STATISTICAL SERVICES

NCCI Circular

NOVEMBER 7, 2011 ANNOUNCEMENT UNITS-2011-01

Units–Announcement of Item U-1398–Revisions to Statistical Plan for Workers Compensation and Employers Liability Insurance

ACTION NEEDED

Item U-1398 was recently submitted in all NCCI states, proposing revisions to the ***Statistical Plan for Workers Compensation and Employers Liability Insurance (Statistical Plan)*** and the ***Experience Rating Plan Manual for Workers Compensation and Employers Liability (Experience Rating Plan Manual)***.

Accompanying this circular are the item filing memorandum, the ***Statistical Plan*** and ***Experience Rating Plan Manual*** national pages, and state special rules where applicable.

Please review the changes outlined in the attachments to this circular for impact on your company's systems and procedures.

At the time of distribution of this circular, this item has been filed with state regulators and is subject to their individual approval process. Please refer to the ***Status of Item Filings*** circular for state approval of this item.

BACKGROUND

NCCI's ***Statistical Plan*** provides rules for reporting unit statistical data in NCCI states. On an ongoing basis, NCCI identifies opportunities for ***Statistical Plan*** reporting enhancements. The primary revisions in this item are:

- Revises the noncompensable and fraudulent claim reporting rules
- Modifies the Permanent Partial definition
- Adds a new Cause of Injury Code
- Clarifies several reporting rules

Additionally, based on the changes to noncompensable and fraudulent claim reporting, revisions to the ***Experience Rating Plan Manual*** were also required.

This filing is proposed to be effective for policies effective January 1, 2013 and subsequent. However, there are two specific reporting changes that require different effective dates:

- Permanent Partial definition change is effective based on accident dates of January 1, 2013 and subsequent
- Elimination of hard copy reporting is based on units received January 1, 2013 and subsequent

IMPACT

The information in this filing cannot be used until state regulatory approval has been obtained and unit reports are within the effective dates specified in this filing.

Please note that Arkansas law does not permit NCCI to file rules and rates on its members' behalf. Therefore, insurance carriers must make an independent filing with the Arkansas Insurance Department electing to adopt, or not adopt, an item filing filed by NCCI and subsequently approved by the Department. When such a filing is made with the Department, make sure that the NCCI item filing number (not the NCCI circular number) is referenced.

NCCI ACTION

NCCI's weekly ***Status of Item Filings*** circular, located at **ncci.com**, will provide you with the latest information on the approval of Item U-1398 and all other NCCI item filings.

In 2012, NCCI will release updated pages of the ***Statistical Plan*** and ***Experience Rating Plan Manual*** prior to the effective date.

PERSON TO CONTACT

If you have any questions or would like access to the manuals referenced in this circular, please contact:

For general questions:

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901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362
800-**NCCI**-123 (800-622-4123)

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NCCI's Customer Service Center is available to assist you Monday–Friday, 8:00 a.m.–8:00 p.m. ET. For faster service, use our simple online form at **ncci.com**.

FILING MEMORANDUM

ITEM U-1398—REVISIONS TO STATISTICAL PLAN FOR WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE

(To become effective 12:01 a.m. on January 1, 2013, applicable to new and renewal voluntary and assigned risk policies, unless otherwise specified.)

PURPOSE

The purpose of this item is to clarify and enhance the rules of NCCI's ***Statistical Plan for Workers Compensation and Employers Liability Insurance (Statistical Plan)***. In addition, this item includes clarification in NCCI's ***Experience Rating Plan Manual for Workers Compensation and Employers Liability Insurance (Experience Rating Plan)*** to support these changes.

BACKGROUND

NCCI's ***Statistical Plan*** provides rules for reporting unit statistical data in NCCI states. On an ongoing basis, NCCI identifies opportunities for improvements and the implementation of reporting rule enhancements. This process ensures that the manual provides clear data reporting instructions. The revisions in the item are described in the following numbered list:

1—Revision of Noncompensable and Fraudulent Claims Reporting

The current ***Statistical Plan*** rules require noncompensable and fraudulent claims to be reported with zero dollars in the loss amounts. When the determination occurs subsequent to units being reported, correction reports are required to reduce loss amounts to zero dollars on prior reports. These corrections allow these claims to be excluded from the calculation of experience ratings.

Based on industry and NCCI actuarial feedback, it was determined that these loss amounts should not be reduced to zero dollars. To ensure that these claims continue to be excluded from the calculation of experience ratings, NCCI's experience rating system will systematically exclude the following claims from the calculation of experience ratings:

- Claims Reported With Loss Condition Code—Type of Settlement—Noncompensable (Code 05)
- Claims Reported With Fraudulent Claim Code—Fully Fraudulent (Code 02)

This process will allow insurers to report loss amounts that are reflective of the insurers' systems without needing to reduce these losses to zero.

Separately, NCCI evaluated the Fraudulent Claim Code values and determined that the Partially Fraudulent Claim Code should be eliminated.

2—Revision of Permanent Partial Injury Type

The current Permanent Partial Injury Type definition requires the inclusion of temporary injuries that satisfy specific conditions. NCCI's Actuarial Department reviewed the appropriateness of these special conditions and determined that all references to temporary injury should be removed. This is intended to simplify reporting and enhance the alignment of Injury Type coding with benefits paid or expected to be paid.

FILING MEMORANDUM

ITEM U-1398—REVISIONS TO STATISTICAL PLAN FOR WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE

This rule change does not apply in Florida and Louisiana.

3—Elimination of Hard Copy Reporting

NCCI currently accepts unit statistical reports submitted in the industry standard electronic format, online entry using reporting tools available on **ncci.com**, and hard copy reporting format. Recent analysis shows that the combination of electronic reporting and online entry represents virtually 100% of unit reports received by NCCI. The hard copy reporting option has become obsolete—replaced by the electronic reporting and online entry options—which are now standard methods of reporting.

4—Elimination of Medical-Only Grouped Claim Reporting

The ***Statistical Plan*** currently includes a rule that medical-only claims of $2,000 or less may be grouped together. When this reporting option is utilized, the medical-only loss amounts of the individual claims are grouped together and reported on one record. For grouped claims, the Claim Count field is reported to reflect the total number of claims that have been grouped together, and the Claim Number is left blank. NCCI analysis shows that this option is rarely used by data reporters, as virtually 100% of medical-only claims are reported individually to NCCI. Industry feedback has indicated that insurers prefer to report these claims individually as they are represented in their company systems.

5—Addition of Cause of Injury Code

The Injury Description Code is a three-part data element comprising Part of Body, Nature of Injury, and Cause of Injury codes. As with other data elements, additions and changes to coding values are coordinated through the Workers Compensation Insurance Organization (WCIO) to promote the uniformity of code values for all workers compensation data collection organizations.

Recently, the WCIO approved a new Cause of Injury Code 93—Gunshot and this code is being implemented by NCCI and the other workers compensation bureaus.

6—Reporting Clarifications

On an ongoing basis, NCCI reviews the ***Statistical Plan*** to identify rules that need further clarification based on questions received from the industry. The rules clarified in this item are:

- Single state, multistate, and “if any” policies
- Coal mine reporting—including the distinction between black lung and traumatic experience
- Excess policies
- Expense Constant and Balance to Minimum Premium
- Individual Risk Rating Plans rule to report NCCI-filed and insurer-filed programs
- Reportable and Non-Reportable Claims
- Correction reporting for Part of Body Code 65—Unknown

FILING MEMORANDUM

ITEM U-1398—REVISIONS TO STATISTICAL PLAN FOR WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE

Additionally, items categorized as administrative updates, such as minor formatting changes, which have no impact on reporting rules, are included.

PROPOSAL

The following changes are proposed for policies effective January 1, 2013 and subsequent unless otherwise specified:

1—Revision of Noncompensable and Fraudulent Claims Reporting

Implement the following noncompensable and fraudulent claims reporting rule changes as provided in the ***Statistical Plan*** and ***Experience Rating Plan Manual*** exhibits:

- Reporting of loss values as reflected in company systems
- Continuation of coding claims with appropriate Type of Settlement Code for noncompensable claims and appropriate Fraudulent Claim Code for fraudulent claims
- Elimination of Partially Fraudulent Claim Code (01)
- Experience Rating usage of Type of Settlement Code—Noncompensable (Code 05) and Fraudulent Claim Code—Fully Fraudulent (Code 02) to exclude these claims from experience ratings

2—Revision of Permanent Partial Injury Type

Modify the Permanent Partial definition to remove references to temporary injury. This is effective for claims with accident dates of January 1, 2013 and subsequent.

This rule change does not apply in Florida and Louisiana.

3—Elimination of Hard Copy Reporting

Eliminate the option to submit hard copy unit statistical reports for units received January 1, 2013 and subsequent. All hard copy references are being removed.

4—Elimination of Medical-Only Group Claim Reporting

Eliminate the option to group medical-only claims and related rules for units with policy effective dates January 1, 2013 and subsequent.

5—Addition of Cause of Injury Code

Add a new Cause of Injury Code, Gunshot—Code 93 in accordance with industry standards.

6—Reporting Clarifications

Implement the following reporting rule clarifications:

- Reporting requirements for single, multistate, and “if any” policies

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ITEM U-1398—REVISIONS TO STATISTICAL PLAN FOR WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE

- Coal mine reporting rules to include distinction of black lung disease experience from other disease and traumatic experience
- Excess policies
- Reporting of Expense Constant and Balance to Minimum Premium
- Redefining Individual Risk Rating Plans rule to separately identify schedule rating, deductibles, and other programs—by NCCI-filed and insurer-filed programs
- Reportable and Non-Reportable Claims
- Correction requirements for Part of Body Code 65—Unknown
- Administrative updates

IMPACT

There will be no premium or experience rating impact as a result of the changes made by this item. As part of NCCI's continuing effort to simplify and clarify manual rules, it is anticipated that these changes will enhance the understanding of the rules in the ***Statistical Plan*** and provide further direction for reporting unit statistical data.

IMPLEMENTATION

In order to implement this item, the attached exhibits detail the changes required in NCCI's ***Statistical Plan***. The following is a summary of the exhibits included in this item:

- **Exhibit 1—**Part 1—General Rules
- **Exhibit 2**—Part 2—Header/Policy Information
- **Exhibit 3—**Part 3—Exposure Information
- **Exhibit 4**—Part 4—Loss and Expense Information
- **Exhibit 5**—Part 5—Correction Information
- **Exhibit 6**—Part 6—Coding Values
- **Exhibit 7**—State-specific rules, if applicable

Additionally, Exhibits 8 and 9 outline the changes required for Rule 1-C-3 and any state exceptions in NCCI's ***Experience Rating Plan Manual***.

In all states except Hawaii and Virginia, this item will be implemented effective 12:01 a.m. on January 1, 2013, applicable to new and renewal voluntary and assigned risk policies, unless otherwise specified within the Filing Memorandum Proposal section.

In Hawaii, the effective date is determined upon regulatory approval of the individual carrier's election to adopt this change.

FILING MEMORANDUM

ITEM U-1398—REVISIONS TO STATISTICAL PLAN FOR WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE

In Virginia, this item will be implemented for new and renewal, voluntary and assigned risk policies effective on or after 12:01 a.m. on January 1, 2013, unless otherwise specified within the Filing Memorandum Proposal section.

EXHIBIT 1
STATISTICAL PLAN—2008 EDITION
PART 1–GENERAL RULES

B. PREPARATION AND COMPLETION OF UNIT STATISTICAL REPORTS

Summarized exposure, premium, and loss data for each workers compensation policy is required under Item F of this part. ~~NCCI strongly encourages data providers to~~ Data providers must report data in the electronic format for unit statistical data received on and after January 1, 2013.

Refer to NCCI's ***Electronic Transmission User's Guide*** for additional information regarding electronic reporting.

~~When electronic reporting is not feasible, NCCI permits statistical data to be reported on hard copy forms.~~

EXHIBIT 1 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 1–GENERAL RULES

C. ~~TRANSMITTAL LETTERS~~ APPLICATION OF MANUAL RULES

~~The filing of statistical data on media, other than electronic data transferred through the Internet, must be accompanied by transmittal letters showing summary totals.~~

- Rules apply separately to each unit report, including its associated exposure and corresponding claims
- The effective date of a rule or a change in any rule is the date approved for use by the insurance department
- NCCI's ***Unit Statistical Reporting Guidebook*** provides supplemental information and examples for reporting accurate and timely unit statistical data to NCCI
- The application of payroll and losses used to calculate a risk's experience modification is in accordance with NCCI's ***Experience Rating Plan Manual***
- Classification code assignment and basis of premium are determined in accordance with NCCI's ***Basic Manual***

EXHIBIT 1 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 1–GENERAL RULES

F. FILING REQUIREMENT

Exposure, premium, and loss data must be filed for every policy governed under the scope of this Plan.

Statistical data must not be reported for the following types of policies:

- Employers liability insurance on residence and farm employees provided in conjunction with other liability insurance.
- Workers compensation on domestic workers provided in conjunction with homeowners insurance.
- Policies providing coverage under the National Defense Projects Rating Plan.
- Policies providing coverage on Nuclear Regulatory Commission projects.
- Policies providing excess coverage.

EXHIBIT 1 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 1–GENERAL RULES

G. FILING OF STATISTICAL DATA

Electronic reports or transmissions must be submitted to NCCI. Refer to NCCI's ***Electronic Transmission User's Guide*** for further information ~~instruction. Exposure, premium, and loss data submitted on hard copy forms must be filed directly with the keying vendor according to the procedures in NCCI's ***Unit Statistical Reporting Guidebook***. All reports, labels, and transmittals **must** be typed or clearly printed with blue or black ink.~~

EXHIBIT 1 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 1–GENERAL RULES

H. STATE FILING REQUIREMENTS ~~FOR MULTISTATE POLICIES~~

~~Data must be filed for each state of a multistate policy in accordance with the scope of this Plan. A report must be filed for each state on a policy with estimated exposure, including those for which no exposure was developed. However, if a state was written on an "If Any" basis, a report is not required provided no exposure developed for that state.~~

1. Single-State Policy

Unit statistical data is required to be reported for a single-state policy when any of the following apply:

- Developed exposure at audit
- Not yet been audited (estimated exposure)
- Developed no exposure at audit

a. Policy With No Exposure Developed

For a policy that developed no exposure at audit, report Statistical Code 1111—No Exposure Developed, along with the applicable expense constant and balance to minimum premium.

2. Multistate Policy

Unit statistical data is required to be reported for any state on the policy when any of the following apply:

- Developed exposure at audit
- Not yet been audited (estimated exposure)
- Developed no exposure at audit after estimated exposure was reported on the policy
- Developed exposure, after being written on an "if any" basis

a. "If Any" State on Policy With No Exposure Developed

Unit statistical data is not reported for a state when all of the following apply:

- Written on an "If Any" basis—the policy was issued with no exposure in that state
- No exposure developed at audit
- The applicable expense constant does not apply in that state
- The applicable policy minimum premium does not apply in that state

EXHIBIT 1
STATISTICAL PLAN—2008 EDITION
PART 1–GENERAL RULES

L. COAL MINE AND BLACK LUNG DISEASE EXPERIENCE

~~The following special reporting requirements apply to coal mine experience:~~

Experience incurred for underground and surface coal mine operators, which are classified in accordance with the ***Basic Manual***, and any risks exposed to Black Lung Disease (also known as Coal Workers' Pneumoconiosis) must be filed according to the rules of this Plan.

1. ~~Underground Coal Mine Risks~~ Reporting of Classification Code and Corresponding Statistical Code

~~Experience incurred for underground coal mine policies, which are classified in accordance with the ***Basic Manual for Workers Compensation and Employers Liability Insurance (Basic Manual)***, must be filed according to the rules of this Plan. This includes all insured underground coal mine operations, incidental operations, and operations other than underground coal mining of any one employer.~~

Experience for traumatic and occupational disease, other than Black Lung Disease, must be reported with the applicable classification code. Black Lung Disease experience for state and/or federal acts must be reported separately from the classification code under the corresponding statistical code.

Following are the classification codes along with their corresponding statistical codes for Black Lung Disease:

Classification Code	Statistical Code
1016—Coal Mining NOC	0158—Black Lung Disease Experience in Connection With Code 1016
1005—Coal Mining—Surface and Drivers	0156—Black Lung Disease Experience in Connection With Code 1005
Any non-coal mining classification code	0164—Black Lung Disease Experience in Connection With Any Classification Other Than Coal Mine Code

a. ~~Advance Reports (Including Six-Month Experience)~~

~~To complete an advance experience rating for an underground coal mine policy, an advance report of the first six months' experience of the current policy must be filed directly with NCCI's Customer Service—Experience Rating Department. Such advance reporting must be filed no later than 75 days prior to the anniversary rating date. Exposure and incurred losses for the first six months only of the current policy must be included in this advance report, and losses must be valued three months prior to the anniversary rating date. These advance reportings are entirely independent of NCCI's *Statistical Plan* filings, and the experience must be reported when due under the requirements of this Plan.~~

b. ~~Traumatic~~

~~If the traumatic rate for the underground coal mine class code contains a catastrophe loading that is not subject to experience modification, then report the authorized rate after adjusting for the nonratable catastrophe loading prior to experience modification. The following formula should be used to obtain the adjusted authorized rate:~~

~~Subject Rate = Traumatic Rate – Catastrophe Rate~~

EXHIBIT 1 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 1–GENERAL RULES

~~Authorized Rate = Subject Rate x Experience Modification + Catastrophe Rate~~

~~Refer to NCCI's ***Unit Statistical Reporting Guidebook*** for additional information.~~

2. ~~Disease Experience for Coal Mine Risks~~ Reporting of Experience for Federal Act Only

~~Report the premium for disease after the application of the experience modification factor with the appropriate exposure coverage code. Refer to Part 3, Item D—Exposure Coverage Code for the definition of exposure coverage code.~~

~~Disease experience must be reported for disease in connection with any coal mine classification in accordance with the ***Basic Manual*** or for any class code other than coal mining where there is liability under the Federal Coal Mine Health and Safety Act.~~

If Black Lung Disease coverage has been provided under the Federal Coal Mine Health and Safety Act only without state act coverage, experience for the Black Lung Disease must be reported under Statistical Code 0164 (Black Lung Disease Experience for Federal Benefits Only). Exposure Act/Exposure Coverage Code 03 and Loss Condition Act Code 03 (Coverage Under the Federal Coal Mine Health and Safety Act Only) must also be used when reporting the exposure, premium, and corresponding losses.

3. Reporting of Traumatic and Occupational Disease Experience (Other Than Black Lung Disease)

a. Exposure and losses for traumatic and occupational disease experience, other than Black Lung Disease, must be reported under the applicable classification code. The appropriate Exposure Act/Exposure Coverage and Loss Condition Act codes must also be reported for the classification code.

Note: Exposure Act/Exposure Coverage Codes 03 and 04 are not valid.

Note: Assignment of Injury Description Code—Nature of Injury that represents the traumatic or Non-Black Lung Disease claim must also be reported appropriately. Nature of Injury Code 62—Black Lung is not valid for these claims.

4. Reporting of Black Lung Disease (Coal Workers' Pneumoconiosis) Experience

Black Lung Disease experience reporting requirements are as follows:

a. Exposure and Premium

Exposure and premium charged for Black Lung Disease coverage under State Act and/or Federal Coal Mine Health and Safety Act are reported separately from the classification code(s) manual premium.

Black Lung Disease premium is not subject to experience rating, premium discounts, or retrospective rating, and it is not included in the Standard Premium.

Black Lung Disease exposure and premium must be reported under the appropriate statistical code as follows, based on the following coverage provided on the policy:

- State Act only coverage—Use Exposure Act/Exposure Coverage Code (01)—State Act or Federal Act Excluding USL&HW and Federal Coal Mine Health and Safety Act

EXHIBIT 1 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 1–GENERAL RULES

- Federal Act only coverage—Use Exposure Act/Exposure Coverage Code (03)—Coverage Under the Federal Coal Mine Health and Safety Act Only
- Federal and State Act coverage—Use Exposure Act/Exposure Coverage Code (04)—Coverage Under the Federal Coal Mine Health and Safety Act and the State Act

b. Losses

Losses resulting from Black Lung Disease coverage under State Act and/or Federal Coal Mine Health and Safety Act are reported separately from the classification code.

Black Lung Disease losses must be reported under the appropriate statistical code as follows, based on the following benefits paid or payable under the policy:

- State Act only benefits—Use Loss Condition Act Code (01)—State Act or Federal Act Excluding USL&HW and Federal Coal Mine Health and Safety Act
- Federal Act only benefits—Use Loss Condition Act Code (03)—Coverage Under the Federal Coal Mine Health and Safety Act Only
- Federal and State Act benefits—Use Loss Condition Act Code (04)—Coverage Under the Federal Coal Mine Health and Safety Act and the State Act

Note: Assignment of Injury Description Code—Nature of Injury that represents the Black Lung Disease claim must also be reported appropriately.

EXHIBIT 1 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 1–GENERAL RULES

R. EXCESS POLICIES

Exposure and losses for excess policies must not be reported.

EXHIBIT 2
STATISTICAL PLAN—2008 EDITION
PART 2–HEADER/POLICY INFORMATION

D. REPLACEMENT REPORT CODE

Identify reports being submitted to replace a report that was previously submitted. The replacement indicator may only be submitted for the first reporting of exposure, premium, and loss data valued 18 months after the policy effective date. Refer to Item Q—Original Administration Number Identifier ~~Pending File Number~~ in this part for Replacement Report processing information.

Refer to NCCI's ***Unit Statistical Reporting Guidebook*** for additional information.

EXHIBIT 2 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 2–HEADER/POLICY INFORMATION

L. ~~PAGE NUMBER (HARD COPY ONLY)~~ LINK DATA FIELDS

~~Report the page number of multipage hard copy reports (e.g., page 1 of X). Not required on single page hard copy reports.~~ Link data fields must be the same on all corresponding records for each unit report. The link data fields are Carrier Code, Policy Number, Exposure State Code, Report Number, and Correction Sequence Number.

EXHIBIT 2 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 2–HEADER/POLICY INFORMATION

M. ~~LAST PAGE NUMBER (HARD COPY ONLY)~~ KEY FIELDS

~~Report the last page number of multipage hard copy reports (e.g., page X of 5). Not required on single-page hard copy reports.~~ For each state on a policy, the key fields must be the same across all report levels including corresponding corrections. Key fields are Carrier Code, Policy Number Identifier, Policy Effective Date, and Exposure State Code.

If any key fields require corrections, they must be applied as follows:

- For Carrier Code, Policy Number Identifier, and/or Policy Effective Date, report a correction to the 1st report only. Report the revised key field(s) being corrected and the previous reported value (Previous Carrier Code, Previous Policy Number Identifier, and Previous Policy Effective Date).
- For Exposure State Code only or in combination with other key fields, report a correction to remove all exposure and losses at every report level, and report new original unit report(s) with the correct values.

EXHIBIT 2 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 2–HEADER/POLICY INFORMATION

Q. ~~PENDING FILE NUMBER~~ ORIGINAL ADMINISTRATION NUMBER IDENTIFIER

Report the ~~pending file number~~ original administration number identifier assigned by NCCI when submitting a replacement report to NCCI.

EXHIBIT 3
STATISTICAL PLAN—2008 EDITION
PART 3–EXPOSURE INFORMATION

H. SPLIT PERIOD CODE ~~(ELECTRONIC REPORTING ONLY)~~

Report when indicating changes in rates or experience modification during a policy period. Valid values are “0–9,” where “0” is reported for the first effective period, “1” is reported for the second effective period, and so on through the ninth effective period (if applicable). This field is zero-filled for policies with no changes in rates or experience modification.

EXHIBIT 3 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 3–EXPOSURE INFORMATION

S. EXPENSE CONSTANT ~~AMOUNT~~

~~Report the approved expense constant separately from classification code exposures and premiums under the designated statistical code. This premium must **not** be included in the standard premium.~~

The expense constant applicable to a single or multistate policy is reported under Statistical Code 0900 and reported separately from the classification code(s) manual premium and any Balance to Minimum Premium. The expense constant amount is not included in the Standard Premium.

The expense constant on a multistate policy must be allocated to the state with the highest expense constant applicable. If two or more states included on the policy have the same highest expense constant, the expense constant must be reported for the state with the highest expense constant and largest amount of standard premium.

Refer to NCCI's ***Basic Manual*** for additional rules.

EXHIBIT 3 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 3–EXPOSURE INFORMATION

U. INDIVIDUAL RISK RATING PLANS ~~PREMIUM ADJUSTMENT AMOUNT (E.G., SCHEDULE RATING)~~

Individual Risk Rating Plans apply to both NCCI-filed and insurer-filed and approved programs. Report the premium credit or debit ~~adjustment~~ resulting from the application of ~~an~~ the following individual risk rating plans ~~(other than an experience rating plan)~~. ~~Please r~~Refer to Part 6—Coding Values for ~~schedule rating statistical coding information~~ the appropriate statistical codes.

1. SCHEDULE RATING PROGRAMS

For both NCCI-filed and insurer-filed programs, report the premium credit or debit amount under the appropriate Schedule Rating Program statistical code.

2. DEDUCTIBLE PROGRAMS

For both NCCI-filed and insurer-filed deductible programs, report any applicable premium credit amount under the appropriate Deductible Reporting statistical code.

3. OTHER NCCI PREMIUM ADJUSTMENT PROGRAMS

For NCCI-filed premium adjustment programs (other than Schedule Rating and Deductible Programs), report the premium credit or debit amount under the appropriate statistical code.

4. OTHER INSURER PREMIUM ADJUSTMENT PROGRAMS

For premium adjustment programs filed independently by the insurer (other than Schedule Rating or Deductible Programs), report the premium credit or debit amount under the appropriate Independent Carrier Filing statistical code.

Refer to NCCI's ***Unit Statistical Reporting Guidebook*** for additional information.

EXHIBIT 3 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 3–EXPOSURE INFORMATION

V. BALANCE TO MINIMUM PREMIUM ~~AMOUNT~~

~~The determination of whether or not a risk falls under the minimum premium criteria is made by comparing the premium obtained by extension of exposure plus the expense and loss constants to the highest minimum premium shown on the state rate pages for the class codes on the policy.~~

~~When the premium plus expense constant and loss constant, if applicable, is less than the minimum premium, then the minimum premium must be charged.~~ When ~~a~~ the minimum premium is ~~charged for a~~ applicable to a single or mulitstate policy, the additional premium required to bring the total ~~risk~~ policy standard premium up to the minimum premium must be reported separately from the classification code(s)' manual premium and the loss and expense constants. This Balance to Minimum Premium is reported under Statistical Code 0990.

~~If the minimum premium applies to~~ For a multistate policy, the ~~additional premium required to bring the total risk standard premium up to the minimum premium~~ Balance to Minimum Premium must be reported to the state with the highest minimum premium ~~shown in the rate pages for the states and classes on the policy.~~ If two or more states included on the policy have the same highest minimum premium, the minimum premium ~~shall~~ must be reported for the state with the highest minimum premium and largest amount of standard premium.

Refer to NCCI's ***Basic Manual*** for additional rules and NCCI's ***Unit Statistical Reporting Guidebook*** for examples.

EXHIBIT 4
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
A. GENERAL INCURRED LOSS INFORMATION
1. Incurred Losses

c. Fraudulent Claims

(1) Fraudulent Claims Definition

For policies effective January 1, 2013 and subsequent, a fraudulent claim is one that has been ruled (or officially declared) fraudulent by a court decision.

For policies effective prior to January 1, 2013, ~~A~~a fraudulent claim is ~~a claim~~ one that meets either of the following conditions:

- The claim has been ruled (or officially declared) fully fraudulent by a court decision
- The claim, or a portion of the claim, has been deemed to be partially fraudulent by a court decision

(a) Fully Fraudulent Claims Reporting

~~When a claim has been ruled or declared to be fully fraudulent, the entire cost of the claim must be netted down to zero for unit statistical reporting.~~

- ~~If the claim has been ruled or declared fully fraudulent prior to the 1st unit statistical report, the claim is considered noncompensable and is not to be reported.~~
- ~~If the claim is ruled or declared to be fully fraudulent after the 1st reporting, but within one year after the 5th report due date of the report on which the claim appears, a correction report must be filed. Reduce the incurred cost on the claim to zero.~~
- ~~If the claim is ruled or declared to be fully fraudulent as of the 6th report due date or subsequent, a correction report is not required. If the claim remains open, reduce the incurred cost on the claim to zero at the next valuation date.~~

~~The reporting of correction reports may impact experience modification(s) pursuant to the rules of the ***Experience Rating Plan Manual***.~~

1) For Policies Effective January 1, 2013 and Subsequent

When a claim has been ruled or declared to be fraudulent:

- As of the 1st report valuation and does not include any paid losses, incurred losses, and/or ALAE, the claim must not be reported.
- As of the 1st report valuation and does include any paid losses, incurred losses, and/or ALAE, the claim must be reported with these loss values. Report this claim with the Fully Fraudulent Claim Code 02.
- After the 1st report valuation and prior to the 6th report correction report(s) are required for all previously submitted unit reports to report the Fully Fraudulent Claim Code 02. The paid losses, incurred losses, and/or ALAE must continue to reflect the loss values as of each specific report level(s).
- As of the 6th report valuation or subsequent, report the claim with the Fully Fraudulent Code 02. The paid losses, incurred losses, and/or ALAE must continue to reflect the losses valued at that report level. Correction report(s) must not be reported for all previously submitted report levels.

Refer to the ***Experience Rating Plan Manual*** for additional rules.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
A. GENERAL INCURRED LOSS INFORMATION
1. Incurred Losses

2) For Policies Effective Prior to January 1, 2013

When a claim has been ruled or declared to be fully fraudulent, the entire cost of the claim must be netted down to zero for unit statistical reporting.

- If the claim has been ruled or declared fully fraudulent prior to the 1st unit statistical report, the claim is considered noncompensable and is not to be reported.
- If the claim is ruled or declared to be fully fraudulent after the 1st reporting, but within one year after the 5th report due date of the report on which the claim appears, a correction report must be filed. Reduce the incurred cost on the claim to zero.
- If the claim is ruled or declared to be fully fraudulent as of the 6th report due date or subsequent, a correction report is not required. If the claim remains open, reduce the incurred cost on the claim to zero at the next valuation date.

The reporting of correction reports may impact experience modification(s) pursuant to the rules of the ***Experience Rating Plan Manual***.

(b) Partially Fraudulent Claims Reporting (for Policies Effective Prior to January 1, 2013)

When a claim, or a portion of the claim, has been ruled or declared to be partially fraudulent, the cost of the claim must be netted down to reduce the net incurred loss by the declared fraudulent amount.

- If the claim, or a portion of the claim, has been ruled or declared partially fraudulent prior to the 1st unit statistical report, the net incurred cost of the claim on the 1st report must reflect the reduction of the claim by the partially fraudulent amount.
- If the claim, or a portion of the claim, is ruled or declared to be partially fraudulent subsequent to the 1st reporting, but within one year after the 5th report due date of the report on which the claim appears, a correction report must be filed. The cost of the claim must be netted down to reduce the net incurred loss by the declared fraudulent amount.
- If the claim, or a portion of the claim, is ruled or declared to be partially fraudulent as of the 6th report due date or subsequent, a correction report is not required. If the claim remains open, reduce the net incurred loss by the declared fraudulent amount at the next valuation date.

The “net incurred cost” is defined as the gross incurred loss (i.e., the gross evaluation of the claim whether the claim is still open or not) minus the amount declared to be partially fraudulent.

For example, consider a claim that has been reported as $10,000 (1st report), $40,000 (2nd report), and $60,000 (3rd report). After the 3rd report, the claim was ruled partially fraudulent with the partially fraudulent amount set at $25,000. The net incurred cost of the claim is the latest value minus the partially fraudulent amount: $60,000 – $25,000 = $35,000. The net incurred cost ($35,000) is less than the claim value reported at the 2nd and 3rd reports. Correction reports must be submitted for the 2nd and 3rd reports. As the net incurred cost is higher than the $10,000 reported in the 1st report, no correction report is needed for the 1st report.

When the partially fraudulent amount has not been allocated into indemnity and medical components by the adjudicator, the net incurred loss must be divided between indemnity and

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
A. GENERAL INCURRED LOSS INFORMATION
1. Incurred Losses

medical losses in the same proportion as the original gross incurred indemnity and medical amount.

The reporting of correction reports may impact experience modification(s) pursuant to the rules of the ***Experience Rating Plan Manual***.

(2) Fraudulent Claim Code

The Fraudulent Claim Code identifies whether the claim is ~~not~~ fraudulent or not~~, partially fraudulent, or fully fraudulent. Specific~~ Each claim must be reported with the appropriate fraudulent claim code~~s~~ as defined ~~are located~~ in Part 6~~—Coding Values,~~ Item P—Fraudulent Claim Code.

EXHIBIT 4
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
A. GENERAL INCURRED LOSS INFORMATION
1. Incurred Losses

d. Noncompensable Claims

(1) Noncompensable Claims Definition

A noncompensable claim is a claim that ~~does not generate payments or reserves~~ meets ~~due to~~ one or more of the following:

- Official ruling denying benefits
- Claimant's failure to file for benefits
- Claimant's failure to prosecute claim following carrier's denial of the claim

(2) Noncompensable Claims Reporting

~~When a claim has been ruled or declared to be noncompensable, the entire cost of the claim must be net down for unit statistical reporting as follows:~~

- ~~If noncompensable prior to the 1st unit statistical report, the claim is not to be reported.~~
- ~~If noncompensable after the 1st reporting, but within one year after the 5th report due date of the report on which the claim appears, a correction report must be filed. Reduce the incurred cost on the claim to zero.~~
- ~~If noncompensable as of the 6th report due date or subsequent, a correction report is not required. If the claim remains open, reduce the incurred cost on the claim to zero at the next valuation date.~~

~~The reporting of correction reports may impact experience modification(s) pursuant to the rules of the ***Experience Rating Plan Manual***.~~

(a) For Policies Effective January 1, 2013 and Subsequent

When a claim has been determined to be noncompensable, based on Part 4, Item A-1-d(1)—Noncompensable Claims Definition:

- As of the 1st report valuation and does not include any paid losses, incurred losses, and/or ALAE, the claim must not be reported.
- As of the 1st report valuation and does include paid losses, incurred losses, and/or ALAE, the claim must be reported with these loss values. Report this claim with the Type of Settlement (Loss Condition) Code 05.
- After the 1st report valuation and prior to the 6th report valuation, correction report(s) are required for all previously submitted unit reports to report the Type of Settlement (Loss Condition) Code 05. The paid losses, incurred losses, and/or ALAE must continue to reflect the loss values as of each specific report level(s).
- As of the 6th report valuation or subsequent, report the claim with the Type of Settlement (Loss Condition) Code 05. The paid losses, incurred losses, and/or ALAE must continue to reflect the losses valued at that report level. Correction report(s) must not be reported for all previously submitted unit reports.

Refer to NCCI's ***Experience Rating Plan Manual*** for additional rules.

Refer to NCCI's ***Unit Statistical Reporting Guidebook*** for reporting examples.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
A. GENERAL INCURRED LOSS INFORMATION
1. Incurred Losses

(b) For Policies Effective Prior to January 1, 2013

When a claim has been ruled or declared to be noncompensable, the entire cost of the claim must be net down for unit statistical reporting as follows:

- If noncompensable prior to the 1st unit statistical report, the claim is not to be reported.
- If noncompensable after the 1st reporting, but within one year after the 5th report due date of the report on which the claim appears, a correction report must be filed. Reduce the incurred cost on the claim to zero.
- If noncompensable as of the 6th report due date or subsequent, a correction report is not required. If the claim remains open, reduce the incurred cost on the claim to zero at the next valuation date.

The reporting of correction reports may impact experience modification(s) pursuant to the rules of the ***Experience Rating Plan Manual***.

(3) Loss Condition Code—Type of Settlement

The Type of Settlement Code includes the identification of noncompensable claims. Each claim must be reported with the appropriate Type of Settlement Code as defined in Part 6, Item K-5—Type of Settlement—Loss Conditions.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
1. Required Claim Components

a. ~~Claim Counting Rules~~ Indemnity, Medical, and Allocated Loss Adjustment Expense Amounts

(1) ~~Cases counted as claims must be those in connection with which a payment has been made or a reserve has been established in connection with an indemnity and/or medical loss.~~

(2) ~~All claims must be reported but are not counted if the only component reported is ALAE, since ALAE is currently excluded from NCCI ratemaking and experience rating processes.~~

(3) ~~A case closed without loss payment must not be counted as a claim or reported unless the claim reopens as of a subsequent valuation.~~

(4) ~~A claim on which more than one payment is made must be counted only once.~~

(5) ~~An accident resulting in two or more reported claims must have each claim counted separately.~~

(6) ~~An accident resulting in an injury to one worker, but on which payments are made under different coverages of the policy (e.g., Workers Compensation Including Employers Liability), must be reported as one claim and be identified with the appropriate loss condition code. Loss condition codes are listed in Part 6 – Coding Values.~~

(7) ~~Subrogation, fraud, and other recoveries (other than reinsurance or deductibles) must net down the claim count only if the recovery is equal to or greater than the total cost of the claim. In this instance, the claim must be removed from previously filed reports.~~

(8) ~~Claims involving contract or capitated medical cannot be counted with grouped contract medical claims. Count each claim once (grouped or individual).~~

For each claim, the following loss amount fields are required when applicable:

- Incurred Indemnity Amount
- Paid Indemnity Amount
- Incurred Medical Amount
- Paid Medical Amount
- Paid Allocated Loss Adjustment Expense (ALAE) Amount

Refer to Part 4, Item A—General Incurred Loss Information, Item B—Medical Losses, Item C—Indemnity Losses, and Item D—Expenses Excluded From Losses for rules regarding the amounts to be reported in each field.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
1. Required Claim Components

b. ~~Number of Claims~~ Claim Count

(1) ~~Single Claim~~

Report ~~the single claim as~~ a number one (1). ~~This includes a single claim that has been netted down pursuant to the rules in Item E-1-a—Claim Counting Rules.~~

(2) ~~Grouped Claims~~

~~Report the number of grouped claims as a numeric of two (2) or more pursuant to the rules in Item E-3-d—Claim Grouping. Report the number of claims within each group. If any claim within the group is open, the entire group must be considered open and subsequent data must be submitted according to Part 4.~~

~~Refer to NCCI's ***Unit Statistical Reporting Guidebook*** for more information.~~

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
1. Required Claim Components

c. Claim Number

(1) ~~Single Claim~~

Report an alphanumeric code that uniquely identifies the specific claim and that will make it possible to locate the claim records in the company files. If a claim number changes during the life of the claim, correction reports are required for all previously submitted unit statistical reporting levels.

The claim number must be reported consistently throughout the life of the claim.

(2) ~~Grouped Claims~~

~~The claim number is not reported if the claims are grouped according to the procedures provided in Item E-3-d—Claim Grouping.~~

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
1. Required Claim Components

d. Accident Date

(1) ~~Single Claim~~

For a traumatic or disease injury, ~~R~~report the ~~month, day, and year~~ date on which the claim ~~accident~~ occurred. The accident date must be ~~fall~~ within the policy period ~~(e.g., accident date of 06/20/98 would be valid for a policy with effective date of 01/1/98 and expiration date of 01/1/99).~~

For a disease injury where the accident date is not specified, report the claimant's last date of exposure to the conditions causing or aggravating the disease injury.

The accident date must be reported consistently throughout the life of the claim.

Refer to NCCI's ***Unit Statistical Reporting Guidebook*** for more information.

(2) ~~Grouped Claims~~

~~The accident date is not reported if the claims are grouped according to the procedures provided in Item E-3-d—Claim Grouping.~~

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
1. Required Claim Components

f. Classification Code

(1) Classification Code Loss Reporting

Report the classification code that corresponds to the injured employee's payroll or other exposure assigned in accordance with Part 1~~—General Rules,~~ Item Q—Classification Code. No claim may be assigned to any classification code unless payroll or other exposure also has been reported for that classification code. The classification code must be reported consistently throughout the life of the claim.

~~Medical-only claims may be coded to the governing classification code on the policy regardless of the original classification code to which the injured employee's payroll was assigned. Any medical-only claim coded to the governing classification code, which subsequently develops into an indemnity case, must be reported with the insured employee's payroll classification code.~~

(2) Additional Classification Code Loss Reporting

Additional classification code reporting rules apply as follows:

(a) Aircraft Operation Losses

Losses related to employees of the risk, other than members of the flying crew, arising out of the operation of an aircraft must be reported under the designated aircraft operation class code.

(b) Losses With Non-Payroll-Based Exposure

Losses must also be reported for volunteer fire fighters, per capita workers, circus car/truck drivers, coal miners, and workers with supplemental disease experience under the designated statistical code.

(c) Contract Medical

A class code is not required for ~~grouped~~ contract medical claims.

Note: ~~Grouped c~~Contract medical claims are medical-only claims covered entirely by a medical contract.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
1. Required Claim Components
g. Injury Type Code
(3) Injury Type Definnitions

(j) Permanent Partial Disability

~~A permanent partial loss is defined as:~~

- ~~Any permanent injury that does not involve permanent total disability~~
- ~~Any temporary injury that satisfies any one of the following criteria:~~
  - ~~The duration of disability benefits exceeds or is expected to exceed one full year. No loss is to be reported as temporary total if the duration of total disability exceeds or is expected to exceed 52 weeks.~~
  - ~~A lump-sum settlement is made or, in the judgment of the carrier, will be required to settle future benefits.~~
  - ~~The extent of liability for future payments cannot be determined.~~

~~The amount entered as incurred indemnity must include specific benefits and compensation for temporary disability as well as loss of earning capacity. At the option of the carrier, losses on lifetime permanent partial claims may be calculated using Table III-M-A, III-M-B, III-M-C, III-F-A, III-F-B, or III-F-C in Part 7—Pension Tables.~~

1. For Claims With Accident Dates January 1, 2013 and Subsequent

A permanent partial loss is defined as any permanent injury that does not involve permanent total disability.

2. For Claims With Accident Dates Prior to January 1, 2013

A permanent partial loss is defined as:

- Any permanent injury that does not involve permanent total disability
- Any temporary injury that satisfies any one of the following criteria:
  - The duration of disability benefits exceeds or is expected to exceed one full year. No loss is to be reported as temporary total if the duration of total disability exceeds or is expected to exceed 52 weeks.
  - A lump-sum settlement is made or, in the judgment of the carrier, will be required to settle future benefits.
  - The extent of liability for future payments cannot be determined.

3. Permanent Partial Amount

The amount entered as incurred indemnity must include specific benefits and compensation for temporary disability as well as loss of earning capacity. At the option of the carrier, losses on lifetime permanent partial claims may be calculated using Table III-M-A, III-M-B, III-M-C, III-F-A, III-F-B, or III-F-C in Part 7—Pension Tables.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
1. Required Claim Components

m. Vocational Rehabilitation Indicator

Report whether or not the claim includes vocational rehabilitation costs. Refer to Part 4, Item C-3—Vocational Rehabilitation for additional rules on vocational rehabilitation.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
2. Conditional Claim Components

c. Deductible Reimbursement Amount

Report the applicable deductible reimbursement or zero as outlined in Part 4, Item A-3—Deductible Reimbursement Amount.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
2. Conditional Claim Components

d. Fraudulent Claim Code

Report the code that identifies whether the claim is fraudulent or not. Refer to Part 4, Item A-1-c—Fraudulent Claims for additional rules regarding fraudulent claims.

EXHIBIT 4
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

(1) ~~Policies Effective July 1, 1999 and Subsequent~~ Policies Effective January 1, 2013 and Subsequent

All claims must be reported individually and cannot be grouped.

(a) ~~Claims Not Eligible for Grouping~~

~~The following claims may not be grouped:~~

- ~~Medical only claims with a total loss greater than $2,000~~
- ~~All claims that involve an indemnity incurred loss, regardless of amount (these claims must be listed individually with the appropriate claim number and accident date)~~
- ~~All claims partially covered by contract or capitated medical (these claims must be listed separately~~
- ~~Medical only claims that do not contain the same loss conditions (act, type of loss, type of recovery, type of claim, type of settlement), fraudulent claim code, lump sum settlement status, or managed care organization status~~

(b) ~~Claims Eligible for Grouping~~

~~The following claims may be grouped:~~

- ~~Medical only claims with a total loss up to $2,000~~
- ~~The number of claims must be reported instead of the claim number and accident date~~
- ~~If any claim within the group is open, the entire group shall be considered open and subsequent reports must be submitted in accordance with Item F—Subsequent Reports~~
- ~~Eligible claims may be coded to the governing classification~~

(c) ~~Claim Grouping Rules~~

~~If any of the following events occur to a claim within a group, the claim must be removed from the group at the next valuation and reported individually with the full statistical detail, according to the instructions in this section of the Plan:~~

- ~~The incurred medical for any claim in the group exceeds the state specified limit.~~
- ~~A grouped medical only claim that subsequently develops into an indemnity case.~~
- ~~A grouped medical only claim coded to the governing classification, which subsequently develops into an indemnity case. Include the injured employee's payroll classification when reporting individually.~~

(2) ~~Policies Effective Prior to July 1, 1999~~ Policies Effective July 1, 1999 Through December 31, 2012

(a) ~~Each claim that involves a total incurred loss (indemnity and medical combined) of greater than $2,000 must be listed individually with the appropriate claim number and accident date.~~

(b) ~~All claims partially covered by contract or capitated medical must be listed separately. Fraudulent claims, vocational rehabilitation claims, deductible claims, claims with lump sum settlements, or claims handled by a managed care organization must be grouped together within injury type and~~

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

~~loss condition. At the option of the carrier, all other claims may be reported individually or grouped by class within injury type and loss condition. Medical-only claims covered entirely by contract or capitated medical may be grouped under the appropriate injury type and loss condition. Claims may be grouped together if the class codes and loss condition codes are identical.~~

(c) ~~Medical-only claims may be coded to the governing class code.~~

(d) ~~Any grouped medical-only claim coded to the governing class code, which subsequently develops into an indemnity case, must be removed from the grouping and reported with the injured employee's payroll class code at the next valuation. If the incurred loss becomes greater than $2,000, the claim must be reported individually with full statistical detail.~~

(e) ~~Under the grouping option, the number of claims must be reported instead of the claim number and accident date.~~

(a) Claims Not Eligible for Grouping

The following claims may not be grouped:

- Medical-only claims with a total loss greater than $2,000
- All claims that involve an Indemnity Incurred loss, regardless of amount (these claims must be listed individually with the appropriate claim number and accident date)
- All claims partially covered by contract or capitated medical (these claims must be listed separately)
- Medical-only claims that do not contain the same Loss Conditions (Act, Type of Loss, Type of Recovery, Type of Claim, Type of Settlement), Fraudulent Claim Code, Lump-Sum Settlement status, or Managed Care Organization status

(b) Claims Eligible for Grouping

The following claims may be grouped:

- Medical-only claims with a total loss up to $2,000
- The number of claims must be reported instead of the claim number and accident date
- If any claim within the group is open, the entire group shall be considered open, and subsequent reports must be submitted in accordance with Part 4, Item G—Subsequent Reports
- Eligible claims may be coded to the governing classification

(c) Claim Grouping Rules

If any of the following events occur to a claim within a group, the claim must be removed from the group at the next valuation and reported individually with the full statistical detail, according to the instructions in this section of the Plan:

- The incurred medical for any claim in the group exceeds the state-specified limit.
- A grouped medical-only claim that subsequently develops into an indemnity case.
- A grouped medical-only claim coded to the governing classification, which subsequently develops into an indemnity case. Include the injured employee's payroll classification when reporting individually.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

(d) Grouped Claim Components

1) Number of Claims

Report the number of grouped claims as a number of two (2) or more. If any claim within the group is open, the entire group must be considered open, and subsequent data must be submitted according to Part 4—Loss and Expense Information.

2) Claim Number

The claim number is not reported for grouped claims.

3) Accident Date

The accident date is not reported for grouped claims.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

f. Incurred Allocated Loss Adjustment Expense (ALAE) Amount

Report the whole dollar amount of incurred allocated loss adjustment expense for the claim as of the loss valuation date.

EXHIBIT 4
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION

F. ~~SUBSEQUENT REPORTS~~ ADDITIONAL CLAIM REPORTING RULES

1. ~~Reporting Rules~~

~~Subsequent reports (2nd–10th reports) must be filed when:~~

- ~~There are open or reopened claims as of the last report submitted, regardless of whether or not there are changes to the loss data.~~
- ~~There are claims indicated as closed on a previous report that are reopened.~~
- ~~There are claims that were previously not reported, or the claim did not exist at the time of the previous reporting.~~
- ~~There are changes in losses valued from the prior to the current valuation period, yet claims were closed in both valuation periods.~~

~~Losses are valued 12 months after the valuation date of the preceding report level. Refer to Part 1 for additional instructions on valuation and filing.~~

~~Affiliate Self-Insurers: 6th–10th subsequent reports are to be reported in accordance with the scope of this Plan.~~

2. ~~Revaluation of Losses~~

~~If a claim is closed and there is no change in the loss in that valuation period, it should not be reported in the next valuation period. If a change occurs, report the revised values for each open, reopened, or closed claim on the 2nd–10th report. The cumulative total may be reported for the following fields:~~

- ~~Number of claims~~
- ~~Paid indemnity~~
- ~~Incurred indemnity~~
- ~~Paid medical~~
- ~~Incurred medical~~
- ~~ALAE paid~~
- ~~ALAE incurred (optional)~~

3. ~~6th–10th Reports~~

~~Unit statistical data with policies effective December 31, 1998 and prior, which meet the requirements for subsequent reporting, require only 2nd–5th subsequent reports. For policies effective January 1, 1999 and subsequent, 6th–10th reports are required.~~

1. Claims are reportable when, as of the valuation date, there are loss values in the paid losses, incurred losses, and/or ALAE.
2. Claims closed without any payments and ALAE as of the 1st unit report valuation date are not to be reported. If these claims subsequently reopen at a future unit report valuation date with loss values in the paid losses, incurred losses, and/or ALAE, these claims are reportable.
3. An accident for one claimant with reportable losses under both Workers Compensation and Employers Liability are to be reported as one claim, with combined loss experience. These claims are to be reported with Loss Condition—Type of Claim Code 03 (Workers Compensation Including Employers Liability). Refer to Part 6, Item K-4—Loss Condition Code—Type of Claim Codes.
4. Claims are reportable for traumatic injuries that occur on an accident date within the policy period.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION

5. Claims are reportable for disease injuries that occur on an accident date within the policy period.
6. Claims are reportable for disease injuries where the accident date is not specified, and the claimant's last date of exposure to the conditions causing or aggravating the disease injury is within the policy period.
7. Claims with accident dates outside of the policy period that are required to be paid due to an official ruling, and where there is no corresponding exposure, must not be reported.

EXHIBIT 4 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 4–LOSS AND EXPENSE INFORMATION

G. SUBSEQUENT REPORTS

1. Reporting Rules

Subsequent reports (2nd–10th reports) must be filed when:

- There are open or reopened claims as of the last report submitted, regardless of whether or not there are changes to the loss data
- There are claims indicated as closed on a previous report that are reopened
- There are newly arising claims as of the current valuation date
- There are changes in losses valued from the prior to the current valuation period, yet claims were closed in both valuation periods

Losses are valued 12 months after the valuation date of the preceding report level. Refer to Part 1—General Rules for additional instructions on valuation and filing.

Affiliate Self-Insurers: 6th–10th subsequent reports are to be reported in accordance with the scope of this Plan.

2. Revaluation of Losses

If a claim is closed and there is no change in the loss in that valuation period, it should not be reported in the next valuation period. If a change occurs, report the revised values for each open, reopened, or closed claim on the 2nd–10th report. The cumulative total may be reported for the following fields:

- Number of claims
- Paid indemnity
- Incurred indemnity
- Paid medical
- Incurred medical
- ALAE paid
- ALAE incurred (optional)

3. 6th–10th Reports

Unit statistical data with policies effective December 31, 1998 and prior, which meet the requirements for subsequent reporting, require only 2nd–5th subsequent reports. For policies effective January 1, 1999 and subsequent, 6th–10th reports are required.

EXHIBIT 5
STATISTICAL PLAN—2008 EDITION
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS

1. When Correction Reports Are Required

Correction reports must be filed without delay when any of the conditions outlined below occur:

a. An error of any kind is made on ~~a~~ previously filed report(s).

b. When the exposure previously reported has been changed by reason of an audit, a reaudit, or any other adjustment affecting class codes, exposure, or premiums, a correction report must be filed. Revised premium discounts, if any, must also be corrected.

c. It is necessary to submit a correction report for premium discounts and expense constant corrections.

d. Corrections to the type of injury are required as defined in Part 4, Item E-1-g—Injury Type Code.

e. Loss values are found to have been included or excluded through clerical errors.

f. The claim is determined to be ~~, or any part thereof, is declared~~ noncompensable as defined in Part 4, Item A-1-d—Noncompensable Claims.

g. If the claim number changes during the life of the claim as described in Part 4, Item E-1-c—Claim Number.

h. If the carrier performs a final audit on an insured subsequent to the ~~performing an~~ estimated audit.

i. If the carrier performs a revised final audit on an insured subsequent to performing a final audit.

j. If the header/policy information was reported incorrectly.

k. The specific Part of Body Code is determined subsequent to reporting Part of Body Code 65—Insufficent Info to Properly Identify—Unclassified.

l. Claim loss amounts are reduced due to a subrogation recovery as defined in Part 4, Item A-1-a—Subrogation.

m. Claim loss amounts are reduced in connection with a special fund as defined in Part 4, Item A-1-b(2)—Special Funds Reimbursement Amount and Item A-1-b(3)—Special Funds Reporting Assessments and Special Funds.

n. The claim has been determined to be fraudulent as defined in Part 4, Item A-1-c—Fraudulent Claims.

Refer to NCCI's ***Unit Statistical Reporting Guidebook*** for correction report examples.

EXHIBIT 5 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS
4. Reporting Corrections for Assessments, Special Funds, and Subrogation

a. Assessments and Special Funds

The carrier or claimant has received or anticipates receiving reimbursement from a second injury fund or similar type of fund. When such a recovery is received by the carrier after reporting the claim (between valuation dates), but within one year after the 5th report due date, correction reports must be filed revising the paid and incurred loss on the claim as described in Part 4, Item A-1-b(3)—Special Funds Reporting ~~E-1-k.~~ If an anticipated recovery becomes known by the carrier, or a recovery is paid to the carrier as of the 6th report due date or subsequent, a correction report is not required; all adjustments are reported at the next valuation date if the claim is open. Correction reports are required only for prior reports that reflected an amount higher than the net incurred cost. Refer to the ***Experience Rating Plan Manual*** for time frames of experience modification revisions.

EXHIBIT 5 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS
4. Reporting Corrections for Assessments, Special Funds, and Subrogation

b. Subrogation

The carrier or claimant has obtained a subrogation recovery in an action against a third party. When such a recovery is received by the carrier after reporting the claim (between valuation dates), but within one year after the 5th report due date, correction reports must be filed revising the paid and incurred loss on the claim as described in Part 4, Item A-1-a(2)—Subrogation Reporting. If an anticipated recovery becomes known by the carrier, or a recovery is paid to the carrier as of the 6th report due date or subsequent, a correction report is not required; all adjustments are reported at the next valuation date if the claim is open. Correction reports are required only for prior reports that reflected an amount higher than the net incurred cost.

Refer to NCCI's ***Experience Rating Plan Manual*** for time frames of experience modification revisions.

EXHIBIT 5 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS

5. Reporting Corrections for 1st–10th Reports

Correction reports submitted in connection with 1st–10th reports must be identified with a correction type and sequence number as described in Part 2, Item B—Correction Sequence Number and Item C—Correction Type Code. Please refer to Part 6—Coding Values for specific correction type codes.

Note: Unit statistical data with policies effective December 31, 1998 and prior, which meet the requirements for subsequent reporting, require only corrections to 2nd–5th reports.

Exceptions for Affiliate Self-Insurers: 6th–10th subsequent reports are to be reported in accordance with the scope of this Plan. Refer to Scope and Effective Date of the Plan for the minimum reporting requirement.

EXHIBIT 6
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES

C. POLICY CONDITION INDICATORS

The policy conditions have seven data elements consisting of one byte each, totaling seven bytes. Report one or more of the following conditions that apply; report **Y (Yes)** if the condition applies, or **N (No)** if the condition does not apply.

- Three-Year Fixed-Rate Policy Indicator

  Florida Exception: Three-year fixed-rate policies are not permitted.
- Multistate Policy Indicator
- Interstate Rated Policy Indicator
- Estimated Audit Code ~~Exposure Indicator~~
- Retrospective Rated Policy Indicator
- Cancelled Midterm Policy Indicator
- Managed Care Organization (MCO) Indicator

  Virginia Exception: For the Managed Care Organization indicator, report Y (Yes) or N (No) according to the following:

  Y The policy has provisions for the administration of losses under an approved Managed Care Program.

  N The policy does not have provisions for the administration of losses under an approved Managed Care Program.

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
D. POLICY TYPE CODE

3. Type of Nonstandard Provisions

The third component of the Policy Type ID Code consists of two digits for the Nonstandard Provisions.

Code	Type of Nonstandard Provisions
01	**Nonstandard Code Does Not Apply**: Coverages as described under the Standard Workers Compensation Including Employers Liability Policy without nonstandard exclusions, endorsements, or exceptions.
05	**Excess Policy**: Applies in West Virginia only as follows: ~~**Rhode Island Exception**: Type of Nonstandard Provisions Code 05 is not applicable.~~ **West Virginia Exception**: Type of Nonstandard Provisions Code 05 is applicable only when Deliberate Intent (Mandolidis) Coverage has been provided as an excess policy.
08	Coverage excludes certain individuals listed on exclusion endorsement, such as officers, partners, sole proprietors, or others (optional).
09	**Voluntary Coverage Not Mandated by State Act**: Coverage as described under the Standard Workers Compensation Including Employers Liability Policy except coverage that was endorsed by Voluntary Special Endorsement. This endorsement affords the benefits of a designated compensation law as if the affected employees were subject to that law, even though the law does not require payment of benefits to these employees. **Hawaii Exception**: Type of Nonstandard Provisions Code 09 is not applicable.

EXHIBIT 6
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES

H. STATISTICAL CODES

Statistical codes are grouped in three separate tables, based on how the amount associated with the statistical code applies to the premium.

- Premium Amount Subject to Experience Modification Factor
- Premium Amount Not Subject to Experience Modification Factor
- Premium Amount Not Part of Standard Premium

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
Claims Deductible Coverage—$500 Deductible	9758	–	RI	05/94	12/31/95
Claims Deductible Coverage—$15,000 Deductible	9770	–	MO	01/93	12/31/95
Claims Deductible Coverage—$20,000 Deductible	9771	–	MO	01/93	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$2,000 Deductible	9796	–	MO	10/95	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$2,500 Deductible	9797	–	MO	10/95	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$5,000 Deductible	9798	–	MO	10/95	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$10,000 Deductible	9799	–	MO	10/95	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$15,000 Deductible	9772	–	MO	10/95	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$20,000 Deductible	9773	–	MO	10/95	12/31/95
Claims Deductible Coverage—$15,000	9780	–	FL	07/95	12/31/95
			MO	10/95	12/31/95

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
Premium Amount *Subject* to Experience Modification Factor (Cont'd)

Description	Stat Code	Premium Credit (–) or Debit (+)	Applicable States	Effective Date	Discontinuation Date
Claims Deductible Coverage—$20,000	9781	–	FL	07/95	12/31/95
			MO	10/95	12/31/95
Coinsurance Coverage—$4,200 Limit	9948	–	IN	01/92	12/31/95
Deductible Coverage (per Accident)—$2,000 Deductible	9981	–	NH	03/92	12/31/95
Deductible Reporting—Subject to Experience Modification Factor	9664(1)	-	All States Except NV, VA, WV	01/96	
			NV	07/01/00	
			VA	01/01/99	
			WV(3)	07/08	
Large Deductible Coverage (Gross Loss Reported)—$25,000	9956	–	All States Except VA	01/90	12/31/95
Large Deductible Coverage (Gross Loss Reported)—$50,000	9957	–	FL	01/90	12/31/95
Large Deductible Coverage (Gross Loss Reported)—$75,000	9958	–	FL	01/90	12/31/95

(1) Statistical Code 9664 is applicable to NCCI-filed and insurer-filed programs. Insurer-independent deductible programs must be filed with the state insurance department and approved as required on or before the date that the insurer uses it.

(3) ~~WV - If an insurer uses an independently filed deductible program, the program must be filed with the Offices of Insurance Commissioner (OIC) on or before the date that the insurer uses it. If an insurer adopts NCCI's small deductible program without modification, a separate filing is not required.~~

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
Claims Deductible Coverage (Net Loss Reported)—$100 Deductible	9789	–	MO	10/95	12/31/95

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
Premium Amount *Not Subject* to Experience Modification Factor (Cont'd)

Claims Deductible Coverage (Net Loss Reported)—$200 Deductible	9790	–	MO	10/95	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$300 Deductible	9791	–	MO	10/95	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$400 Deductible	9792	–	MO	10/95	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$500 Deductible	9793	–	MO	10/95	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$1,000 Deductible	9794	–	MO	10/95	12/31/95
Claims Deductible Coverage (Net Loss Reported)—$1,500 Deductible	9795	–	MO	10/95	12/31/95
Deductible Reporting—Not Subject to Experience Modification Factor	9663(1)	-	All States Except NV and, ~~VA,~~WV	01/96	
			NV	07/01/00	
			WV(3)	07/08	
Large Deductible Coverage (Gross Loss Reported)—$25,000	9856	–	All States Except VA	01/90	12/31/95
Large Deductible Coverage (Gross Loss Reported)—$50,000	9857	–	All States Except VA	01/90	12/31/95
Large Deductible Coverage (Gross Loss Reported)—$75,000	9858	–	All States Except VA	01/90	12/31/95

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
Premium Amount *Not Subject* to Experience Modification Factor (Cont'd)

Schedule Rating Program (2)	9887	–	All States Except NV and WV~~Those Listed Below~~	03/82	
			~~AL~~	~~07/97~~	
			~~AZ~~	~~07/82~~	
			~~CO~~	~~07/83~~	
			~~CT~~	~~10/01~~	
			~~DC~~	~~02/83~~	
			~~FL~~	(4)	
			~~IA~~	~~04/97~~	
			~~ID~~	~~01/98~~	
			~~IN~~	~~09/89~~	
			~~KS~~	~~07/01/11~~	
			~~KY~~	~~01/03~~	
			~~MD~~	~~10/98~~	
			~~ME~~	(5)	
			~~MS~~	~~11/83~~	
			~~MT~~	~~07/94~~	
			~~NH~~	~~10/91~~	
			~~NM~~	~~04/97~~	
			NV	07/00	
			~~OK~~	~~09/95~~	
			~~RI~~	~~03/83~~	
			~~SC~~	~~04/83~~	
			~~SD~~	~~06/92~~	
			~~TN~~	~~05/83~~	
			~~UT~~	~~01/83~~	
			~~VA~~	~~04/01/02~~	
			~~VT~~	~~07/90~~	
			WV(6)	01/08	

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
Premium Amount *Not Subject* to Experience Modification Factor (Cont'd)

	9889	+	All States Except NV and WV~~Those Listed Below~~	03/82	
			~~AL~~	~~06/83~~	
			~~AR~~	~~07/82~~	
			~~AZ~~	~~07/82~~	
			~~CO~~	~~07/83~~	
			~~CT~~	~~10/01~~	
			~~DC~~	~~02/83~~	
			~~FL~~	~~(4)~~	
			~~IA~~	~~04/97~~	
			~~ID~~	~~01/98~~	
			~~IN~~	~~09/89~~	
			~~KS~~	~~07/01/11~~	
			~~KY~~	~~01/03~~	
			~~MD~~	~~10/98~~	
			~~ME~~	~~(5)~~	
			~~MS~~	~~11/83~~	
			~~MT~~	~~07/94~~	
			~~NH~~	~~10/91~~	
			~~NM~~	~~01/85~~	
			NV	07/00	
			~~OK~~	~~09/95~~	
			~~RI~~	~~03/83~~	
			~~SC~~	~~04/83~~	
			~~SD~~	~~06/92~~	
			~~TN~~	~~05/83~~	
			~~UT~~	~~01/83~~	
			~~VA~~	~~04/01/02~~	
			~~VT~~	~~07/90~~	
			WV(6)	01/08	

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
Premium Amount *Not Subject* to Experience Modification Factor (Cont'd)

(1) Statistical Code 9663 is applicable to NCCI-filed and insurer-filed programs. Insurer-independent deductible programs must be filed with the state insurance department and approved as required on or before the date that the insurer uses it.

(3) ~~WV—If an insurer uses an independently filed deductible program, the program must be filed with the Offices of Insurance Commissioner (OIC) on or before the date that the insurer uses it.~~

(2) Schedule rating programs are for voluntary policies only. Statistical Codes 9887 and 9889 are applicable to NCCI-filed and insurer-filed programs. Insurer-independent schedule rating plans must be filed with the state insurance department and approved as required on or before the date that the insurer uses it. If an insurer adopts NCCI's schedule rating plan without modification, a separate filing is not required.

(4) ~~FL—Scheduled rating would be available for use in Florida only if prior approval is obtained for a schedule rating plan from the Florida Office of Insurance Regulation.~~

(5) ~~ME—Schedule Rating would be available for use in Maine only if prior approval is obtained for a schedule rating plan from the Maine Bureau of Insurance.~~

(6) ~~WV—If an insurer uses an independently filed schedule rating plan, the plan must be filed with the Offices of Insurance Commissioner (OIC) on or before the date that the insurer uses it. If an insurer adopts NCCI's schedule rating plan without modification, a separate filing is not required.~~

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
Deductible Reporting—Not Part of Standard Premium	9657(1)	-	All States Except OR, SC, VA, WV	09/01/08	
			OR	01/01/09	
			SC	07/01/08	
			VA	01/01/11	
			WV(3)	07/08	

(1) Statistical Code 9657 is applicable to insurer-filed programs. Insurer-independent deductible programs must be filed with the state insurance department and approved as required on or before the date that the insurer uses it.

(3) ~~WV—If an insurer uses an independently filed deductible program, the program must be filed with the Offices of Insurance Commissioner (OIC) on or before the date that the insurer uses it.~~

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6—CODING VALUES
K. LOSS CONDITION CODE

5. Type of Settlement—Loss Conditions

The fifth component of Loss Conditions consists of two digits for the Type of Settlement.

Code	Description
00	**Claim Not Subject to Settlement**
03	**Stipulated Award (Data Provider/Claimant Settlement)**: An award that has been agreed to between the carrier and claimant and submitted for approval to the applicable state workers compensation authority having jurisdiction over claim settlements.
04	**Findings and Award (Judicial Award)**: An award that has been issued by a judge based on evidence presented in the process of litigation.
05	**Dismissal or Take Nothing (Noncompensable)**: The claim meets ~~will generate no payments or reserves due to~~ one or more of the following: • Official ruling denying benefits • Claimant's failure to file for benefits • Claimant's failure to prosecute claim following carrier's denial of the claim
06	**Compromise Settlement**: Compromise and release. A settlement over the issues of applicability, extent of injury and future benefits.
07	**No Safety Devices**: A type of liability resulting from the employer's failure to provide safety devices as required by the New Mexico Compensation Act. **New Mexico Exception**: Type of Settlement—Loss Conditions—Code 07 for No Safety Devices applies in New Mexico only.
09	**All Other Settlements**
10	**Aggravation of Prior Work-Related Injuries:** Claim eligible for exclusion from experience rating under Maine Rule 450. **Maine Exception:** Type of Settlement—Loss Conditions—Code 10 for Aggravation of Prior Work-Related Injuries applies in Maine only.

Oregon Exception: The reporting of Type of Settlement is optional.

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES

L. MANAGED CARE ORGANIZATION (MCO) TYPE CODE

Managed Care Organization is a two-digit code that corresponds to the type of organization that will administer the applicable medical losses of this claim.

Code	Description
00	The claim is not administered by an approved/certified managed care organization.
01	The claims' medical losses are administered by an approved managed care organization not specifically listed in Codes 02–06~~5~~ below such as a Preferred Maintenance Organization (PMO).
02	**Healthcare Maintenance Organization (HMO):** The claim's medical losses are administered by an approved Health Maintenance Organization.
03	**Preferred Provider Organization (PPO):** The claim's medical losses are administered by an approved Preferred Provider Organization.
04	**Exclusive Provider Organization (EPO):** The claim's medical losses are administered by an approved Exclusive Provider Organization.
05	**Independent Practice Association (IPA):** The claim's medical losses are administered by an approved Independent Practice Association.
06	**Managed Care Organization (MCO):** The claim is totally or partially covered by a Managed Care Organization under a Contract Medical agreement. The medical care provider will directly treat injured workers for a predetermined fee and amount of time.

EXHIBIT 6
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
M. INJURY DESCRIPTION CODE (PART, NATURE, CAUSE)

3. Cause of Injury Codes

Cause of Injury Codes

Code	Cause of Injury	Narrative Description
a.	**Burn or Scald—Heat or Cold Exposures—Contact With**	
01	Chemicals	
02	Hot Objects or Substances	
11	Cold Objects or Substances	
03	Temperature Extremes	
04	Fire or Flame	
05	Steam or Hot Fluids	
06	Dust, Gases, Fumes, or Vapors	
07	Welding Operation	
08	Radiation	
14	Abnormal Air Pressure	
84	Electrical Current	
09	Contact With, NOC	
b.	**Caught In, Under, or Between**	
10	Machine or Machinery	
12	Object Handled	
20	Collapsing Materials (Slides of Earth)	Either Man-Made or Natural
13	Caught In, Under, or Between, NOC	

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
M. INJURY DESCRIPTION CODE (PART, NATURE, CAUSE)
Cause of Injury Codes (Cont'd)

Code	Cause of Injury	Narrative Description
c.	**Cut, Puncture, Scrape— Injured By**	
15	Broken Glass	
16	Hand Tool, Utensil; Not Powered	
17	Object Being Lifted or Handled	
18	Powered Hand Tool, Appliance	
19	Cut, Puncture, Scrape, NOC	
d.	**Fall, Slip, or Trip Injury**	
25	From Different Level (Elevation)	Off Wall, Catwalk, Bridge, etc.
26	From Ladder or Scaffolding	
27	From Liquid or Grease Spills	
28	Into Openings	Shafts, Excavations, Floor Openings, etc.
29	On Same Level	
30	Slipped, Did Not Fall	
32	On Ice or Snow	
33	On Stairs	
31	Fall, Slip, or Trip, NOC	
e.	**Motor Vehicle**	
40	Crash of Water Vehicle	
41	Crash of Rail Vehicle	
45	Collision or Sideswipe With Another Vehicle	Both Vehicles in Motion

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
M. INJURY DESCRIPTION CODE (PART, NATURE, CAUSE)
Cause of Injury Codes (Cont'd)

Code	Cause of Injury	Narrative Description
46	Collision With a Fixed Object	Standing Vehicle or Stationary Object
47	Crash of Airplane	
48	Vehicle Upset	Overturned or Jackknifed
50	Motor Vehicle, NOC	
f.	**Strain or Injury By**	
52	Continual Noise	
53	Twisting	
54	Jumping	
55	Holding or Carrying	
56	Lifting	
57	Pushing or Pulling	
58	Reaching	
59	Using Tool or Machinery	
61	Wielding or Throwing	
97	Repetitive Motion	Carpal Tunnel Syndrome
60	Strain or Injury by, NOC	
g.	**Striking Against or Stepping On**	
65	Moving Part of Machine	
66	Object Being Lifted or Handled	
67	Sanding, Scraping, Cleaning Operation	
68	Stationary Object	
69	Stepping on Sharp Object	
70	Striking Against or Stepping On, NOC	

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
M. INJURY DESCRIPTION CODE (PART, NATURE, CAUSE)
Cause of Injury Codes (Cont'd)

Code	Cause of Injury	Narrative Description
h.	**Struck or Injured By**	**Includes Kicked, Stabbed, Bit, etc.**
74	Fellow Worker; Patient	Not in Act of a Crime
75	Falling or Flying Object	
76	Hand Tool or Machine in Use	
77	Motor Vehicle	
78	Moving Parts of Machine	
79	Object Being Lifted or Handled	
80	Object Handled by Others	
85	Animal or Insect	
86	Explosion or Flare Back	
81	Struck or Injured, NOC	Includes Kicked, Stabbed, Bit, etc.
i.	**Rubbed or Abraded By**	
94	Repetitive Motion	Callous, Blister, etc.
95	Rubbed or Abraded, NOC	
j.	**Miscellaneous Causes**	
82	Absorption, Ingestion or Inhalation, NOC	
87	Foreign Matter (Body) in Eye(s)	
88	Natural Disasters	Earthquake, Hurricane, Tornado, etc.
89	Person in Act of a Crime (Other Than Gunshot)	Robbery or Criminal Assault
90	Other Than Physical Cause of Injury	
91	Mold	

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES
M. INJURY DESCRIPTION CODE (PART, NATURE, CAUSE)
Cause of Injury Codes (Cont'd)

Code	Cause of Injury	Narrative Description
93	Gunshot	
96	Terrorism (for use with an assigned Catastrophe Code only)	
98	Cumulative, NOC	All Other
99	Other—Miscellaneous, NOC	

EXHIBIT 6 (CONT'D)
STATISTICAL PLAN—2008 EDITION
PART 6–CODING VALUES

P. FRAUDULENT CLAIM CODE

All states except Louisiana:

This code identifies the involvement of fraud in a claim.

Code	Description
00	**Not Fraudulent:** The claim does not involve fraud.
01	**Partially Fraudulent:** The claim, or a portion of the claim, has been deemed partially fraudulent by a court decision. (Applies only to policies effective prior to January 1, 2013.)
02	**Fully Fraudulent:** The claim has been ruled (or officially declared) fully fraudulent by a court decision.

Nevada Exception: Partially and fully fraudulent claims are further defined to also include the ruling of the authorized state workers compensation agency or other authorized adjudicator.

Louisiana Exception: Fraudulent claim code descriptions are as follows:

Code	Description
00	**Not Fraudulent:** The claim does not involve fraud.
01	**Partially Fraudulent:** A portion of the claim cost is deemed invalid, unnecessary, or excessive in accordance with the law of the jurisdiction state, if applicable. (Applies only to policies effective prior to January 1, 2013.)
02	**Fully Fraudulent:** A claim where all claim costs are found to have arisen from a falsely reported injury in accordance with the law of the jurisdiction state, if applicable.

EXHIBIT 7
STATISTICAL PLAN—2008 EDITION
ALABAMA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

(1) ~~Policies Effective July 1, 1999 and Subsequent~~

(a) ~~Claims Not Eligible for Grouping~~

~~Add the following to Part 4, Item E-3-d (1) (a):~~

- ~~Medical-only claims covered by a deductible plan.~~

(2) Policies Effective July 1, 1999 Through December 31, 2012

(a) Claims Not Eligible for Grouping

Add the following to Part 4, Item E-3-d(2)(a):

- Medical-only claims covered by a deductible plan.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
ARKANSAS STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

~~Change Part 4, Item E-3-d (1) and E-3-d (2) as follows:~~ Change Part 4, Item E-3-d(2) as follows:

(1) ~~Policies Effective July 1, 2007 and Subsequent~~

(2) ~~Policies Effective Prior to July 1, 2007~~ Policies Effective July 1, 2007 Through December 31, 2012

~~Change Part 4, Item E-3-d (2) as follows:~~

(a) ~~Arkansas allows for grouping of claims that involve a total incurred loss (indemnity and medical combined) if less than the $2,000 monetary limit (if greater, these claims must be listed individually with the appropriate claim number and accident date).~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
COLORADO STATE EXCEPTIONS
PART 1–GENERAL RULES

L. COAL MINE AND BLACK LUNG EXPERIENCE

1. Reporting of Classification Code and Corresponding Statistical Code

Change Part 1, Item L-1 as follows:

Experience for traumatic and occupational disease, other than Black Lung Disease, must be reported with the applicable classification code. Black Lung Disease experience for state and/or federal acts must be reported separately from the classification code under the corresponding statistical code.

Following are the classification codes along with their corresponding statistical codes for Black Lung Disease:

Classification Code	Statistical Code
1016—Coal Mining NOC	0158—Black Lung Disease Experience in Connection With Code 1016, 1015, or 1019
1015—Mining, Underground—With Shafts, Tunnels or Drifts: Underground Employees (Colorado State Fund Only)	
1019—Mining, Underground, Surface Employees, Including Drivers: No Interchange of Labor with Code 1015 (Colorado State Fund Only)	
1005—Coal Mining—Surface and Drivers	0156—Black Lung Disease Experience in Connection With Code 1005
Any non-coal mining classification code	0164—Black Lung Disease Experience in Connection With Any Classification Other Than Coal Mine Code

3. Reporting of Traumatic and Occupational Disease Experience (Other Than Black Lung Disease)

Add the following to Part 1, Item L-3:

b. If the traumatic rate for the underground coal mine class code contains a catastrophe loading that is not subject to experience modification, then report the authorized rate after adjusting for the nonratable catastrophe loading prior to experience modification. The following formula should be used to obtain the adjusted authorized rate:

Subject Rate = Traumatic Rate – Catastrophe Rate

Authorized Rate = Subject Rate x Experience Modification + Catastrophe Rate

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
FLORIDA STATE EXCEPTIONS
PART 3–EXPOSURE INFORMATION

S. ~~EXPENSE CONSTANT AMOUNT~~

~~Change Part 3, Item S as follows:~~

~~The expense constant on a multistate policy must be allocated to the state with the highest expense constant applicable. If two or more states included on the policy have the same highest expense constant, the expense constant shall be reported for the state with the highest expense constant and largest amount of premium. The premium adjustment resulting from the application of the approved expense constant must be reported separately from class code exposures and premiums under the designated statistical code. This premium must not be included in the standard premium.~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
FLORIDA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

~~Change Part 4, Item E-3-d(1) and E-3-d(2) as follows:~~

(1) ~~Policies Effective August 1, 1999 and Subsequent~~

(b) ~~Claims Eligible for Grouping~~

~~Change the last bullet of Part 4, Item E-3-d(1)(b) as follows:~~

- ~~Medical-only claims must be coded to the classification code to which the injured worker's payroll is assigned.~~

(2) ~~Policies Effective Prior to August 1, 1999~~ Policies Effective August 1, 1999 Through December 31, 2012

~~Change Part 4, Item E-3-d(2) as follows:~~

(a) ~~Each claim that involves a total incurred loss (indemnity and medical combined) of greater than $2,000 must be listed individually with the appropriate claim number and accident date.~~

(b) ~~All claims partially covered by contract or capitated medical must be listed separately. Fraudulent claims, vocational rehabilitation claims, deductible claims, claims with lump-sum settlements, or claims handled by a managed care organization must be grouped together within injury type and loss condition. At the option of the carrier, all other claims may be reported individually or grouped by class within injury type and loss condition. Medical-only claims covered entirely by contract or capitated medical may be grouped under the appropriate injury type and loss condition. Claims may be grouped together if the class codes and loss condition codes are identical.~~

(c) ~~Medical-only claims must be coded to the classification code to which the injured worker's payroll is assigned.~~

(d) ~~This rule does not apply.~~

(e) ~~Under the grouping option, the number of claims must be reported instead of the claim number and accident date.~~

(f) ~~When Coinsurance Coverage is provided, Florida requires individual reporting of claims with total losses greater than $1,500.~~

(b) Claims Eligible for Grouping

Change the last bullet of Part 4, Item E-3-d(2)(b) as follows:

- Medical-only claims must be coded to the classification code to which the injured worker’s payroll is assigned.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
FLORIDA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

F. ~~SUBSEQUENT REPORTS~~

3. ~~6th–10th Reports~~

~~Change Part 4, Item F-3 as follows:~~

~~Unit statistical data with policies effective December 31, 2000 and prior, which meet the requirements for subsequent reporting, require only 2nd–5th subsequent reports. For policies effective January 1, 2001 and subsequent, 6th–10th reports are required.~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
FLORIDA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

G. SUBSEQUENT REPORTS

3. 6th–10th Reports

Change Part 4, Item G-3 as follows:

Unit statistical data with policies effective December 31, 2000 and prior, which meet the requirements for subsequent reporting, require only 2nd–5th subsequent reports. For policies effective January 1, 2001 and subsequent, 6th–10th reports are required.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
FLORIDA STATE EXCEPTIONS
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS

1. When Correction Reports Are Required

Add the following to Part 5, Item A-1:

k. ~~Corrections are required for an aggravated inequity. An aggravated inequity occurs when all of the following conditions are present:~~

- ~~Calculation of an experience modification based on the claim reserve(s) at the most recently reported valuation date is compared to the calculation of the experience modification based on the claim(s) closed between that valuation date and the next rating effective date~~
- ~~Comparison between the experience modifications resulted in a Total Standard Premium change of 5% or more~~

~~When an aggravated inequity occurs, submit a correction report to the claim(s) at the most recent unit report level. The correction report must reduce the incurred loss amount(s) to equal the paid loss amount(s).~~

~~Refer to NCCI's ***Experience Rating Plan Manual*** and ***Unit Statistical Reporting Guidebook*** for further details.~~

o. Corrections are required for an aggravated inequity. An aggravated inequity occurs when all of the following conditions are present:

- Calculation of an experience modification based on the claim reserve(s) at the most recently reported valuation date is compared to the calculation of the experience modification based on the claim(s) closed between that valuation date and the next rating effective date
- Comparison between the experience modifications resulted in a Total Standard Premium change of 5% or more

When an aggravated inequity occurs, submit a correction report to the claim(s) at the most recent unit report level. The correction report must reduce the incurred loss amount(s) to equal the paid loss amount(s).

Refer to NCCI's ***Experience Rating Plan Manual*** and ***Unit Statistical Reporting Guidebook*** for further details.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
GEORGIA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

F. ~~SUBSEQUENT REPORTS~~

3. ~~6th–10th Reports~~

~~Change Part 4, Item F-3 as follows:~~

~~Unit statistical data with policies effective June 30, 2001 and prior, which meet the requirements for subsequent reporting, require only 2nd–5th subsequent reports. For policies effective July 1, 2001 and subsequent, 6th–10th reports are required.~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
GEORGIA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

G. SUBSEQUENT REPORTS

3. 6th–10th Reports

Change Part 4, Item G-3 as follows:

Unit statistical data with policies effective June 30, 2001 and prior, which meet the requirements for subsequent reporting, require only 2nd–5th subsequent reports. For policies effective July 1, 2001 and subsequent, 6th–10th reports are required.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
GEORGIA STATE EXCEPTIONS
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS

1. When Correction Reports Are Required

Add the following to Part 5, Item A-1:

k. ~~When reimbursement of the benefits deductible is received subsequent to the valuation date of the unit report on which the specific claim is originally reported, a correction ("C") report must be immediately filed to report the amount of the reimbursed deductible.~~

o. When reimbursement of the benefits deductible is received subsequent to the valuation date of the unit report on which the specific claim is originally reported, a correction ("C") report must be immediately filed to report the amount of the reimbursed deductible.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
HAWAII STATE EXCEPTIONS
PART 1–GENERAL RULES

H. STATE FILING REQUIREMENTS ~~FOR MULTISTATE POLICIES~~

~~Change Part 1, Item H as follows:~~

~~Data must be filed for each state of a multistate policy in accordance with the scope of this Plan. A report must be filed for each state on a policy with estimated exposure, including those for which no exposure was developed. However, if Hawaii was written on an "If Any" basis, a report is required, unless the policy was cancelled flat.~~

2. Multistate Policy

Change Part 1, Item H-2 as follows:

Data must be filed for each state of a multistate policy in accordance with the scope of this Plan. A report must be filed for each state on a policy with estimated exposure, including those for which no exposure was developed. However, if Hawaii was written on an "If Any" basis, a report is required, unless the policy was cancelled flat.

Unit statistical data is required to be reported for a policy that has:

- Developed exposure at audit
- Not yet been audited (estimated exposure)
- Developed no exposure at audit after estimated exposure was reported on the policy
- No exposure written on an "If Any" basis, unless the policy was cancelled flat

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
HAWAII STATE EXCEPTIONS
PART 4–LOSS AND EXPOSURE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

(1) ~~Policies Effective July 1, 1999 and Subsequent~~

(b) ~~Claims Eligible for Grouping~~

~~Change the last bullet of Part 4, Item E-3-d-(1)-(b) as follows:~~

- ~~Medical-only claims must be coded to the classification code to which the injured worker's payroll is assigned.~~

(2) ~~Policies Effective Prior to July 1, 1999~~ Policies Effective July 1, 1999 Through December 31, 2012

~~Change Part 4, Item E-3-d-(2) as follows:~~

(a) ~~Hawaii requires individual reporting of claims with a total loss greater than $750.~~

(c) ~~Medical-only claims must be coded to the classification code to which the injured worker's payroll is assigned.~~

(d) ~~This rule does not apply.~~

(b) Claims Eligible for Grouping

Change the last bullet of Part 4, Item E-3-d(2)(b) as follows:

- Medical-only claims must be coded to the classification code to which the injured worker’s payroll is assigned.

ITEM U-1398—REVISIONS TO STATISTICAL PLAN FOR WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
IDAHO STATE EXCEPTIONS
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS

1. When Correction Reports Are Required

Add the following to Part 5, Item A-1:

k. ~~If a claim exceeds the incurred loss limit of $1,000 after the initial reporting of the claim, submit a correction report to remove the compensation reimbursement for all report levels. Claims that exceed the $1,000 loss limit become the insurer's responsibility, and a compensation reimbursement from the insured is not allowed.~~

o. If a claim exceeds the incurred loss limit of $1,000 after the initial reporting of the claim, submit a correction report to remove the compensation reimbursement for all report levels. Claims that exceed the $1,000 loss limit become the insurer's responsibility, and a compensation reimbursement from the insured is not allowed.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
ILLINOIS STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

(1) ~~Policies Effective July 1, 1999 and Subsequent~~

(a) ~~Claims Not Eligible for Grouping~~

~~Change the first bullet of Part 4, Item E-3-d-(1)-(a) as follows:~~

- ~~Medical-only claims with a total loss greater than $1,000~~

(b) ~~Claims Eligible for Grouping~~

~~Change the first bullet of Part 4, Item E-3-d-(1)-(b) as follows:~~

- ~~Medical-only claims with a total loss up to $1,000~~

(2) ~~Policies Effective Prior to July 1, 1999~~ Policies Effective July 1, 1999 Through December 31, 2013

~~Change Part 4, Item E-3-d-(2)-(a) as follows:~~

(a) ~~Each claim on which the total loss is greater than $1,000 must be listed individually.~~

(a) Claims Not Eligible for Grouping

Change the first bullet of Part 4, Item E-3-d(2)(a) as follows:

- Medical-only claims with a total loss greater than $1,000

(b) Claims Eligible for Grouping

Change the first bullet of Part 4, Item E-3-d(2)(b) as follows:

- Medical-only claims with a total loss up to $1,000

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
KANSAS STATE EXCEPTIONS
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS

1. When Correction Reports Are Required

Add the following to Part 5, Item A-1:

k. ~~For policies effective prior to January 1, 2012, when reimbursement of the benefits deductible is received after the valuation date of a claim, a correction report must be filed immediately. For reporting procedures, refer to Part 5, Item A-1-d.~~

o. For policies effective prior to January 1, 2012, when reimbursement of the benefits deductible is received after the valuation date of a claim, a correction report must be filed immediately. For reporting procedures, refer to Part 5, Item A-1-d.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
KENTUCKY STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

(1) ~~Policies Effective July 1, 1999 and Subsequent~~

(a) ~~Claims Not Eligible for Grouping~~

~~Add the following to Part 4, Item E-3-d (1) (a):~~

- ~~Medical-only claims covered by a deductible plan.~~

(2) Policies Effective July 1, 1999 Through December 31, 2012

(a) Claims Not Eligible for Grouping

Add the following to Part 4, Item E-3-d(2)(a):

- Medical-only claims covered by a deductible plan

ITEM U-1398—REVISIONS TO STATISTICAL PLAN FOR WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE

EXHIBIT 7
STATISTICAL PLAN—2008 EDITION
LOUISIANA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
A. GENERAL INCURRED LOSS INFORMATION
1. Incurred Losses
c. Fraudulent Claims

(1) Fraudulent Claims Definition

(a) Fully Fraudulent Claims Reporting

~~Change Part 4, Item A-1-c-(1)-(a) as follows:~~

~~When a claim has been ruled or declared to be fully fraudulent, the entire cost of the claim must be netted down to zero for unit statistical reporting.~~

- ~~If the claim has been ruled or declared fully fraudulent prior to the 1st unit statistical report, the claim is considered noncompensable and is not to be reported.~~
- ~~If the claim has been ruled or declared fully fraudulent as of or after the 1st unit statistical report, all loss components (e.g., medical costs, indemnity costs, etc.) must be apportioned as existed in the gross loss unless a more accurate split can be determined. The Type of Recovery code must be reported. When reporting the Type of Recovery on a fully fraudulent claim, use the Type of Recovery code for Subrogation only (Third Party). When the Subrogation only (Third Party) code is used for indicating fraud recovery, the Fraudulent Claim Code field must be populated with the applicable Fully Fraudulent code appropriate to the determination under the applicable state law.~~

~~The reporting of correction reports may impact experience modification(s) pursuant to the rules of the ***Experience Rating Plan Manual***.~~

2) For Policies Effective Prior to January 1, 2013

Change Part 4, Item A-1-c(1)(a)2) as follows:

When a claim has been ruled or declared to be fully fraudulent, the entire cost of the claim must be netted down to zero for unit statistical reporting.

- If the claim has been ruled or declared fully fraudulent prior to the 1st unit statistical report, the claim is considered noncompensable and is not to be reported.
- If the claim has been ruled or declared fully fraudulent as of or after the 1st unit statistical report, all loss components (e.g., medical costs, indemnity costs, etc.) must be apportioned as existed in the gross loss unless a more accurate split can be determined. The Type of Recovery code must be reported. When reporting the Type of Recovery on a fully fraudulent claim, use the Type of Recovery code for Subrogation only (Third Party). When the Subrogation only (Third Party) code is used for indicating fraud recovery, the Fraudulent Claim Code field must be populated with the applicable Fully Fraudulent code appropriate to the determination under the applicable state law.

The reporting of correction reports may impact experience modification(s) pursuant to the rules of the ***Experience Rating Plan Manual***.

(b) Partially Fraudulent Claims Reporting

Change Part 4, Item A-1-c(1)(b) as follows:

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
LOUISIANA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
A. GENERAL INCURRED LOSS INFORMATION
1. Incurred Losses
c. Fraudulent Claims

When a claim has been ruled or declared to be partially fraudulent, the cost of the claim must be netted down to reduce the net incurred cost by the declared fraudulent amount.

- If the claim, or a portion of the claim, has been ruled or declared partially fraudulent prior to the 1st unit statistical report, the net incurred cost of the claim on the 1st unit report must reflect the reduction of the claim by the partially fraudulent amount.
- If the claim, or a portion of the claim, has been ruled or declared to be partially fraudulent as of or after the 1st unit report statistical report, all loss components (e.g., medical costs, indemnity costs, etc.) must be apportioned as existed in the gross loss unless a more accurate split can be determined. The Type of Recovery code must be reported. When reporting the Type of Recovery on a partially fraudulent claim, use the Type of Recovery code for Subrogation only (Third Party). When the Subrogation only (Third Party) code is used for indicating fraud recovery, the Fraudulent Claim Code field must be populated with the applicable Partially Fraudulent code appropriate to the determination under the applicable state law.

The reporting of correction reports may impact experience modification(s) pursuant to the rules of the ***Experience Rating Plan Manual***.

EXHIBIT 7
STATISTICAL PLAN—2008 EDITION
MISSOURI STATE EXCEPTIONS
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS

1. When Correction Reports Are Required

Add the following to Part 5, Item A-1:

~~k. For the Missouri Employer-Paid Medical Program, if a claim reported under this program later exceeds the defined program limits, then correction report(s) are required for all applicable unit report levels. In addition, the carrier is required to reimburse the insured (employer) for the medical losses that were previously within the limits of this program. The correction(s) for these claims should include the reduction of the Deductible Reimbursement (Amount) to zero (0) and the revision of the applicable incurred loss amounts. For additional information on this program's requirements, refer to Part 4, Item A-3, Deductible Reimbursement (Amount) under the Missouri exception.~~

~~l. Effective for unit statistical reports received on and after January 1, 2009: In accordance with the ***Experience Rating Plan Manual***, for eligible required revision claims that are subject to adjustment, unit statistical correction reports are required. The following conditions and requirements apply:~~

~~Correction Report Conditions~~

- ~~Corrections only apply to 1st through 3rd unit reports and only when the claim closes between the 1st unit report valuation date and prior to the 4th unit report valuation date.~~
- ~~Corrections to 1st through 3rd unit reports only apply when the previously reported total incurred loss (Incurred Medical and Incurred Indemnity) is greater than the final paid amount (Paid Indemnity and Paid Medical) for the claim.~~

~~Correction Report Requirements~~

~~Correction report(s) must reduce the claim to equal the final paid amount of the claim. For these claims, the Incurred Indemnity must be equal to the Paid Indemnity, and the Incurred Medical must be equal to the Paid Medical.~~

o. For the Missouri Employer-Paid Medical Program, if a claim reported under this program later exceeds the defined program limits, then correction report(s) are required for all applicable unit report levels. In addition, the carrier is required to reimburse the insured (employer) for the medical losses that were previously within the limits of this program. The correction(s) for these claims should include the reduction of the Deductible Reimbursement (Amount) to zero (0) and the revision of the applicable incurred loss amounts. For additional information on this program's requirements, refer to Part 4, Item A-3—Deductible Reimbursement (Amount) under the Missouri exception.

p. Effective for unit statistical reports received on and after January 1, 2009: In accordance with the ***Experience Rating Plan Manual***, for eligible required revision claims that are subject to adjustment, unit statistical correction reports are required. The following conditions and requirements apply:

Correction Report Conditions

- Corrections only apply to 1st through 3rd unit reports and only when the claim closes between the 1st unit report valuation date and prior to the 4th unit report valuation date
- Corrections to 1st through 3rd unit reports only apply when the previously reported total incurred loss (Incurred Medical and Incurred Indemnity) is greater than the final paid amount (Paid Indemnity and Paid Medical) for the claim

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
MISSOURI STATE EXCEPTIONS
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS

Correction Report Requirements

Correction report(s) must reduce the claim to equal the final paid amount of the claim. For these claims, the Incurred Indemnity must be equal to the Paid Indemnity, and the Incurred Medical must be equal to the Paid Medical.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
NEVADA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

F. ~~SUBSEQUENT REPORTS~~

~~Change Part 4, Item F 3 as follows:~~

3. ~~6th–10th Reports~~

~~Unit statistical report levels 6–10 are applicable for all policies effective July 1, 1999 and subsequent.~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
NEVADA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

G. SUBSEQUENT REPORTS

Change Part 4, Item G-3 as follows:

3. 6th–10th Reports

Unit statistical report levels 6–10 are applicable for all policies effective July 1, 1999 and subsequent.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
NEW HAMPSHIRE STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

(1) ~~Policies Effective July 1, 1999 and Subsequent~~

(b) ~~Claims Eligible for Grouping~~

~~Change the last bullet of Part 4, Item E-3-d-(1)-(b) as follows:~~

- ~~Medical-only claims must be coded to the classification code to which the injured worker's payroll is assigned.~~

(2) ~~Policies Effective Prior to July 1, 1999~~ Policies Effective July 1, 1999 Through December 31, 2013

~~Change Part 4, Item E-3-d-(2) as follows:~~

(c) ~~Medical-only claims must be coded to the classification code to which the injured worker's payroll is assigned.~~

(d) ~~This rule does not apply.~~

(b) Claims Eligible for Grouping

Change the last bullet of Part 4, Item E-3-d(2)(b) as follows:

- Medical-only claims must be coded to the classification code to which the injured worker’s payroll is assigned.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
NEW MEXICO STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

(1) ~~Policies Effective July 1, 1999 and Subsequent~~

(a) ~~Claims Not Eligible for Grouping~~

~~Add the following to Part 4, Item E-3-d (1) (a) as follows:~~

- ~~Medical-only claims covered by a deductible plan.~~

(2) Policies Effective July 1, 1999 Through December 31, 2012

(a) Claims Not Eligible for Grouping

Add the following to Part 4, Item E-3-d(2)(a):

- Medical-only claims covered by a deductible plan.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
OREGON STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
1. Required Claim Components
g. Injury Type Code

(3) Injury Type Definitions

(j) Permanent Partial Disability

~~Change Part 4, Item E-1-g-(3)-(j) as follows:~~

~~A permanent partial loss is defined as:~~

- ~~Any permanent injury that does not involve permanent total disability~~
- ~~Any temporary injury that satisfies any one of the following criteria:~~
  - ~~A lump-sum settlement is made or, in the judgment of the carrier, will be required to settle future benefits~~
  - ~~The extent of liability for future payments cannot be determined~~

~~The amount entered as incurred indemnity must include specific benefits and compensation for temporary disability as well as loss of earning capacity. At the option of the carrier, losses on lifetime permanent partial claims may be calculated by using Table III-M-A, III-M-B, III-M-C, III-F-A, III-F-B, or III-F-C in Part 7—Pension Tables.~~

2) Claims With Accident Dates Prior to January 1, 2013

Change Part 4, Item E-1-g(3)(j)2) as follows:

A permanent partial loss is defined as:

- Any permanent injury that does not involve permanent total disability
- Any temporary injury that satisfies any one of the following criteria:
  - A lump-sum settlement is made or, in the judgment of the carrier, will be required to settle future benefits
  - The extent of liability for future payments cannot be determined

3. Permanent Partial Amount

The amount entered as Incurred Indemnity must include specific benefits and compensation for temporary disability as well as loss of earning capacity. At the option of the carrier, losses on lifetime permanent partial claims may be calculated by using Table III-M-A, III-M-B, III-M-C, III-F-A, III-F-B, or III-F-C in Part 7—Pension Tables.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
OREGON STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

F. ~~SUBSEQUENT REPORTS~~

3. ~~6th–10th Reports~~

~~Change Part 4, Item F-3 as follows:~~

~~Unit statistical data with policies effective December 31, 2001 and prior, which meet the requirements for subsequent reporting, require only 2nd–5th subsequent reports. For policies effective January 1, 2002 and subsequent, 6th–10th subsequent reports are required.~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
OREGON STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

G. SUBSEQUENT REPORTS

3. 6th–10th Reports

Change Part 4, Item G-3 as follows:

Unit statistical data with policies effective December 31, 2001 and prior, which meet the requirements for subsequent reporting, require only 2nd–5th subsequent reports. For policies effective January 1, 2002 and subsequent, 6th–10th subsequent reports are required.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
OREGON STATE EXCEPTIONS
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS

1. When Correction Reports Are Required

Add the following to Part 5, Item A-1:

k. ~~Pursuant to Oregon Workers' Compensation Division Bulletin No. 345, the Employer Paid Medical Program option allows the insured to reimburse the insurer for up to $1,500 of medical costs on each nondisabling claim for policies with accident dates on or after January 1, 2006. For policies with accident dates prior to January 1, 2006, the insured may elect to reimburse the insurer for up to $500 of medical costs on each nondisabling claim.~~

~~Effective January 1, 2009, under ORS 656.262(5), the maximum reimbursable amount for medical services for the Employer Paid Medical Program option is subject to annual adjustment. The revised amount applies to claims with a date of injury on or after January 1 of each year. This will be published in Bulletin No. 345 prior to the annual adjustment.~~

~~Under this program, a correction report is to be filed when amounts paid on a claim prior to being reported are reimbursed after the claim is reported.~~

o. Pursuant to Oregon Workers' Compensation Division Bulletin No. 345, the Employer Paid Medical Program option allows the insured to reimburse the insurer for up to $1,500 of medical costs on each nondisabling claim for policies with accident dates on or after January 1, 2006. For policies with accident dates prior to January 1, 2006, the insured may elect to reimburse the insurer for up to $500 of medical costs on each nondisabling claim.

Effective January 1, 2009, under ORS 656.262(5), the maximum reimbursable amount for medical services for the Employer Paid Medical Program option is subject to annual adjustment. The revised amount applies to claims with a date of injury on or after January 1 of each year. This will be published in Bulletin No. 345 prior to the annual adjustment.

Under this program, a correction report is to be filed when amounts paid on a claim prior to being reported are reimbursed after the claim is reported.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
RHODE ISLAND STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

(1) ~~Policies Effective July 1, 1999 and Subsequent~~

(a) ~~Claims Not Eligible for Grouping~~

~~Change the first bullet of Part 4, Item E-3-d-(1)-(a) as follows:~~

- ~~Medical-only claims with a total loss greater than $750~~

(b) ~~Claims Eligible for Grouping~~

~~Change Part 4, Item E-3-d-(1)-(b) as follows:~~

~~The following claims may be grouped:~~

- ~~Medical-only claims with a total loss up to $750~~
- ~~The number of claims must be reported instead of the claim number and accident date~~
- ~~If any claim within the group is open, the entire group will be considered open and subsequent reports must be submitted in accordance with Item F—Subsequent Reports~~
- ~~Medical-only claims must be coded to the classification code to which the injured worker's payroll is assigned~~

(2) ~~Policies Effective Prior to July 1, 1999~~ Policies Effective July 1, 1999 Through December 31, 2012

~~Change Part 4, Item E-3-d-(2) as follows:~~

(a) ~~Rhode Island requires individual reporting of claims with a total loss greater than $750~~

(b) ~~Medical-only claims must be coded to the classification code to which the injured worker's payroll is assigned~~

(d) ~~This rule does not apply.~~

(a) Claims Not Eligible for Grouping

Change the first bullet of Part 4, Item E-3-d(2)(a) as follows:

- Medical-only claims with a total loss greater than $750

(b) Claims Eligible for Grouping

Change Part 4, Item E-3-d(2)(b) as follows:

The following claims may be grouped:

- Medical-only claims with a total loss up to $750
- The number of claims must be reported instead of the claim number and accident date
- If any claim within the group is open, the entire group will be considered open and subsequent reports must be submitted in accordance with Part 4, Item G—Subsequent Reports
- Medical-only claims must be coded to the classification code to which the injured worker's payroll is assigned

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
VIRGINIA STATE EXCEPTIONS
PART 1–GENERAL RULES

L. COAL MINE AND BLACK LUNG EXPERIENCE

1. Reporting of Classification Code and Corresponding Statistical Code

Change Part 1, Item L-1 as follows:

Experience for traumatic and occupational disease other than Black Lung Disease must be reported with the applicable classification code. Black Lung Disease experience for state and/or federal acts must be reported separately from the classification code under the designated statistical code.

Following are the classification codes along with their corresponding statistical codes for Black Lung Disease:

Classification Code	Statistical Code
1016—Coal Mining NOC	0158—Black Lung Disease Experience in Connection With Code 1016
1005—Coal Mining—Surface and Drivers	0156—Black Lung Disease Experience in Connection With Code 1005
Any non-coal mining classification code	0161—Black Lung Disease Experience of Insureds Exposed to Coal Workers' Pneumoconiosis With Substantial Underground Coal Mine Experience 0162—Black Lung Disease Experience of All Other Insureds Exposed to Coal Workers' Pneumoconiosis

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
VIRGINIA STATE EXCEPTIONS
PART 1–GENERAL RULES

R. ~~EXCESS BENEFITS (ADDITIONAL BENEFITS COVERAGE)~~

~~Add the following to Part 1:~~

~~Excess benefits coverage as described under the standard Workers Compensation and Employers Liability policy except coverage that was endorsed by excess Special Endorsement.~~

~~When excess benefits coverage is provided in Virginia, the following rules govern the reporting of exposure and premium:~~

- ~~Exposure, manual rates,and premium on the basis of the Virginia manual rates must be reported according to the rules in Part 3 – Exposure Information of this Plan.~~
- ~~The additional increment to the Virginia manual rate for providing excess benefits (i.e, the total authorized rate for excess benefits coverage minus the Virginia manual rate) must be reported with the designated classification code and exposure coverage. The exposure should be identified as an excess policy. The premium applicable to this rate must be included in the total standard premium.~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
VIRGINIA STATE EXCEPTIONS
PART 1–GENERAL RULES

S. EXCESS BENEFITS (ADDITIONAL BENEFITS COVERAGE)

Add the following to Part 1:

Excess benefits coverage as described under the standard Workers Compensation and Employers Liability policy except coverage that was endorsed by excess Special Endorsement.

When excess benefits coverage is provided in Virginia, the following rules govern the reporting of exposure and premium:

- Exposure, manual rates, and premium on the basis of the Virginia manual rates must be reported according to the rules in Part 3—Exposure Information of this Plan.
- The additional increment to the Virginia manual rate for providing excess benefits (i.e, the total authorized rate for excess benefits coverage minus the Virginia manual rate) must be reported with the designated classification code and exposure coverage. The exposure must be reported as Excess Benefits Coverage Code 07. Loss Condition Type Code—Type of Claim must be reported as Excess Benefits Code 05. The premium applicable to this rate must be included in the total standard premium.

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EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
VIRGINIA STATE EXCEPTIONS
PART 3–EXPOSURE INFORMATION

S. ~~EXPENSE CONSTANT AMOUNT~~

~~Change Part 3, Item S as follows:~~

~~The premium adjustment resulting from the application of the approved expense constant must be reported separately from class code exposures and premiums under the designated statistical code. This premium must not be included in the standard premium. The expense constant on a multistate policy must be allocated to the state with the highest expense constant applicable. If two or more states included on the policy have the same highest expense constant, report the expense constant for the state with the highest expense constant and largest amount of premium.~~

~~Refer to NCCI's ***Basic Manual*** for additional rules.~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
VIRGINIA STATE EXCEPTIONS
PART 3–EXPOSURE INFORMATION
U. INDIVIDUAL RISK RATING PLANS

4. Other Insurer Premium Adjustment Programs

Change Part 3, Item U-4 as follows:

For premium adjustment programs filed independently by the insurer (other than Deductible, Schedule Rating, and Drug-Free Workplace Programs), report the premium credit or debit amount under the appropriate Independent Carrier Filing statistical code. Refer to Part 6—Coding Values for codes subject to experience modification factor, not subject to experience modification factor, and not part of standard premium.

For Drug-Free Workplace premium adjustment programs filed independently by the insurer, report the premium credit under Statistical Code 9841 if the premium credit is subject to experience rating and under Code 9846 if the premium credit is not subject to experience rating.

EXHIBIT 7
STATISTICAL PLAN—2008 EDITION
VIRGINIA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

d. Claim Grouping

~~Change Part 4, Item E-3-d as follows:~~

(1) ~~Policies Effective September 1, 1999 and Subsequent~~

(a) ~~Claims Not Eligible for Grouping~~

~~The following claims may not be grouped:~~

- ~~All claims that involve an indemnity incurred loss, regardless of amount (these claims must be listed individually with the appropriate claim number and accident date).~~
- ~~All claims partially covered by contract or capitated medical (these claims must be listed separately).~~
- ~~Medical only claims that do not contain the same loss conditions (act, type of loss, type of recovery, type of claim, type of settlement), fraudulent claim code, lump sum settlement status or managed care organization status.~~
- ~~Medical only claims with a total loss greater than $2,000.~~

~~All other claims are eligible for grouping under the Claim Grouping Option.~~

(b) ~~Claims Eligible for Grouping~~

~~If the claims are eligible for grouping and the carrier chooses the Claim Grouping Option, the following rules apply:~~

- ~~The number of claims must be reported instead of the claim number and accident date.~~
- ~~If any claim within the group is open, the entire group shall be considered as open and subsequent reports must be submitted in accordance with Part 4, Item F – Subsequent Reports.~~
- ~~Eligible claims may be coded to the governing classification.~~

(c) ~~Claims Grouping Rules~~

~~If any of the following events should occur to a claim within a group, the claim must be removed from the group at the next valuation and reported individually with the full statistical detail, according to the instructions in this section of the Plan:~~

- ~~The incurred medical for any claim in the group exceeds the $2,000 limit.~~
- ~~A grouped medical only claim that subsequently develops into an indemnity case.~~
- ~~A grouped medical only claim coded to the governing classification, which subsequently develops into an indemnity case. Include the injured employee's payroll classification when reporting individually.~~

(2) Policies Effective ~~Prior to~~ September 1, 1999 Through December 31, 2013

Change Part 4, Item E-3-d(2) as follows:

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
VIRGINIA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION
E. CLAIM COMPONENTS
3. Optional Claim Components

(a) Claims Not Eligible for Grouping

The following claims may not be grouped:

- All claims that involve an Incurred Indemnity loss, regardless of amount (these claims must be listed individually with the appropriate claim number and accident date).
- All claims partially covered by contract or capitated medical (these claims must be listed separately).
- Medical-only claims that do not contain the same Loss Conditions (Act, Type of Loss, Type of Recovery, Type of Claim, Type of Settlement), Fraudulent Claim Code, Lump-Sum Settlement status or Managed Care Organization status.
- Medical-only claims with a total loss greater than $2,000.

All other claims are eligible for grouping under the claim grouping option.

(b) Claims Eligible for Grouping

If the claims are eligible for grouping and the carrier chooses the claim grouping option, the following rules apply:

- The number of claims must be reported instead of the claim number and accident date.
- If any claim within the group is open, the entire group shall be considered as open, and subsequent reports must be submitted in accordance with Part 4, Item G—Subsequent Reports.
- Eligible claims may be coded to the governing classification.

(c) Claims Grouping Rules

If any of the following events occur to a claim within a group, the claim must be removed from the group at the next valuation and reported individually with the full statistical detail, according to the instructions in this section of the Plan:

- The incurred medical for any claim in the group exceeds the $2,000 limit.
- A grouped medical-only claim that subsequently develops into an indemnity case.
- A grouped medical-only claim coded to the governing classification, which subsequently develops into an indemnity case. Include the injured employee's payroll classification when reporting individually.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
VIRGINIA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

F. ~~SUBSEQUENT REPORTS~~

1. ~~Reporting Rules~~

~~Change Part 4, Item F-1 as follows:~~

~~Subsequent reports (2nd–10th reports) must be filed when:~~

- ~~There are open or reopened claims as of the last report submitted, regardless of whether or not there are changes to the loss data.~~
- ~~There are claims indicated as closed on a previous report that are reopened.~~
- ~~There are claims that were previously not reported, or the claim did not exist at the time of the previous reporting.~~
- ~~There are changes in losses valued from the prior to the current valuation period, yet claims were closed in both valuation periods.~~

~~Losses are valued 12 months after the valuation date of the preceding report level. Refer to Part 1 for additional instructions on valuation and filing.~~

~~Affiliate Self-Insurers: 6th–10th subsequent reports are to be reported in accordance with the scope of this Plan. Refer to A-2 of the Preface for the minimum reporting requirements.~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
VIRGINIA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

G. SUBSEQUENT REPORTS

1. Reporting Rules

Change Part 4, Item G-1 as follows:

Subsequent reports (2nd–10th reports) must be filed when:

- There are open or reopened claims as of the last report submitted, regardless of whether or not there are changes to the loss data
- There are claims indicated as closed on a previous report that are reopened
- There are claims that were previously not reported, or the claim did not exist at the time of the previous reporting
- There are changes in losses valued from the prior to the current valuation period, yet claims were closed in both valuation periods

Losses are valued 12 months after the valuation date of the preceding report level. Refer to Part 1 for additional instructions on valuation and filing.

Affiliate Self-Insurers: 6th–10th subsequent reports are to be reported in accordance with the scope of this Plan. Refer to A-2 of the Preface for the minimum reporting requirements.

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
VIRGINIA STATE EXCEPTIONS
PART 5–CORRECTION INFORMATION
A. CORRECTION REPORTS

1. When Correction Reports Are Required

Change Part 5, Item A-1 as follows:

Correction reports must be filed without delay when any of the conditions outlined below occur:

a. An error of any kind is made on ~~a~~ previously filed report(s).

b. When the exposure previously reported has been changed by reason of an audit, a reaudit, or any other adjustment affecting class codes, exposure, or premiums, a correction report must be filed. Revised premium discounts, if any, must also be corrected. Corrections to Total Subject Premium, Total Modified Premium, Total Exposure, and Total Standard Premium are optional.

c. It is necessary to submit a correction report for premium discounts and expense constant corrections.

d. Corrections to the type of injury are required as defined in Part 4, Item E-1-g—Injury Type Code.

e. Loss values are found to have been included or excluded through clerical errors.

f. The claim is determined to be~~, or any part thereof, is declared~~ noncompensable as defined in Part 4, Item A-1-d—Noncompensable Claims.

g. If the claim number changes during the life of the claim as described in Part 4, Item E-1-c—Claim Number.

h. If the carrier performs a final audit on an insured subsequent to the~~performing an~~ estimated audit.

i. If the carrier performs a revised final audit on an insured subsequent to performing a final audit.

j. If the header/policy information was reported incorrectly.

k. Where a compromise settlement with a *known recovery amount* has been determined as defined by the ***Experience Rating Plan Manual*** after the 1st report but within one year after the 5th report due date on which the claim appears. If a compromise settlement occurs as of the 6th report due date or subsequent, a correction report is not required; all adjustments are reported at the next valuation date if the claim remains open.

l. If the exposure does not change but the total standard premium previously reported is revised solely because of a change in the experience modification, it is necessary to submit a correction report.

m. The specific Part of Body Code is determined subsequent to reporting Part of Body Code 65—Insufficent Info to Properly Identify—Unclassified.

n. Claim loss amounts are reduced due to a subrogation recovery as defined in Part 4, Item A-1-a—Subrogation.

o. Claim loss amounts are reduced in connection with a special fund as defined in Part 4, Item A-1-b(2)—Special Funds Reimbursement Amount and Item A-1-b(3)—Special Funds Reporting Assessments and Special Funds.

p. The claim has been determined to be fraudulent as defined in Part 4, Item A-1-c—Fraudulent Claims.

EXHIBIT 7
STATISTICAL PLAN—2008 EDITION
WEST VIRGINIA STATE EXCEPTIONS
PART 1–GENERAL RULES

L. COAL MINE AND BLACK LUNG EXPERIENCE

2. ~~Disease Experience for Coal Mine Risks~~

~~Change Part 1, Item L 2, as follows:~~

~~Coal mine disease experience reporting requirements are as follows:~~

~~a. Coal Mine Disease Premium~~

~~Coal disease coverage under State Act and/or Federal Coal Mine Health and Safety Act is not subject to experience rating, premium discounts, or retrospective rating.~~

~~Report the premium for coal disease under State Act and/or Federal Act after (not part of) Standard Premium with the appropriate Exposure Act/Exposure Coverage Code.~~

~~b. Coal Mine Disease Exposure and Losses~~

~~Report premium, exposure, and losses with the appropriate Exposure Act/Exposure Coverage Code and Loss Conditions Act Code respectively, by State Act, Federal Act, or Federal and State Act for the applicable statistical code. Assignment to the specific code is according to the benefits provided on the policy:~~

- ~~When State Act only benefits are provided, use code (01) – State Act or Federal Act Excluding USL&HW and Federal Coal Mine Health and Safety Act;~~
- ~~When Federal Act only benefits are provided, use code (03) – Coverage Under the Federal Coal Mine Health and Safety Act Only;~~
- ~~When Federal and State Act benefits are provided, use code (04) – Coverage Under the Federal Coal Mine Health and Safety Act and the State Act.~~

~~c. Coal Mine Disease Statistical and Classification Codes~~

~~(1) Use of Statistical Code in Connection with Classification Code~~

~~Disease experience must be reported for disease in connection with any coal mine classification in accordance with the Basic Manual or for any class code other than coal mining where there is liability under the State and/or Federal Coal Mine Health and Safety Act. Statistical codes used in connection with the corresponding classification codes are:~~

- ~~Statistical Code 0156 in connection with Classification Code 1005~~
- ~~Statistical Code 0158 in connection with Classification Code 1016~~
- ~~Statistical Code 0164 in connection with any other classification code~~

~~(2) Use of Statistical Code for Federal Act~~

~~If coal disease coverage has been provided for Federal Coal Mine Health and Safety Act Only, report the coal disease experience to Statistical Code 0164 and Exposure Act/Exposure Coverage Code and Loss Condition Act Code (03).~~

~~(3) Coal Mine Classification Code and Non-Coal Mine Classification Code~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
WEST VIRGINIA STATE EXCEPTIONS
PART 1–GENERAL RULES

~~The assigned classification code for any corresponding exposure or loss must be reported as Exposure Act/Exposure Coverage Code (01) – State Act or Federal Act Excluding USL&HW and Federal Coal Mine Health and Safety Act.~~

3. Reporting of Traumatic and Non-Black Lung Disease Experience

Add the following to Part 1, Item L-3:

b. If the traumatic rate for the underground coal mine class code contains a catastrophe loading that is not subject to experience modification, then report the authorized rate after adjusting for the nonratable catastrophe loading prior to experience modification. The following formula should be used to obtain the adjusted authorized rate:

Subject Rate = Traumatic Rate – Catastrophe Rate

Authorized Rate = Subject Rate x Experience Modification + Catastrophe Rate

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
WEST VIRGINIA STATE EXCEPTIONS
PART 1–GENERAL RULES
R. EXCESS POLICIES

R. EXCESS POLICIES

Change Part 1, Item R as follows:

Excess policies cover losses above a specified threshold. Exposure and losses for excess policies must not be reported, except when the excess policy is for West Virginia Deliberate Intent (Mandolidis) Coverage. For this coverage, use Policy Type Code—Type of Nonstandard Provisions 05 (Excess Policy).

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
WEST VIRGINIA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

F. ~~SUBSEQUENT REPORTS~~

3. ~~6th–10th Reports~~

~~Change Part 4, Item F-3 as follows:~~

~~Unit statistical report levels 6–10 are applicable for all policies effective July 1, 2006 and subsequent.~~

EXHIBIT 7 (CONT'D)
STATISTICAL PLAN—2008 EDITION
WEST VIRGINIA STATE EXCEPTIONS
PART 4–LOSS AND EXPENSE INFORMATION

G. SUBSEQUENT REPORTS

3. 6th–10th Reports

Change Part 4, Item G-3 as follows:

Unit statistical report levels 6–10 are applicable for all policies effective July 1, 2006 and subsequent.

EXHIBIT 8
EXPERIENCE RATING PLAN MANUAL—2003 EDITION
RULES
RULE 1–GENERAL EXPLANATIONS
C. DEFINITIONS

3. Losses

Incurred losses for each classification in the experience period are those reported according to the ***Statistical Plan.***

a. No loss is excluded from the experience of a risk even if the employer was not responsible for the accident that caused such loss.

Exception: Losses reported with Catastrophe Number 87 are excluded from experience rating calculations. Catastrophe Number 87 claims include all workers compensation occupational disease claims resulting from the rescue, recovery, and clean-up work at the World Trade Center occurring between the dates of September 11, 2001 and September 12, 2002. This rule applies to experience rating modifications with rating effective dates of May 27, 2002 through June 12, 2007.

Exception: Losses reported with Catastrophe Number 48 are excluded from experience rating calculations. Catastrophe Number 48 claims include all workers compensation claims directly attributable to the September 11, 2001 attacks with accident dates of September 11 through September 14, 2001. This rule applies to experience rating modifications with anniversary rating dates of May 27, 2002 through June 14, 2006.

Exception: Claims that are reported as noncompensable according to the ***Statistical Plan*** are excluded from experience rating calculations.

Exception: Claims that are reported as fraudulent according to the ***Statistical Plan*** are excluded from experience rating calculations.

Exception: Claims that are reported as coal mine disease (Black Lung) according to the ***Statistical Plan*** are excluded from experience rating calculations.

EXHIBIT 9
EXPERIENCE RATING PLAN MANUAL—2003 EDITION
MAINE STATE RULE EXCEPTIONS
RULE 1–GENERAL EXPLANATIONS
C. DEFINITIONS

3. Losses

Change Rule 1-C-3-a as follows:

Incurred losses for each classification in the experience period are those reported according to the ***Statistical Plan***.

a. No loss is excluded from the experience of a risk even if the employer was not responsible for the accident that caused such loss.

Exception: Losses reported with Catastrophe Number 87 are excluded from experience rating calculations. Catastrophe Number 87 claims include all workers compensation occupational disease claims resulting from the rescue, recovery, and clean-up work at the World Trade Center occurring between the dates of September 11, 2001 and September 12, 2002. This rule applies to experience rating modifications with rating effective dates of May 27, 2002 through June 12, 2007.

Exception: Losses reported with Catastrophe Number 48 are excluded from experience rating calculations. Catastrophe Number 48 claims include all workers compensation claims directly attributable to the September 11, 2001 attacks with accident dates of September 11 through September 14, 2001. This rule applies to experience rating modifications with anniversary rating dates of May 27, 2002 through June 14, 2006.

Exception: Beginning with policies effective May 1, 2007 and subsequent, any claim identified by a carrier as an aggravation of a prior lost-time work-related injury, in accordance with Maine Rule 450, and reported as such according to NCCI's ***Statistical Plan***, is excluded from experience rating calculations.

Exception: Claims that are reported as noncompensable according to the ***Statistical Plan*** are excluded from experience rating calculations.

Exception: Claims that are reported as fraudulent according to the ***Statistical Plan*** are excluded from experience rating calculations.

Exception: Claims that are reported as coal mine disease (Black Lung) according to the ***Statistical Plan*** are excluded from experience rating calculations.

EXHIBIT 9 (CONT'D)
EXPERIENCE RATING PLAN MANUAL—2003 EDITION
MASSACHUSETTS STATE RULE EXCEPTIONS
RULE 1–GENERAL EXPLANATIONS
C. DEFINITIONS

3. Losses

Change Rule 1-C-3-a as follows:

Except for non-compensable claims, no loss is excluded from the experience of a risk even if the employer was not responsible for the accident that caused such loss. For instructions on non-compensable claims, refer to the Massachusetts Rule 4-B-2-f.

Change Exception to Rule 1-C-3-a as follows:

Exception: Losses reported with Catastrophe Number 48 are excluded from experience rating calculations. Catastrophe Number 48 claims include all workers compensation claims directly attributable to the September 11, 2001 attacks with accident dates of September 11 through September 14, 2001. This rule applies to experience rating modifications with anniversary rating dates of June 1, 2002 through May 31, 2006.

Exception: Losses reported with Catastrophe Number 87 are excluded from experience rating calculations. Catastrophe Number 87 claims include all workers compensation occupational disease claims resulting from the rescue, recovery, and cleanup work at the World Trade Center occurring between the dates of September 11, 2001 and September 12, 2002. The employee's injury must have occurred within the jurisdiction of New York and the claimant must be filing for benefits under New York law. This rule applies to experience rating modifications with anniversary rating dates of June 1, 2002 through May 31, 2007.

Exception: Claims that are reported as fraudulent according to the ***Statistical Plan*** are excluded from experience rating calculations.

Exception: Claims that are reported as coal mine disease (Black Lung) according to the ***Statistical Plan*** are excluded from experience rating calculations.

EXHIBIT 9 (CONT'D)
EXPERIENCE RATING PLAN MANUAL—2003 EDITION
WEST VIRGINIA STATE RULE EXCEPTIONS
RULE 1–GENERAL EXPLANATIONS
C. DEFINITIONS

3. Losses

~~Change Rule 1-C-3-a as follows:~~

~~Incurred losses for each classification in the experience period are those reported according to the ***Statistical Plan.***~~

a. ~~No loss is excluded from the experience of a risk even if the employer was not responsible for the accident that caused such loss.~~

~~**Exception:** Losses reported with Catastrophe Number 48 are excluded from experience rating calculations. Catastrophe Number 48 claims include all workers compensation claims directly attributable to the September 11, 2001 attacks with accident dates of September 11 through September 14, 2001. This rule applies to experience rating modifications with anniversary rating dates of May 27, 2002 through June 14, 2006.~~