BASIC

COMPANY	INDEMNITY CASE COUNT	INDEMNITY COST PER CLAIM	EST. COST OF INDEMNITY	MED ONLY CASE COUNT#	MED ONLY COST PER CLAIM	MED ONLY LIMIT	EST. COST MEDICAL ONLY	ANNUAL ADMIN FEE	TOTAL ANNUAL FEE YEAR 1	TOTAL ANNUAL FEE YEAR 2 (+3%)	Contract Duration	TAKE OVER EXPENSES	TOTAL W TAKE-OVER	
CCMSI	18	$ 945.00	$ 17,010.00	25	$ 155.00	Less then $5000	$ 3,875.00	$5,400	$ 26,285.00	$ 27,073.55	2 yrs		$ 26,285.00	800# REPORTING
PMA	20	$ 785.00	$ 15,700.00	25	$ 131.00	$ -	$ 3,275.00	$10,200	$ 29,175.00	$ 29,175.00	2 + 1 YR	$ 14,025.00	$ 43,200.00	$35 P/CLAIM
GB	18	$ 975.00	$ 17,550.00	25	$ 160.00	$ -	$ 4,000.00	2500	$ 24,050.00			$ 23,165.00	$ 47,215.00	

ADMINISTRATIVE MGT FUNCTIONS								ADMINISTRATIVE MGT. W/ ADDITIONA FEES						
COMPANY	INCIDENT REPORTS	FEE SCHEDULE REPRICING PER BILL	USUAL & CUSTOM RE-PRICING	PPO REPRICING (% OF SAVINGS)	UTILIZATION REVIEW	CLAIMS INDEX FILING	PHARM NETWORK (% OF SAVINGS)	CUSTOM REPORTS (P/HR)	TELEPHONIC CASE MGT P/HR	OSHA REPORTING	FIELD CASE MGT	ELECTRONIC BILLING	LOSS CONTROL / TRAINING (P/4 HR)	MMSEA SECT. 111 REPORT
CCMSI	$ 35.00	$ 9.00	$ 9.00	33%	$95	$12.10 p/Index	33%	$ 125.00	No price given	$ 5,000.00	$85 p/hr	Inc. in adm fee	$500/$1000	$25 per claim w 'hit' one time fee
PMA	$ 25.00	$ 8.25	$ 8.25	29%	Inc. in adm fee	Inc. in adm fee	29%	$ 95.00	$ 95.00	No price given		Inc. in adm fee	$300/$600	$6.00
GB	$ 49.00	$ 9.50	$ 9.50	28%	$ 105.00	No price given	28%		$75-$290	$ 4,500.00	$85 p/hr	$2.00		

PROGRAM MGT

COMPANY	DESIGNATE ACCT. MGT	REPORT TO EXCESS CARRIER	TEAM MEETINGS	WEB-BASED INFO SYSTEM	MAINTAIN LOSS FUND ACCT	MONTHLY LOSS FUNDS & LOSS FUND REPORTS	FILE ALL STATE OF IL FORMS
CCMSI	YES	YES	QRTLY	6 USERS	YES	YES	YES
PMA	YES	YES	QRTLY	6 USERS	YES	YES	YES
GB	YES	YES	BI-ANNUAL	6 USERS	YES	YES	YES

*CCMSI Fees Include:	Financial & Account administration: ICE (web based reporting) & electronic billing
**PMA FEES INCLUDE:	Financial & account administration; Cinch Risk Management (web based reporting); Access to Websource Risk Control online material; PMA Org Safety Institute webinars; Nurse Triage; OSHA Log tool; utilization review; claims index; OSHA reporting & electronic billing

ORG	EST LOST TIME CLAIMS	PER CLAIM RATE	PER CLAIM RATE YR 2	PER CLAIM RATE YR 3	EST MED ONLY	PER MED CLAIM RATE	DATA CONVERSION	TOTAL LOST TIME	TOTAL MED YR 1	TOTAL COST YR 1
PMA	25	$ 275.00	$ 275.00	$ 275.00	15	$ 110.00	$ 5,500.00	$ 6,875.00	$ 1,650.00	$ 14,025.00
GB										$ 13,500.00

MMSEA SECTION 11 REPORTING	Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires the providers of liability insurance (including self-insurance), no fault insurance and workers' compensation insurance to determine the Medicare-entitlement of all claimants and report certain information about those claims to the Secretary of Health and Human Services.	The purpose of the Section 111 reporting requirements is to enable the Centersfor Medicare & Medicaid Services (CMS) to correctly pay for the servicesprovided to Medicare beneficiaries who also receive employer-sponsored healthbenefits. Section 111 information helps the Medicare program determine primaryversus secondary payment responsibility. Section 111 requires that in certaininsurance situations, entities will electronically send health insurance benefitentitlement information.
CLAIMS INDEX FILING	Section 6(b) of the Workers' Compensation Act requires employers (or insurers acting on their behalf) to send reports to the Commission on all accidents involving more than three lost work days. First reports on fatal accidents are due within two work days after the death; reports on nonfatal cases shall be reported within the month. A supplementary or subsequent report should be made if it is determined that a permanent disability is involved.	
INDEMNITY CLAIMS	With workers' comp, indemnity describes payments made to an injured or sick employee whose injury or illness occurred as a result of employment. Workers' comp indemnity attempts to compensate the employee for lost wages and make the employee financially whole.	
MEDICAL ONLY CLAIMS	Claims that require attention from a healthcare provider. The injured worker may be released completely after treatment or subjected to a follow up visit to the clinic prior to release	

LOST TIME CLAIMS	Claims serious enough to warrant the doctor taking the injured worker off his regular duty for a period of time. The injured worker may be released to modified (light) duty during his recovery period. As long as the employer accommodates the doctor's restrictions on the injured worker's activity during the light duty period, the claim may remain as medical only – if the injured worker returns to light duty before the elimination period lapses.	Lost time claims not only affect the client's experience modifier and loss ratio (which can translate into higher premiums down the road), the benefits paid to injured workers during a lost time claim often exceed the total amount paid for treatment of the injury as a medical only claim.
REPORTING/INCIDENT CLAIMS	Claims which require only input int RMIS system and no required claim management activity.	
LOSS RUN REPORTS	Reports provided by your insurance company that document the claim activity on each of your policies. Even if no claims have been reported on a policy, a loss run report should be generated reflecting no losses.	
EXCESS CARRIER	Some companies make the decision to self insure workers' compensation claims. Because an extremely large claim could cause financial damage to a small business, it is typical for a self-insured company to use an excess carrier and to take out excess carrier insurance. A predetermined cutoff is defined, and the excess carrier reimburses the claim expenses above that point, up to the policy limit. Determining the need for an excess insurer is based on the number of employees and the ability of the employer to meet the financial obligations defined by workers' compensation laws.	Excess coverage typically falls into one of three categories: specific only, aggregate and a combination of the two. Specific only is for a single bad event. You set a self-insured limit and your policy pays you for expenses incurred above that limit, up to the limits of your policy. Aggregate coverage refers to frequency and minimizes your exposure over a specified time period. All of your self-insured workers' compensation payments during that time period are totaled and, if that total reaches the maximum you have set aside for self-insurance, the excess coverage policy takes over.
Field Case Managemnt	Various programs designed to help an injured worker to obtain the medical care that he or she needs.	

REPRICING	Repricing is a way to reduce cost without reducing payments to injured workers or reducing their access to medical services. Repricing saves money by taking advantage of fee schedules and negotiated provider discounts to reduce the amount paid to medical providers.	Fee schedules are the state-mandated caps on the fees that providers are allowed to charge for services paid for by workers compensation. Discounts are prearranged prices for services that are negotiated with medical providers. Discounts can be arranged directly by claim payers or by other organizations that allow claim payers to use their network for a fee.
CARRIER FEES	Expenses and services provided above the flat fee (i.e. travel costs, investigators et al)	