with any government agency.

We will not ask any other insurer of the labor contractor to share with us a loss covered by this endorsement.

Premium will be charged for your leased employees while provided by the labor contractor. You must obtain from the labor contractor and furnish to us a complete payroll record of your leased employees provided by the labor contractor to satisfy your obligations under Part Five (Premium), C.2.

The policy may be canceled according to its terms or for violation of rules applicable to employee leasing operations provided that the labor contractor has been provided a reasonable opportunity to cure the violation. If the policy is canceled, we will send notice of such cancellation to the labor contractor.

Part Four (Your Duties If Injury Occurs) applies to you and the labor contractor. The labor contractor will recognize our right to defend under Parts One and Two and our right to inspect under Part Six (Conditions).

Schedule

1. Labor Contractor Address
2. State Where Work Performed
3. Contract or Project

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-B (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
LABOR CONTRACTOR EXCLUSION ENDORSEMENT (WC 00 03 21)
(National Endorsement to Be Withdrawn in Tennessee—Withdrawal Is Applicable to
Assigned Risk Policies Only)**

~~LABOR CONTRACTOR EXCLUSION ENDORSEMENT (WC 00 03 21)~~

~~As used in this endorsement, "employee leasing" shall mean an arrangement whereby an entity utilizes the services of a third party to provide its workers for a fee or other compensation. The third party providing employee leasing services shall be referred to as a "labor contractor." The entity receiving the services shall be referred to as a "client."~~

~~This endorsement applies only with respect to workers provided by you to a client under an employee leasing arrangement to engage in work for the client. Your policy does not provide coverage for workers you lease to the clients listed below.~~

~~Schedule~~

~~Client Address~~

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-B (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
EMPLOYEE LEASING CLIENT EXCLUSION ENDORSEMENT (WC 00 03 22)
(National Endorsement to Be Withdrawn in Tennessee—Withdrawal Is Applicable to
Assigned Risk Policies Only)**

EMPLOYEE LEASING CLIENT EXCLUSION ENDORSEMENT ~~(WC 00 03 22)~~

As used in this endorsement, "employee leasing" shall mean an arrangement whereby an entity utilizes the services of a third party to provide its workers for a fee or other compensation. The third party providing employee leasing services shall be referred to as a "labor contractor." The entity receiving the services shall be referred to as a "client."

This endorsement applies only with respect to your leased workers engaged in any work provided under an employee leasing arrangement. Your policy does not provide coverage for workers you lease from labor contractors listed below.

Schedule

Labor Contractor Address

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT 5-B (CONT'D)
FORMS MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE
MULTIPLE COORDINATED POLICY ENDORSEMENT (WC 00 03 23)
(National Endorsement to Be Withdrawn in Tennessee—Withdrawal Is Applicable to
Assigned Risk Policies Only)**

MULTIPLE COORDINATED POLICY ENDORSEMENT ~~(WC 00 03 23)~~

The multiple coordinated policy to which this endorsement is attached provides coverage for the workers you lease from the labor contractor listed below and does not provide coverage for any other workers leased or non-leased.

Schedule

- 1- Labor Contractor Address
- 2- State Where Work Performed
- 3- Contract or Project
- 4- Labor Contractor Policy Number

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

**EXHIBIT INFORMATIONAL—NONFILED
ASSIGNED CARRIER PERFORMANCE STANDARDS—2009 EDITION
(National Performance Standards to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)**

PREFACE

A. JURISDICTIONS WHERE THESE PERFORMANCE STANDARDS APPLY

The jurisdictions where these *Performance Standards* apply are listed below. Exceptions are shown in the state pages.

01	AL	Alabama	12	IL	Illinois	36	OR	Oregon
54	AK	Alaska	13	IN	Indiana	39	SC	South Carolina*
02	AZ	Arizona	14	IA	Iowa*	40	SD	South Dakota
03	AR	Arkansas	15	KS	Kansas	41	<u>TN</u>	<u>Tennessee</u>
06	CT	Connecticut	23	MS	Mississippi	44	VT	Vermont
08	DC	District of Columbia*	27	NV	Nevada	45	VA	Virginia
07	DE	Delaware	28	NH	New Hampshire	47	WV	West Virginia*
10	GA	Georgia	29	NJ	New Jersey			
11	ID	Idaho	32	NC	North Carolina			

* This jurisdiction does not currently have state specific *Performance Standards* in the 2009 edition of the *Assigned Carrier Performance Standards*. Refer to the national pages of this publication.

B. JURISDICTIONS WHERE THESE PERFORMANCE STANDARDS DO NOT APPLY

04	CA	California	22	MN	Minnesota	38	RI	Rhode Island
05	CO	Colorado	24	MO	Missouri	44	TN	Tennessee
09	FL	Florida	25	MT	Montana	42	TX	Texas
52	HI	Hawaii	26	NE	Nebraska	43	UT	Utah
16	KY	Kentucky	30	NM	New Mexico†	46	WA	Washington
17	LA	Louisiana	31	NY	New York	48	WI	Wisconsin
18	ME	Maine	33	ND	North Dakota	49	WY	Wyoming
19	MD	Maryland	34	OH	Ohio			
20	MA	Massachusetts	35	OK	Oklahoma			
21	MI	Michigan	37	PA	Pennsylvania			

† Refer to NCCI's *New Mexico Workers' Compensation Assigned Risk Pool Manual*.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT INFORMATIONAL—NONFILED (CONT'D)
ASSIGNED CARRIER PERFORMANCE STANDARDS—2009 EDITION
(National Performance Standards to Be Established in Tennessee—Applicable to Assigned
Risk Policies Only)****PERFORMANCE STANDARD 1—INTRODUCTION****A. GENERAL EXPLANATION****1. Purpose**

- a. The purpose of these **Assigned Carrier Performance Standards (Performance Standards or PS)** is to provide policy issuance and service level requirements that assigned carriers must adhere to, in order to provide residual market employers with uniform quality service while containing residual market system costs.
- b. While these **Performance Standards** are the minimum requirements, assigned carriers are not precluded from providing enhanced levels of service.
- c. It is not the purpose of these **Performance Standards** to duplicate information contained in other NCCI manuals. They are to be used in conjunction with the NCCI manuals.

2. Assigned Carrier Compliance**a. Application**

- (1) These **Performance Standards** apply to new and renewal policies effective only on or after the effective date of this publication. Changes made to the **Performance Standards** during a policy period are effective as of the next policy effective date on or after the date of change, unless otherwise specified.
- (2) The **Performance Standards** apply to all assigned carriers. Unless otherwise indicated, all **Performance Standards** apply to both direct assignment carriers and servicing carriers.
- (3) These **Performance Standards** apply whether or not the assigned carriers perform the services in-house or contract with outside vendors. In all cases, the assigned carrier is responsible for ensuring compliance with these **Performance Standards**.
- (4) While not published in these **Performance Standards**, standards that are enhanced by servicing carriers through their individual servicing carrier contracts must be applied.
- (5) The **Performance Standards** are applied separately to each legal entity of the employer, regardless of whether multiple legal entities are at the same location(s).
- (6) Assigned carriers are required to monitor and implement all manual rules, classifications, forms, and rate changes in accordance with the filing's approved effective date (e.g., replacing one classification code with another).

b. State and Federal Laws

- (1) Assigned carriers are responsible for complying with all applicable state and federal laws and Workers Compensation Insurance Plan (WCIP) rules, as well as the **Performance Standards**. For purposes of these **Performance Standards**, state and federal laws include, but are not limited to, statutes, regulations, and administrative laws or rules, and may be referred to as "law," "laws," or "applicable laws."
- (2) Where these **Performance Standards** conflict with the applicable state and/or federal laws and/or the WCIP rules, the more stringent applies.
- (3) Where these **Performance Standards** conflict with servicing carrier enhanced standards, as defined in PS 1-A-4-g through a bid process and/or executed contract, the more stringent applies.

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**EXHIBIT INFORMATIONAL—NONFILED (CONT'D)
ASSIGNED CARRIER PERFORMANCE STANDARDS—2009 EDITION
(National Performance Standards to Be Established in Tennessee—Applicable to Assigned
Risk Policies Only)****c. Time Periods**

- (1) For the purposes of these **Performance Standards**, the day following the date of receipt, issuance, or other required action (either electronically, telephonically, or by hard copy), is counted as the first day.
- (2) Except where otherwise indicated, all time periods are calendar days.

d. Staff and Team Approach

- (1) Assigned carriers must have the facilities as well as staff of sufficient expertise necessary to comply with all state laws, **Performance Standards**, WCIP rules, and procedures for its assigned duties.
- (2) Assigned carriers must administer these **Performance Standards** and any enhanced **Performance Standards** using a team approach. The team approach requires communication, interaction, and training among Customer Service, Underwriting, Claims, Loss Prevention, Audit, Billing, and Collections staff.
- (3) These **Performance Standards** must be implemented by the assigned carrier with objectively measurable and enforceable written procedures to include ongoing monitoring of quality controls. Compliance with these **Performance Standards** and corresponding written procedures ensures understanding and proper underwriting and servicing of each policy.

e. Termination

Failure to adhere to these **Performance Standards** constitutes a failure to fulfill the requirements of the servicing carrier contract or direct assignment carrier appointment, and termination or other penalties may result at the discretion of the Plan Administrator and/or regulatory authority.

3. Administration

- a. The Plan Administrator determines the applicability of all **Performance Standards**.
- b. The Plan, Pool, and Reinsurance Administrators have the authority to audit servicing carriers and, where mandated, direct assignment carriers, in order to furnish informed, objective, and independent opinions and evaluations of assigned carrier performance as outlined in the applicable WCIPs, **Performance Standards**, and data reporting guidelines.
- c. The Plan, Pool, and Reinsurance Administrators use the evaluations of assigned carrier performance to ensure compliance with Plan, Pool, and Association requirements and contractual obligations.

4. Definitions and Terms**a. Assigned Carrier**

Assigned carrier refers to direct assignment carriers and servicing carriers as defined in **Basic Manual** Rule 4-A-2-e.

b. Audit

Audit refers to premium audits performed by assigned carriers or their outside vendors to determine adequate estimated or actual payroll, confirm classification assignment(s), and estimated or actual annual premium. For more information about audits, *refer to PS 6*.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT INFORMATIONAL—NONFILED (CONT'D)
ASSIGNED CARRIER PERFORMANCE STANDARDS—2009 EDITION
(National Performance Standards to Be Established in Tennessee—Applicable to Assigned
Risk Policies Only)****(1) Midterm Audits**

Midterm audits are conducted during the policy period and are in the form of:

(a) Interim Audit

The employer submits externally verifiable payroll, tax, and/or other requested information via mail or other electronic means.

(b) Interim Telephone

The employer provides externally verifiable payroll, tax, and/or other requested information via telephone.

(c) Preliminary Physical

Generally conducted at the employer's location(s), typically early in the policy term, to review verifiable payroll, tax, and/or other requested information.

(2) Final Audits

Final audits are conducted after the cancellation or expiration of a policy and are in the form of:

(a) Estimated

Where permitted by state law, the audit is closed out with payrolls and classifications based on the assigned carrier's sound underwriting judgment due to the carrier's inability to conduct a mail, telephone, or physical audit.

(b) Mail

The employer submits externally verifiable payroll, tax, and/or other requested information via mail or other electronic means.

(c) Physical

Generally conducted at the employer's location(s) to review verifiable payroll, tax, and/or other requested information.

(d) Telephone

The employer provides externally verifiable payroll, tax, and/or other requested information via telephone.

c. Binder Package

The assigned carrier will receive binder information electronically. This information is referred to as the binder package or assignment package, in accordance with *Basic Manual* Rule 4-A-3-i(2).

d. Competitive Servicing Carrier Selection Process

Generally, servicing carriers are selected through a competitive process, which results in providing residual market stakeholders with a consistent quality of service at the most cost-effective price.

e. Data

Data refers to actuarial, financial, policy, and statistical data unless otherwise indicated.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT INFORMATIONAL—NONFILED (CONT'D)
ASSIGNED CARRIER PERFORMANCE STANDARDS—2009 EDITION
(National Performance Standards to Be Established in Tennessee—Applicable to Assigned
Risk Policies Only)****f. Employer**

Employer refers to an insured or a policyholder, in accordance with *Basic Manual* Rule 4-A-2-i. Further, for purposes of these *Performance Standards*, it also includes the employer's representative or producer of record, unless otherwise specified.

g. Enhanced Standards

An enhanced standard is a contractual commitment to perform at a measurably higher level of service that exceeds the minimum *Performance Standards*.

h. Estimated Annual Premium

Estimated annual premium refers to premium developed in accordance with *Basic Manual* Rule 3-A-9.

i. Manuals Referenced in These Standards**(1) Assigned Risk Supplement to the Basic Manual**

Applies in accordance with the States of Application section of the *Assigned Risk Supplement*.

(2) Basic Manual

Applies in NCCI jurisdictions and where licensed to independent jurisdictions in accordance with the Preface of the *Basic Manual*. In jurisdictions where NCCI's *Basic Manual* does not apply, substitute the appropriate state rules.

(3) Experience Rating Plan Manual

The appropriate *Experience Rating Plan Manual* provides the authority for the experience rating modifications referenced in these *Performance Standards*.

(4) Servicing Carrier Reference Guide

Applies in its entirety to residual market servicing carriers and to direct assignment carriers as detailed in its Preface. Provides prescribed procedures and reporting requirements regarding workers compensation insurance plans and reinsurance pooling mechanisms.

(5) Statistical Plan

The *Statistical Plan* references mean all unit statistical plans approved for use in states where these *Performance Standards* apply.

(6) WCIO Workers Compensation Data Specifications Manual

Applies to data providers. Contains the electronic specifications for reporting policy and unit statistical data and detailed claim information to data collection organizations.

(7) Workers Compensation Policy Data Reporting Manual

Applies to data providers. Contains rules and requirements for reporting policy data, including new/renewal policies, cancellations, reinstatements, endorsements, and other required documents.

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
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**EXHIBIT INFORMATIONAL—NONFILED (CONT'D)
ASSIGNED CARRIER PERFORMANCE STANDARDS—2009 EDITION
(National Performance Standards to Be Established in Tennessee—Applicable to Assigned
Risk Policies Only)****(8) Pool Data Reporting Guidebook**

Applies to residual market servicing carriers only. Provides procedures and reporting requirements regarding reinsurance of residual market policies through the applicable reinsurance pooling mechanisms.

j. New Business

New business is the first year an employer is assigned to an assigned carrier by the Plan Administrator.

k. Plan

Plan refers to NCCI's Workers Compensation Insurance Plan (WCIP), as defined in *Basic Manual* Rule 4-A-2-y or applicable state workers compensation insurance plan.

l. Plan Administrator

The organization designated to administer the affairs of the Plan as approved by the regulatory authority in a state.

m. Pool, NWCRA, or Association

Pool refers to the National Workers Compensation Reinsurance Association NFP (NWCRA or Association), a reinsurance pooling mechanism as defined by *Basic Manual* Rule 4-A-2-m, or the applicable state reinsurance pooling mechanism.

n. Pool or Reinsurance Administrator

The organization appointed, contracted, or designated to administer the affairs of the Pool.

o. Producer

A licensed insurance agent, broker, or insurance representative as defined in the state insurance law, regulation, and/or rule, whose privileges under the WCIP have not been suspended or revoked, designated by the employer that applied under the WCIP to secure and maintain workers compensation and employers liability insurance on behalf of the employer. For purposes of the WCIP, the producer is considered to be acting on behalf of the employer and not as an agent of the Plan Administrator or of any assigned carrier for Plan business.

p. Renewal Business

Policies issued after the expiration of a new business policy are considered renewal business.

B. DATA REPORTING

Assigned carriers are responsible for reporting data in accordance with the *Statistical Plan*, and other appropriate manuals and materials (e.g., circulars, statutes) as directed by the appropriate advisory, rating, statistical organization, Plan Administrator, Pool Administrator, and/or Reinsurance Administrator.

1. Assigned Carriers

All assigned carriers must:

- a. Identify, distinguish, and segregate residual market data from voluntary market data.

ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION INSURANCE PLAN DOCUMENTS AND RULES

EXHIBIT INFORMATIONAL—NONFILED (CONT'D)
ASSIGNED CARRIER PERFORMANCE STANDARDS—2009 EDITION
(National Performance Standards to Be Established in Tennessee—Applicable to Assigned Risk Policies Only)

- b. Collect and maintain residual market data required to carry out all necessary reporting requirements.
- c. Report all data to NCCI and/or other appropriate advisory, rating, statistical organization, Plan Administrator, and/or Pool Administrator.
- d. Report all assigned risk policy information to the Plan Administrator. Information includes, but is not limited to:
 - Policies
 - Endorsements
 - Binder number
 - Cancellations and reinstatements
 - Noncompliance and compliance transactions
- e. Report other required data in the form and manner specified by the Plan and/or Pool Administrator that is used for the oversight of assigned carriers (e.g., used for the selection of policy or claim data for audits).

2. Servicing Carriers

All servicing carriers must also segregate and report actuarial and financial data in accordance with the *Servicing Carrier Reference Guide*.

C. NONCOMPLIANCE AND COMPLIANCE WITH POLICY TERMS AND CONDITIONS**1. Purpose**

Employers are not entitled to insurance in the residual market if they are not in compliance with the Good Faith Rules of Eligibility as defined in *Basic Manual* Rule 4-A-3-b. Therefore, the assigned carriers must determine when employers are not in compliance with the terms and conditions of its policy and report this to the Plan Administrator.

2. Noncompliance Categories and Continuing Eligibility for Coverage

- a. The assigned carrier must determine which noncompliance category applies.
- b. An employer may be considered to be noncompliant with the terms and conditions of its policy under one of these categories:
 - Nonpayment
 - Other than Nonpayment
- c. The employer remains ineligible for coverage under the WCIP while it is noncompliant.
- d. Once the employer becomes compliant, the employer may be eligible for coverage in accordance with the good faith rules of eligibility located in *Basic Manual* Rule 4-A-3-b.

3. Determination of Noncompliance

The assigned carrier must determine which noncompliance reason(s) applies:

a. Nonpayment

An employer may be noncompliant for nonpayment for any of the following reasons:

- (1) Nonpayment of amount billed:

**ITEM RM-01-TN-2015—ESTABLISHMENT OF NCCI'S WORKERS COMPENSATION
INSURANCE PLAN DOCUMENTS AND RULES**

**EXHIBIT INFORMATIONAL—NONFILED (CONT'D)
ASSIGNED CARRIER PERFORMANCE STANDARDS—2009 EDITION
(National Performance Standards to Be Established in Tennessee—Applicable to Assigned
Risk Policies Only)**

- (a) Through a payment plan during the policy term (e.g., deposit, installment, or endorsement premium)
- (b) At final audit
- (2) There is an undisputed premium obligation
- (3) After resolving a bona fide dispute in accordance with *Basic Manual* Rule 4-A-10, outstanding premium is still unpaid
- (4) Any other nonpayment (e.g., installments, nonpayment of claim deductible)

b. Other Than Nonpayment

An employer may be noncompliant for reasons other than nonpayment including, but not limited to:

- (1) Knowingly refusing to meet reasonable health, safety, premium audit, or loss prevention requirements
- (2) Not allowing any insurer or assigned carrier reasonable access to its records for audit or inspection under the policy
- (3) Not complying with any other policy obligations (e.g., submission of required underwriting information, ERM-14s)

4. Noncompliance Reporting

- a. All noncompliance transactions must be reported to the Plan Administrator within five business days of the assigned carrier's determination that the employer is noncompliant.
- b. Assigned carriers must report and update noncompliance of policy terms and conditions electronically using one or both of the following data reporting options:
 - (1) *DCA Access*[®] *Online*
 - (2) WCPOLS Record Layout

For the form and manner in which the data must be reported, *refer to the Workers Compensation Policy Data Reporting Manual and WCIO Workers Compensation Data Specifications Manual.*

- c. The Plan Administrator will reject any application submitted for a known noncompliant employer.
- d. If the Plan Administrator receives notification from a carrier of an employer's noncompliance, the Plan Administrator will notify the current assigned risk carrier, if any (and if different than the carrier reporting the noncompliance), that the employer is ineligible for continuing coverage. The current assigned carrier must then comply with cancellation requirements in accordance with *Basic Manual* Rules 3-A-3 and 4-A-4-a(3) and PS 3-D-2.

5. Reporting Multiple Noncompliance Transactions

- a. An employer may be noncompliant for more than one reason.
- b. Assigned carriers may report a maximum of four noncompliance reasons on an individual policy at any given time.
- c. The employer cannot have more than one noncompliance transaction for nonpayment of premium, on any individual policy, at the same time.
- d. The maximum combination of noncompliance transactions are:

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- Nonpayment
 - Audit
 - Loss Control (Loss Prevention)
 - Other
- e. In multiple noncompliance situations the assigned carrier must report all reasons within five business days of determination of each individual issue.

6. Determination of Compliance

- a. An employer is deemed compliant for any of the following reasons:
- (1) Payment in full of all outstanding premium or deductible obligations
 - (2) Receipt of first payment in accordance with written agreement to use a payment plan
 - (3) Bona fide dispute is received as defined in *Basic Manual* Rule 4-A-2-g
 - (4) Audit adjustment reduces the premium obligation to a zero or credit balance
 - (5) Compliance with audit requirements or loss prevention survey recommendations
 - (6) Agreement and scheduling of audit or loss prevention survey
 - (7) Bankruptcy and carrier is listed as a secured creditor for all outstanding premium obligations
 - (8) Submission of required underwriting information (e.g., ERM-14s)
- b. When multiple noncompliance issues occur, individual issues may be deemed compliant, but if there are any remaining noncompliant issues, the employer remains noncompliant.
- c. **Compliance Effective Date**
- (1) If the employer becomes compliant for reasons not related to submitting outstanding premium or deductible payments, the compliance effective date is the date the employer is deemed compliant.
 - (2) If the employer submits the outstanding premium or deductible payment, the compliance effective date must be in accordance PS 7-A-3 and 8-A-3, respectively.

7. Compliance Reporting

- a. Assigned carriers must report compliance transactions within five business days of the item correcting any noncompliance issue.
- b. When multiple noncompliance issues occur, assigned carriers must report all appropriate compliance transactions as they occur, each within five business days, regardless of other outstanding noncompliance transactions.
- c. If the Plan Administrator receives notification from a carrier of an employer's compliance, the Plan Administrator will notify the current assigned risk carrier, if any (and if different than the carrier reporting the noncompliance), that the employer is eligible for continuing coverage. The current assigned carrier must then comply with reinstatement requirements in accordance with *Basic Manual* Rule 4-A-4-a(4) and PS 3-E.

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PERFORMANCE STANDARD 2—CUSTOMER SERVICE

A. GENERAL INFORMATION REQUESTS

1. Employer Requests

Upon telephone or written request by the employer, the assigned carrier must:

- a. Provide information regarding the classification of the business and other factors resulting in the policy premium within 14 days.
- b. Furnish a contact list of names, addresses, e-mail addresses, toll-free telephone and facsimile numbers for Customer Service, Underwriting, Audit, Claims, Loss Prevention, and Billing and Collections, within 14 days.
- c. Maintain and make available loss records within 20 days.

When an initial inquiry is made to the assigned carrier via telephone, the assigned carrier should require, where appropriate, that the inquiry be submitted in writing, including hard copy, fax, or e-mail, to ensure proper handling.

2. Injured Worker Requests

Injured workers may directly contact the assigned carrier. Injured worker inquiries should be responded to with the same completeness and timeliness as employer inquiries, in accordance with **Performance Standard 5—Claims**.

When an initial inquiry is made to the assigned carrier via telephone, the assigned carrier should require, where appropriate, that the inquiry be submitted in writing, including hard copy, fax, or e-mail, to ensure proper handling.

B. WRITTEN CORRESPONDENCE

Employers may inquire about or “dispute” policy issues (e.g., classification assignment, audits) because they do not understand the rules or policy contract, or they may request policy changes. The assigned carrier must make every effort to educate the employer in order to ultimately avoid premium billing and payment issues, noncompliance with policy terms and conditions, and/or cancellation.

1. Initial Response

The assigned carrier must respond to written correspondence within 14 days of receipt. If research is required for a response that will delay resolution beyond 14 days, an expected date of resolution must be provided within the initial 14 days.

2. Review and Resolution

a. Review

The assigned carrier must review all correspondence and research as appropriate to respond to and/or resolve the issue(s). If it is determined that additional information is needed from the employer, provide a detailed written explanation of what information is needed, with a reasonable deadline for the requested information.

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b. Resolution

Upon receipt of all necessary information and completion of appropriate research and review, respond to the employer with:

- (1) Appropriate resolution.
- (2) All documentation relevant to the issue(s), including a clear, written explanation detailing the applicable rule(s) and/or policy condition(s) and how it applies to the specific inquiry.
- (3) An explanation of how to contact the Plan Administrator if the resolution is unsatisfactory to the employer.

3. Timeliness

- a. Issues must be resolved within 45 days of the date of receipt of written correspondence, even if additional information is requested in accordance with PS 2-B-2-a. If a resolution cannot be achieved within 45 days, the file must be documented reflecting the reason and the revised expected resolution date.
- b. Where certain **Performance Standards** require time frames for specific types of requests (e.g., endorsement and/or cancellation requests), the subject-appropriate **Performance Standard** applies.

C. BONA FIDE DISPUTES

If a bona fide dispute exists in accordance with **Basic Manual** Rule 4-A-2-g, the assigned carrier must comply with the dispute resolution procedures located in **Basic Manual** Rule 4-A-10.

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Risk Policies Only)****PERFORMANCE STANDARD 3—UNDERWRITING****A. POLICY ISSUANCE (NEW AND RENEWAL BUSINESS)****1. General Information****a. Consideration and Forms**

All policies must be issued in consideration of premiums and such additional fees and charges as authorized by the Plan Administrator and/or approved by the regulatory authority. The assigned carrier must use the policy forms prescribed by the Plan Administrator and/or approved by the regulatory authority.

b. State Filing and Regulatory Requirements

The assigned carrier is responsible for maintaining adequate safeguards to ensure employer and assigned carrier compliance with all state regulatory requirements as well as all terms and conditions of the policy contract.

c. Proof of Coverage

Proof of coverage (state filing) effective periods must coincide with policy coverage periods. For the employer and producer's use, the Plan Administrator's binder letter serves as proof of coverage until it is cancelled or a policy is issued.

2. New Business**a. Welcome Letter**

Within five business days of the assigned carrier's receipt of the WCIP binder package from the Plan Administrator, the assigned carrier must send a welcome letter to the employer that includes:

- Its toll-free telephone number(s)
- Where and how to file claims
- Notice that the binder is proof of coverage until cancelled or the policy is issued
- Where and how to obtain certificates of insurance
- Key contact information
- The policy number or other means by which the assigned carrier can track the policyholder

b. Eligibility Verification

- (1) Prior to issuing the policy, the assigned carrier must verify the eligibility of the employer in accordance with **Basic Manual** Rule 4-A-3-b.
- (2) If a question of eligibility arises, the assigned carrier must document the issue(s) and provide the employer an opportunity to respond and/or resolve the issue(s). If the issue cannot be resolved within five business days, the assigned carrier must immediately report the issue to the Plan Administrator. The assigned carrier must notify the Plan Administrator when outstanding eligibility issue(s) are resolved.
- (3) If the employer is ultimately found to be ineligible for coverage under the WCIP, the assigned carrier must:

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- (a) Request that the Plan Administrator rescind the binder (if appropriate, based on coverage effective date), or
- (b) Issue the policy and then immediately initiate appropriate cancellation procedures

c. Payroll and Classification Verification

Prior to issuing the policy, the assigned carrier must:

- (1) Review the application to determine if there is any missing information.
- (2) Review the description of the operations, the name of the business, payroll, and the classification codes to ensure they are consistent for each location.
- (3) Use sound underwriting judgment based on WCIP binder package information and/or the latest available audit information to develop current policy premium.
- (4) Review the employer history to develop current policy premium.
- (5) Review ownership and experience rating information to ensure that the correct experience rating modification is applied to the policy.
- (6) Obtain additional information if there is a discrepancy, and make any appropriate changes. Assigned carriers must use sound underwriting judgment to determine if any missing information is critical to accurate policy issuance.

d. Policy Issuance

- (1) New policies must be accurately issued within 30 days from the date of assignment of coverage from the Plan Administrator and assigned carrier's receipt of required information. For more information about binding coverage, refer to **Basic Manual Rule 4-A-3-i**.
- (2) If the employer is found to be ineligible for residual market coverage, the time standard for policy issuance is suspended as of the date of documented contact with the Plan Administrator. It restarts on the date the resolution of the eligibility issue is communicated to the assigned carrier. When the time standard is restarted, the assigned carrier has the balance of the 30-day time frame or 10 days, whichever is greater, to issue the policy.

3. Renewal Business**a. Renewal or Nonrenewal Notices**

- (1) At least 60 days before expiration of the current policy, the assigned carrier must send a renewal proposal and/or nonrenewal notice, as appropriate, to the employer and the producer of record.
- (2) When developing a renewal proposal, the assigned carrier should consider reasonable payroll inflation and employment level changes in the employer's operation.
- (3) In situations where the issuance of a renewal proposal or nonrenewal notice has been suspended or delayed due to the current policy being in cancellation status, the renewal proposal and/or nonrenewal notice, as appropriate, must be sent to the employer within 15 days after receipt of funds satisfying the premium obligation or receipt of the item correcting the fault.

b. Eligibility, Payroll, and Classification Verification

Prior to renewal policy issuance, the assigned carrier must:

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- (1) Accurately reflect the exposure base and/or classification(s) of the employer.
- (2) Review:
 - (a) Eligibility of the employer in accordance with **Basic Manual** Rule 4-A-3-b and PS 3-A-2-b.
 - (b) The previous and/or current policy information to determine if there is any missing information.
 - (c) The description of the operations, the name of the business, and the classification codes to ensure that they are consistent for each location.
 - (d) The employer history to develop current policy premium.
 - (e) Ownership and experience rating information to ensure that the correct experience rating modification is applied to the policy.
 - (f) Information discovered or received, either through audit, endorsement request, claim information, loss prevention survey, or other means, verifiable:
 - 1) Payroll information that is not consistent with the annual exposure base as assigned, or
 - 2) Classification information that raises doubt concerning the accuracy of the policy's classification(s).
- (3) Obtain additional information if there is a discrepancy, and make any appropriate changes. Assigned carriers must use sound underwriting judgment to determine if any missing information is critical to accurate policy issuance. If needed, the assigned carrier must contact the employer and/or the producer to obtain the additional information.

c. Policy Issuance

- (1) Renewal policies will be accurately issued within 30 days after the receipt of the required deposit premium, if applicable.
- (2) If the required renewal premium is received late, the policy will be issued with an effective date consistent with **Basic Manual** Rule 4-A-4-a(4).

B. REAPPLICATION AND REASSIGNMENT

1. Occasionally, employers previously covered under the WCIP may reapply for coverage. According to **Basic Manual** Rule 4-A-9-c, the employer will be assigned back to the assigned carrier that had provided the prior assigned risk coverage, where available. However, reassignment requests made by either the employer or assigned carrier in a timely manner are granted when:
 - a. A valid reassignment request is submitted in accordance with **Basic Manual** Rule 4-A-3-k; the Plan Administrator will contact the current or prior assigned carrier for documentation concerning the employer's eligibility. The assigned carrier must review its records and inform the Plan Administrator of any outstanding premium obligation or other unresolved incidents affecting eligibility within five days of receipt of the request.
 - b. The prior assigned carrier cannot provide all the requested coverage(s).
 - c. The quota mechanism determines that another carrier is needed to ensure proper Plan participation.

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2. The assigned carrier to which the employer was reassigned will receive a notice of prior coverage, the effective date and policy number, if available. For purposes of these *Performance Standards*, reassignments are serviced as follows:
 - a. An employer reassigned to a new assigned carrier must be serviced as new business.
 - b. An employer reassigned back to a prior assigned carrier must be serviced as a renewal; however, if there is a gap of six months or more between the policy periods, the reassignment must be serviced as new business.
3. All data reporting requirements must continue to be met according to the *Workers Compensation Policy Data Reporting Manual* and *Statistical Plan*.

C. MIDTERM POLICY CHANGES**1. Payroll and Classification Verification**

- a. The assigned carrier must periodically review the operations of the employer throughout the policy period to determine if the correct classification and/or payroll information is being used to develop current policy premium.
- b. After the assignment and/or initial policy issuance, the assigned carrier may discover or receive, either through audit, assigned carrier initiated endorsement request, claim information, loss prevention survey, or other means, verifiable:
 - (1) Payroll information that is not consistent with the annual exposure base as assigned, or
 - (2) Classification information that raises doubt concerning the accuracy of the policy's classification(s)
- c. The assigned carrier must investigate and decide within 30 days whether an endorsement to the policy is needed to accurately reflect the exposure base and/or classification(s) of the policyholder.
- d. The assigned carrier must use sound underwriting judgment using the latest available audit information to develop current policy premium.

2. Endorsements**a. Employer-Initiated Endorsements**

- (1) When requested by the employer or producer, endorsements will be accurately issued within 20 days after receipt of request, required documentation, and any additional deposit premium.
- (2) The assigned carrier must contact the employer or producer within 10 days of receipt of the request if:
 - (a) Additional documentation and/or premium is necessary, or
 - (b) The policy will not be endorsed as requested
- (3) If additional information or deposit premium is required, the time standard is suspended as of the date of the request for additional information or deposit premium. It restarts on the date the additional information or deposit premium is received. On the restart of the time standard, the assigned carrier has the balance of the 20-day time frame or 10 days, whichever is greater, to issue the endorsement.

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- (1) A change in exposure or payroll determined by any type of audit or by other verifiable means may result in the need to issue an additional premium endorsement. In order to make such a determination, recalculate the new estimated annual premium using the new exposure and payroll and compare it to the current policy's estimated annual premium. If the additional premium generated is at least \$500 or 25% of the most recent estimated annual premium of the current policy, whichever is the greater amount, the endorsement must be accurately issued within 50 days of the accurate determination of the exposures and payroll.
- (2) All files must be documented as to when accurate exposure and payroll information is obtained.
- (3) Policies must be endorsed in accordance with appropriate *Basic Manual* and *Experience Rating Plan Manual* rules.

D. CANCELLATION**1. Employer-Initiated Cancellation or Nonrenewal**

- a. Written requests for cancellation by an employer or its representative must be processed and notice of cancellation issued within five business days after receipt of request and required documentation.
- b. The employer, producer, premium finance company, Plan Administrator, regulators, known certificate holders, and/or other appropriate parties must be provided notices of cancellation detailing the specific reason(s) for cancellation or nonrenewal of the policy. Such notification must be in accordance with all applicable state laws.
- c. Retroactive cancellation is not permitted unless other workers compensation insurance has been secured, the employer has been approved as a self-insured, or to comply with statutory cancellation notice requirements.

2. Assigned Carrier-Initiated Cancellation

- a. When authorized by the WCIP, the assigned carrier must initiate cancellation and notify the employer, producer, premium finance company, Plan Administrator, regulators, known certificate holders, and/or other appropriate parties within five business days if, after opportunity to cure, an employer is not in good faith entitled to workers compensation insurance.
- b. Assigned carriers must comply with eligibility and cancellation related *Basic Manual* Rules 3-A-3, 4-A-3-b, 4-A-4-a(3), and/or other state specific WCIP rules.

E. REINSTATEMENT/RESCISSION OF CANCELLATION NOTICES

Requests for reinstatement or rescission of a cancellation notice must be accepted or denied and communicated to the employer, producer, premium finance company, Plan Administrator, regulators, known certificate holders, and/or other appropriate parties within five business days after receipt of request, receipt of funds satisfying the premium obligation, or receipt of the item correcting the fault. For more information about effective dates and cancellations, refer to *Basic Manual* Rule 4-A-4-a(4) and PS 3-A-3-a(3) and 3-D.

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1. On request, the assigned carrier must issue certificates of insurance. If the request is consistent with the terms and conditions of the policy, the certificate must be issued within five business days after receipt of the request.
2. Producers are authorized to issue certificates of workers compensation insurance, in accordance with Section 1-A-4-a of the *Assigned Risk Supplement to the Basic Manual*.
3. Assigned carriers may permit producers to issue certificates of insurance on the assigned carrier's own forms; however, such certificates may only be issued subject to the same terms and conditions under which certificates on the standard ACORD® form may be issued. If the assigned carrier authorizes the use of such a form, the assigned carrier must instruct producers in the use of that particular form.
4. The "Special Items" section of the certificate may be modified by the assigned carrier, or by the employer/producer if authorized by the assigned carrier, to include clauses required by contract. This is the only basis for modification and must be authorized by the assigned carrier. An example of such modification is the addition of the special cancellation and notification clause required by many government contracts.

G. PRODUCER FEES

1. Assigned carriers must adhere to *Basic Manual* Rules 4-A-3-I and 4-H and regulatory requirements for payment of producer fees.
2. Assigned carriers must have and adhere to internally documented state producer and agency licensing requirements for payment of producer fees.
3. It is the assigned carrier's responsibility to determine whether or not the producer and/or agency is properly licensed in the appropriate jurisdictions for payment of fees.
4. Assigned carriers must make a diligent effort to collect producer fees due to them from producers as determined by the Plan Administrator.

H. PREMIUM AVOIDANCE, LEAKAGE, AND FRAUD**1. Procedures and Investigation**

Some employers may take actions for the purpose of avoiding premium or committing fraud. Other employers may take actions for otherwise legitimate business reasons that nonetheless result in improper premium determination. The assigned carrier must establish measurable and enforceable written standards and procedures to investigate premium avoidance, leakage, and fraud.

2. Notification and Resolution

- a. Regardless of the employer's intent, action should be taken by the assigned carrier to ensure proper calculation and collection of policy premium. Any evidence of possible misrepresentation or premium avoidance, leakage, or fraud as determined by audit, claims, loss prevention, or any other assigned carrier function must be communicated promptly to Underwriting with such notice and resulting action documented in the underwriting file.
- b. The assigned carrier must notify the Plan Administrator of suspected premium avoidance, leakage, or fraud cases. In states where there is a formal state agency set up to investigate insurance fraud, all cases involving suspected fraud must also be reported to that agency.

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- a. At the time of policy issuance in accordance with PS 3-A-2-d, the assigned carrier must notify the employer and producer of record in writing, of:
 - Available loss prevention services and safety information, and
 - Assigned carrier contacts and instructions for obtaining services and information
- b. Any employer may request reasonable loss prevention services from the assigned carrier regardless of its size or operations, as referenced in PS 4-A-1-c.
- c. To support the loss prevention efforts of the employer, the assigned carrier will provide, at no additional cost to the employer, appropriate consultation regarding:
 - Accident prevention programs
 - Accident trends
 - Preinjury/illness programs
 - Safety seminars
 - Safety literature
 - Other administrative aids

2. Scheduling and Follow-Up

- a. When scheduling appointments for loss prevention services, the assigned carrier must make reasonable allowances for scheduling conflicts or other employer difficulties.
- b. Assigned carriers must make two reasonable documented attempts to schedule loss prevention services (e.g., survey, follow-ups). The attempts to begin scheduling appointments must be made early in the process to ensure that the timeliness requirements in PS 4-B are met. Documented initial and follow-up attempts include:
 - Written correspondence (mail, e-mail, or fax)
 - Telephone contact
 - Other procedures
- c. The assigned carrier must issue a notice of cancellation in accordance with the applicable state laws for violation of the good faith provisions of the WCIP and/or state laws if:
 - (1) After at least two good faith attempts at contact by the assigned carrier to schedule a loss prevention survey (LPS), one of which must be in writing, the employer fails to afford reasonable access to its operations within 60 days of the last attempt.
 - (2) After 60 but no later than 90 days from submission of the critical recommendations, the employer fails to implement or demonstrate substantial evidence of intent to implement the recommendations. For more information about following up on critical recommendations, refer to PS 4-C-2.

Note: Assigned carriers must comply with eligibility and cancellation-related *Basic Manual* Rules 3-A-3, 4-A-3-b, 4-A-4-a(3), and/or other state specific WCIP rules, and PS 3-D-2.

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- a. Assigned carriers must document files with a sufficient level of detail indicating all:
- LPS scheduling attempts
 - Requests for, and receipt of, information
 - LPS completion
 - Any other item or decision that impacts loss prevention
- b. File documentation must be retained in accordance with policy terms and applicable laws.

4. Noncompliance and Compliance Notification

- a. Employers are required to comply with all policy terms and conditions, including allowing loss prevention services.
- b. Assigned carriers are required to comply with loss prevention noncompliance and compliance reporting in accordance with PS 1-C.

5. Loss Prevention Survey Content

Loss prevention surveys include, but are not limited to:

- a. Definitive analysis of past accident experience to determine causes and trends, supported by loss runs or other related documentation.
- b. Review of potential employer exposures; specifically identifying conditions and operations that could cause loss.
- c. Review and documentation of major elements of employer loss prevention program and activities.
- d. Description of nature and size of operations, number of locations, and loss potential for classification and underwriting purposes.
- e. Description of all employees' job duties and their exposure to coal dust for policies with a governing code for surface or underground coal mine exposure. Under such a policy, if there is no exposure to coal dust, the description must state as such.

6. Recommendations and Additional Services

- a. Recommendations are the results of a loss prevention survey. They indicate employer control of actual or potential exposures and, where applicable, program activities or management principles.
- b. The status of recommendations submitted on prior surveys must be reviewed with the employer during the loss prevention survey visit. Such review must:
- Be confirmed in writing, and
 - Indicate the status of these recommendations (completed or not), and
 - Include employer agreement with those recommendations not previously completed, and
 - Include the status of findings, orders, and/or citations issued by the Mine Safety and Health Administration (MSHA) for policies with a governing code for surface or underground coal mine exposure.

- c. There are two types of recommendations:

(1) Critical Recommendations

- (a) Critical recommendations address:

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- Exposures of imminent danger
- Serious loss potential or continuing losses, which address uncontrolled exposures expected for the type of operation as indicated in *Best's Loss Control Manual* or other materials

(b) These recommendations must be identified as critical to both the employer and producer with notification stating that failure to comply with these recommendations may result in the cancellation of coverage.

(2) Desirable Recommendations

Desirable recommendations address minor exposures that exist but are not of pressing importance.

d. Additional loss prevention services must be provided where, at the assigned carrier's discretion, they determine the services will be effective in reducing losses. These services include one or more of the following:

- (1) Assessment of identified occupational disease exposure
- (2) Workstation ergonomic assessments
- (3) Supervisor safety training materials to supplement insurer training efforts

B. TIMELINESS AND PROCEDURES**1. Employer Requested Loss Prevention Services**

When an employer requests loss prevention services, the assigned carrier must:

- a. Respond to the employer within 14 days of the receipt of request
- b. Complete the survey or provide other appropriate assistance (e.g., safety literature, video) within 45 days from the date of response

2. Assigned Carrier-Initiated Loss Prevention Surveys (LPS)**a. Loss Prevention Survey****(1) New Policies**

- (a) An LPS must be performed on qualifying employers.
- (b) An LPS must be performed if the assigned carrier has knowledge of a prior LPS that contained critical recommendations, regardless of qualification for that policy period.

(2) Renewal Policies

- (a) An LPS must be performed if the prior policy's LPS contained critical recommendations, regardless if the current policy is a qualifying employer.
- (b) An LPS must be performed for a qualifying employer if an LPS was not conducted within the last three policies regardless of whether or not the employer qualified during the last three policies. For examples, *refer to Appendix B*.

Note: If the assigned carrier chooses to perform an LPS at its discretion for a renewal policy within the three-year time frame, that LPS would be used to determine the next three-year qualifying policy.

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- (3) An LPS typically is performed by visiting and observing the physical operations of an employer. However, an LPS may be performed by visiting an employer's office or by telephone, in accordance with the Location Determination Table in PS 4-D.
- (4) For purposes of the three-year LPS cycle:
 - (a) Policies that are cancelled and reinstated with a lapse are combined to be treated as an individual full policy term based on the original effective and expiration dates.
 - (b) An employer reassigned back to a prior assigned carrier must be serviced as a renewal; however, if there is a gap of six months or more between the policy periods, the reassignment must be serviced as new business.

b. Basic Timeliness for Qualifying Employers and Locations

- (1) The assigned carrier must complete an LPS for all locations within 120 days of the policy effective date or receipt of assignment by the assigned carrier, whichever is later, with the date of receipt being maintained in the file.
- (2) The assigned carrier is not required to conduct an LPS if, at policy issuance:
 - (a) The policy qualified for an LPS, and
 - (b) Is subsequently endorsed within 90 days of policy effective date, and
 - (c) No longer meets the LPS requirement
- (3) The assigned carrier must complete an LPS within 120 days of the endorsement issuance date if, at policy issuance:
 - (a) The policy did not qualify for an LPS, and
 - (b) Is subsequently endorsed within 180 days of policy effective date, and
 - (c) Now meets the LPS requirement
- (4) The assigned carrier must complete an LPS on the renewal policy within 120 days of the policy effective date if:
 - (a) The current policy did not originally qualify for an LPS, and
 - (b) Is subsequently endorsed more than 180 days after policy effective date, and
 - (c) The current policy now meets the LPS requirement

Note: If the assigned carrier chooses to perform an LPS on the current policy, then an LPS on the renewal policy is not required.

c. Multiple and Active Location Operations Timeliness

- (1) In addition to PS 4-B-2-b, the assigned carrier must complete a minimum of one LPS within 120 days from identification of any new qualifying location not known at policy issuance.
- (2) When a job site becomes active and the assigned carrier has knowledge of that active job site, the LPS must be completed within 120 days of the date the assigned carrier becomes aware of the active job site, if it qualifies according to PS 4-D.

C. COMPLETION OF RECOMMENDATIONS**1. Communication**

- a. Critical and/or desirable recommendations must be provided to the employer and the producer in writing within 30 days of completion of the survey.

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- b. The completion date is defined as the date the survey is finalized in the field.
- c. When surveying multiple locations, the completion date is defined as the date the final location is surveyed in the field.

2. Critical Recommendations Follow-Up

The assigned carrier must follow up within 30 days and between 30 and 60 days from the submission of critical recommendations to the employer and producer, and apply PS 4-A-2-c(2) as appropriate.

3. Desirable Recommendations Follow-Up

Assigned carriers should use sound underwriting judgment regarding follow-up of desirable recommendations.

D. QUALIFYING EMPLOYERS AND SURVEY LOCATION DETERMINATION

LPSs are to be conducted in accordance with the following premium ranges, governing classifications, experience rating modifications, and locations for all employers except domestic servants. While these are the minimum requirements, assigned carriers are encouraged to perform LPSs for non-qualifying employers based on sound underwriting judgment.

Note: Premium Range refers to estimated annual premium developed in accordance with *Basic Manual* Rule 3-A-9. Governing classification is determined in accordance with *Basic Manual* Rule 1-B-5.

Loss Prevention Survey Table

Premium Range	Governing Classification Codes									
\$50,000 and over	All employers, regardless of governing classification code.									
\$20,000 to \$49,999	0037	0042	0050	0083	0106	0401	1005	1016	1164	1165
	1320	1322	1438	1472	1624	1741	1803	1852	2095	2701
	2702	2709	2710	2802	2883	2916	3030	3507	3632	3724
	3821	4420	4511	4581	4583	4635	4771	4828	4829	5022
	5037	5040	5057	5059	5069	5183	5190	5213	5348	5403
	5437	5445	5474	5506	5535	5551	5610	5645	6204	6217
	6235	6251	6252	6260	6319	6702	6703	6704	6834	6836
	6854	6872	6874F	6882	6884	7038	7050	7090	7098	7099
	7228	7229	7309F	7317F	7350F	7370	7403	7420	7422	7425
	7431	7515	7539	7610	7705	7710	7711	8018	8021	8215
	8227	8265	8279	8288	8292	8293	8380	8824	8826	8829
	8831	8832	8833	8835	8842	8864	8868	9014	9015	9016
	9082	9083	9088	9156	9178	9180	9186	9403		
\$1 to \$19,999	At assigned carrier's discretion, based on sound underwriting judgment.									

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Loss Prevention Survey Table (Cont'd)**

Premium Range	Governing Classification Codes
Experience Rating	
1.40 and higher, with an estimated annual premium of \$10,000 and over	All employers, regardless of governing classification code and status of experience rating modification (e.g., preliminary, final, contingent).
1.39 and lower	At assigned carrier's discretion, based on sound underwriting judgment.
Claim Frequency	The assigned carrier must develop written procedures to identify and perform LPSs by comparing claim frequency with policy premium size during the course of the policy period.

Location Determination Table

If . . .	Then survey . . .
Each location meets the criteria of a mandatory LPS based on premium range	All locations and active job sites
The total annual premium for a state meets the criteria of a mandatory LPS based on premium range, but no single location within the state meets the criteria	The principal location for that state
The total annual premium for a multistate policy meets the criteria of a mandatory LPS based on premium range, but no single state on the policy meets the criteria	The principal location of the employer
An employer qualifies based on its experience rating modification	Location(s) based on assigned carrier's underwriting judgment including, but not limited to: <ul style="list-style-type: none"> • High exposure, or • Frequent or severe loss history
<ul style="list-style-type: none"> • There are no active job sites, or • The operations are transient in nature, or • The operations are seasonal 	By telephone, until the job site becomes active
An office is not located in the state(s) covered by the policy	By telephone, until the job site becomes active
A location received a critical recommendation during a prior LPS	That location—additional locations may be surveyed at the assigned carrier's discretion

Note: Principal location is defined as the location of the operation with the governing classification that produces the greatest amount of payroll for the business.

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Risk Policies Only)****PERFORMANCE STANDARD 5—CLAIMS****A. PRE-LOSS ACTIVITIES**

Assigned carriers must provide employers with cost-effective measures to reduce or control claims costs. Such measures must include, but are not limited to:

- Preaccident medical care arrangements
- Procedures for policyholders to immediately report notice of losses
- A team approach to help return the injured employee safely to work

B. FILE MANAGEMENT AND DOCUMENTATION

1. The assigned carrier must develop reasonable standard procedures for:
 - Contacting appropriate parties
 - Obtaining pertinent information
 - Documenting the case file
 - Ensuring that claims are coded to classification codes that are on the policy at the time of the loss or upon completion of a final premium audit
2. Assigned carriers must make documented attempts to make appropriate contact and obtain information required in these **Performance Standards**. Documented initial (unless otherwise indicated) and follow-up contact attempts include:
 - Written correspondence (mail, e-mail, or fax)
 - Personal contact
 - Telephone contact
 - Other procedures
3. Assigned carriers must fully document files with a sufficient level of detail, either electronically or by hard copy, indicating all:
 - Contact attempts
 - Sources of information and dates of all activity, including date the claim was received, established, and assigned
 - Requests for, and receipt of, information
 - Copies of documents confirming relationships, dependency, investigations by public entities, etc.
 - Team review, supervision and management direction and control of file consistent with the injury severity and the extent of disability
 - Any other item or decision that impacts compensability
4. For occupational disease claims, PS 5-B-4 applies in addition to PS 5-B-1 through PS 5-B-3, and the assigned carrier must:
 - (a) Include an electronic copy or hard copy of the appropriate policy's Information Page and applicable endorsements in the claim file to document that the employer was the named insured and had a policy in force with the assigned carrier.
 - (b) For Federal Mine Safety and Health Act occupational disease claims:
 - (1) Document that the policy provided federal coverage by having either an electronic copy or hard copy of the appropriate Federal Mine Safety and Health Act endorsement contained in the claim file

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(2) Document if the injured worker is a owner, partner, or officer and include in the claim file an electronic copy or hard copy endorsement providing coverage for the owner, partner, or officer

(3) Notify the Plan Administrator when two or more carriers are identified by the US Department of Labor as potential responsible parties, so a defense strategy may be coordinated

5. File documentation must be retained in accordance with policy terms and applicable laws.

C. COMPLIANCE AND NOTIFICATION OF INJURY

1. Assigned carriers must:

a. Provide employers submitting an untimely report of injury or illness with a written notice or documented verbal notice explaining:

- The importance of early intervention emphasizing the benefits to the employer and the injured worker
- State and/or federal law and insurance contract obligations of employers to report injuries in a timely manner

Note: Untimely is defined as 10 or more days from the employer notice of injury to the assigned carrier, or as defined by state and/or federal law, whichever is more stringent.

b. Comply with all state and federal laws regarding claims handling and reporting requirements.

2. When assigned carriers receive a notification of an injury, the assigned carrier must review it within one business day of the notification to determine whether it is a medical-only, lost-time, or potential lost-time claim.

**D. MEDICAL-ONLY CLAIMS AND LOST-TIME CLAIMS NOT EXCEEDING THE APPLICABLE
WAITING PERIOD**

Assigned carriers must:

1. Establish objectively measurable written standards, procedures, and guidelines for appropriate handling of medical-only claims and lost-time claims not exceeding the applicable state-determined waiting period. These must include, but are not limited to, the ability to transfer the file to appropriate claims personnel based on the following as determined by the assigned carrier:

- Medical payout limit
- Injury severity limit
- Lost-time or potential lost-time indicators

2. Ensure coverage and compensability. If denial of compensability and/or liability is in order, ensure that prompt and legally sufficient denial is made to proper parties, followed up with timely administrative filings where required, providing vigorous defense for nonmeritorious claims.

3. Establish timely and adequate medical reserves commensurate with all known claim factors and information developed.

4. Activate an integrated medical management program that includes, but is not limited to, where required or permitted by the applicable law:

- Preaccident medical care arrangements
- Timely reporting of accidents
- PPO/PPN/MCO and similar arrangements. PPO/PPN/MCO and similar entities should be accredited through recognized accreditation organizations
- Peer review

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- Utilization review
 - Hospital precertification/preadmission review, consistent with the severity of injury
5. Obtain narrative reports from the treating physician(s) and/or other medical practitioners documenting the status of the worker's injury and disability to use in conjunction with medical bill screening.
 6. Screen all medical bills to ensure that treatment is related to the injury and charges are reasonable and necessary, utilizing fee schedules, relative value studies, and/or usual and customary rates to reduce billed amounts accordingly. Where questions of compensability, liability, necessity, or reasonableness:
 - a. Do not exist, and physician reports have been received, pay all bills within 30 days of receipt or earlier if the applicable law so provides.
 - b. Exist, notify the medical provider/vendor within 30 days of receipt, explaining the reasons for the need for further information or investigation.
 7. Provide and update required reports to appropriate administrative agencies.
 8. Immediately notify the underwriter concerning any coverage or classification issues that surface as a result of an injury or illness report.

E. EARLY INTERVENTION FOR LOST-TIME OR POTENTIAL LOST-TIME CLAIMS**1. Assignment**

Within one business day of assigned carrier's receipt of notice of loss for a claim that exceeds or may exceed the applicable waiting period, assigned carriers must assign cases based on:

- a. Type of injury
- b. A claim handler's appropriate expertise and knowledge regarding, but not limited to, potential:
 - (1) Lost time in excess of the applicable waiting period
 - (2) Permanent disability
 - (3) Subrogation
 - (4) Compensability issues
 - (5) Fraudulent or abusive acts or practices
 - (6) Coverage issues
 - (7) Medical severity

2. Early Intervention**a. Timeliness**

- (1) Assigned carriers must initiate aggressive early intervention in accordance with PS 5-E-2-b within two business days of receipt of notice of loss to establish control of lost-time cases.
- (2) If the injury was not initially reported as a lost-time claim and the injured worker subsequently loses time from work that exceeds the waiting period, assigned carriers must initiate aggressive early intervention in accordance with PS 5-E-2-b within one business day of receipt of notice of lost time.
- (3) At least two documented contacts must be attempted, assuming the first attempt is unsuccessful. *Refer to PS 5-B-2 for what constitutes documented attempts.*

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(4) If the second attempt is also unsuccessful, then the assigned carrier must follow up in accordance with PS 5-B-2 within one business day of the second unsuccessful attempt.

b. Three-Point Contact

The injured worker, employer, and medical practitioner(s) must be contacted in accordance with PS 5-E-2-a as follows:

(1) Injured Worker

Contact the injured worker (when appropriate) to:

(a) Confirm:

- Facts of the injury
- Medical history or prior injuries
- Work history
- Current wages
- Job duties

(b) Provide an explanation/full disclosure of benefits

(c) Establish the foundation for the injured worker's safe and timely return to work

(2) Employer and Other Witness(es)

Contact the employer and witness(es) to:

- Verify accident facts
- Obtain description of job duties
- Determine prior injury information
- Involve the employer in a safe and timely return-to-work plan

(3) Medical Practitioners

(a) Contact the treating medical practitioner(s) and/or physician(s) (when appropriate) to establish initial contact and request their procedures for obtaining the following information:

- Diagnosis and prognosis
- Treatment plan
- Causal relationship
- Medical history
- Safe and timely return-to-work plan

(b) Within two business days of the assigned carrier's knowledge of the procedure, the assigned carrier must adhere to the medical staff's procedure for obtaining information.

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F. LOST-TIME AND POTENTIAL LOST-TIME CLAIMS

1. Compensability and Coverage Determination

a. Investigation

(1) The overall completeness of an investigation of a lost-time case is based on:

- Severity of injury
- Potential extent of disability
- Questions of compensability, jurisdiction, and/or medical causal relationship
- Fatal injuries
- Employer liability actions
- Applicable claims laws

(2) When necessary, statements must be promptly taken from the injured worker, the employer/supervisor and/or witnesses.

(3) If recorded statements are taken, they do not need to be transcribed initially, provided a clear and legible summary detailing the relevant points is prepared at the time the statements are taken.

(4) Verify and document that the injured worker's average wage is consistent with jurisdictional requirements using payroll and/or tax records for salaried, hourly, seasonal, or piecemeal workers, or owners, partners, and officers. For owners, partners, or officers, the average wage may also be verified using premium-based payroll.

(5) Investigations should include "Inquiry Reports" to and/or from other insurers/administrators when appropriate.

(6) Investigation of assigned claims must be substantially completed within 30 days following assignment.

b. Documentation

Assigned carriers must summarize the following items and activity:

- Coverage
- Assignment date
- Accident data and description
- Liability and medical investigation
- Subrogation/second injury fund and/or apportionment potential
- Disability status
- Prior and/or subsequent related injuries or health conditions
- Need for physical and/or vocational rehabilitation
- Employer's liability exposure
- Compensability judgment
- Identification of outstanding issues as well as plans for future handling
- Contact log

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- (1) Assigned carriers must provide and update required reports to appropriate state and federal administrative agencies in accordance with the agency requirements.
- (2) Assigned carriers must submit all lost-time injury claims to the Insurance Services Office (ISO). Claims should be reindexed as appropriate, based on sound claims judgment. In addition, permanent total claims and scheduled loss awards may be reindexed based on sound claims judgment. Document any use of information developed as a result of an ISO inquiry.
- (3) If denial of compensability and/or liability is in order, ensure that prompt and legally sufficient denial is made to proper parties, followed up with timely administrative filings where required, providing vigorous defense for nonmeritorious claims.
- (4) The underwriter must be immediately notified concerning any coverage or classification issues that surface as a result of an injury or illness report.
- (5) Any claim filed by any employee of an uninsured entity affiliated with or owned by an insured entity must be thoroughly investigated to determine proper coverage and compensability. The review must include, but is not limited to, a review of the original application for insurance to determine if the uninsured affiliate has insurance through some other source. The underwriter must be immediately notified of the results of the review in order to take immediate appropriate action under the existing policy. The action(s) includes but is not limited to:
 - (a) Endorsing the policy to include or exclude coverage for the affiliate
 - (b) Initiating cancellation

2. Pursuit of Recovery and/or Offset

- a. Based on case circumstances, develop a strategy to promptly obtain needed evidence to pursue recovery and/or offsets, including:
 - (1) Second injury fund possibilities
 - (2) Apportionment or contribution possibilities
 - (3) Social Security or other applicable offsets
 - (4) Third party subrogation recovery
- b. Recovery and/or offset investigations must be conducted simultaneously with the compensability investigations, and include where appropriate:
 - Statements
 - Photographs
 - Diagrams
 - Engineering opinions
 - Preservation of evidence to support a recovery
- c. Reasons for or against pursuit of recovery/offsets must be documented.

3. Initial Payment of Indemnity Benefits

- a. If a claim is compensable, the first payment must be sent either by mail or by electronic means on or before the 14th day of disability or earlier, if required by applicable law.

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- b. If compensability cannot be determined by or before the 14th day of disability, a strategy for promptly concluding the compensability investigation must be documented and implemented.

4. Reserving

Assigned carriers must:

- a. Establish timely and adequate medical and indemnity reserves consistent with all known claim factors and information developed.
- b. Use the tables authorized by the applicable law or prescribed by the appropriate Statistical Plan to report indemnity reserves on fatal and permanent total cases that have the potential for lifetime benefits.
- c. Document the items considered when establishing cost estimates including, but not limited to:
- (1) Proper application of:
 - Discount and escalation for state and federal cases and medical reserves
 - State and federal offsets including, but not limited to, Second Injury Fund
 - Earning offsets
 - (2) Any liability resulting from a companion claim
 - (3) Interest accrual
 - (4) Compensability
- d. Revise medical and/or indemnity reserves within a reasonable time after developments occur that change the ultimate loss exposure. Developments include, but are not limited to:
- Changes in the tables authorized by the applicable law or prescribed by the appropriate Statistical Plan
 - The claim, or any part thereof, is declared noncompensable, or other compensability considerations
 - The assigned carrier or claimant has received, or anticipates receipt of, reimbursement from a second injury fund or similar type fund
- e. Document the basis for cost estimate changes either by hard copy or electronically, using reserve worksheets or other appropriate means.

5. Medical Care and Cost Control

- a. Activate an integrated medical management program that includes, but is not limited to, where required or permitted by applicable law:
- Preaccident medical care arrangements
 - Timely reporting of accidents
 - PPO/PPN/MCO and similar arrangements; these should be accredited through recognized accreditation organizations.
 - Peer review
 - Utilization review
 - Hospital precertification/preadmission review, consistent with the severity of injury
 - Return-to-work programs

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- Physical rehabilitation case management and catastrophic case management, consistent with the severity of injury and extent of disability
- b. Obtain periodic reports from the treating physician(s) and/or other medical practitioners documenting the status of the worker's injury and disability and for use in conjunction with medical bill screening.
- c. Screen all medical bills to ensure that treatment is related to the injury and charges are reasonable and necessary, utilizing fee schedules, PPO/PPN/MCO and similar entities, relative value studies, and/or usual and customary rates to reduce billed amounts accordingly.
- d. Where questions of compensability, liability, necessity, or reasonableness:
 - (1) Do not exist, and physician reports have been received, pay all bills within 30 days of receipt or earlier if applicable law so provides.
 - (2) Exist, notify the medical provider/vendor within 30 days of receipt, explaining the reasons for the need for further information or investigation.
- e. For occupational disease claims, PS 5-F-5-e applies in addition to PS 5-F-5-a through PS 5-F-5-d, and the assigned carrier must:
 - (1) Develop a medical history relevant to the claim including the names and addresses of all medical providers, and:
 - (a) Obtain information on all surgical procedures, hospital admissions, and, if the injured worker is deceased, obtain information on any autopsy and death certificates
 - (b) Secure the injured worker's medical examination reports including, but not limited to, the interpretation of X-rays, pulmonary function tests, and blood gas studies
 - (c) Verify the quality and accuracy of the injured worker's objective tests, and arrange for medical information relative to the claim to confirm the diagnosis
 - (d) Verify that the injured worker's medical evidence is in compliance with applicable regulations
 - (e) Consider an independent medical examination where there are questions of disability, causal relationship, reasonableness and necessity of treatment, or where reports of treating physicians do not adequately resolve these questions
 - (2) Develop relevant information about the habits and activities of the claimant including, but not limited to:
 - (a) Military service and/or other employment
 - (b) Use of tobacco products and alcohol consumption
 - (c) Hobbies

6. Indemnity and Disability Management

Assigned carriers must:

- a. Arrange for medical care consistent with diagnostic and treatment guidelines and/or current medical practice patterns to treat and cure the injury or illness.
- b. Promote, through documented preaccident medical care arrangements, treatment by physicians and/or other medical practitioners experienced in occupational medicine and managed care concepts, where permitted by applicable law.

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- c. Depending on the case circumstances and consistent with sound claims judgment and the applicable law, initiate, determine, and/or implement the following:
- (1) Establish a working relationship with all parties to control disability through:
 - Ongoing contact with the injured worker, employer, and physician at intervals consistent with the injury severity and the extent of disability.
 - Establishing a return-to-work target date.
 - Promptly adjusting return-to-work strategies as conditions change. Consult with the employer, nurse case managers, or other physical rehabilitation managers to formulate a strategy to return the injured worker to the workforce.
 - Immediate involvement of medical case management on severe injuries.
 - Providing the treating physician with a complete job description and/or videotape of the job, when necessary, to facilitate an objective evaluation of the injured worker's ability to return to the work.
 - (2) Document consideration of, or use of, independent medical examinations (where allowed by the applicable law) when reports from the treating physician are not forthcoming or questions exist regarding:
 - Disability
 - Causal relationship
 - Need for surgery
 - Existing treatment
 - (3) Document consideration of, or conduct, activity checks due to:
 - Length of disability
 - Suspicion of the injured worker exaggerating or prolonging disability, if the potential for intervening events exists (e.g., another injury, other employment)
 - (4) Investigate the availability of return to other employment, modified- or light-work duties consistent with medical restrictions if:
 - A safe return of the injured worker to the preinjury job position with the employer does not appear medically feasible, or
 - The job is unavailable
 - (5) Provide assistance to the employer in the development of a transitional and/or modified job, when necessary.
 - (6) Consistent with the applicable law, provide vocational rehabilitation in the form of:
 - Alternative work
 - Modified work
 - Job placement
 - On-the-job training
 - Education
- d. Document and timely pay all benefit payments made in accordance with applicable laws.

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- e. Conduct dependency checks at least every 12 months to determine, if applicable, whether the:
 - (1) Injured worker is still alive
 - (2) Widow/widower has remarried
 - (3) Current dependents still qualify to be dependent

G. LEGAL MANAGEMENT AND SETTLEMENTS**1. Legal Management**

- a. Assigned carriers must review the file to determine that all efforts to resolve disputes have been exhausted before litigation. Litigated issues must be clearly identified and all claims must be asserted in a timely manner.
- b. Once it has been determined that litigation is necessary, assigned carriers must ensure that all cases are properly prepared to defend or resolve all outstanding issues before conference, hearing, alternative dispute process, or trial including, but not limited to, the following:
 - (1) Have documentation of complete pretrial preparation in the areas at issue, such as coverage, liability, medical, and disability.
 - (2) Have available all necessary lay and professional witnesses or their depositions prior to formal hearing or trial.
 - (3) If litigation encompasses issues of extent of disability and/or permanency, have medical reports and opinions and witnesses available and ready for testimony or deposition, depending on the applicable law.
 - (4) The possibility of a negotiated settlement should be evaluated on a continual basis throughout the litigation process. Do not wait until day of pretrial conference or hearing to initiate negotiations.
 - (5) When litigation is handled by an attorney:
 - (a) The assigned carrier must provide the necessary material and direction, issues to be litigated, and actions needed to resolve those issues.
 - (b) The assigned carrier must document attorney's receipt of the claim file and opinion about the merits of the issues to be litigated and the probable success of the litigation.
 - (c) If an adverse finding is made, the attorney must comment about the costs and merits of an appeal, including the potential impact on future claims costs.
 - (6) Consistent with the assigned carrier/attorney agreement, assigned carriers must review and adjust attorney bills to ensure that they reflect authorized billing practices and expense controls.

Refer to NCCI's ***Servicing Carrier Reference Guide*** for more information about litigation.

2. Settlements

- a. Before settlement negotiations, ensure that the medical and/or indemnity reserves reflect medical and/or indemnity settlement value.
- b. Conduct settlement negotiations promptly after completion of investigation, assuming plaintiff's attorney and employer's willingness (or lack of response by employer), consistent with sound claims judgment and the applicable laws.

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- c. Base all permanency or compromise settlements on sound claims judgment consistent with liability and medical evidence developed, in accordance with the applicable laws and benefit structure.

H. SPECIAL CONDITIONS—OCCUPATIONAL DISEASE CLAIMS**1. General Information**

- a. For occupational disease claims, PS 5-H applies in addition to PS 5-A through PS 5-G.
- b. For federal coal occupational disease claims that can be denied within 30 days due to no coverage documented, only the following claims **Performance Standards** apply:
- PS 5-B for file management and documentation
 - PS 5-H-2 for compensability and coverage determination
 - PS 5-H-3-b for verification of employment
- c. State act and/or federal act claims for occupational disease must be handled by the assigned carrier in accordance with state and/or federal laws.

2. Compensability and Coverage Determination

In accordance with state and federal law, the assigned carrier must:

- a. Assign cases to the correct in-force policy, and
- b. Determine the date that the claim was first filed and the date of the injured worker's last exposure with the policyholder.

3. Investigation**a. Timeliness**

- (1) All claims must have a claim number assigned and the date of loss established within one business day of receipt.
- (2) Within five days of receipt of the claim or reopening, the assigned carrier must:
- (a) Verify coverage
 - (b) Report the claim to ISO
 - (c) Cross-reference federal and state occupational disease claims by the same injured worker

b. Verification of Injured Worker's Employment with Employer

- (1) Assigned carriers must verify the employment of the injured worker with the employer, based on the date that the claim was first filed, by obtaining the injured worker's profile including, but not limited to:
- Occupation
 - Age
 - Marital status
 - A copy of the application for employment
 - Social Security record

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- Actual payroll information, including cash payments or housing, in accordance with NCCI's *Basic Manual* and the policy terms and conditions
 - Other documentation of coal mine employment
 - Number of dependents and their:
 - Name(s)
 - Occupation(s)
 - Age(s)
 - Marital status(es)
- (2) Assigned carriers must develop a complete work history of the injured worker with the employer including, but not limited to:
- Job duties
 - Type of work performed
 - Specific dates of employment
 - State and location of last employment
 - Type of mine (surface or underground), if applicable
- c. Independent Verification**
- (1) Assigned carriers must independently verify information provided by the employer as well as the injured worker, widow, and/or dependents. The assigned carrier should:
- (a) Request birth records, marriage certificates, Social Security awards for disabled dependents, or divorce decrees, if applicable
 - (b) Obtain signed authorizations from the injured worker, widow, dependents, and/or other appropriate parties
- (2) Social Security disability determinations must be investigated and documented in the claim file for all federal claims where benefits are claimed for disabled dependents. Acceptance of the Social Security Administration's disability determinations, without independent collaboration, is not a basis for payment of benefits.
- d. Post-Exposure Employment**
- (1) When a claim is accepted and/or awarded, assigned carriers must:
- (a) Determine the injured worker's job and job requirements since the date of loss and determine whether the injured worker's post-exposure employment causes or contributes to the injured worker's condition that was accepted and/or awarded
 - (b) Verify dates of such employment
- (2) At least once a year, for claims filed after January 1, 1982, verify the injured worker's actual earnings on a monthly or annual basis for any period after the date of loss.
- e. Continuing Items of Investigation**
- (1) When a claim is accepted and/or awarded:
- (a) Activity checks must be performed at least once every three years in person, and should also be considered annually via telephone or written correspondence (mail, email, or fax), to determine, if applicable, whether the:

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- 1) Injured worker is still alive
 - 2) Injured worker is working, disabled, or retired
 - 3) Widow/widower has remarried
 - 4) Current dependents still qualify to be dependent
- (b) Determine if the initial and ongoing payments were made in accordance with the applicable laws
- (c) At least once a year, assigned carriers must review and document a plan of action for awarded claims
- (2) At least every 90 days, assigned carriers must review nonaccepted and/or nonawarded active claims, and document a plan of action identifying outstanding issues as well as plans for future handling. If a nonaccepted and/or nonawarded active claim is not reviewed every 90 days, document the reason(s) for the exception.

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PERFORMANCE STANDARD 6—AUDITS

A. TIMELINESS

1. Employer Requested Audits

- a. Physical audits will be performed whenever requested by the employer with reasonable grounds.
- b. The requested audit must be completed, billed, recorded, and closed on the company records within 90 days of the date of receipt of the request.

2. Preliminary Physical Audits (PPA) or Interim Audits

- a. PPAs are performed for qualifying employers in accordance with PS 6-C as follows:
 - (1) All preliminary physical audits (PPA) must be completed within 90 days of policy effective date or receipt of assignment by the assigned carrier, whichever is later, with the date of receipt being maintained in the file.
 - (2) The assigned carrier must conduct a PPA within 75 days of the endorsement issuance date if, at issuance the policy:
 - (a) Did not qualify for a PPA, and
 - (b) Is subsequently endorsed within 90 days of policy effective date, and
 - (c) Now meets the PPA requirement
 - (3) The assigned carrier is not required to conduct a PPA if, at issuance the policy:
 - (a) Qualified for a PPA, and
 - (b) Is subsequently endorsed within 90 days of policy effective date, and
 - (c) No longer meets the PPA requirement
- b. Interim audits are performed at the assigned carrier's discretion.

3. Final Audits

- a. The assigned carrier must develop standard timeliness procedures to evaluate a policy's qualification for a final physical audit in accordance with PS 6-C-2. Mail or telephone audit reports are permitted only when a physical audit is not required.
- b. All final audits must be completed, billed, recorded, and closed on the company records within 75 days of:
 - (1) The policy expiration or the effective date of cancellation if initiated by the assigned carrier, or
 - (2) The effective date of cancellation or the date of receipt of cancellation notification, whichever is later, if initiated by the employer.

4. Three-Year Audit Cycle

- a. A final physical audit must be conducted for a qualifying employer if a final physical audit was not conducted within the last three years, regardless of whether or not the employer qualified during the last three years. For examples, *refer to Appendix C.*

Note: If the assigned carrier chooses to perform a final physical audit at its discretion for a renewal policy within the three-year time frame, that final physical audit would be used to determine the next three-year qualifying policy.

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- b. If an employer's new business policy did not qualify for a final physical audit, the employer must receive a final physical audit the first year it qualifies, which begins the three-year audit cycle.
- c. For purposes of the three-year audit cycle:
 - (1) Policies that are cancelled and reinstated with a lapse are combined to be treated as an individual full policy term based on the original effective and expiration dates.
 - (2) An employer reassigned back to a prior assigned carrier must be serviced as a renewal; however, if there is a gap of six months or more between the policy periods, the reassignment must be serviced as new business.

5. Cancelled and Reinstated Policies

Audits of cancelled and reinstated policies must be completed in accordance with the Cancelled and Reinstated Policies Audit Table.

Cancelled and Reinstated Policies Audit Table

If a policy . . .	And . . .	Then . . .
Cancels within 90 days of the policy effective date	A PPA has not been conducted	A PPA is not required and a final audit must be conducted in accordance with PS 6-A-3 and 6-C-2.
	A PPA has been conducted	A final physical audit is not required and a mail or telephone audit must be conducted in accordance with PS 6-A-3.
Qualified for a PPA and: <ul style="list-style-type: none"> • Was in cancellation status but did not cancel • Cancelled but was reinstated with a lapse • Cancelled but was reinstated without a lapse 	A PPA has not been conducted on that qualifying policy	The time requirements of PS 6-A-2 are extended for the number of days the policy was in cancellation status plus any lapse, with the lapse not exceeding 60 days.
Cancels more than 90 days from the policy effective date	N/A	All audits must be conducted in accordance with PS 6-A-3 and 6-C-2.

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Cancelled and Reinstated Policies Audit Table (Cont'd)**

Cancels and is reinstated with a lapse	A final audit has not been conducted on the first short-term portion	The assigned carrier must complete a final audit covering the entire policy period between the original effective and expiration dates. Note: Premium cannot be charged for the lapsed coverage.
	A final audit has been conducted on the first short-term portion	The assigned carrier must complete a final audit covering the period from the effective date of reinstatement to the expiration date. Note: Premium cannot be charged for the lapsed coverage.

For more information about reinstating with lapses and rescission of cancellation, refer to **Basic Manual Rule 4-A-4-a(4)**.

6. Billing

Billing as a result of an audit must:

- a. Occur in accordance with **Performance Standard 7**—Billing and Collection of Premium, and
- b. Be sent electronically or mailed to the policyholder within the time frames detailed in PS 6-A.

B. DOCUMENTATION AND UNCOOPERATIVE EMPLOYERS

1. Scheduling Attempts and Information Requests

- a. The assigned carrier must develop reasonable standard procedures for preliminary and final audits for:
 - Scheduling appointments for physical audits.
 - Obtaining audit information for mail or telephone audits. These procedures must include reasonable allowances for scheduling conflicts or other employer difficulties.
- b. Assigned carriers must make reasonable documented attempts to schedule physical audits or obtain audit information for mail or telephone audits. The attempts to begin scheduling appointments must be made early in the process to ensure the timeliness requirements in PS 6-A are met. These attempts must occur in accordance with PS 6-A. Documented initial and follow-up attempts include:
 - Written correspondence (mail, email, or fax)
 - Telephone contact
 - Other procedures
- c. The order in which the attempts are to be made for mail, telephone, or physical audits are to be completed in accordance with the Audit Attempt Table.

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Audit Attempt Table

If an employer refuses or does not respond to a . . .	Then . . .
First inquiry or scheduling attempt for a preliminary physical or interim audit of a new policy	Send a second notice.
Second attempt for a preliminary physical or interim audit of a new policy	Initiate cancellation procedures on the current policy in accordance with the applicable state laws for violation of policy provision. Notify the Plan Administrator of the employer's noncompliance, in accordance with PS 1-C. Note: Assigned carriers may make more than two attempts before initiating cancellation.
First inquiry or scheduling attempt for a final audit	Send a second notice.
Second attempt for a final audit	Initiate cancellation procedures on the current policy in accordance with the applicable state laws for violation of policy provision. If there is no current coverage, notify the Plan Administrator of the employer's noncompliance, in accordance with PS 1-C.

Note: Assigned carriers must comply with eligibility and cancellation-related *Basic Manual* Rules 3-A-3, 4-A-3-b and 4-A-4-a(3), or other state specific WCIP rules, as well as PS 3-D.

2. File Documentation

- a. Assigned carriers must document files with a sufficient level of detail indicating all:
 - Scheduling attempts
 - Requests for, and receipt of, information
 - Any other item or decision that impacts policy premium or coverage
- b. File documentation must be retained in accordance with policy terms and state laws.

3. Noncompliance and Compliance Notification

- a. Employers are required to comply with all policy terms and conditions, including allowing assigned carrier audits.
- b. Assigned carriers are required to comply with audit noncompliance and compliance reporting in accordance with PS 1-C.

4. Physical Audits

- a. Prior to the audit for preliminary and final physical audits, auditors must be provided complete policy information, including, but not limited to:
 - Payroll
 - Claims data
 - Experience rating modification factor(s)

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- Adverse loss conditions
 - Suspected payroll
 - Classification discrepancies
- b. If payroll records are located in a state that is not listed on the policy or in a remote location, a mail audit must be conducted and is considered as a physical audit.

5. Mail and Telephone Audits

Assigned carriers must obtain, via a documented attempt, the most recent applicable state and/or federal tax forms on all mail and telephone audits to assess reasonableness of reported payroll.

C. QUALIFYING EMPLOYERS

Audits are to be conducted in accordance with PS 6-A based on the following minimum frequencies, premium ranges, and governing classifications for all employers except domestic servants. While these are the minimum requirements, assigned carriers are not precluded from physically auditing non-qualifying employers based on sound underwriting judgment.

Note: Premium Range refers to estimated annual premium developed in accordance with *Basic Manual* Rule 3-A-9. Governing classification is determined in accordance with *Basic Manual* Rule 1-B-5.

1. Preliminary Physical Audits (PPA)

a. New Business

PPAs must be completed in accordance with the PPA—New Business Table.

PPA—New Business Table

Premium Range	Governing Classification Codes									
\$50,000 and over	All employers, regardless of governing classification code.									
\$10,000 to \$49,999	0036	0037	0042	0050	1005	1016	1165	1320	1322	2701
	2702	2709	2710	2759	2802	2812	3030	3040	3076	3179
	3365	3400	3507	3632	3724	3726	4000	4299	4635	5022
	5040	5057	5059	5102	5146	5160	5183	5188	5190	5191
	5213	5215	5221	5223	5348	5403	5437	5445	5472	5473
	5474	5478	5479	5506	5507	5535	5537	5551	5606	5610
	5645	5703	6003	6204	6216	6217	6229	6306	6319	6325
	6400	7228	7229	7231	7380	7538	7600	7605	7705	7720
	8006	8010	8017	8018	8107	8227	8232	8264	8279	8292
	8350	8380	8393	8742	8829	8833	8835	8842	8864	9014
	9015	9058	9082	9083	9084	9101	9178	9179	9516	9534

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PPA—New Business Table (Cont'd)**

Premium Range	Governing Classification Codes									
\$5,000 to \$9,999	3726	5022	5057	5102	5183	5190	5191	5213	5215	5221
	5348	5403	5437	5445	5474	5478	5479	5507	5535	5537
	5551	5606	5610	5645	5703	6204	6217	6325	6400	7228
	7229	7538	7600	8279						
\$1 to \$4,999	At assigned carrier's discretion, based on sound underwriting judgment.									
ALL	All employers engaged in leasing employees to others or in providing temporary help to others, regardless of premium size.									

b. Renewal Business

The assigned carrier should conduct PPAs whenever warranted, based upon sound underwriting judgment.

2. Final Physical Audits

a. New Business

Final physical audits must be completed in accordance with the Final Physical Audit—New Business Table.

Final Physical Audit—New Business Table

Premium Range	Governing Classification Codes									
\$50,000 and over	All employers, regardless of governing classification code.									
\$5,000 to \$49,999	0036	0037	0042	0050	1005	1016	1165	1320	1322	2701
	2702	2709	2710	2759	2802	2812	3030	3040	3076	3179
	3365	3400	3507	3632	3724	3726	4000	4299	4635	5022
	5040	5057	5059	5102	5146	5160	5183	5188	5190	5191
	5213	5215	5221	5223	5348	5403	5437	5445	5472	5473
	5474	5478	5479	5506	5507	5535	5537	5551	5606	5610
	5645	5703	6003	6204	6216	6217	6229	6306	6319	6325
	6400	7228	7229	7231	7380	7538	7600	7605	7705	7720
	8006	8010	8017	8018	8107	8227	8232	8264	8279	8292
	8350	8380	8393	8742	8829	8833	8835	8842	8864	9014
	9015	9058	9082	9083	9084	9101	9178	9179	9516	9534

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Final Physical Audit—New Business Table (Cont'd)**

Premium Range	Governing Classification Codes									
\$1,000 to \$4,999	3726	5022	5057	5102	5183	5190	5191	5213	5215	5221
	5348	5403	5437	5445	5474	5478	5479	5507	5535	5537
	5551	5606	5610	5645	5703	6204	6217	6325	6400	7228
	7229	7538	7600	8279						
\$1 to \$999	At assigned carrier's discretion, based on sound underwriting judgment.									
ALL	All employers engaged in leasing employees to others or in providing temporary help to others, regardless of premium size.									

b. Exceptions to Final Physical Audit—New Business Table

For those employers where a PPA was conducted, a final mail audit may be substituted for the final physical audit if all of the following conditions are met:

- The PPA agrees with the information submitted on the application
- The employer is not seasonal or variable in nature
- The governing classification code is not a trucking or construction code
- The business is not in its first year of operation
- The business is not engaged in leasing employees to others or in providing temporary help to others, regardless of premium size

c. Renewal Business

Final physical audits must be completed in accordance with the Final Physical Audit—Renewal Business Table.

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Final Physical Audit—Renewal Business Table

Premium Range	Governing Classification Code									
\$20,000 and over	All employers, regardless of governing classification code, every third year.									
\$1,000 to \$19,999	3726	5022	5057	5102	5183	5190	5191	5213	5215	5221
	5348	5403	5437	5445	5474	5478	5479	5507	5535	5537
	5551	5606	5610	5645	5703	6204	6217	6325	6400	7228
	7229	7538	7600	8279						
\$1 to \$999	At assigned carrier's discretion, based on sound underwriting judgment.									
ALL	All employers engaged in leasing employees to others or in providing temporary help to others, regardless of premium size.									

3. Final Mail or Telephone Audit

A final mail or telephone audit must be completed on all risks that do not receive a physical audit, regardless if the business is new or renewal.

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PERFORMANCE STANDARD 7—BILLING AND COLLECTION OF PREMIUM

A. BILLING PROCEDURES

1. Billing Cycle

For purposes of this *Performance Standard*, the billing cycle consists of 45 days. The 45-day billing cycle begins the day after the date of billing. It includes 30 days from the date of billing and a 15-day period for follow-up and/or collection activity.

2. Billing Statements

- a. Billing statements may be sent either by mail or by electronic means.
- b. Billing statements for less than \$100 are not required to be billed, excluding final billing, until the cumulative amount of premium due for a single policy period equals or exceeds \$100.
- c. Billing statements for additional premium of \$100 or greater must be sent within 15 days of posting the premium transaction on company records. However, if the billing is on an installment basis, and an installment is due within the next 30 days, the additional premium may be allocated to all remaining installments.
- d. Billing statements for scheduled installments must be dated and issued at least 30 days prior to the payment due date as established by the appropriate WCIP payment plan.
- e. Billing statements for deposit premium on renewal policies must be dated and issued at least 30 days prior to the renewal effective date.
- f. The billing statement must require payment to be postmarked or submitted electronically on or before 30 days from date of billing or earlier, if required by state law.
- g. Billing statements must include a clear explanation of the bill and specific information on how the employer may inquire about the billing determination. For more information about customer service, refer to PS 2.

3. Receipt of Premium

Premium must be posted to the policy, regardless of when the funds clear, in accordance with the following tables.

Receipt of Premium Table 1

If the payment is submitted by regular mail and the envelope containing the payment has . . .	Then, the received date is the date of the . . .
A legible US postmark	Postmark
An illegible US postmark	Receipt of the payment
A meter mark only	Receipt of the payment
Internet postage with a legible cancellation stamp	Cancellation stamp
Internet postage without a cancellation stamp or an illegible cancellation stamp	Receipt of the payment

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Receipt of Premium Table 2

If the payment is submitted by overnight mail and . . .	Then, the received date is the date of the . . .
The package containing the payment has proof of mailing that can be verified	The date the payment was sent
The package containing the payment does not have proof of mailing or proof of mailing cannot be verified	Receipt of the payment
Proof of mailing (e.g., certified mail receipt) can be obtained	Postmark
Proof of mailing cannot be obtained	Receipt of the payment

Receipt of Premium Table 3

If the payment is submitted . . .	Then, the received date is the date of the . . .
Electronically	Employer's electronic submission
Telephone	Telephone submission

4. Collection Attempts

- a. At least one written follow-up collection attempt must be made within the billing cycle.
- b. In addition to the initial billing and one written follow-up collection attempt, additional collection attempts consist of:
 - Billing
 - Telephone contact
 - Cancellation notices, or
 - Other procedures
- c. On all accounts with an outstanding premium balance of \$10,000 or more, a documented telephone call to the employer must be made in addition to the initial billing and one written follow-up collection attempt.

5. Cancellation

- a. If the amount due is not received in accordance with the Receipt of Premium Tables by the end of the billing cycle, a cancellation notice must be issued no later than five business days from the end of the billing cycle, and must be in accordance with all applicable state laws, WCIP rules and PS 3-D.
- b. Cancellation notices issued for nonpayment cannot have a cancellation date earlier than the 46th day from the date of initial billing, and must be in accordance with state law timeliness requirements.
- c. Cancellations cannot occur if:
 - (1) The first payment has been received in accordance with written agreement to use payment plan, or
 - (2) A bona fide dispute exists according to **Basic Manual** Rules 4-A-2-g and 4-A-10.
- d. The employer, producer, premium finance company, Plan Administrator, regulators, known certificate holders, and/or other appropriate parties must be provided notices of cancellation

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detailing the specific reason for cancellation. Such notification must be in accordance with all applicable state laws, WCIP rules and PS 3-D.

- e. The assigned carrier must report noncompliance in accordance with PS 1-C.

6. Return Premium

- a. If return premium is due, statements and return premium checks must be mailed within 15 days of recording on company records.
- b. Return premium checks must be made payable:
- (1) To the employer, unless directed otherwise by a valid power of attorney on file with the assigned carrier, and
 - (2) On the gross amount of the return premium
- c. A bill for the unearned commission may be sent to the producer of record or an offset must be made against other commissions due to the same producer from the assigned carrier on other assigned risk business.

B. COLLECTION PROCEDURES**1. Servicing Carriers****a. Outstanding Premium of \$999 or Under**

Pursuit of collections is at the servicing carrier's discretion.

b. Outstanding Premium of \$1,000 and Over

- (1) Uncollectible accounts must be referred to an approved collection agency for further collection activity within 10 business days of the completion of the billing cycle unless:
 - (a) Potential for imminent settlement is reasonably certain, or
 - (b) The premium is in dispute, and the dispute is being actively resolved
- (2) Preapproval is required from the Pool Administrator for referral directly to outside counsel instead of an approved collection agency.

*Refer to NCCI's **Servicing Carrier Reference Guide** for more information about:*

- Approved collection agencies
- Financial and uncollectible reporting
- Indemnification procedures
- Litigation

2. Direct Assignment Carriers

Direct assignment carriers are expected to have collection procedures in accordance with state laws. However, PS 7-B-1 does not apply.

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TENNESSEE STATE EXCEPTIONS—APPLICABLE TO ASSIGNED RISK POLICIES ONLY**

PERFORMANCE STANDARD 4—LOSS PREVENTION

D. QUALIFYING EMPLOYERS AND SURVEY LOCATION DETERMINATION

Add the following to the Loss Prevention Survey Table:

Loss Prevention Survey Table

Premium Range	Additional Governing Classification Codes
\$20,000 to \$49,999	5604 5613

PERFORMANCE STANDARD 6—AUDITS

C. QUALIFYING EMPLOYERS

1. Preliminary Physical Audits (PPA)

a. New Business

Add the following to the PPA—New Business Table:

PPA—New Business Table

Premium Range	Additional Governing Classification Codes
\$10,000 to \$49,999	5604
\$5,000 to \$9,999	5604

2. Final Physical Audits

a. New Business

Add the following to the Final Physical Audit—New Business Table:

Final Physical Audit—New Business Table

Premium Range	Additional Governing Classification Codes
\$5,000 to \$49,999	5604
\$1,000 to \$4,999	5604

c. Renewal Business

Add the following to the Final Physical Audit—Renewal Business Table:

Final Physical Audit—Renewal Business Table

Premium Range	Additional Governing Classification Codes
\$1 to \$19,999	5604

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TENNESSEE STATE EXCEPTIONS—APPLICABLE TO ASSIGNED RISK POLICIES ONLY**

PERFORMANCE STANDARD 7—BILLING AND COLLECTION OF PREMIUM

A. BILLING PROCEDURES

2. Billing Statements

Add the following to PS 7-A-2:

- h. Assigned carriers may allow the below payment plan for final earned premium when Tennessee is the governing state of the audited policy. The payment plan is available only if the employer has a current policy with any assigned carrier and Tennessee is the governing state.

The final earned premium payment plan is as follows:

- 50% of the final earned premium is due followed by equal monthly installments in accordance with the billing cycle detailed in PS 7-A-1
- The final installment is due 60 days before the expiration of the current policy
- If the current policy is cancelled before the expected expiration date, all remaining final earned premium is due immediately

PERFORMANCE STANDARD 8—BILLING AND COLLECTION FOR DEDUCTIBLES

Change PS 8 as follows:

PS 8 does not apply in Tennessee.