COVERAGE, CLAIMS & LITIGATION COMMITTEE
Meeting Agenda

Wednesday, September 19, 2018
IRMA Office – 9:30 a.m.

I. CALL TO ORDER

II. APPROVAL OF MINUTES
- ✓ May 3, 2018 (pg. 1)

III. CLAIMS & LITIGATION REPORTS
A. Litigation Reports
1. New Litigation Report – April – August 2018 (pg. 4)
2. Closed Liability Claims Report – April – August 2018 (pg. 5)
3. Firm Trending by Amounts Billed GL & WC (pg. 11)
4. Subrogation Reports GL & WC (pg. 16)
5. Defense Counsel Performance Survey Report (pg. 18)

IV. ✓ 2019 COVERAGE RENEWAL (pg. 20)

V. ✓ 2019 CLAIMS AUDIT RECOMMENDATION (pg. 22)

VI. ✓ 2019 PRELIMINARY BUDGET (pg. 23)

VII. ✓ COVERAGE CHANGES (pg. 25)
A. Law Enforcement Activities (pgs. 28-33)
B. Employment Practices (pgs. 34-37)
C. Auto Liability Exclusion & Criminal Conduct (pgs. 38-40)

VIII. ✓EXPANDED AUTO COVERAGE FOR NEW VEHICLES (pg. 41)

IX. ✓CLAIMS MANUAL CHANGES (pg. 45)

X. LITIGATION SUCCESSES (pg. 86)

XI. EXECUTIVE SESSION
A. Pending litigation pursuant to 5 ILCS 120/2 (c)(11)
B. Review of closed session minutes pursuant to 5 ILCS 120/2(c)(21)

XII. ADDITIONS TO AGENDA

XIII. CONFIRMATION OF NEXT MEETING
Thursday, November 8, 2018
9:30 a.m. - IRMA Office

✓ Requires Vote

XIV. ADJOURNMENT

To ensure a quorum, please contact Donna Sluis at donnas@irmarisk.org or (708) 236-6349, if you are not able to attend the meeting.

Copy to: Jessica Frances, IRMA Chair

✓ Requires Vote

COVERAGE, CLAIMS & LITIGATION COMMITTEE
Meeting Minutes

Thursday, May 3, 2018
IRMA Office – 9:30 a.m.

PRESENT:	Julia Cedillo, Chair	Doris Hamon-Warren
	Greg Van Dahm	Bryon Vana
	Barbara Maziarek	John DuRocher
	Kate Croteau	Patrick Brennan
	Kevin Wachtel	
ALSO PRESENT:	Margo Ely	Susan Garvey
	Donna Sluis	Jennifer Swahlstedt
	Keena Marks-Cutler	
ABSENT:	Peter Vadopalas	

I. CALL TO ORDER

Cedillo called the meeting to order at 9:28 a.m., roll was taken and a quorum declared.

II. APPROVAL OF MINUTES

A motion was made by DuRocher and seconded by Hamon-Warren to approve the minutes of February 8, 2018. A voice vote was called and the motion carried.

III. MILLIMAN PRESENTATION – PREDICTIVE MODELING

Mike Paczolt from Milliman presented a quarterly update on the predictive modeling project to the committee.

IV. CLAIMS & LITIGATION REPORTS

Cedillo mentioned the reports have a new look and will be a great chance to look at the changes. Cedillo asked if anyone had any questions or comments on the New Litigation Report, Closed Liability Claims Report January through March 2018, reports. Hearing none, moved to the new Litigation Costs by Line of Coverage. Hamon-Warren commented that the coloring at the bottom was hard to figure out.

Cedillo mentioned the Firm Trending by Amounts Billed with charts providing the average fees per matter and average dollars per matter for each of the law firms. Harmon-Warren commented that it makes sense to her but is a little misleading are that some of them went up to $15M, $20M, and $10M and when looking at the actual schedules they are not actually comparable. Ely commented we can have this look as apples to apples. Cedillo

added when reviewing the reports, I forget what types of cases these firms handle. Staff will add the number and types of cases for each firm. Cedillo commented the next report is the Subrogation Reports GL & WC. Ely commented that last year we started entering in the receivable amount. Wachtel asked the question if we can use the state's IDROP program (Illinois Debt Recovery Program)? Marks-Cutler mentioned she would research it. Cedillo thanked Marks-Cutler for a great job on the report. Cedillo mentioned next is the Defense Counsel Performance Survey Report. Ely commented that we have been doing this for 9 months now and we are not getting much response to our surveys. Marks-Cutler commented that it seems the same members are getting sued and commenting on the same attorney and may not have much feedback after doing the survey once before.

V. COVERAGE CHANGES

Expanded Auto Coverage for New Vehicles

Cedillo gave a brief overview of the expanded auto coverage and that staff is recommending that we expand our auto coverage to full replacement value. This change would provide a full new car to a member if a vehicle is less than 2 years old and is a total loss. Cedillo commented this was an enhancement based on feedback that we have received from some of the members. Brennan commented he would feel more comfortable seeing some numbers going back 3-4 years to know the cost. After much discussion, it was recommended to bring market trends, the impacted premiums, how many claims fall in this area and how many are subrogated back to the September meeting.

IRMA Property Coverage-Coverage Section B1.h. Outdoor Property

Cedillo commented that staff has received feedback from some members that members' labor costs are not being covered for the replacement of damaged outdoor equipment. Staff has made some recommended language changes to the coverage that will not only cover the cost to remove debris, but it will also cover the labor cost for reinstalling that equipment. A motion was made by Harmon-Warren and seconded by Mazurek to concur with the recommended revision to the language in the first party property coverage, as attached, to include coverage for labor charges for the repair or reinstallation of damaged outdoor property. The motion carried.

VI. PANEL COUNSEL HOURLY RATE INCREASE

Cedillo commented that staff's memo outlined the item very well. There has not been an increase to these rates for at least 10 years. There has been a history of looking at these fees every 3 years and typically there is an 8% increase to the rate. Given the fact that we have not made any changes to these rates in 10 years, staff has proposed an hourly rate increase to $200 per hour for Category 1, $167 per hour for Category 2 and $140 per hour for Category 3. After much discussion, a motion was made by Brennan and seconded by Harmon-Warren to recommend the modification. The motion carried.

VII. MOUNT PROSPECT CLAIMS HANDLING

Cedillo commented that Mount Prospect's third party claims administrator contract expires June 30, 2018, and is requesting IRMA administer their past claims not covered by IRMA. Staff put together an estimated cost and a proposal for the committee to consider and discuss to administer the 6 open general liability claims at a cost of $7,726. After much discussion, a motion was made by DuRocher and seconded by Vana to concur with staff's

recommendation and authorize claims administration services for Mount Prospect's GL claims effective July 1, 2018 for a price of $7,726. The motion carried.

VIII. EXECUTIVE SESSION

A motion was made by Wachtel and seconded by Harmon-Warren to move into Executive Session to discuss matters of: review of closed session minutes; Opioid Litigation and Executive Director's Performance review pursuant to 5 ILCS 120/2(c)(21) and (11) respectively.

A roll call vote was called and the motion carried.

IX. ADDITIONS TO AGENDA

None

X. CONFIRMATION OF NEXT MEETING

Cedillo reported that the next scheduled meeting of the CCLC would be Wednesday, September 19, 2018 at 9:30 a.m. at the IRMA Office.

XI. ADJOURNMENT

At 1:45 p.m., a motion was made by DuRocher and seconded by Harmon-Warren to adjourn the meeting. A voice vote was called and the motion carried.

Submitted by:	Accepted by:
Susan Garvey Director of Legal Services	Julia Cedillo Chair, Coverage, Claims & Litigation Committee

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New Litigated Claims
April - August 2018

Received	Member	Type	Description	Attorney
4/2/2018	Northfield	GLLEA	Malicious Prosecution; Indemnification	O'Reilly
4/4/2018	LaGrange	GLBI	Trip and Fall Sidewalk	Hartigan
4/5/2018	Northfield	GLPOL	Employment Offer Rescinded	O'Reilly
4/9/2018	Western Springs	GLBI	Trip and Fall Sidewalk	Yambert
4/10/2018	Villa Park	GLPOL	Alleged Retaliation; intimidation; abuse of power	O'Reilly
4/10/2018	Park Forest	GLPOL	EEOC - Alleged Discrimination; Hostile Work Environment	Best
4/10/2018	Park Forest	GLLEA	DUI - stopped by police allowed to leave w/o arrest	Hartigan
4/16/2018	Northbrook	GLBI	Slip and Fall on ice	Hartigan
4/18/2018	Hanover Park	GLBI	Accepted Tender of RE Management Co	Querrey
4/27/2018	Woodridge	GLLEA	False Arrest; Detention; Malicious Prosecution	Best
5/2/2018	Lake Forest	GLBI	Slip and Fall on ice	Hartigan
5/18/2018	Lisle	GLPOL	Vlg filed suit for code violations - alleged civil rights violations	Hartigan
5/22/2018	LaGrange	GLBI	Trip and Fall Sidewalk	Hartigan
6/7/2018	Hanover Park	GLBI	Trip and Fall Sidewalk; business named as co-defendant	Yambert
6/29/2018	NIPSTA	GLPOL	EEOC - Alleged harassment and retaliation	Best
7/12/2018	Carol Stream	PD	Water Tank Damage - Not in suit	O'Reilly
7/13/2018	Buffalo Grove	GLLEA	False Arrest; illegal search	Querrey
7/13/2018	Lake Zurich	GLLEA	False Arrest; illegal search	Querrey
7/13/2018	Crystal Lake	GLPOL	Alleged Discrimination - pregnancy	Best
7/13/2018	Glencoe	GLPD	Alleged property damage - storm	O'Reilly
7/13/2018	Northbrook	GLBI	Slip Trip and Fall	Hartigan
7/19/2018	Crystal Lake	GLBI	Child Almost Drowned - Not in suit	Yambert
7/25/2018	Hanover Park	GLPOL	Alleged Disability Discrimination	O'Reilly
7/25/2018	Olympia Fields	GLBI	Slip and Fall at Metra Train Station	Yambert
7/25/2018	LaGrange	GLBI	Trip and Fall Sidewalk	Hartigan
8/1/2018	Morton Grove	GLLEA	False Arrest;Unreasonable Search Seizure; Excessive Force	Sotos
8/1/2018	Mundelein	GLLEA	False Arrest; illegal search	Querrey
8/2/2018	Tinley Park	GLLEA	False arrest; excessive force;illegal search	Hartigan
8/2/2018	LaGrange	GLBI	Trip and Fall Sidewalk	Hartigan
8/20/2018	West Chicago	GLBI	Fall from motorcycle due to construction debris	Querrey
8/22/2018	LaGrange Park	GLBI	Bicyclist alleged that she struck pothole and sustained injuries	Yambert
8/23/2018	Richton Park	GLLEA	Police Shooting - not in suit	Sotos
8/23/2018	Park Forest	GLLEA	Police Shooting - not in suit	Sotos
8/27/2018	Lake Bluff	GLPD	Drainage issues; continuing nuisance	O'Reilly
8/27/2018	Wilmette	GLBI	Slip Fall Sidewalk;resident named co-defendant	Best
8/29/2018	Brookfield	GLLEA	False Arrest; Excessive force;malicious prosectuion	Hartigan

GLBI = 3rd party bodily injury
GLLEA = law enforcement activities
GLPOL= public officials liability

Closed Litigated Claims by Firm

April - August 2018

Best Vanderlaan & Harrington

Adjuster	Claim Number	Event Date	Date Closed	Member	Claim Type	Description	Verdict/Outcor	Indemnity	Defense
Zarcone	171416-01	1/25/2017	5/29/2018	Village of Richton Park	GLPOL	Alleged discrimination based upon his disability.	Vol. Dismissal (Prior to Trial);	0	2,883
Zarcone	169979-01	4/1/2016	8/9/2018	Village of Richton Park	GLPOL	Employment Discrimination Charge	Vol. Dismissal (Prior to Trial);	0	9,657

Chilton Yambert & Porter

Adjuster	Claim Number	Event Date	Date Closed	Member	Claim Type	Description	Verdict/Outcor	Indemnity	Defense
Zarcone	164842-02	3/28/2014	4/30/2018	Village of Flossmoor	GLBI	Person fell through ventilation well grate.	Dismissed on MSJ	0	54,556
Rhodes	172015-01	6/13/2016	4/9/2018	Village of Richton Park	GLBI	Trip & Fall	Settled Prior to Trial;	13,000	9,372
Zarcone	168084-02	9/14/2015	4/27/2018	Village of Addison	ALBI	Squad 340 struck a light pole base.	Settled Prior to Trial;	7,500	12,798

Closed Litigated Claims by Firm

April - August 2018

Sierra	167871-01	7/17/2015	5/30/2018	Village of Bartlett	GLBI	Bicycle accident on sidewalk	Vol. Dismissal (Prior to Trial);	0	21,323
Rhodes	172363-01	6/3/2017	4/9/2018	Village of Arlington Heights	GLBI	Alleged trip & fall.	Settled Prior to Trial;	2,000	4,917
Sierra	169639-01	6/10/2016	6/11/2018	Village of Northbrook	GLBI	Intersection accident/lawsuit	Settled Prior to Trial;	5,000	28,878
Sierra	164624-01	3/4/2014	7/17/2018	Village of Hanover Park	ALPD	Mbr struck other vehicle	Settled Prior to Trial;	131,215	28,826
Zarcone	165766-02	8/22/2014	7/30/2018	Village of Hanover Park	GLBI	Alleged inhalation of debris/chemicals.	Vol. Dismissal (Prior to Trial);	0	32,627
Zarcone	170400-01	10/25/2016	7/19/2018	Village of Kenilworth	GLBI	Park District employee injured	Settled Prior to Trial;	268,500	14,101
Sierra	171987-01	7/7/2017	7/3/2018	Village of Lisle	GLBI	Fell off bicycle	Dismissed on S/J/M;	0	1,529
Sierra	162950-01	6/24/2013	8/28/2018	Village of Western Springs	GLPD	Parkway tree fell onto vehicle	Settled Prior to Trial;	177,757	119,327

Closed Litigated Claims by Firm

April - August 2018

Sierra	163917-02	12/13/2013	8/7/2018	Village of Tinley Park	ALBI	Plow 57 struck vehicle.	Settled Prior to Trial;	225,000	62,129
Sierra	167086-02	4/3/2015	8/31/2018	Village of Bloomingdale	ALPD	Mbr caused chain collision accident.	Settled Prior to Trial;	61,980	18,312
Sierra	167086-03	4/3/2015	8/31/2018	Village of Bloomingdale	ALBI	Mbr caused chain collision accident.	Settled Prior to Trial;	14,500	27
Sierra	170074-02	8/23/2016	8/21/2018	Village of Villa Park	ALPD	Accident while changing lanes	Settled Prior to Trial;	10,000	11,998

Hartigan & O'Connor

	Claim Number	Event Date	Date Closed	Member	Claim Type	Description	Verdict/Outcor	Indemnity	Defense
Zarcone	151690-01	3/1/2007	4/27/2018	Village of Park Forest	GZ	Lawsuit/Denial of License	Adverse Verdict	158,615	342,997
Zarcone	159291-01	8/17/2011	4/4/2018	Village of LaGrange	GLBI	Injured while riding bike.	Settled Prior to Trial	12,000	14,972
Zarcone	169592-02	6/10/2016	5/3/2018	Village of Lake Bluff	ALBI	Bicyclist ran into mbr scooter.	Settled Prior to Trial;	42,500	21,956

Closed Litigated Claims by Firm

April - August 2018

Zarcone	149868-01	10/18/2007	6/7/2018	Village of Park Forest	GZ	Administrative Complaint	Adverse Verdict;	2,735,025	361,498
Zarcone	150652-01	3/22/2008	6/7/2018	Village of Park Forest	GZ	Lawsuit/Failed to issue license.	Adverse Verdict;	158,615	392,797
Zarcone	168994-01	2/17/2016	6/5/2018	Village of East Hazel Crest	GLBI	Slip & fall at Metra	Dismissed on S/J/M;	0	36,867
Sierra	158263-01	3/23/2010	8/6/2018	Village of Tinley Park	GLPD	Foundation of home damaged.	Dismissed on S/J/M;	0	103,095
Zarcone	173195-01	12/13/2017	8/23/2018	Village of Richton Park	GLPOL	Alleged wrongful eviction	DWP-Dismissed for Want of Prosecution;	0	6,001

O'Reilly Law Offices

Adjuster	Claim Number	Event Date	Date Closed	Member	Claim Type	Description	Verdict/Outcor	Indemnity	Defense
Zarcone	170517-01	6/28/2016	4/23/2018	Village of Barrington	GLPOL	Alleged Discrimination due to Military Status	Vol. Dismissal - Prior to Trial	0	11,191
Zarcone	165317-02	1/1/2014	5/1/2018	Village of Buffalo Grove	GLPOL	ADA Discrimination	Awaiting appeal decision from IDHR	0	18,802

Closed Litigated Claims by Firm

April - August 2018

Zarcone	170893-01	1/12/2017	5/31/2018	Village of Brookfield	GLBI	Injured when stepping into a whole in the sidewalk	Vol. Dismissal (Prior to Trial);	0	5,203
Zarcone	168195-01	10/5/2015	6/8/2018	Village of LaGrange Park	GLBI	Trip & Fall	Settled Prior to Trial;	70,000	28,359
Rhodes	171802-01	7/26/2016	6/4/2018	Village of Clarendon Hills	GLBI	Trip and Fall	Settled Prior to Trial;		16,275

Querrey & Harrow Ltd

Adjuster	Claim Number	Event Date	Date Closed	Member	Claim Type	Description	Verdict/Outcor	Indemnity	Defense
Zarcone	169313-01	2/4/2016	5/15/2018	Village of Tinley Park	GZ	Alleged Discriminatory Zoning Practices	Settled Prior to Trial;	1,670,000	90,230
Zarcone	169213-01	6/14/2007	6/5/2018	Village of Palatine	GLPOL	Alleged DPPA Violation	Dismissed - MTD;	0	53,560

Closed Litigated Claims by Firm

April - August 2018

The Sotos Law Firm

Adjuster	Claim Number	Event Date	Date Closed	Member	Claim Type	Description	Verdict/Outcor	Indemnity	Defense

General Liability Attorney Fees and Legal Expenses as of 9/11/18

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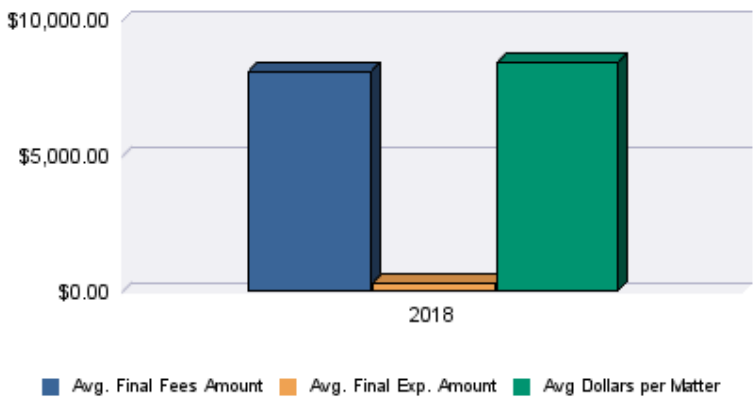
Intergovernmental Risk Management Agency

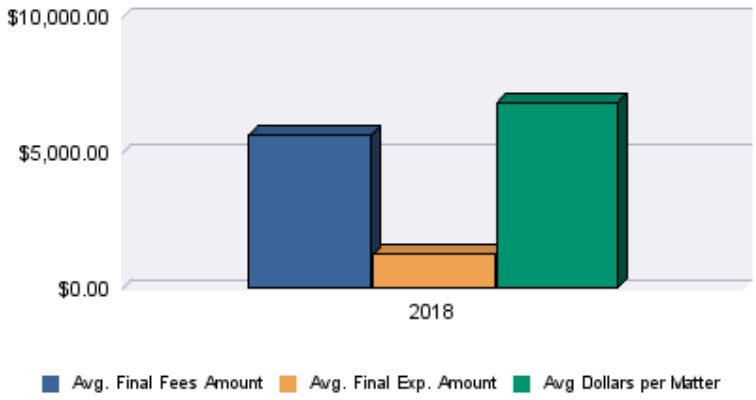
Best Vanderlaan & Harrington

	Year
	2018
# of Matters	29
# of Invoices	167
Avg # of Invoices per Matter	6
Final Fees Amount	$235,452.40
Final Exp. Amount	$9,045.26
Final Amount	$244,497.66
Avg Fees per Matter	8,119.05
Avg Exp per Matter	311.91
Avg Dollars per Matter	$8,430.95



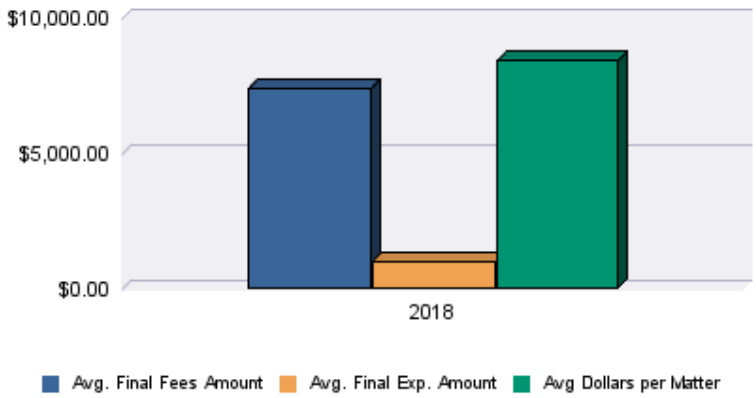
Chilton, Yambert, & Porter

	Year
	2018
# of Matters	39
# of Invoices	189
Avg # of Invoices per Matter	5
Final Fees Amount	$219,135.90
Final Exp. Amount	$48,152.73
Final Amount	$267,288.63
Avg Fees per Matter	5,618.87
Avg Exp per Matter	1,234.69
Avg Dollars per Matter	$6,853.55



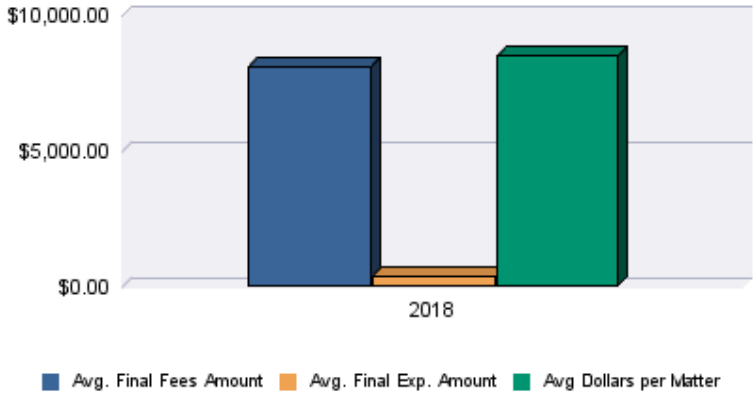
Hartigan & O'Connor

	Year
	2018
# of Matters	35
# of Invoices	191
Avg # of Invoices per Matter	5
Final Fees Amount	$258,660.30
Final Exp. Amount	$35,608.67
Final Amount	$294,268.97
Avg Fees per Matter	7,390.29
Avg Exp per Matter	1,017.39
Avg Dollars per Matter	$8,407.68



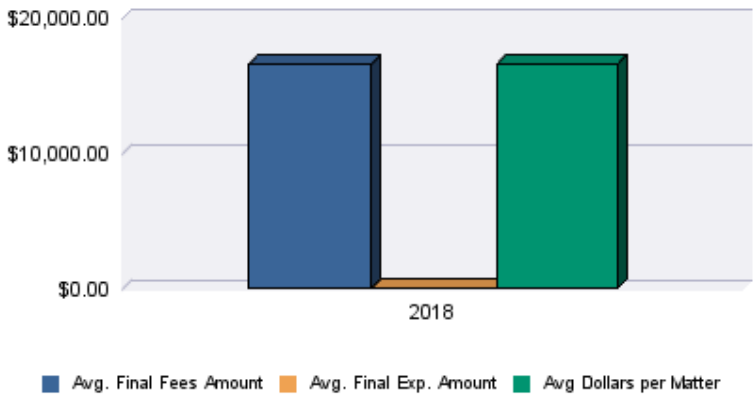
O'Reilly Law Offices

	Year
	2018
# of Matters	26
# of Invoices	56
Avg # of Invoices per Matter	2
Final Fees Amount	$210,547.00
Final Exp. Amount	$10,016.18
Final Amount	$220,563.18
Avg Fees per Matter	8,097.96
Avg Exp per Matter	385.24
Avg Dollars per Matter	$8,483.20



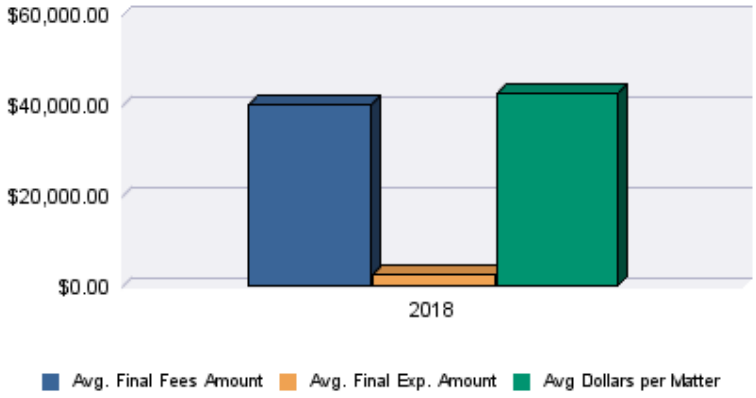
Querrey & Harrow Ltd.

	Year
	2018
# of Matters	12
# of Invoices	65
Avg # of Invoices per Matter	5
Final Fees Amount	$198,481.00
Final Exp. Amount	$1,062.27
Final Amount	$199,543.27
Avg Fees per Matter	16,540.08
Avg Exp per Matter	88.52
Avg Dollars per Matter	$16,628.61



The Sotos Law Firm, P.C.

	Year
	2018
# of Matters	12
# of Invoices	65
Avg # of Invoices per Matter	5
Final Fees Amount	$480,774.69
Final Exp. Amount	$31,071.92
Final Amount	$511,846.61
Avg Fees per Matter	40,064.56
Avg Exp per Matter	2,589.33
Avg Dollars per Matter	$42,653.88



Workers' Compensation Attorney Fees and Legal Expenses as of 9/12/18

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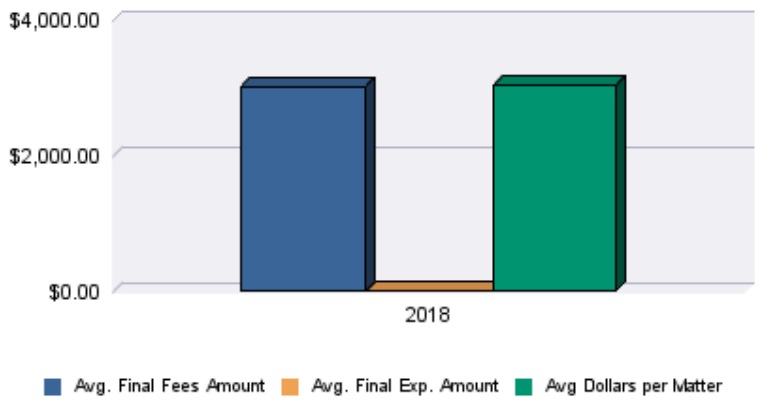
Workers Compensation

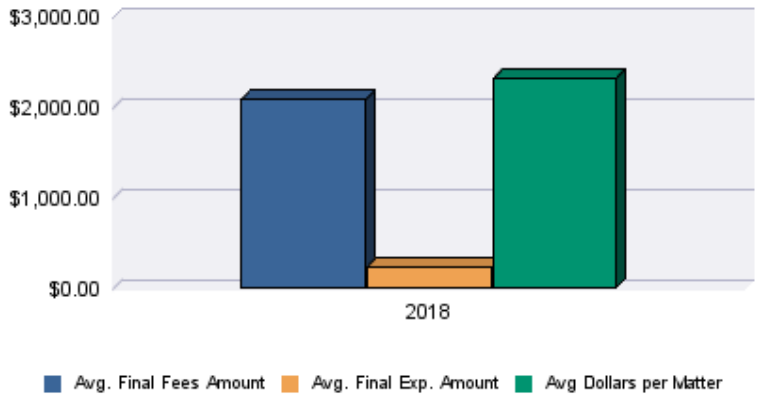
Ancel Glink Diamond Bush DiCianni & Krafthefer PC

	Year
	2018
# of Matters	12
# of Invoices	42
Avg # of Invoices per Matter	4
Final Fees Amount	$36,291.80
Final Exp. Amount	$201.46
Final Amount	$36,493.26
Avg Fees per Matter	3,024.32
Avg Exp per Matter	16.79
Avg Dollars per Matter	$3,041.11



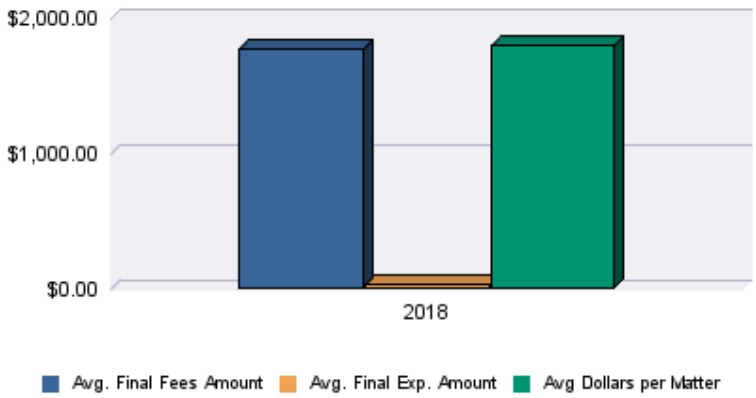
Bryce Downey & Lenkov LLC

	Year
	2018
# of Matters	35
# of Invoices	208
Avg # of Invoices per Matter	6
Final Fees Amount	$72,887.25
Final Exp. Amount	$8,366.63
Final Amount	$81,253.88
Avg Fees per Matter	2,082.49
Avg Exp per Matter	239.05
Avg Dollars per Matter	$2,321.54



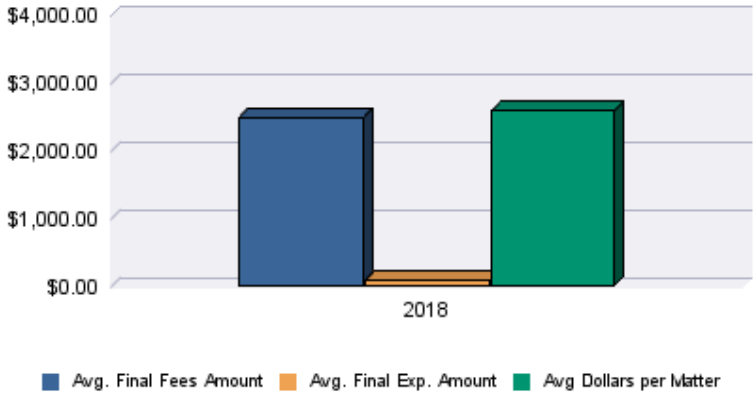
Power & Cronin, LTD

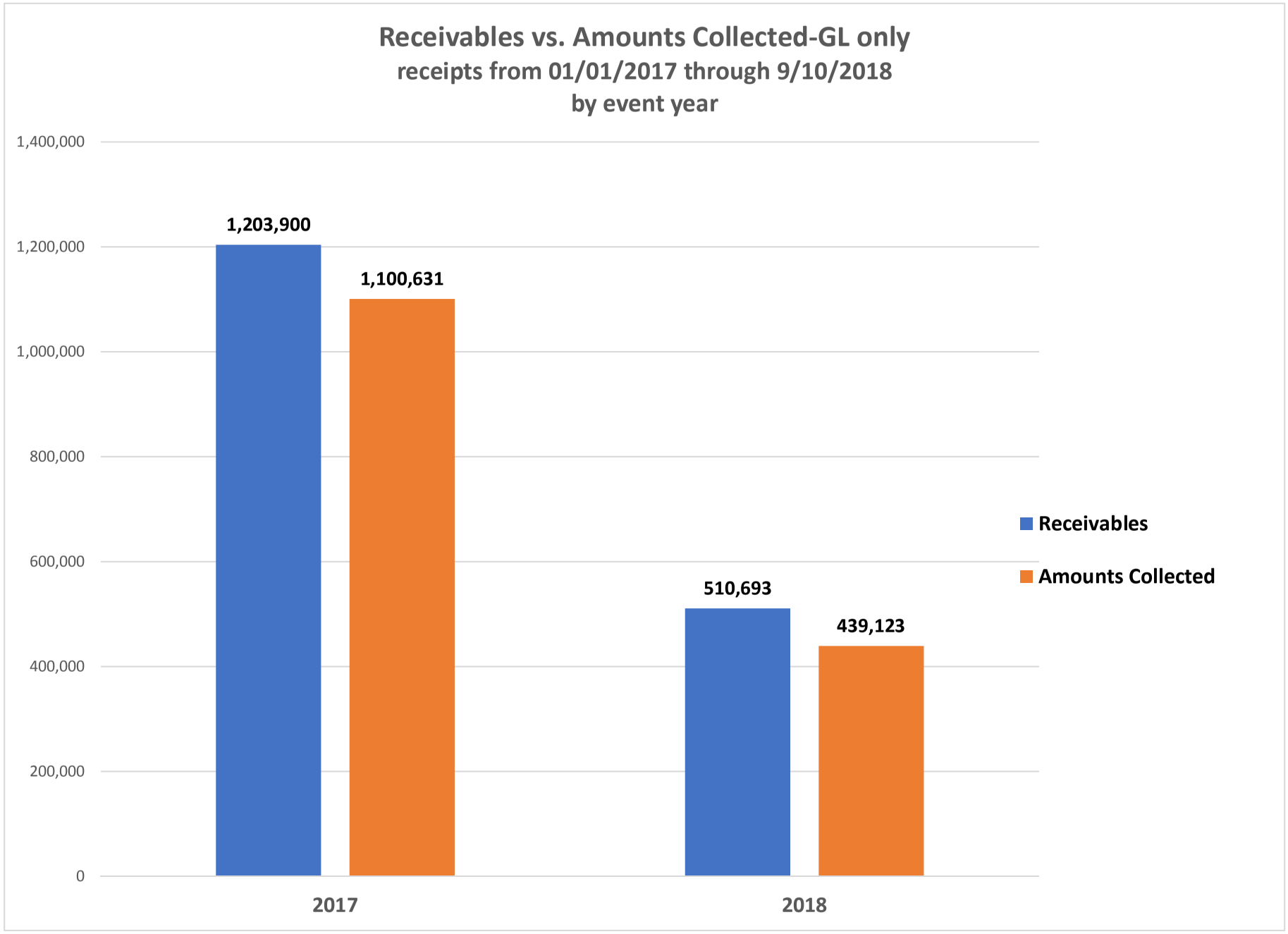
	Year
	2018
# of Matters	73
# of Invoices	409
Avg # of Invoices per Matter	6
Final Fees Amount	$128,999.70
Final Exp. Amount	$1,771.15
Final Amount	$130,770.85
Avg Fees per Matter	1,767.12
Avg Exp per Matter	24.26
Avg Dollars per Matter	$1,791.38

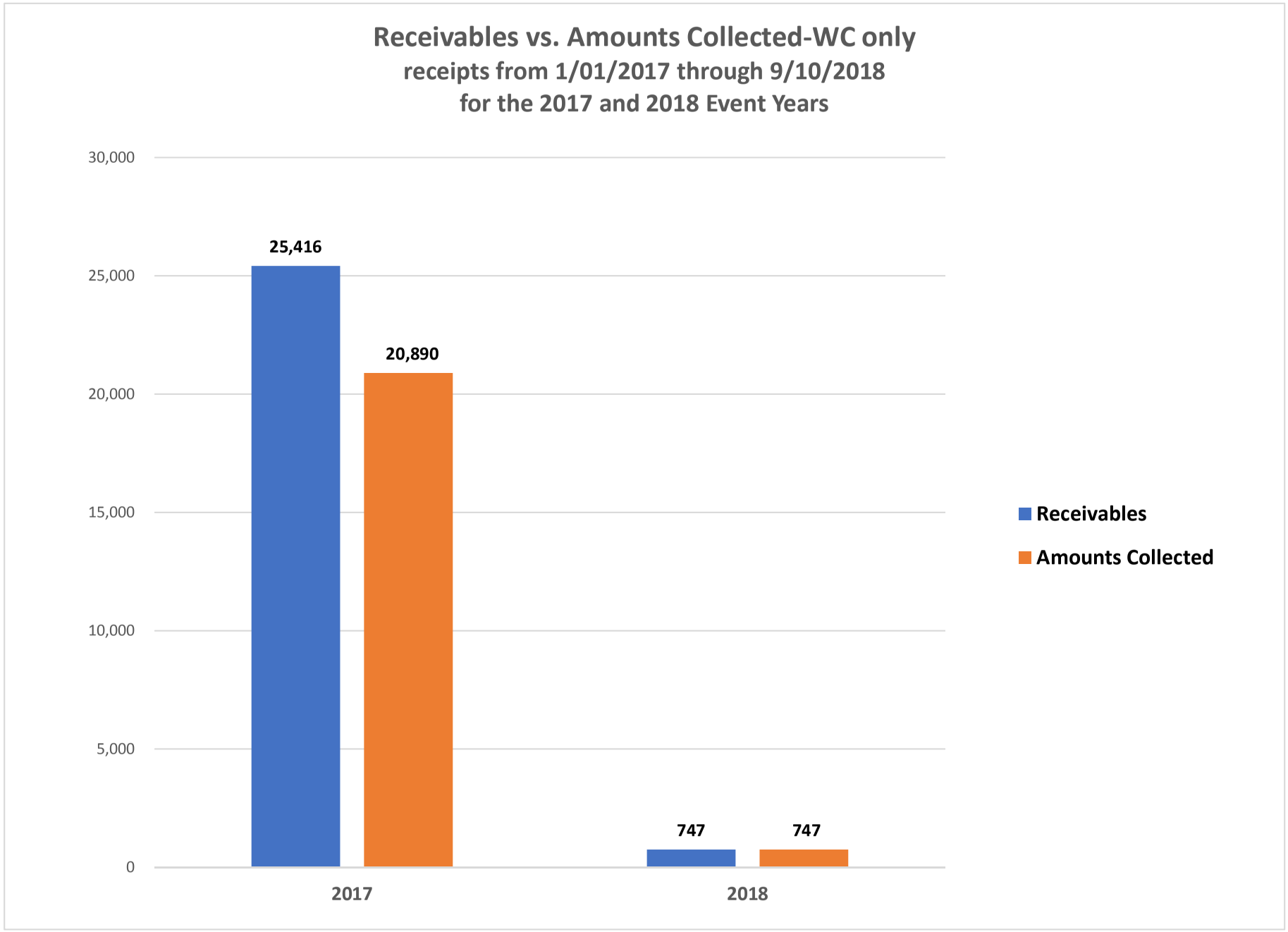


Rusin & Maciorowski Ltd

	Year
	2018
# of Matters	75
# of Invoices	398
Avg # of Invoices per Matter	5
Final Fees Amount	$186,955.80
Final Exp. Amount	$6,724.46
Final Amount	$193,680.26
Avg Fees per Matter	2,492.74
Avg Exp per Matter	89.66
Avg Dollars per Matter	$2,582.40




Receivables vs. Amounts Collected-GL only
receipts from 01/01/2017 through 9/10/2018
by event year
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
1,203,900
1,100,631
510,693
439,123
2017
2018
Receivables
Amounts Collected


Receivables vs. Amounts Collected-WC only
receipts from 1/01/2017 through 9/10/2018
for the 2017 and 2018 Event Years
30,000
25,000
20,000
15,000
10,000
5,000
0
25,416
20,890
747
747
2017
2018
Receivables
Amounts Collected

M E M O R A N D U M

TO: Coverage, Claims, & Litigation Committee

FROM: Susan Garvey, Legal Director
Keena Marks-Cutler, Supervisor of Liability Claims Operations

DATE: September 12, 2018

RE: Defense Counsel Performance Survey Report

Purpose: The purpose of this memorandum is to report to the CCLC regarding staff's efforts to monitor attorney performance through contact with members.

Background/Discussion: To ensure that members are properly represented by counsel and to identify potential problems with representation during the litigation process, we contact members to inquire about attorney interactions and performance. Since the last CCLC, we obtained member feedback from 23 members regarding litigated files and obtained the following information related to attorney performance:

- Attorney Performance:
  - O'Reilly Law Office:
    - John responds very promptly when asked questions and has an appropriate level of knowledge and expertise.
    - "Both John and Molly are a PLEASURE to work with. They both go out of their way to keep us informed and make sure we understand the nature of the claim."
  - Best, Vanderlaan & Harrington:
    - Scott McKenna explained everything and told the member what to expect in the deposition. The member was pleased to see that what he stated is exactly what happened at the deposition.
    - Lori and Allie are some of the best attorneys that the member has worked with.
  - Querrey & Harrow:
    - NA/ No recent cases ripe for survey
  - Hartigan & O'Connor:
    - Mike is very detail oriented and thorough. He gives each case his full attention and takes the time to know the entire case front to back.
    - "Mike Hartigan was tremendous over the course of this long, drawn out case."
    - "I thoroughly appreciate and respect the work done by Mike Hartigan and would gladly recommend his services to other municipal colleagues."

- Chilton, Yambert & Porter:
  - "Jon Yambert and his staff were very open about how the case was proceeding and what to expect…I hope we never need their services again, but if so, it's good to know they will work very diligently on our behalf."
  - The member indicates that the Village staff has faith and confidence in Jon's work and they look forward to working with him again.

- Sotos Law Firm:
  - NA/ No recent cases ripe for survey

Recommendation: Continue to survey members on litigated cases to proactively identify and correct potential deficiencies and address issues or concerns that may arise.

SG/KMC/ds

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M E M O R A N D U M

TO: Coverage, Claims & Litigation Committee

FROM: Dan LeTourneau, Director of Risk Management Services

DATE: September 11, 2018

RE: 2019 IRMA Excess & Reinsurance Coverage Renewal

Action Requested: Review and approve the 2019 Excess & Reinsurance Coverage Program renewal which will be presented to the CCLC at the September 19th meeting.

Background: Each year IRMA prepares an underwriting submission to present to the excess & reinsurance marketplace to obtain our excess & reinsurance program. IRMA continues to manage a significant self-insured retention which varies by line of coverage. Our primary retentions are as follows:

- General Liability/Public Officials Liability/Auto Liability = $3 million per occurrence
- First Party Property = $450,000 per occurrence
- Workers' Compensation = $1.5 million per occurrence

Reinsurance is then purchased to provide coverage up to our total limit for each coverage type, except for Workers' Compensation where excess insurance is required to obtain the full statutory limits. Reinsurance coverage allows IRMA to control the coverage document terms and litigation management of member claims. We continue to evaluate our coverage limits on a regular basis to ensure members are provided with adequate limits. We have recently increased on liability limits from $10 to $12 million per occurrence. As of 2018, we also offer an optional $3 million layer of coverage for members to obtain a $15 million of liability limit. Overall, our excess & reinsurance coverage costs represent only approximately $2.6 million of a $35 million overall budget.

Discussion: Based on review of the US Commercial Limes Insurance Pricing Survey (CLIPS) conducted by Willis Towers Watson, a large brokerage and consulting firm, nearly every line of coverage has continued to show an upward pricing trend as of the second quarter of 2018. This represents the most significant rise in almost four years. Overall, most commercial insurance rates rose nearly 3% in the second quarter. As of September, IRMA has already received flat rates commitments from all major lines of coverage. IRMA has maintained excellent working relationships with several major reinsurers, presents a strong safety/risk management program to actively manage risk, and has an aggressive claims and litigation management program. These factors have continued to result in below market pricing.

On September 5th we were able to reduce our property reinsurance rate to a 3% rate reduction, in addition to obtain some significant property coverage enhancements. We are currently in the process of attempting to obtain some rate reductions from our underwriters in our liability/auto reinsurance layers which are currently at a flat rate for renewal. We will have final details of the 2019 Excess & Reinsurance Program at the September 19th committee meeting.

Recommendation: Continue efforts to negotiate rate improvements and provide a complete 2019 Excess & Reinsurance Coverage Program analysis at the September 19, 2018 CCLC meeting for review and approval.

DLT/ds

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M E M O R A N D U M

TO: Coverage, Claims & Litigation Committee

FROM: Susan Garvey, Director of Legal Services

DATE: September 10, 2018

RE: 2019 Claims Audit Recommendation

Action Requested: Approve the selection of NiiS to complete the 2019 Claims Audit at a cost of $14,175.

Background/Discussion: Section 3.09(E) of the IRMA Contract and Bylaws requires that an independent claims auditor provide a written report concerning IRMA's claims processing and reserving practices no less than once every three (3) years. The last audit was conducted in 2016; consequently, an audit must be performed in 2019. The RFP for Claims Auditors issued in 2016 requested that the auditor provide a fee for a follow up audit at three (3) years.

Northshore International Insurance Services, Inc. ("NiiS") was selected to complete the claims audit in 2016. NiiS's proposal provided for a fee of $29,747 for the initial audit and a cost of $14,175 for the three (3) year follow up audit. The fees proposed by the other two auditors considered by the Committee in 2016 were $23,640 and $31,900. After interviews were conducted with the three firms, NiiS was determined to have proposed a concise process and method to conduct the audit with a reasonable cost in the midline of the proposals submitted. Niis was selected by the Committee to conduct the audit. Since the proposed cost for the follow-up audit is based upon NiiS completing the original audit, the $14,175 fee will be significantly less than retaining new auditors through an RFP process If a new RFP process is conducted, there will be no reduction based upon it being a follow-up audit; it will be more in line with the costs proposed for the 2016 audit.

Overall the auditor rated the claims handling as Compliant/Excellent, and also made some recommendations. The first recommendation was to increase the number of adjusters to decrease caseloads within industry guidelines. New adjusters were hired and caseloads are now within acceptable limits. The second recommendation related to member contact, investigations and documentation in questionable workers' compensation cases. The auditor suggested that there was room for improvement. Some of the issues raised in this recommendation were addressed by hiring additional staff and the workers' compensation department has changed its practices in some areas to address noted concerns. The changes implemented by the workers' compensation department are provided to the Committee under separate memo. The last recommendation related to IRMA's reserving practices.

Although staff did not agree with all aspects of NiiS's process and feedback in 2016, their evaluation in 2016 was professional. We will work with them so that they understand the unique IRMA financial and reserving process better in 2019. Staff believes it is important to have the same auditor reassess the operation after the findings and recommendations were addressed. Staff is recommending that NiiS be retained to complete the 2019 audit at the proposed cost of $14,175, rather than conducting another RFP process.

Recommendation: Approve Staff's recommendation to retain NiiS to complete the 2019 Claims Audit at a cost of $14,175.

M E M O R A N D U M

TO: Coverage, Claims and Litigation Committee

FROM: Susan Garvey, Director of Legal Services

DATE: September 10, 2018

RE: CCL Committee Preliminary Budget

Action Requested: Approve the Committee's preliminary budget for 2019.

Background/Discussion: In accordance with the IRMA Budget Policy and the Standing Committees' Statements of Responsibility, each standing committee reviews and approves its portion of the budget. The Administration and Finance Committee and the Executive Board then review the detailed operating budget in total.

The Coverage Claims and Litigation Committee is responsible for four categories, the specific detail of which is provided in the attached Budget Report:

Contractual Services – 3rd Party Claims Administration: Gallagher Bassett continues to administer a 1986 workers' compensation wage differential claim. Annual cost is expected to be $600.

Contractual Services – Claims Audit: The independent claims audit was completed in 2016. Pursuant to the Contract and Bylaws an audit must be completed every 3 years, so an audit is due in 2019. The 2016 RFP requested that the auditors give a cost for a 3 year follow up audit. Staff is recommending retaining the previous auditor at a cost of $14,175. The recommendation for the Claims Audit is provided under separate memo.

Contractual Services – Insurance Brokerage Consultant Services: in 2014, the agreement with JLT Towers Re was extended for 5 years effective November 1, 2014 through October 31, 2019. The fee for the fourth year, November 1, 2018 through October 31, 2019 is $102,000. The agreement provides for a 5% annual performance bonus, if earned. The budget item for Insurance Brokerage & Risk Management Services for 2019 is increased by $5,100 to $107,100 to accommodate for the 5% bonus on $102,000.

Staff is recommending the 5% bonus for JLT Re. JLT Re has exceeded or met all goals with regard to the coverage renewal. JLT Re aggressively markets of our coverage programs including enhanced coverage terms. They have provided significant assistance with coverage analysis of proposed commercial insurance in both member retention and new member marketing. Additionally, they provide exceptional customer service to both IRMA staff and members and have expended significant efforts in assisting members in pursuing individual non-program related policies and placing optional coverage for members.

Contractual Services – Property Appraisal Services: The budget item for Property Appraisal Services for 2019 was increased from $15,000 to $20,000 to allow for property appraisals of any new members coming in to IRMA. The 2018 total amount spent in this category was $23,925, due to the addition of Village of Mount Prospect.

Commercial Insurance Services: We are still awaiting some final figures from our reinsurers for the 2019 Excess/Reinsurance Coverage Renewal. A short summary of this item is provided under separate memo. This budget amount will be distributed at the September 12, 2018 Committee meeting.

Recommendation: Approve the Committee's 2019 preliminary budget as presented.

SG/ds

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M E M O R A N D U M

TO: Coverage, Claims & Litigation Committee

FROM: Susan Garvey, Director of Legal Services

DATE: September 12, 2018

RE: Proposed Coverage Changes

Action Requested: Consider and approve recommended changes to the IRMA General Liability, Public Officials Liability and Business Auto Liability coverages as presented.

Background: The membership has directed staff to be more proactive in marketing, member recruitment and member retention. In response, staff has increased marketing activities, as well as member recruitment and retention. In response to the recruitment and retention activities, prospective and current members have either retained independent consultants or completed in-house reviews and analyses of IRMA's coverage for comparison to other coverage programs. The result of two of those analyses were the new membership of the Village of Arlington Heights and Mount Prospect. At the end of 2017, the Village of Glenview, a HELP member, retained an independent consultant to complete an analysis of IRMA's coverage versus commercial insurance. The consultant noted that some of the provisions of IRMA's coverage relied on intent or interpretation for application, as opposed to concise coverage language. As a risk pool, governed by its members and with the ultimate decision on coverage terms, provisions and limits, coverage determinations that are based upon a determination of intent of the membership or an interpretation in favor of coverage for a member are appropriate. However, staff has reviewed the concerns that have been raised and has determined that certain language would benefit from revisions to provide additional clarity.

Discussion:

Staff is recommending 3 changes, all of which are language revisions that clarify coverage and are consistent with past practice.

General Liability Coverage - Law Enforcement Activities

One of the most important coverages relates to law enforcement activities and needs to be clear and concise. Coverage for law enforcement activities is provided under the General Liability coverage. There are two coverage parts, Coverage A and Coverage B. Coverage A is occurrence-based coverage for bodily injury and property damage. An occurrence is defined as an accident. Coverage B is offense-based coverage for law enforcement claims, meaning coverage is dependent on the offense that was committed, i.e. malicious prosecution or false arrest. Coverage B excludes coverage for bodily injury resulting from law enforcement activities. Law enforcement claims, especially excessive force claims, will contain allegations of bodily injury. As a result, coverage for bodily injury needs to be found under Coverage A. Because the actions of the police are necessarily intentional, an argument can be made that there is no coverage for bodily injury resulting from law enforcement activities because it is not an accident. The coverage language has always been interpreted to find coverage for bodily injury under Coverage A contending that while the officers' actions may be intentional, they are not, in all cases, intending to cause injury. However, it has been pointed out that this is an interpretation and it could be interpreted differently in a different situation, creating ambiguity.

Staff is recommending changes be made to the General Liability coverage to clarify this potential ambiguity.

Staff has reviewed other law enforcement liability language and has proposed a change to the General Liability coverage excepting from the exception in Coverage A for intentional conduct, bodily injury and property damage arising from law enforcement activities. Additionally, the definition of personal injury in Coverage B has been modified to remove the exception for bodily injury. The proposed changes are attached for the Committee's consideration.

Contractual Liability – Coverage B

Another matter relates to the provisions of Coverage B excluded coverage for liability assumed in a contract. Coverage A has an affirmative provision that coverage is available to a member for liability it assumes in a contract. For example, agreeing to defend and indemnify another entity or organization for injury or damage that a member causes while using the other entity's property. While not an ambiguity, the exclusion in Coverage B is a limitation to coverage available to members. In explanation, if a member contracts to have another entity provide police services and agrees to defend and indemnify that other entity party for the member's negligence in using those law enforcement services, the current language in Coverage B would exclude coverage for the member. The proposed changes to this provision eliminate this exclusion regarding law enforcement activities. The proposed changes are attached for the Committee's consideration.

There are other areas of coverage that can benefit from clarifications and additions. Those include Employment Practices coverage, Business Auto Liability. Additionally, staff is proposing the addition of exclusions for criminal conduct in the General Liability and Auto Liability coverages. The Public Officials Liability coverage already contains an exclusion for criminal conduct.

<u>Public Officials Liability - Employment Practices.</u>

Coverage for employment practices is provided in the Public Officials coverage in Amendment 1. Amendment 1 as currently written is an exception to an exclusion rather than a positive statement of coverage. Staff is recommending changes to Amendment 1 to create a positive statement of coverage rather than an exception to an exclusion.

A matter noted in the recent coverage comparisons was that Exclusion 5 of the POL which excludes coverage for law enforcement activities and operational functions could be argued to remove law enforcement employees from the employment practices coverage. This provision has never been interpreted to exclude law enforcement employee claims from employment practices coverage, however it is another matter of interpretation. Staff proposes modification to Exclusion 5 to the Public Officials Liability to affirmatively state that claims by law enforcement employees is not excluded. The proposed changes to Exclusion 5 are attached for consideration.

Exclusion 12 to the Public Officials Liability excludes coverage for "back pay, front pay, overtime and similar claims". It does not however specify that employment benefits are included in the exclusion. The exclusion of employment benefits, such as health insurance, is in line with the types of damages that are excluded in this exclusion and are not the type of damages for which the pool should be responsible. For this reason, there is a potential ambiguity that the exclusion

would not apply to employment benefits. This language has also been added to Amendment 9 of the GL which references the employment practice coverage.

Business Auto Liability – Definition of Member

Finally, a recent case has raised a question about the definition of Member in the Business Auto Liability coverage and the exclusion of criminal conduct from coverage. A member employee driving a Village vehicle in violation of the member's policy was involved in an accident and charged with DUI. IRMA has taken the position and denied coverage to the employee (now former employee) and denied coverage to the driver of the other vehicle. The denial of coverage was based upon the argument that the employee was not acting within the scope of his employment when he was driving the vehicle in violation of the member's policy and was not a permitted user because he was in violation of the member's policy. To be entitled to coverage under any of the IRMA coverage documents, including the Business Auto Liability coverage, the employee must be a member of IRMA as that term is defined in the appropriate coverage. In reviewing the definition of member as it now reads in the Business Auto Liability coverage it is extremely broad, referencing a general "You". This again could raise a matter of interpretation of who is included in the term "You". To be clear, staff is proposing a modification to the definition of member in the Business Auto Liability coverage to specify the member as the entity, its employees and lawfully elected and appointed officials. The proposed modification to the definition of member is attached for consideration.

The case also raised the question of the exclusion from coverage for conduct that is criminal in nature, i.e. DUI. The pool should not be liable for the criminal conduct of an employee. Staff is proposing adding an exclusion to the General Liability and Auto Liability coverage for damages that result from criminal conduct. Exclusion 2 to the Public Officials Liability coverage already provides an exclusion for criminal conduct. To be clear, if an employee is denied coverage because of criminal conduct, the member would still be entitled to coverage if it is made a part of a claim. In explanation, in the recent case, if the member and the employee is sued by the other driver, the member would be entitled to a defense and indemnification, but coverage and defense would be denied to the employee. The proposed modifications are attached for consideration.

The proposed coverage changes have been submitted to the reinsurers, MunichRe and Great American. While, the agreements with the reinsurers provide that they agree to the terms of the coverage as set by IRMA, Staff submitted the proposed changes to the reinsurers for their thoughts as they deal with coverage terms on a regular basis. If there are any significant changes proposed by the reinsurers, those will be discussed with the Committee at the meeting.

Recommendation: Approve the changes to the General Liability, Public Officials and Business Auto Liability coverages as presented in the attachments contingent upon any additional changes approved at the meeting.

SG/ds
Attachment

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GENERAL LIABILITY COVERAGE FORM
(IRMA-CGL 1188)

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Various provisions in this Coverage Document restrict coverage. Read the entire Coverage Document carefully to determine rights, duties and what is and is not covered.

Throughout this Coverage Document the words "you" and "your" refer to the Named Member shown in the Declarations, and any other person or organization qualifying as a Named Member under this Coverage Document. The words "we", "us" and "our" refer to the self-insurance pool (IRMA) providing this coverage.

The word "Member" means any person or organization qualifying as such under WHO IS A MEMBER (SECTION II).

Other words and phrases that appear in quotation marks have special meaning. Refer to DEFINITIONS (SECTION V).

SECTION I - COVERAGES

COVERAGE A. BODILY INJURY AND PROPERTY DAMAGE LIABILITY

1. Coverage Agreement.

a. We will pay those sums that the Member becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this coverage applies. We will have the right and duty to defend any "suit" seeking those damages. We may at our discretion investigate any "occurrence" and settle any claim or "suit" that may result. But:

1. The amount we will pay for damages and supplementary payments is limited as described in LIMITS OF COVERAGE (SECTION III); and

2. Our right and duty to defend end when we have used up the applicable limit of coverage in the payment of judgments, settlements or supplementary payments under Coverage A or B or medical expenses under Coverage C.

No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under SUPPLEMENTARY PAYMENTS - COVERAGES A AND B.

b. This coverage applies to "bodily injury" and "property damage" only if:

1. The "bodily injury" or "property damage" is caused by an "occurrence" that takes place in the "coverage territory"; and

2. The "bodily injury" or "property damage" occurs during the Coverage Document period.

c. Damages because of "bodily injury" include damages claimed by any person or organization for care, loss of services or death resulting at any time from the "bodily injury".

2. Exclusions.

This coverage does not apply to:

a. "Bodily injury" or "property damage" expected or intended from the standpoint of the Member and/or deemed to be a criminal act.

This exclusion does not apply to:

1. ~~"b~~Bodily ~~i~~Injury~~"~~ or Property Damage resulting from the use of reasonable force to protect persons or property; or ~~to willful and wanton conduct without the intent to injure or harm.~~

2. With respect to your law enforcement activities, Bodily Injury or Property Damage resulting from the investigation, arrest or incarceration process or any action directed toward the prevention or control of crime (unless deemed to be a criminal act).

b. "Bodily injury" or "property damage" for which the Member is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages:

1. Assumed in a contract or agreement that is a "covered contract", provided the "bodily injury" or "property damage" occurs subsequent to the execution of the contract or agreement; or

2. That the Member would have in the absence of the contract or agreement.

c. "Bodily injury" or "property damage" for which any Member may be held liable by reason of:

1. Causing or contributing to the intoxication of any person;

2. The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or

3. Any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

This exclusion applies only if you are in the business of manufacturing, distributing, selling, serving or furnishing alcoholic beverages.

d. Any obligation of the Member under a workers' compensation, disability benefits, including but not limited to the Public Safety Employee Benefits Act and Public Employee Disability Act,or similar statutory disability benefits or amendments thereto , unemployment compensation law or any similar law.

e. "Bodily injury" to:

1. An employee of the Member arising out of and in the course of employment by the Member; or

2. The spouse, child, parent, brother or sister of that employee as a consequence of 1. above.

This exclusion applies:

1. Whether the Member may be liable as an employer or in any other capacity; and

2. To any obligation to share damages with or repay someone else who must pay damages because of the injury.

b. Vehicles maintained for use solely on or next to premises you won or rent; any land motor vehicle, trailer or semi-trailer designed for travel on public roads (including any machinery or apparatus that is attached) owned or leased by you shall be deemed an “auto” and not “mobile Equipment” if the only reason for considering it “mobile equipment” is that is maintained for use exclusively on streets or highways owned by you.

c. Vehicles that travel on crawler treads;

d. Vehicles, whether self-propelled or not, maintained primarily to provide mobility to permanently mounted:

1. Power cranes, shovels, loaders, diggers or drills; or

2. Road construction or resurfacing equipment such as graders, scrapers or rollers;

e. Vehicles not described in a., b., c. or d. above that are not self-propelled and are maintained primarily to provide mobility to permanently attached equipment of the following types:

1. Air compressors, pumps and generators, including spraying, welding, building cleaning, geophysical exploration, lighting and well servicing equipment; or

2. Cherry pickers and similar devices used to raise or lower workers;

f. Vehicles not described in a., b., c. or d. above maintained primarily for purposes other than the transportation of persons or cargo.

However, self-propelled vehicles with the following types of permanently attached equipment are not "mobile equipment" but will be considered "autos":

1. Equipment designed primarily for:

a. Snow removal;

b. Road maintenance, but not construction or resurfacing;

c. Street cleaning;

2. Cherry pickers and similar devices mounted on automobile or truck chassis and used to raise or lower workers; and

3. Air compressors, pumps and generators, including spraying, welding, building cleaning, geophysical exploration, lighting and well servicing equipment.

9. "Occurrence" means an accident, including continuous or repeated exposure to substantially the same general harmful conditions.

10. "Personal injury" means injury ~~other than “bodily injury”~~ arising out of one or more of the following offenses, actual or alleged act, error omission, neglect or breach of duty:

a. False arrest, detention or imprisonment, improper search or seizure;

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b. Malicious prosecution;

c. The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies by or on behalf of its owner, landlord or lessor;

d. Oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services; or

e. Oral or written publication of material that violates a person's right of privacy.

The ~~definition of "personal injury" includes injury, other than "bodily injury" arising out of the~~ following offenses, actual or alleged act, error, omission, neglect or breach of duty, are added with respect to the law enforcement activities of the Named Member: ~~BUT ONLY WITH RESPECT TO THE LAW ENFORCEMENT ACTIVITIES OF THE NAMED MEMBER:~~

f. Discrimination (unless coverage and/or insurance thereof is prohibited by law) but not discrimination arising out of employment related practices, policies, acts or omissions.

g. Humiliation, mental anguish, emotional distress, but not humiliation, mental anguish or emotional distress arising out of employment related practices, policies, acts or omissions.

h. Improper Service of Process

i. Violation of Property Rights

j. Violation of Civil Rights protected under 42USC 1981 et. sequential or state or local law.

"Law Enforcement Activities" shall apply to sworn municipal police officers, community service officers and code enforcement personnel. Code enforcement personnel is defined as "individuals whose scope of authority or employment explicitly includes enforcing municipal codes or ordinances within their specific area of responsibility."

11. a. "Products-completed operations hazard" includes all "bodily injury" and "property damage" occurring away from premises you own or rent and arising out of "your product" or "your work" except.

1. Products that are still in your physical possession; or

2. Work that has not yet been completed or abandoned.

b. "Your work" will be deemed completed at the earliest of the following times:

1. When all of the work called for in your contract has been completed.

2. When all of the work to be done at the site has been completed if your contract calls for work at more than one site.

3. When that part of the work done at a job site has been put to its intended use by any person or organization other than another contractor or subcontractor working on the same project.

Work that may need service, maintenance, correction, repair or replacement, but which is otherwise

COVERAGE B. PERSONAL AND ADVERTISING INJURY LIABILITY

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1. Coverage Agreement.

a. We will pay those sums that the Member becomes legally obligated to pay as damages because of "personal injury" or "advertising injury" to which this coverage part applies. We will have the right and duty to defend any "suit" seeking those damages. We may at our discretion investigate any "occurrence" or offense and settle any claim or "suit" that may result. But:

1. The amount we will pay for damages and supplementary payments is limited as described in LIMITS OF COVERAGE (SECTION III); and

2. Our right and duty to defend end when we have used up the applicable limit of coverage in the payment of judgments, settlements or supplementary payments under Coverage A or B or medical expenses under Coverage C.

No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under SUPPLEMENTARY PAYMENTS - COVERAGES A AND B.

b. This coverage applies to:

1. "Personal injury" caused by an offense arising out of your business, excluding advertising, publishing, broadcasting or telecasting done by or for you;

2. "Advertising injury" caused by an offense committed in the course of advertising your goods, products or services;

but only if the offense was committed in the "coverage territory" during the policy period.

2. Exclusions.

This coverage does not apply to:

a. "Personal injury" or "advertising injury":

1. Arising out of oral or written publication of material, if done by or at the direction of the Member with knowledge of its falsity;

2. Arising out of oral or written publication of material whose first publication took place before the beginning of the coverage document period;

3. Arising out of the willful violation of a penal statute or ordinance committed by or with the consent of the Member; or

4. For which the Member has assumed liability in a contract or agreement. This exclusion does not apply to liability for damages that the Member would have in the absence of the contract or agreement or for damages that the Member has assumed in a service agreement in your law enforcement activities, provided such agreement is departmentally approved.

b. "Advertising injury" arising out of:

1. Breach of contract, other than misappropriation of advertising ideas under an implied contract;

2. The failure of goods, products or services to conform with advertised quality or performance;

Amendment #1

COVERAGE DOCUMENT CHANGES

Named Member:	Intergovernmental Risk Management Agency and Participating Municipalities/Special Districts - See Named Member Amendment #1 and changes thereto.
Coverage Document Number:	January 1, 1991 (as amended)
Coverage Parts Affected:	Public Officials Liability
Effective Date of Change:	January 1, 20191~~1993~~

EMPLOYMENT RELATED COVERAGE

Subject to all applicable exclusions, i~~I~~t is agreed that this coverage shall apply ~~Exclusions No. 3 and 4 of the "Public Officials Liability Coverage Document" do not apply, except for assault and battery,~~ to any loss or claim by an employee, or prospective employee of yours, made as a result of:

(a) refusal to employ;

(b) termination of employment; or

(c) coercion, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination or other employment related practices, policies, or wrongful acts.

It is agreed that Exclusions 3 and 4 of the POL do not apply, except for assault and battery.

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4. whether serving as a board member or officer, subject to the following conditions:

   a. Service on the board is approved by the IRMA member employer,
   b. Service on the board furthers the interests of the IRMA member employer,
   c. Any coverage available from the independent organization shall be primary with coverage provided under this document to be excess only.

   This coverage does not extend to the independent organization itself or to non-IRMA member employees.

PUBLIC ENTITY - means the governmental body named in Item 1 of the Declarations.

WRONGFUL ACT(S) - means any actual or alleged violation of any federal, state, or local civil rights, or, breach of duty by the MEMBER in the discharge of duties for the PUBLIC ENTITY individually or collectively.

COVERAGE DOCUMENT PERIOD - means the period of one year following the effective date and hour of the Coverage Document, or if the time between the effective date and the termination date of the Coverage Document is less than one year, such lesser period.

DEDUCTIBLE - means the amount the MEMBER must contribute to loss and LOSS ADJUSTMENT EXPENSE. LOSS ADJUSTMENT EXPENSE shall not include the salaries of our employees.

LOSS ADJUSTMENT EXPENSE - means expenditures including, but not limited to, costs of investigations, experts, adjustment services, legal services, court costs, and other similar expenses to us.

EXCLUSIONS

We shall not be obligated to make any payment nor to defend any lawsuit in connection with any claim against the MEMBER:

1. Based upon or attributable to the MEMBER gaining any profit, advantage or remuneration to which the MEMBER is not entitled. The defense provisions contained in Amendment 4 are applicable to this exclusion.

2. Brought about or contributed to by fraud, dishonesty or bad faith by a MEMBER or arising from the deliberate violation of any federal, state, or local statute, ordinance, rule or regulation committed by or with the knowledge and consent of the MEMBER. This exclusion applies only when the Member is found to have acted with intent to injure or harm. The defense provisions contained in Amendment 4 are applicable to this exclusion.

3. For any damage arising from bodily injury, sickness, disease or death of any person, or for damage to or destruction of property, including diminution of value or loss of use thereof.

4. For false arrest, false imprisonment, libel, slander, defamation, invasion of privacy, wrongful eviction, assault, battery, malicious prosecution, or abuse of process.

5. Arising out of law enforcement activities or arising out of operational functions including the operation of adult and juvenile detention facilities. This exclusion does not apply to employment practices claims brought by law enforcement personnel.

6. As a result of strikes, riots or civil commotion.

7. Based upon or arising out of any fiduciary activity by the MEMBER concerning any employee benefit plan.

8. For claims, demands, or actions seeking relief or redress in any form other than monetary damages, such as injunction, mandamus or declaratory relief or for any fees, including attorneys' fees of opposing counsel, costs or expenses which the MEMBER may become obligated to pay where a judgment providing no other monetary relief to the plaintiff is entered; however, we will afford defense to the MEMBER for such actions, claims, suits or demands in which monetary damages are requested if not otherwise excluded pursuant to the provisions of Amendment 4, Defense Provisions.

9. For any damages arising from inverse condemnation, adverse possession, dedication by adverse use or eminent domain.

10. For any loss, cost or expense arising out of any governmental direction or request to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants. Pollutants means any solid, liquid, gaseous, or thermal irritant or contaminant, including, but not limited to, smoke, vapor, soot, fumes, acids, asbestos, alkalis, chemicals and waste. Waste includes, but is not limited to, materials to be recycled, reconditioned or reclaimed.

11. For any loss, cost, civil fine, penalty or expense against any MEMBER arising from any complaint or enforcement action from any federal, state or local governmental regulatory agency, other governmental authority or awarded by a Court or other administrative agency.

12. For back wages, front wages, retroactive salary increases, employment benefits, overtime or similar claims, even if designated as liquidated damages, or claims arising from collective bargaining agreements.

13. For punitive or exemplary damages. In addition, we will not pay defense costs nor shall we be obligated to provide a defense for claims or legal actions in anyway requesting punitive or exemplary damages, except as provided in a unified defense under Amendment 4.

14. For causes of action grounded solely in contract.

15. In respect of any loss, claim, proceeding, suit or other legal or administrative action for benefits, damages, costs, fees, fines or penalties, by whatever name called, based upon Public Safety Employee Benefit Act, Public Employee Disability Act and other similar statutory disability benefits, and any amendments thereto.

16. For claims arising from the issuance of bonds or improperly collected taxes.

17. For claims arising from procurement, construction or architect or engineer contracts.

18. Based upon or attributable to any failure or omission of the MEMBER to effect or maintain insurance of any kind.

19. Notwithstanding anything to the contrary contained in this coverage, it is agreed that this coverage does not apply to and we will not provide a defense or pay attorneys fees or defense costs for any liability arising out of or by any reason of:

    (1) The purchase, or sale, or offer of sale, or solicitation of any security, debt, bank deposit or financial interest or instrument;

Amendment # 9

COVERAGE DOCUMENT CHANGES

Named Member:	Intergovernmental Risk Management Agency and Participating Municipalities/Special Districts - See Named Member Amendment #1 and changes thereto.
Coverage Document Number:	January 1, 1991 (as amended)
Coverage Parts Affected:	General Liability/Business Auto
Effective Date of Change:	January 1, 1993

MISCELLANEOUS EXCLUSIONS

It is hereby agreed that the Intergovernmental Risk Management Agency shall not provide pooling coverage, insurance, or defense costs for the following:

1. Punitive or exemplary damages.

2. Causes of action grounded solely in contract, except for validly extended contractual obligations of Members to indemnify third parties against personal injury, bodily injury, or property damage.

3. Causes of action seeking back pay, front pay, retroactive salary increases, employment benefits, overtime or similar claims, even if designated as liquidated damages, or claims arising from collective bargaining agreements.

4. Causes of action alleging improper acts by employees or other officials of IRMA Members who serve on other intergovernmental agencies, to the extent that such claim alleges actions performed beyond service as a mere Member of the legislative body of such agency. (For example, acts performed by an agency officer are not covered.)

5. To any causes of action seeking only non-monetary claims such as injunction, mandamus or declaratory relief or to the payment of attorneys' fees of opposing counsel or other court costs where a judgment providing no other monetary relief to the plaintiff is entered.

6. To property damage arising out of, or in any way connected with, the operation of the principles of eminent domain, condemnation proceedings, or inverse condemnation, by whatever name called, whether such liability occurs directly against the Member or by virtue of any agreement entered into by or on behalf of the Member.

SECTION II - LIABILITY COVERAGE

A. COVERAGE

We will pay all sums a "Member" legally must pay as damages because of "bodily injury" or "property damage" to which this coverage applies, caused by an "accident" and resulting from the ownership, maintenance or use of a covered "auto".

We will also pay all sums a "Member" legally must pay as a "covered pollution cost or expense" to which this coverage applies, caused by an "accident" and resulting from the ownership, maintenance or use of covered "autos". However, we will only pay for the "covered pollution cost or expense" if there is either "bodily injury" or "property damage" to which this coverage applies that is caused by the same "accident".

We have the right and duty to defend any "suit" asking for such damages or a "covered pollution cost or expense". However, we have no duty to defend "suits" for "bodily injury" or "property damage" or a "covered pollution cost or expense" not covered by this Coverage Form. We may investigate and settle any claim or "suit" as we consider appropriate. Our duty to defend or settle ends when the Liability Coverage Limit of Coverage has been exhausted by payment of judgments, settlements or supplementary payments.

1. WHO IS A MEMBER

The following are "Members" for any covered auto:

a. The Public Entity Member, it's employees and all persons who are lawfully elected or appointed officials of the Public Entity Member; ~~You for any covered "auto".~~

b. Anyone else is a "Member" while using with your permission a covered "auto" you own, hire or borrow except:

1. The owner or anyone else from which you hire or borrow a covered "auto". This exception does not apply if the covered "auto" is a "trailer" connected to a covered "auto" you own.

2. Your employee if the covered "auto" is owned by that employee, or a member of his or her household.

3. Someone using a covered "auto" while he or she is working in a business of selling, servicing, repairing or parking "autos" unless that business is yours.

4. Anyone other than your employees, partners, a lessee or borrower or any of their employees, while moving property to or from a covered "auto".

~~5. A partner or yours for a covered "auto" owned by him or her or a member of his or her household.~~

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c. Anyone liable for the conduct of a "Member" described above but only to the extent of that liability.

2. COVERAGE EXTENSIONS

a. Supplementary Payments. In addition to the Limit of Coverage, we will pay for the "Member":

1. All expenses we incur.

2. Up to $250 for cost of bail bonds (including bonds for related traffic law violations) required because of an "accident" we cover. We do not have to furnish these bonds.

3. The cost of bonds to release attachments in any "suit" we defend, but only for bond amounts within our Limit of Coverage.

4. All reasonable expenses incurred by the "Member" at our request, including actual loss of earning up to $100 a day because of time off from work.

5. All costs taxed against the "Member" in any "suit" we defend.

6. All interest on the full amount of any judgment that accrues after entry of the judgment in any "suit" we defend; but our duty to pay interest ends when we have paid, offered to pay or deposited in court the part of the judgment that is within our Limit of Coverage.

b. Out-of-State Coverage Extensions

While a covered "auto" is away from the state where it is licensed, we will:

1. Increase the Limit of Coverage for Liability Coverage to meet the limits specified by a compulsory or financial responsibility law of the jurisdiction where the covered "auto" is being used. This extension does not apply to the limit or limits specified by any law governing motor carriers of passengers or property.

2. Provide the minimum amounts and types of other coverages, such as no-fault, required of out-of-state vehicles by the jurisdiction where the covered "auto" is being used.

We will not pay anyone more than once for the same elements of loss because of these extensions.

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B. EXCLUSIONS

This coverage does not apply to any of the following:

1. EXPECTED OR INTENDED INJURY

"Bodily injury" or "property damage" expected or intended from the standpoint of the "Member" or resulting from a criminal offense.

2. CONTRACTUAL

Liability assumed under any contract or agreement.

But this exclusion does not apply to liability for damages:

a. Assumed in a contract or agreement that is a "covered contract" provided the "bodily injury" or "property damage" occurs subsequent to the execution of the contract or agreement; or

b. That the "Member" would have in the absence of the contract or agreement.

3. WORKERS' COMPENSATION

Any obligation for which the "Member" or the "Member's" insurer may be held liable under any workers' compensation, disability benefits or unemployment compensation law or any similar law.

4. EMPLOYEE INDEMNIFICATION AND EMPLOYER'S LIABILITY

"Bodily injury" to:

a. An employee of the "Member" arising out of and in the course of employment by the "Member", or

b. The spouse, child, parent, brother or sister of that employee as a consequence of paragraph a. above.

This exclusion applies:

1. Whether the "Member" may be liable as an employer or in any other capacity; and

2. To any obligation to share damages with or repay someone else who must pay damages because of the injury.

M E M O R A N D U M

TO: Coverage Claims and Litigation Committee

FROM: Susan Garvey, Director of Legal Services
Keena Marks Cutler, General Liability Claims Supervisor

DATE: September 12, 2018

RE: Expanded Auto Coverage for New Vehicles

Action Requested: Approve a recommended revision to the First Party Property Coverage - Vehicle Damage language that will expand coverage to provide for full replacement value coverage for member covered vehicles under 1 year old.

Background: At the May 3, 2018 Committee meeting, Staff brought a recommendation to the Committee to enhance auto liability coverage to provide for full replacement value coverage for member vehicles under 1 year old. The original memo is attached for your reference. After discussion at the meeting, the Committee requested Staff to bring back the following additional data relative to this proposed expanded coverage: 3-4 years of historical data of vehicles that would fall within this coverage, market trends, the impacted premiums, and how many are subrogated.

Discussion: Staff completed the research requested at the May meeting and provides the following additional information for the Committee's consideration.

In the past three years there have been 6 vehicles less than a year old that have been totaled. When adjusting auto claims it is not necessary to obtain the original purchase price because the loss is based upon the actual cash value of the vehicle at the time of the loss. Consequently, our records do not reflect the actual purchase price of the 6 vehicles. As a result, we have used the base MSRP of the year, make, and model of the vehicles for comparison purposes. The base MSRP does not include options that may have been added to the vehicles, which we are unable to ascertain. With that disclaimer, a review of the 6 claims shows that IRMA paid a total of $142,670 on the 6 vehicles. The total MSRP for the referenced 6 vehicles is $172,995. The difference is $30,285 which is the estimate of the additional amounts that would have been paid under the new car replacement coverage.

All 6 of the vehicles have been or are in the process of subrogation against a responsible third party. We have recovered 100% on 3 of the claims and the other 3 remain in subrogation as of this date. It is important to note however, if we pay full replacement cost, we will not collect that full amount in subrogation. A carrier is only going to pay the actual cash value of the vehicle at the time of loss so, there will still be additional amounts paid that are not recovered.

Even assuming an additional $10 thousand per vehicle for added options, with a $30 million loss fund, any impact to the pool would be minimal at best.

New vehicle or full vehicle replacement coverage is no longer unusual. Most commercial insurance companies provide some variation of this type of coverage. While we are not an insurance company and generally don't compare ourselves to insurance companies, we do find ourselves in competition with private insurance as we continue to enhance our member recruitment efforts. As such, for illustrative purposes, here are some insurance companies that provide this type of enhanced coverage, (this list is not all inclusive): State Farm, Liberty Mutual, Travelers, Nationwide, Hartford, Farmers and Allstate.

Another concern raised by the Committee was the original recommendation for this coverage to be applicable to vehicles under 2 years old. The insurance companies vary as to the age of the vehicle. For example, Nationwide covers vehicles that are under 3 years old, Allstate, under 2 years old while Liberty Mutual provides coverage for cars that are under 1 year old. Based upon the Committee's concern, staff is recommending that we modify the vehicles available for this coverage to vehicles that are less than 1 year old.

The redlined version of Amendment 12 to the 1st Party Property is attached for the Committee's consideration.

Recommendation: Concur with staff's recommendation to expand the Vehicle Damage coverage to full replacement value for vehicles under 1 year old, effective January 1, 2019.

SG/KMC/ds
Attachment

ENDORSEMENT 12

VEHICLE DAMAGE

This endorsement modifies insurance provided under the Property Coverage Form.

The following coverage is added:

Vehicle Damage

1. IRMA will pay for direct physical loss or damage to Covered Vehicles at the Member's premises caused by or resulting from a Covered Cause of Loss. When "over the road exposures" are indicated as included in the Property Coverage Declarations, this coverage also applies to Covered Vehicles while anywhere within the Coverage Agreement Territory including while being operated over the road.

   The exclusion of vehicles licensed for use on public roads under Section C., of the Property Coverage Form, PROPERTY AND COSTS NOT COVERED, does not apply to loss or damage to Covered Vehicles to which this coverage applies.

2. All of the exclusions that apply to the Property Coverage Form apply to loss or damage under this coverage, except as follows:

   a. When "over the road exposures" are indicated as included in the Property Coverage Declarations, exclusions D.1.a. EARTH MOVEMENT and D. 1. b. FLOOD does not apply to loss or damage to Covered Vehicles while at any location other than the Member's premises.
   b. The following exclusions are added:
      (1) IRMA will not pay for loss or damage under this coverage that is caused by or results from any of the following, unless such loss or damage is itself caused by or results from other loss or damage not otherwise excluded under this coverage:
         (a) Wear and tear;
         {b) Freezing;
         (c) Mechanical or electrical breakdown;
         (d) Blowouts, punctures or other road damage to tires.
      (2) IRMA will not pay under this coverage for loss or damage to any of the following:
         (a) Tapes, records, discs or other similar audio, visual or data electronic devices designed for use with any audio, visual or sound reproducing equipment;
         (b) Equipment designed or used for the detection or location of radar;
         (c) Any electronic equipment, without regard to whether this equipment is permanently installed, that receives or transmits audio, visual or data signals, and any accessories used with such equipment. But this exclusion does not apply to:
            (i) Equipment designed solely for the reproduction of sound and accessories used with such equipment, provided such equipment is permanently installed in the Covered Vehicle or is removable from a housing unit which is permanently installed in the Covered Vehicle, and such equipment is designed to be solely operated by use of the power from the Covered Vehicle's electrical system; or
            (ii) Any other electronic equipment that is:
               - Necessary for the normal operation of the Covered Vehicle or the monitoring of the Covered Vehicle's operating system; or
               - An integral part of the same unit housing any sound reproducing equipment described in (i) above and permanently installed in the opening of the dash or console of the covered vehicle normally used by the manufacturer for installation of a radio, With respect only to the insurance provided under this endorsement;

(d) Any Covered Vehicle while being used in or practicing for any professional or organized racing or demolition contest or stunting activity, or while being prepared for such contest or activity.

(3) IRMA will not pay under this coverage for loss of use, loss of income or any other consequential loss.

3. The most IRMA will pay for loss or damage in any one occurrence under this coverage is the applicable Limit of Insurance shown in the Property Coverage Declarations for Vehicle Damage. This is additional insurance.

4. With respect only to the insurance provided under this coverage:

a. The following is added to the Notice of Loss and Duties in the Event of Loss or Damage condition in the General Conditions;

The Member must also permit IRMA to inspect the Covered Vehicles and records proving the loss before the repair or disposition of the Covered Vehicles.

b. The valuation provisions of this Coverage Agreement are replaced by the following:

Except as provided in c. and d. below, ~~I~~in the event of covered loss or damage to Covered Vehicles~~, except emergency vehicles valued at $75,000 or greater,~~ the value of the Covered Vehicles will be determined at actual cash value, meaning the cost to repair or replace the lost or damaged property, at the time and place of loss, with other property of comparable size, material and quality, less allowance for physical deterioration, depreciation, obsolescence and depletion.

c. For Covered Emergency Vehicles valued at $75,000 or greater, agreed value coverage applies. Agreed value means original purchase price new plus any major refurbishments.

~~c.~~d. Effective January 1, 2019, for Covered Vehicles less than 1 year old, full replacement value coverage applies. Full replacement value means payment to replace a vehicle that is declared to be a total loss with a new vehicle of the same make and model in the current model year up to total purchase price expended for the totaled vehicle. .

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5. As used in this coverage:

a. Covered Vehicles means motor vehicles that are:
(1) Licensed for use on public roads; and
(2) (a) Owned by the Member; or
(b) Owned by others and in the Member's care, custody or control, but only to the extent of the Member's legal liability for such vehicles; and
(3) (a) Included in the most recent Statement of Values or other documentation on file with IRMA; or
(b) Newly Acquired Vehicles.

b. Newly Acquired Vehicles means motor vehicles that are acquired by the Member after the inception date of this insurance are covered under this policy.

M E M O R A N D U M

TO: Coverage, Claims & Litigation Committee

FROM: Susan Garvey, Director of Legal Services

DATE: September 11, 2018

RE: Changes to Claims Manual

Action Requested: Approve changes to IRMA's Claims Manual in response to recommendations from Claims Auditor in most recent Claims Audit.

Background/Discussion: Pursuant to Section 3.09(E) of the IRMA Contract and Bylaws Northshore International Insurance Services, Inc. ("NiiS") was selected to complete the claims audit in 2016 and made some recommendations for revisions to claims handling practices. We implemented the recommendations and now we need to memorialize the changes in our policies. The recommendations are explained herein and the red-lined policy revisions are attached as referenced.

Reserving Practices

As an intergovernmental risk pool, IRMA is different from private insurance companies, which are profit-driven corporate entities. IRMA is non-profit and owned by its members. As such, IRMA's operation is unique financially and our reserving practices reflect our values reflected in the Bylaws, which give our members a right to object to reserves. In addition, we take into consideration that our reserves will impact our rates and member contributions, so they must be very carefully set. In the private insurance world, the appropriate reserve approach is to reserve cases at the level for the "worst possible outcome." This approach would result in unnecessarily high member contributions and is simply not in the best interest of IRMA members. Rather, the IRMA Claim Policy states that the reserve should be set at "the most likely ultimate outcome as early as possible." As such, IRMA's reserving policy has been to reserve based upon the percentage chance of winning or losing with the benefit of defense counsel's opinion, and after enough information is available to make such a determination.

The 2016 audit noted that reserving based upon a percentage chance of winning or losing a claim is not accepted in the insurance industry. The auditor suggested that the appropriate reserving practice is to reserve at the "worst possible outcome." However, if a claim is a 100% liability claim, it would be reserved at 100%. From a financial perspective, there is no concern about the levels of IRMA's reserves. IRMA's actuaries reviews the adequacy of IRMA's reserves every year and they consistently report that IRMA's reserves are well funded and the pool is financially stable.

However, the comments relative to reserving have been made in previous audits. Therefore, in order to address the continued comments on IRMA's deviation from insurance industry standards for reserving, staff is proposing changes to the Reserving Policy portion of the Claims Policy to reflect the unique reserving concerns and considerations based on IRMA's operations and claims administration. The proposed changes to the Reserving Philosophy provision of the Claims Policy are attached for the Committee's consideration.

Member Contact, Investigations and Documentation in Workers' Compensation Cases

Each IRMA member identifies a Claims Coordinator as our primary point of contact for claims administration. As such, our claim adjusters rely on member claims coordinators for most of the investigation we perform. The audit suggested that member contact, investigations and documentation in questionable workers' compensation cases had room for improvement. The audit noted that in suspicious or questionable claims, contact should be beyond the member claims coordinator to supervisors or other witnesses to the incident to do a more in-depth compensability investigation. The auditor also noted that the claim notes should more fully document the investigation, status, analysis and action plan for the claim. Some of the issues raised in this recommendation were because the adjusters had case-loads that were higher than industry standards for manageability of claims. This was addressed by hiring additional staff. Some of the methods of investigation noted in this recommendation were not required by the Claims Manual at that time. In response to this comment, the workers' compensation department reviewed the audit results and changed its practices in some areas to address noted deficiencies. Those practices are now being memorialized in the Claims Manual. For ease of reading, the claims handling standards for Liability and Workers' Compensation have been separated into separate documents. The revised Claim Handling Standards are attached for the Committee's consideration.

Excess Reporting

While this area was not addressed in the Claims Audit, staff is proposing changes to assure that our reinsurers and excess insurers are kept fully apprised of cases that may pierce their coverage. The reinsurers and excess insurers all have specific requirements as to when they are to be notified of a claim that may enter their layer and guidelines for when they should be provided status updates of any such claim. Each reinsurer or excess insurer's guidelines may be different for when status updates are required. To be consistent and assure that the insurers are kept advised of the status, changes to IRMA's Excess Notification provisions are proposed. Those changes include reporting to the reinsurer or excess on a quarterly basis in addition to the adjuster's compliance with the reporting guidelines of the reinsurer or excess insurer. Additionally, claims on which the excess or re-insurer is liable on the claim, the claim will have a status of ER Excess Open Recovery. Reimbursement will be sought from the workers compensation excess carrier on a quarterly basis and reimbursement from the general liability reinsurers will be sought as required in the reinsurance agreement or if no requirement then on a quarterly basis. The Excess Notification requirements are attached for the Committee's consideration.

Recommendation: Approve Staff's recommended changes to the Reserving Policy, the Workers' Compensation Claims Handling Standards and the Excess Notification in the Claims Manual.

SG/ds

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CLAIMS POLICY *

I. CLAIM HANDLING PHILOSOPHY/ETHICS STATEMENT

IRMA intends to move promptly, and aggressively, to process its Members' claims, investigate the cause (s), determine the liability, and dispose of the claims in a fair and equitable manner. We recognize that we have a responsibility to pay claims when damage has resulted from the negligence of a Member, or when covered by the Illinois Workers Compensation statute. We have a responsibility to resist payment of those claims when we are not liable or when not covered by statute or when the demand to settle is clearly beyond the norm of fair and reasonable compensation.

The IRMA Claims Unit will uphold high ethical standards in the administration of claims. The Claims staff will perform in a manner that promotes professionalism within the organization.

It is IRMA's operating objective to attract and retain claims personnel of above average quality, by offering competitive compensation, good training, comfortable working environment, and opportunities for advancement.

II. CLAIMS RESERVING

The Board of Directors has granted to the Executive Director full authority to establish reserves and associated procedures, consistent with well-recognized claims standards and practices, taking into consideration factors which are unique to IRMA's operations, the significant interaction of members in the claims administration process, a Member's right to object to reserves over $10,000 and the direct impact that a reserve has on a Member's contribution. ~~Independent Claims Auditors will perform claims Audits every 2-3 years.~~

Philosophy: IRMA's goal is to establish each case reserve to the most likely ultimate outcome as early as possible. IRMA's consideration of reserving at most likely outcome when reserving is not always defined as the worst possible outcome. Reserving for the worst possible outcome for each case reserve is not IRMA's philosophy since, among other factors, reserves have a direct impact on member contributions. The practice of reserving based upon a percentage chance of winning or losing a case is appropriate when sufficient documentation has been collected to make a determination of the chance of winning or losing and/or based upon defense counsel's opinion of the percentage.

Stair-stepping (incremental increases to cover short-term expenses) must be avoided. The Member will receive written notice (Reserve Notice –Authority to Settle) of any settlement reserve set over $10,000, except that such a Reserve Notice shall not be required for the first party property or auto physical damage claims when the Member has provided the estimates or invoices for payment of the claim to IRMA.

The setting of these settlement reserves, and their written notice, shall also be considered advance notice of settlement, in accordance with the IRMA Bylaws, Section 4.02 (A). In cases in which there is not sufficient information to establish a settlement reserve but it has been determined that there is a potential financial

exposure to the pool in excess of $10,000, the Member will receive written notice of the establishment of a financial reserve (Financial Reserve Notice). The setting of a financial reserve does not grant any settlement authority.

Independent Claims Auditors will perform claims Audits every 2-3 years.

III. ALLOCATION OF SETTLEMENT AMOUNT

When a claim includes covered and non-covered counts, and it is to the benefit of all parties to settle all aspects of the case simultaneously or when there is an adverse verdict or determination on the non-covered counts, the Executive Director will determine what portion, if any, of the amount required to settle a case or the amount of the verdict or adverse determination should be allocated to the Member. For purposes of the allocation, when a case is subject to the assessment of plaintiff's attorneys' fees, any such fees awarded, paid or included as a part of a settlement may be included as a part

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* IRMA Website Document

of any allocation whether or not any other compensatory damages are awarded or paid. Each case will be determined on the merits and circumstances of the specific case, but in general Members will be expected to contribute to a settlement in the following situations:

- When, in the opinion of IRMA's Legal Counsel assigned to the case, there is 50% or greater likelihood that the Member will be found guilty if the case is taken to trial due to liability associated with non-covered counts.

- When more than 50% of the alleged damages arise out of non-covered counts and there is a reasonable probability that the Member will be found liable for the non-covered counts.

- When the preponderance of the plaintiff's legal fees are spent proving the allegations included in non-covered counts, and there is a reasonable probability that the Member will be found liable for the non-covered counts.

- When the covered counts have been dismissed.

When determining the amount to be allocated to the Member, only amounts associated with non-covered allegations directly against the Member or non-covered allegations indemnified by the Member will be considered by the Executive Director. If IRMA chooses to settle non-covered allegations against employees of the Member that cannot be indemnified by the Member, no portion of the amount paid to settle such allegations will be allocated to the Member.

When the Executive Director determines that a Member should contribute to a settlement, an Allocated Settlement Notice shall be sent to the Member in accordance with Section 4.02 of the IRMA Bylaws. Any such notice may be appealed by the affected Member in accordance with Section 4.04 of the IRMA Bylaws.

When a member is contributing to a settlement or has been assessed damages by a jury for non-covered counts, the member may delay reimbursement of IRMA for the payment of non-covered damages if the member pays interest at the rate included in the budget for investments. Any available Excess Surplus Funds must first be utilized to reduce the amount due to IRMA.

IV. CLAIMS SETTLEMENT

It is IRMA's philosophy to:

a) Settle Workers' Compensation cases in accordance with statutory guidelines and sound claims practices; and Liability/First Party Property cases based on sound claims practices.

b) Compromise those cases of questionable liability, disability or compensability when appropriate.

c) Defend those cases which are non-compensable or where there is no liability.

A *"cost-of-defense"* type settlement is always a consideration, but must be used sparingly. The loss reserve notice is the notification to the Member of any claim that may settle above $10,000. Settlement authority and concurrence is on a per claimant basis.

Loss authority levels:

- Executive Board

  Liability Indemnity over $ $750,000

  Workers' Compensation over $750,000

- Coverage Claims and Litigation Committee

  Liability Indemnity over $500,000 to $750,000

  Workers' Compensation over $500,000 to $750,000

- Executive Director

  Liability Indemnity up to $ $500,000

  Workers' Compensation Indemnity up to $500,000

- Director of Legal Services

  Liability Indemnity up to $300,000

  Workers' Compensation Indemnity up to $300,000

- Supervisor of Liability Claims Operations up to $100,000

- Supervisor of Workers' Compensation Claims Operations up to $100,000

V. CLAIM PRACTICES AND PROCEDURES

IRMA's claims philosophy, reserving and settlement authority levels, and other claims practices set out in the Claims Department Manual will be in accordance with this policy.

Revised 1/1997
Revised 2/26/99
Revised 10/1/03
Revised 10/13/04
Revised 3/23/05
Revised 5/24/06
Revised 6/24/09
Revised 12/9/09
Revised 6/30/10
Revised 10/30/13
Revised 10/29/14

*** IRMA Website Document**

SECTION IV

WORKERS' COMPENSATION CLAIM HANDLING STANDARDS
(Revised 2/04/2016)

FILE CREATION

Claim files will be created and assigned within one business day after receipt of a claim. The Claims Supervisor or his/her designee will review the information received to determine the type of claim file to be created.

- ~~Lawsuit/~~**Application for Adjustment of Claim:** Priority is given to claims received in suit. A new file will be created or the suit papers will be matched with the existing file, and assigned within one business day. The Claims Representative assigned will immediately contact the plaintiff attorney to attempt to work directly with the plaintiff attorney to resolve any ongoing issues as well as to attempt to settle the claim when appropriate. ~~to~~ The Claims Representative has discretion to assign defense at any point after the receipt of the Application for Adjustment of Claim if they feel assigning defense will be beneficial to the claim. Upon receipt of notice of an upcoming hearing the Claims Representative should request an extension-of-time to attempt to settle the claim or resolve any ongoing disputed issues if appropriate. If the claim and/or disputed issues are not likely to be resolved before the upcoming hearing, defense should be assigned immediately if not already assigned. ~~answer or otherwise plead, if appropriate, and, if possible, resolve (or temporarily resolve) the issues disputed.~~

- ~~**Tender Letters / Dec Actions:** Whether or not we should tender a claim or file a declaratory (dec action) should be determined on a case by case basis. Once the adjuster determines that the claim should be tendered to the responsible entity, the adjuster is responsible for gathering the necessary documentation from the member and preparing the tender letter. Within 2 weeks of requesting the information from the member, the adjuster should receive the documentation and the tender letter should be prepared. If the adverse carrier has been identified, the adjuster should address the letter to the responsible entity and carbon copy the carrier and broker if applicable. The adjuster should follow-up with the adverse within 2 weeks after the initial tender letter has been mailed. If we have not received a response from the adverse within 45 days, a dec action should be considered and the Director of Legal Services should be consulted. This information should be properly documented in the file notes.~~

- **Employers' First Report of Injury (Form 45):** The Claims Supervisor or his/her designee will screen the first report for lost time. The Claims Processor may also be asked to screen cases for "lost time." If there is no lost time, the claim will be reassigned as a medical-only file. If it is a lost-time case, a file will be created and assigned to the appropriate Claims Representative for investigation. When a lost-time case is being set up, the Processor will make a copy of the Form 45 to be sent to the Industrial Commission. If a medical-only file becomes a lost-time case, the file handler must make a copy of the Form 45 and give it to the Processor to send to the Industrial Commission.

    - **Wage Statement:** A wage statement will be requested from the Member on all lost-time workers' compensation cases and litigated cases.

- **Assignment:**

1) The Claims Supervisor or his/her designee will assign an adjuster and give the claim to the Claims Processor the same day it is received or within one business day after receipt.

2) The Processor then has one business day to set up the file and give it to the assigned Claims Representative.

3) The Claims Representative will commence investigation within one business day after receiving the file from the Processor.

- **Data Entry:** The assigned date on the computer is the date that IRMA received the claim from the member. The entry date is the date the file is set up in the system by the Processor and given to the Claims Representative.

Acknowledgment of Claim Letter: ~~In every case, t~~The Member and the injured employee ~~-~~will be sent an acknowledgment letter within one business day of receipt of the claim. The ~~In workers' compensation cases, the~~ injured employee will also receive a~~n acknowledgement letter and~~ medical release form.

- **Incident Report:** An incident report is when an injury~~occurrence~~ takes place ~~(liability)~~ and the injured employee does not require any medical treatment. ~~party does not make a formal claim.~~ An incident/event file will be set up for future reference. If the injured employee requires treatment at a later date, ~~a formal claim is made, the~~ the file will be converted into a claim and assigned to a Claims Representative for investigation. ~~We should not set up incident claims for workers' compensation cases.~~ If outside medical was not rendered, the Member should document on a First Aid Log ~~and should not send the information to IRMA~~.

- **Claim File Folder Management:** For occurrences involving multiple claims, suffixes will be set up. The main investigative material will be stored in the suffix 01 (master file). All subsequent suffixes will have their own file folders.

~~**Acknowledgment of Suit Letter:** Once a lawsuit has been set up, within three (3) business days, we will send the attorney the assignment via email along with a copy of the complaint and we will carbon copy the member. The email must include the date of service and the named defendant(s) who the attorney has been hired to represent. The email will also advise counsel whether or not this matter should be billed at the complex fee rate and it will provide instructions as to whether or not a Seibert meeting is necessary.~~

Reserves: The claims representative will establish an initial ~~$1 indemnity~~ reserve ~~during initial file handling. W~~within 14 calendar days of receipt of the claim in accordance with the IRMA Claims Policy. ~~t~~Thereafter, the ~~Claims Representative must evaluate reserve levels. If warranted, the reserves should be increased or decreased to reflect the most likely outcome of the case. The~~ reserves should be reviewed for accuracy and adjusted depending upon the information obtained to date with each review of the file. ~~–~~PPD reserves will be established when the Claims Representative has received sufficient file documentation to reflect the permanency exposure. ~~The $1 reserve should remain on claims when it does not appear that the member has a legal obligation to pay damages. When an exposure in excess of $10,000 exists but discovery or investigation must be completed to quantify the amount, the reserve will be set at $9999. All efforts should be made to adjust a $9999 reserve within 60 days. If a reserve of $9999 remains~~

past 60 days, an explanation should be documented in the file notes. Once the final indemnity payment is made, the indemnity reserves should be closed promptly. All reserve entries must be documented in the file notes.

- In Workers' Compensation cases, the PPD reserve will be established when the Claims Representative has received sufficient file documentation to reflect the permanency exposure.

- On POL and PPL claims the claims representative should set a standard legal reserve of $15,000 and an expense reserve of $5,000 on the date of initial handling.

- On State cases, etc. the claims representative should set a standard legal reserve of $7500 and an expense reserve of $2500

- On EEOC cases, the claims representative should set a standard legal reserve of $7500. These cases do not typically generate expenses so expense reserves are not required.

INVESTIGATION

Each IRMA member has a designated Claims Coordinator. The Claims Coordinator is IRMA's key contact person at the member. We rely on the Claims Coordinator to verify the details of the injury and to provide us with investigation information, including any report forms. Investigation report forms such as the Supervisor's Investigation Report and the Employee's Statement of Incident form are tools we use as part of our investigation.

- **Claimant Contact:** Telephone contact on third-party injury and lost-time workers' compensation cases must be initiated within one business day after the Claims Representative receives the assignment and completed as soon as possible. In personPersonal contact should be attempted on all cases of a catastrophic nature, depending on the circumstances of the claim. Written correspondence is sufficient and telephone call is not required on clear liability third-party automobile cases, workers' compensation medical-only cases unless contact is requested by supervisor or otherwise indicated., or first-party property cases less than $2,500. A telephone call is also not required on blind lawsuits.

- **Member Contact:** The Member's Claims Coordinator must be contacted in all cases within one business day of receipt of the claim to verify the case and gather additional facts and information. It is not necessary to contact the injured employee's supervisor on a claim that is not questionable if a Supervisor's Investigation Report has been completed.

- **Medical Provider Contact:** The Provider will be contacted within one business day after receipt of the claim or within one business day of receiving knowledge of the identity of the provider. The adjuster will attempt to confirm the injury, gather the facts as related by the claimant and inquire as to the diagnosis and prognosis. Contact is not necessary if we have already received the medical records. If records are already received, the adjuster will document receipt of the records and document a summary of the records.

- **Statements:** Recorded statements of injured employees are required in all cases of a questionable nature. The adjuster should use their discretion as to when recorded statements are necessary on cases , or those involving conflicting facts, , serious injury, prior injury to the same part of the body or third party potential.serious injury, prior injury to the same body part or third-party potential. Statements of witnesses should be obtained promptly. Written witness

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statements will suffice if all necessary information is provided. Witness statements are not necessary on non-questionable claims. The adjuster should use their discretion as to when a recorded statement of a co-worker witness is necessary. Statements of claimants should be taken simultaneously with first contact or within one business day after receipt of the assignment. If any statements are refused, the electronic file should ~~be~~ document~~ed with~~ the attempt and the injured employee's refusal.~~s and the reasons for refusal~~.

- **Reports:** Police reports must be obtained in every case involving the police. Medical reports should be obtained when appropriate. Weather reports are required in cases where weather is a factor. Medical reports or a verbal report is required from a physician, confirming workers' compensation disability and causal relationship of the injury to the work/accident.

~~**Estimates:** We require two (2) estimates on all third-party auto liability and general liability property damage claims where the damages are less than $3,500. We require an independent appraisal on all third-party auto liability and general liability property damage claims where the damages are over $3,500 unless circumstances indicate an appraisal is not appropriate. The requirement for an independent appraisal can be waived if deemed appropriate by the claims representative. Third-party general liability claims pertaining to damaged utilities are an exception to this procedure and the required documentation will be determined on a case-by-case basis.~~

~~We require one estimate or an itemization of costs provided by the member on all first-party auto physical damage and first-party property claims where the damages are under $3,500. All first-party auto physical damage claims over $3,500 either require two (2) estimates or an independent appraisal as deemed necessary by the claims representative. Required documentation for first-party property damage claims over $3,500 will be determined on a case-by-case basis and at the claim representative's discretion.~~

- ~~The independent appraiser is authorized to write a repair estimate utilizing CAPA Certified & LKQ parts whenever available. However, IRMA will utilize OEM parts to replace all parts that affect the safe operation of the motor vehicle. OEM parts will also continue to be used on vehicles that are still under the manufacturer's warranty. For parts other than sheet metal and plastic body parts (i.e. radiators, condensers, mufflers, shock absorbers, wheels, etc.) the appraiser will use discretion to determine the most cost effective part that will return the vehicle to its pre-loss condition as long as safety is not be compromised.~~

- **Expert Opinion:** Depending on the nature of the loss, an expert opinion may be warranted. Prior to the retention of an expert, the file handler should review the credentials of the expert and be involved in the selection process. Experts will be required to submit an estimate-of-costs prior to commencement of work. If defense counsel requests use of a certain expert, secure above information before approving their use. This does not pertain to independent medical evaluations.

- **Index Bureau:** All new bodily injury or lost-time workers' compensation claims will be reported to the Central Index Bureau upon file creation, or when enough information is obtained to report to the Bureau. This also includes medical-only files that become lost-time cases. After indexing, the Processor will stamp the copy of the Form 45 or the BI index sheet and drop it to the file. The adjuster will re-index the claimant as needed during the life of the file. Any matches will be investigated in order to attempt to mitigate the pending claim.

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Outside Investigation: ~~Outside~~ In person investigation will be initiated as soon as possible~~immediately~~ when required. The outside investigation should be completed~~done~~ by the Claims Representative whenever possible.

INDEPENDENT ADJUSTERS AND OUTSIDE VENDORS

- **Authority for Referral:** The Claims Supervisor or his/her designee is required to approve the use of any Independent Adjusters, surveillance~~surveillance,~~ or special assignments. No approval is required for routine assignments to nurse case managers~~in which independent vendors are~~ utilized on a regular basis.

- **Referral Process:** The assignment will be made by telephone, faxed or e-mailed and confirmed. The precise scope of the investigation **including time frame** will be outlined.

- **Reporting Standards:** A summary report is to be submitted within 30-days of assignment. Exception to this reporting period must be documented and approved by the Claims Supervisor or his/her designee.

INVESTIGATION STANDARDS – SERIOUS CLAIMS

The following serious claims require more extensive investigation than the usual, routine claims. In addition to the basic investigation, the following is necessary:

- **Stress-Mental (Psychological) or Physical (Heart):**

  - Obtain employment records.
  - Statement from claimant with emphasis on details of the events preceding the onset of illness and prior medical history.
  - Obtain all prior relevant medical records after securing a signed medical authorization.
  - Statements from claimant's spouse (if appropriate), co-worker(s), supervisor(s), and all known witnesses.
  - IME and/or expert review of medical records for opinion on causal relationship of work to illness.

- **Occupational Disease:**

  - Obtain employment records
  - Statement from claimant with emphasis on details of the events preceding the onset of illness and prior medical history.
  - Obtain all prior relevant medical records after securing a signed medical authorization.
  - Statements from claimant's spouse (if appropriate), co-worker(s), supervisor(s), and all known witnesses.
  - IME and/or expert review of medical records for opinion on causal relationship of work to illness.

- **Fatality – If due to Illness/Injury:**

- Obtain employment records
- Obtain all prior medical records after securing a signed medical authorization from the spouse or designated representative.
- Statement from claimant's spouse concerning events preceding the death, information concerning status of dependents and prior marriages.
- Obtain copies of marriage license and dependents' birth certificates.
- ~~Recorded S~~statements from co-worker(s), supervisor(s), and all known witnesses.
- Secure a copy of autopsy report, if autopsy was performed.
- IME and/or expert review of medical records for opinion on causal relationship of work to illness.
- Activity check of spouse or signed marital affidavit from spouse on yearly basis to confirm marital status.
- Work with the employer to ensure that OSHA reporting is done in an appropriate and timely manner.

***** Recorded statements are ~~p~~referred, but taken per adjuster discretion.

PROTOCOL FOR QUESTIONABLE COMPENSABILITY
WORKERS' COMPENSATION CLAIMS

When a new workers' compensation loss is reported, the workers' compensation supervisor or his/her designee will review it. On any claim that involves questionable compensability, i.e., heart attack, stress claims, occupational disease, chemical exposure, etc., a detailed claims investigation must be completed before a decision on compensability is made. This investigation must be comprehensive and done in a timely fashion.

- **Investigation:** See Section IV, "Investigation Standards – Serious Claims (Workers' Compensation)" in the Claim Manual.

- **Required Communication:**

  - Contact letter to the Claimant requesting a signed Medical Authorization

  - Contact Letter to the Member

- **Compensability Decision:**

a) If case is compensable:

1. Review the file and determine the need for possible medical management.~~vocational or medical rehabilitation.~~ If medical management is assigned, the representative will notify the member. The medical case manager will send e-mail status update reports to the Claims Representative and e-mail a copy to the Claims Coordinator at the member.

2. Schedule meetings/teleconferences ~~–~~with the member, defense counsel (if assigned), ~~nurse case~~ medical manager, and the vocational rehabilitation specialist to discuss the case, when appropriate or if specially requested by the Member.

b) If case is denied:

1. In most cases, ~~C~~call member to discuss denial before issuing denial.
~~1.~~2. Send denial letter to injured employee fully explaining reasons for denial. ~~fully explaining reasons for denial~~.
~~2.~~3. Send a copy of the denial letter to the Member.

DISABILITY MANAGEMENT

- **Claimant/Physician Contact:** If the claimant is off work on temporary total disability (TTD), the Claims Representative will contact the claimant, member, or treating physician on an ongoing basis as indicated by medical reports. Reports will be requested as needed.

- **Activity Checks:** Social medial checks and medical records checks can be assigned at the discretion of the claims representative. Activity checks other than annual remarriage checks will be conducted only as needed, after discussion between the Claims Representative and the Executive Director ~~of Claims Administration~~ or his/her designee. The member shall also be included in the discussion if warranted.

- **IME:** An IME will be utilized on an as-needed-basis to assess appropriateness of treatment, to address causal relationship, to confirm disability, or to determine the extent of permanency.

- **Medical~~Nurse Case~~ Management:** ~~Cases~~Medical management should be considered ~~will be assigned~~ on all lost time claims and all claims involving injured workers on modified duty for more than ~~45~~30 days. Medical management may include a nurse, a doctor or a physical therapist. The assignment will be made by telephone, email or fax. Necessary file contents are provided via e-mail or fax.

- **Return-To-Work Program:** Work closely with the members to bring the claimant back to work within the parameters of the return-to-work program.

DOCUMENTATION

- **Documentation Standards:** The claim file (computer system notes/attachments and hard-copy file ~~and computer system notes~~) must be an accurate reflection of the work performed. File contents in the hard-copy file are to be placed in chronological order (most recent on top). For workers' compensation claims, medical bills will be kept on the left side of the hard-copy file. Recorded statements should be attached to the electronic file and there should be a summary in the text. Any substantive correspondence should be documented in the computer notes and attached to the electronic file. A copy of any letter or form sent out on any file should be ~~placed in the specific claim file or~~ attached to the electronic file. Letters that are created but not sent should be deleted from the system and discarded.

- **System Diary Notes:** All file activity must be documented in the diary notes. Independent thought process must be documented, but personal, subjective comments should be avoided. Diary notes must reflect the method and date of contact (and attempted contact) with members, claimants and witnesses, etc. If a statement is not taken from a claimant, witness, etc., (where

one would be normally required), the reasons must be documented. The compensability~~liability~~, extent of injury,~~damages~~ and rationale of every settlement, regardless of amount, must be explained and supported in the diary notes.

- ~~Liability: Every fee shifting case must have an offer of judgment analysis entered in the notes no more than 90 days after receipt of the file. This analysis should be added under the "Offer of Judgment" caption. Each case update that pertains to the offer of judgment should be documented under this case caption as well.~~

- **Correspondence:** All mailed correspondence must be typed onto IRMA letterhead and must be of professional quality. All correspondence and electronic messages must be proofread.

- **Reserve/Settlement Authority:** All requests for authority above the Claim Representative's level must be approved by the person with the appropriate authority level. This should be reflected in the file notes. File notes must reflect the thought process used in arriving at the reserve/settlement figures.

CLAIM RESERVING

- **Philosophy:** IRMA's goal is to establish each case reserve to the most likely ultimate outcome as early as possible in accordance with the IRMA Claims Policy. Stair stepping (incremental increases to cover short-term expenses) must be avoided. The Member will receive written notice (Reserve Notice) of any settlement reserve for indemnity set over $10,000.~~, except that a Reserve Notice shall not be required for the first party property or auto physical damage claims when the Member has provided the estimates or invoices for payment of the claim to IRMA.~~

  The setting of these reserves, and their written notice, shall also be considered advance notice of settlement, in accordance with the IRMA By-Laws, Section 4.02(A).

  The Board of Directors has granted to the Executive Director full authority to establish reserves and associated procedures, consistent with well-recognized claims standards and practices. Independent Claims Auditors will perform claims Audits every 2-3 years.

QUALITY CONTROL

- **Authority Levels:**

  - Executive Board

    Liability Indemnity over $ $750,000

    Workers' Compensation over

    $750,000

  - Coverage Claims and Litigation Committee

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Liability Indemnity over $500,000 to $750,000

Workers' Compensation over $500,000 to $750,000

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- Executive Director

  ~~Liability Indemnity up to $500,000~~

  Workers' Compensation Indemnity up to $500,000

  Unlimited Reserving

- Director of Legal Services

  ~~Liability Indemnity up to $300,000~~

  Workers' Compensation Indemnity up to $300,000

- ~~Supervisor of Liability Claims Operations up to $100,000~~
- Supervisor of Workers' Compensation Claims Operations up to $100,000

Claims Staff — Reserving authority levels to be determined at the discretion of the Executive Director

Claims Staff Member	**Reserve**	**Expense**	**Settlement**
Claims Supervisor	$150,000	$30,000	$100,000
Senior Claim Representative	$100,000	$15,000	$ 60,000
Claims Representative III	$ 80,000	$10,000	$ 50,000
Claims Representative II	$ 60,000	$10,000	$ 40,000
Claims Representative I	$ 30,000	$ 5,000	$ 20,000
Claims Representative	$ 10,000	$ 5,000	$ 7,500

- **Standard Timelines for Claims Processing:** The IRMA claims staff desires to provide prompt, efficient and professional claims service to each of the Members. Our main contact with the Member is through the designated Claims Coordinator. Below is a list of the primary

timeliness the Claims Representative is required to meet when processing the Member's claims:

1. Set up all new claims within one business day of receipt.

2. Send claim acknowledgment letter within one business day (by email or fax) to the Claim Coordinator, from date new claim received.

3. Contact the injured employee (WC lost time cases) or injured third party claimants within one work day from date claim was set up.

4. Follow up with the claims coordinator in all cases where accident report information is needed.

5. ~~Within one business day from claim representative's receipt of claim, coordinate through the Claims Coordinator when automobile/property appraisals are needed.~~

6. Return all phone calls as soon as possible or no later than one work day.

7. Acknowledge ~~lawsuits/~~workers' compensation applications within three (3) business days of receipt and assign legal counsel when appropriate.

8. ~~All claims involving coverage issues should be given to the Director of Legal Services within two (2) business days. The reservation of rights or coverage denial should be completed and sent to the member within three (3) business days thereafter.~~

9. ~~Third-party claimants should be advised of denials promptly whenever possible.~~

10. Notify the Claims Coordinator of settlements and denials.

11. Assigned defense counsel keeps the Claims Coordinator and Claims Representative advised on the status of all assigned lawsuits, and provides copies of 60-day litigation reports with defense budget estimates and subsequent 60-day reports.

The goal of this process is to keep the Claims Coordinator fully informed each step of the way from inception to disposition of the claim/lawsuit. The Claims Representative has the ultimate responsibility of keeping the Claims Coordinator advised of all significant activity.

In addition, reserves must be established within fourteen (14) calendar days after creation of a claim file. The Claims Representative, upon all file reviews, must evaluate reserve levels. If warranted, the reserves should be either increased or decreased to reflect the most likely outcome of the case. In workers' compensation cases, the PPD reserve will be established when the Claims Representative has received sufficient file documentation to reflect the permanency exposure.

- **Periodic Audit:** Regular claim audits will be performed by independent auditors pursuant to By-Laws, Section 3.09(E).

- **Diary System:** The Claims Representative must establish a formal diary system. Files should be reviewed on a thirty (30) to sixty (60) day basis. Longer or shorter diaries can be established on certain files, and the reason for longer diaries should be clearly documented. The Claims

Supervisor will maintain a formal diary for all files requiring reporting to the excess/reinsurance carrier. All claim files must have a diary.

- **Accuracy of Information:** The file handler is ultimately responsible for all information on the computer or in the hard-copy file, including, coding accident description, names, etc.

- **Open and Closed File Review**: See Section XII.

SETTLEMENT

IRMA's settlement philosophy is described in the Claims Policy Statement adopted by the IRMA Board of Directors.

- **Member Service Payments:** If a member opts to pay a claim when there is no legal obligation to pay damages, we should change the coverage code to MSP (Member Service Payments). In this case, the member must send a letter to the Claims Representative acknowledging that there is no liability and no legal obligation to pay damages. The letter must also state that the member agrees to reimburse IRMA for the entire amount of the settlement. The IRMA Claims Representative will evaluate the damages and discuss the proposed claim settlement with the member before settlement occurs and the claim will be handled in accordance with the normal claims handling procedures.
    - **Supervisor approval is** required for MSPs over $2,500 and approval from the Executive Director is required for MSPs over $10,000
    - **Once the settlement draft** is issued, the Claims Representative must notify the Principal Accounting Assistant for invoicing purposes.

- **Timeliness Standards:** Settlement checks will be processed as soon as proper documentation is received, or has been verified by the Claims Representative. A check will be released by the Claims Representative upon receipt of a signed release.

RELEASES

A signed release is required for all BI and 3rd party PD claim settlements.

Settlement contracts are required on all workers' compensation cases settled in which an application has been filed and when a claimant is or Pro Se.

- **Standard wording:** Claims Representatives and Defense Counsel will utilize IRMA's standard release form (or wording). Defense Counsel may modify the standard language if necessary.

EXPENSE PAYMENTS

- **Bill Review:** The Claims Representative assigned to the file will review all bills for appropriateness and reasonableness. For bills in excess of a Claims Representative's authority, the bill should be submitted to the next level of authority. An authorization sheet is not necessary. The bill should also be signed or initialed by the Claims Representative, indicating that they agree with payment of the bill.

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PAYMENT PROCEDURES

CALCULATING TTD & PPD BENEFITS

Pursuant to the provisions of Section 138.10 of the Illinois Workers' Compensation Act, the TTD rate will be determined as follows:

When handling "Lost Time" cases involving three (3) missed work shifts, we will obtain a wage statement from the Member outlining the wages for the injured employee for fifty-two (52) weeks prior to the date of injury.

Temporary Total Disability (TTD) Benefits will be calculated based on 66 2/3% of the employee's average weekly wage, not to exceed the maximum TTD rate for that time period. ~~The calculation tape (done by Claims Representative) should be attached to the wage statement form.~~

All TTD checks will be made payable to the injured worker, unless the member has special handling instructions to issue the check payable to the member. All TTD checks are sent to the member unless we are otherwise instructed to send to the injured worker. All payments will be made in accordance with the Illinois Workers' Compensation Act. Payment of TTD benefits is not taxable under Federal or State law.

Permanent Partial Disability (PPD) will be calculated based on 60% of the employee's average weekly wage, not to exceed the maximum PPD rate for that time period.

All PPD payments will be made in accordance with the Illinois Workers' Compensation Act.

Employees Returning Part-Time (TPD)

If an employee returns to work on a part-time basis, pursuant to the treating doctor's orders, IRMA will continue to pay a proportionate share of TTD for the time the injured worker misses from work, when the Member continues the full salary of the injured worker. The TTD check needs to be signed over by the claimant to the member so that the member receives TTD reimbursement for the portion of salary they paid the employee for the time the employee missed from work while on light duty.

When an injured employee is working light duty on a part-time or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job, the employee shall be entitled to Temporary Partial Disability (TPD) Benefits. TPD benefits are equal to two-thirds of the difference between the employee's average weekly wage at the time of the injury and the amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working.

Workers' Compensation Medical Bill Review Procedure: Medical bills received by IRMA will be forwarded to the approved medical bill review firm (Corvel) for auditing and applicable PPO discount.

When a medical bill is received at IRMA, the Claims Processor will date stamp the bill and put the bill in Corvel's mail bin. The medical bills can also be sent directly to Corvel by the Member. The

medical bills are reviewed by Corvel and charges are reduced when appropriate. The recommended payments are entered into Corvel's CareMC system, where the Claims Representative reviews the recommended payment and releases or denies the payment as appropriate.

The Claims Processor prints payable sheets on Monday through Tuesday and Thursday and gives them to the Claims Representatives to review and approve. Once the Claims Representative approves the payable sheets, they are approved by the supervisor and returned to the Claims Processor. The payable sheets will include indemnity payments, expense payments, and any medical bills that are not reviewed by Corvel.

TIMELINESS STANDARDS – MEDICAL BILLS

Bills will be reviewed and approved if compensable within five (5) business days after receipt by the Claims Representative.

TELEPHONIC CASE MANAGEMENT REFERRAL GUIDELINES

1. All new lost time claims with an uncertain return to work date.
2. All modified duty claims with 45 days or more of modified duty with an uncertain date of release to full duty.
3. All claims where surgical intervention is recommended.
4. Percutaneous disc decompression (lumbar)
5. IDET procedures (radiofrequency, radioablation)
6. Extra Corporeal shock wave therapy treatments (for epicondylitis)
7. Claims with ongoing pain management treatment.
8. Claims with ongoing psychiatric or psychological treatment.
9.1. Injuries involving lacerations of muscles or tendons.

UTILIZATION REVIEW CRITERIA GUIDELINES

1. Compound MedicationAll Inpatient Hospitalization
2. Cartisel Transplants (meniscus tears)
3. Inpatient HospitalizationArtificial lumbar disc replacements
4. Percutaneous disc decompression (lumbar)
5. Orthotics and medical equipment if questioning whether appropriate.Repeat surgeries (2nd surgery same diagnosis/body part) (inpatient/outpatient)

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6. Outpatient surgeries with questionable diagnostic evidence/clinical findings. An example would be when a claimant has a negative MRI and doctor is still recommending surgery.

7. IDET procedures (radiofrequency, radioablation)

8. Extra Corporeal shock wave therapy treatments (for epicondylitis)

9. PT/OT treatment meeting the following criteria:
    a. Treatment exceeding PT vendor's recommendations. ~~12 visits &/or 6 weeks of treatment, unless post operative therapy.~~
    b. No documented improvement.
    c. PT in excess of ODG Guidelines.~~Any physical therapy in doctor owned facility.~~

10. Chiropractic treatment meting the following criteria:
    a. Chiropractor has determined patient to be temporary totally disabled.
    b. Treatment exceeding 12 chiropractic adjustments &/or 4 weeks of treatment.
    c. No documented improvement.

11. Work Hardening meeting the following criteria:
    a. Treatment exceeds 4 weeks
    b. Program is not directed towards a specific type of employment/simulation of work activities absent.

12. Pain Management meeting the following criteria:
    a. Injections requested within first 6 weeks of treatment.
    b. Request for third injection without any documented relief from prior injections.
    c. More than 3 injections
    d. Treatment exceeding 12 weeks.
    e. Cervical injections without use of imaging to guide needle localization.
    f. Experimental treatment.

13. All unnecessary high cost diagnostic test to include:
    MRI, CT Scan, Bone Scan, Myelogram, Arthrogram, Discogram, EEG, Video Fluoroscopy

14. Other treatment that may need to be referred to Utilization Review:
    a. Psychiatric treatment
    b. Ongoing psychological testing &/or services.
    c. All weight loss programs
    d. Gym programs vs. physical therapy
    e. All bone growth stimulators
    f. All cognitive therapy
    g. Biofeedback exceeding 6 visits.
    h. All acupuncture.

SUBROGATION

Subrogation is an essential activity for the IRMA claims program. All claims personnel are required to make a special effort to identify subrogation potential, to thoroughly investigate the possibility of recovery, and to pursue recovery aggressively.

- **Investigation:** All claims will be evaluated for subrogation potential. If potential exists, investigation of the third party (or product) will be completed in conjunction with the standard accident investigation.

- **Notice:** If the investigation suggests any potential for liability of a third party, that party and/or their insurance carrier will be placed on notice of a possible claim.

- **Subrogation Settlement Authority:** Same as settlement (if no reduction is taken).

- **Follow-Up:** All subrogation files should be updated at least every ninety (90) days. Exceptions must be clearly documented in the diary notes.

- **Use of Counsel and/or Collection Agency:** Counsel and/or a collection agency will be utilized only when necessary. IRMA claims personnel are to exhaust all means available to them before turning over a subrogation file to an outside source. Counsel and/or a collection agency's fees for subrogation should be in accordance with litigation and billing guidelines.

- **Write-off:** Any write-off can be done only when all efforts to recover have been exhausted without results. Management must approve any write-off over the Claims Representative's settlement authority. The reason for any write-off should be documented in the diary notes.

NOTE: See "Subrogation File Handling Procedures" (Section XVI) for in-depth details on IRMA's handling of subrogation matters.

EXCESS NOTIFICATION (See Section XI)

FILE CLOSURE

- **Timeliness Standards:** All payments (including expense bills) should ~~must~~ be made prior to closing when possible. Bills received after the file is closed can be paid on a closed file. If the file become active after closure it will need ~~require the file~~ to be reopened by the Claims Representative.

- **Notification of Rights (to Claimant):** For claims denied, a written denial letter must be sent. For unrepresented claimants, the statute-of-limitations should be defined, and the date clearly noted on those files in which the denial letter is being sent within sixty (60) days of expiration.

- **Closed File Checklist:** A closed file checklist must be completed when a file closes. The checklist is in Section XII.

- **Closed File Review Procedures:** See Section XII.

- **Destruction Date:** All closed files will be assigned a destruction date of seven (7) years from date of loss, or two (2) years from date-of-closing (whichever is greater). Cases involving minors will be retained until the person reaches twenty-one (21) years of age. Destruction dates will be entered into the computer as well as on the file jacket.

- **Claim File Storage and Purging Procedure:** Closed files will be purged based upon the above destruction date criteria. A computer run will be generated to identify those files to be purged and destroyed. One report will be run for the closed files IRMA inherited from Gallagher Basset. Another report will be run for the open files that IRMA has created.

- **Purging Procedure for Closed Claim Files:** See Section XIV.

  The Claims Department will purge closed files on a quarterly basis.

SECTION IV

LIABILITY CLAIM HANDLING STANDARDS

FILE CREATION

Claim files will be created and assigned within one business day after receipt of a claim. The Claims Supervisor or his/her designee will review the information received to determine the type of claim file to be created.

- **Lawsuit/Application for Adjustment of Claim:** Priority is given to claims received in suit. A new file will be created or the suit papers will be matched with the existing file, and assigned within one business day. When applicable, tThe Claims Representative assigned will immediately contact the plaintiff attorney to request an extension-of-time to answer or otherwise plead, if appropriate, and, if possible, resolve (or temporarily resolve) the issues disputed.

- **Tender Letters / Dec Actions:** Whether or not we should tender a claim or file a declaratory ~~(dec~~ action~~)~~ should be determined on a case~~-~~by~~-~~case basis. Once the adjuster determines that the claim should be tendered to the responsible entity, the adjuster is responsible for gathering the necessary documentation from the member and preparing the tender letter. Within 2 weeks of requesting the information from the member, the adjuster should receive the documentation and the tender letter should be prepared. If the adverse carrier has been identified, the adjuster should address the letter to the responsible entity and carbon copy the carrier and broker if applicable. The adjuster should follow-up with the adverse within 2 weeks after the initial tender letter has been mailed. If we have not received a response from the adverse within 45 days, a declaratory action should be considered and the Director of Legal Services should be consulted. This information should be properly documented in the file notes.

- ~~**Employers' First Report of Injury (Form 45):** The Claims Supervisor or his/her designee will screen the first report for lost time. The Claims Processor may also be asked to screen cases for "lost time." If there is no lost time, the claim will be reassigned as a medical-only file. If it is a lost-time case, a file will be created and assigned to the appropriate Claims Representative for investigation. When a lost-time case is being set up, the Processor will make a copy of the Form 45 to be sent to the Industrial Commission. If a medical-only file becomes a lost-time case, the file handler must make a copy of the Form 45 and give it to the Processor to send to the Industrial Commission.~~

    - ~~**Wage Statement:** A wage statement will be requested from the Member on all lost-time workers' compensation cases and litigated cases.~~

- **Assignment:**

    1) The Claims Supervisor or his/her designee will assign an adjuster and give the claim to the Claims Processor the same day it is received or within one business day after receipt.

    2) The Processor then has one business day to set up the file and give it to the assigned Claims Representative.

3) The Claims Representative will commence investigation within one business day after receiving the file from the Processor.

- **Data Entry:** The assigned date on the computer is the date that IRMA received the claim from the member. The entry date is the date the file is set up in the system by the Processor and given to the Claims Representative.

Acknowledgment of Claim Letter: In every case, the Member will be sent an acknowledgment letter within one business day of receipt of the claim. ~~In workers' compensation cases, the injured employee will also receive an acknowledgement letter and medical release form.~~

- ~~**Incident Report:** An incident report is when an occurrence takes place (liability) and the injured party does not make a formal claim. An incident file will be set up for future reference. If a formal claim is made, the file will be converted into a claim and assigned to a Claims Representative for investigation. We should not set up incident claims for workers' compensation cases. If outside medical was not rendered, the Member should document on a First Aid Log and should not send the information to IRMA.~~

- **Claim File Folder Management:** For occurrences involving multiple claims, suffixes will be set up. The main investigative material will be stored in the suffix 01 (master file). All subsequent suffixes will have their own file folders.

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Acknowledgment of Suit Letter: Once a lawsuit has been set up, within three (3) business days, we will establish the file in LSS and provide the attorney with the Complaint. ~~send the attorney the assignment via email along with a copy of the complaint and we will carbon copy the member.~~ The assignment letter in LSS provides counsel with the named defendants who they have been retained to represent and advises counsel whether or not ~~The email must include the date of service and the named defendant(s) who the attorney has been hired to represent. The email will also advise counsel whether or not this matter should be billed at the complex fee rate and it will provide instructions as to whether or not~~ a Seibert meeting is necessary.

Reserves: The Cclaims Rrepresentative will establish a $1 indemnity reserve during initial file handling. Within 14 calendar days thereafter, the Claims Representative must evaluate reserve levels. If warranted, the reserves should be increased or decreased to reflect the most likely ultimate outcome in accordance with the IRMA Claims Policy~~most likely outcome of the case~~. The reserves should be reviewed for accuracy and adjusted depending upon the information obtained to date with each review of the file. The $1 reserve should remain on claims when it does not appear that the member has a legal obligation to pay damages. ~~When an exposure in excess of $10,000 exists but discovery or investigation must be completed to quantify the amount, the reserve will be set at $9999. All efforts should be made to adjust a $9999 reserve within 60 days. If a reserve of $9999 remains past 60 days, an explanation should be documented in the file notes.~~ Once the final indemnity payment is made, the indemnity reserves should be closed promptly. All reserve entries must be documented in the file notes.

- ~~In Workers' Compensation cases, the PPD reserve will be established when the Claims Representative has received sufficient file documentation to reflect the permanency exposure.~~

- On POL and PPL claims the claims representative should set a standard legal reserve of $15,000 and an expense reserve of $5,000 on the date of initial handling.

- On State cases, etc. the claims representative should set a standard legal reserve of $7500 and an expense reserve of $2500

- On EEOC cases, the claims representative should set a standard legal reserve of $7500. These cases do not typically generate expenses so expense reserves are not required.

INVESTIGATION

- **Claimant Contact:** Telephone contact on third-party injury ~~and lost-time workers' compensation cases~~ cases must be initiated within one business day after the Claims Representative receives the assignment and completed as soon as possible. Personal contact should be attempted on all cases of a catastrophic nature. Written correspondence is sufficient and a telephone call is not required on clear liability third-party automobile cases, ~~workers' compensation medical-only cases,~~ or first-party property cases less than $2,500. A telephone call is also not required on blind lawsuits.

- **Member Contact:** The Member's Claims Coordinator must be contacted in all cases within one business day of receipt of the claim to verify the case and gather additional facts and information.

- ~~**Medical Provider Contact (WC Cases):** The Provider will be contacted within one business day after receipt of the claim or within one business day of receiving knowledge of the identity of the provider. The adjuster will attempt to confirm the injury, gather the facts as related by the claimant and inquire as to the diagnosis and prognosis.~~

- **Statements:** The claim representative should request a recorded statement from all claimants, injured parties, and pertinent witnesses. Statements should be requested during the initial contact with the party and if the party refuses to take a statement, the electronic file must document the attempt.~~Recorded statements are required in all cases of a questionable nature, or those involving conflicting facts, serious injury, prior injury to the same body part or third-party potential. Statements of witnesses should be completed promptly. Statements of claimants should be taken simultaneously with first contact or within one business day after receipt of the assignment. If any statements are refused, the electronic file should be documented with the attempts and the reasons for refusal.~~

- **Reports:** Police reports must be obtained in every case involving the police. Medical reports should be obtained when appropriate. Weather reports should be ordered ~~are required~~ in cases where weather is a factor. If the reports are not obtained, the claim representative must document the rationale for not doing so in the claim notes. ~~Medical reports or a verbal report is required from a physician, confirming workers' compensation disability and causal relationship of the injury to the work/accident.~~

- **Estimates:** We require two (2) estimates on all third-party auto liability and general liability property damage claims where the damages are less than $3,500. We require an independent appraisal on all third-party auto liability and general liability property damage claims where the damages are over $3,500 unless circumstances indicate an appraisal is not appropriate. The requirement for an independent appraisal can be waived if deemed appropriate by the claims

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representative. Third party general liability claims pertaining to damaged utilities are an exception to this procedure and the required documentation will be determined on a case-by-case basis.

- We require one estimate or an itemization of costs provided by the member on all first-party auto physical damage and first-party property claims where the damages are under $3,500. All first-party auto physical damage claims over $3,500 either require two (2) estimates or an independent appraisal as deemed necessary by the claims representative. Required documentation for first-party property damage claims over $3,500 will be determined on a case-by-case basis and at the claim representative's discretion.

    - The independent appraiser is authorized to write a repair estimate utilizing CAPA Certified & LKQ parts whenever available. However, IRMA will utilize OEM parts to replace all parts that affect the safe operation of the motor vehicle. OEM parts will also continue to be used on vehicles that are still under the manufacturer's warranty. For parts other than sheet metal and plastic body parts (i.e. radiators, condensers, mufflers, shock absorbers, wheels, etc.) the appraiser will use discretion to determine the most cost effective part that will return the vehicle to its pre-loss condition as long as safety is not be compromised.

- **Expert Opinion:** Depending on the nature of the loss, an expert opinion may be warranted. Prior to the retention of an expert, the file handler should review the credentials of the expert and be involved in the selection process. Experts will be required to submit an estimate-of-costs prior to commencement of work. If defense counsel requests use of a certain expert, secure above information before approving their use.

- **Index Bureau:** All new bodily injury ~~or lost-time workers' compensation~~ claims will be reported to the Central Index Bureau upon file creation, or when enough information is obtained to report to the Bureau. ~~This also includes medical-only files that become lost-time cases.~~ The Processor will provide the adjuster with a copy of the report and ~~After indexing, the Processor will stamp the copy of the Form 45 or the BI index sheet and drop it to the file.~~ ~~T~~he adjuster will re-index the claimant as needed during the life of the file. Any matches will be investigated ~~in order to attempt~~ to mitigate the pending claim.

  Outside Investigation: Outside investigation will be initiated immediately when required. ~~The outside investigation should be done by the Claims Representative whenever possible.~~

INDEPENDENT ADJUSTERS AND OUTSIDE VENDORS

- **Authority for Referral:** The Claims Supervisor his/her designee is required to approve the use of any Independent Adjusters, surveillance, or special assignments. No approval is required for routine assignments in which independent vendors are utilized on a regular basis.

- **Referral Process:** The assignment will be made by telephone, faxed or e-mailed and confirmed. The precise scope of the investigation **including time frame** will be outlined.

- **Reporting Standards:** A summary report is to be submitted within 30-days of assignment. Exception to this reporting period must be documented and approved by the Claims Supervisor or his/her designee.

INVESTIGATION STANDARDS – SERIOUS CLAIMS (WORKERS' COMPENSATION)

The following serious claims require more extensive investigation than the usual, routine claims. In addition to the basic investigation, the following is necessary:

- **Stress-Mental (Psychological) or Physical (Heart):**

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- Obtain employment records.

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- Statement from claimant with emphasis on details of the events preceding the onset of illness and prior medical history.
- Obtain all prior medical records after securing a signed medical authorization.
- Statements from claimant's spouse (if appropriate), co-worker(s), supervisor(s), and all known witnesses.
- IME and/or expert review of medical records for opinion on causal relationship of work to illness.

- **Occupational Disease:**

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- Obtain employment records

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- Statement from claimant with emphasis on details of the events preceding the onset of illness and prior medical history.
- Obtain all prior medical records after securing a signed medical authorization.
- Statements from claimant's spouse (if appropriate), co-worker(s), supervisor(s), and all known witnesses.
- IME and/or expert review of medical records for opinion on causal relationship of work to illness.

- **Fatality – If due to Illness/Injury:**

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- Obtain employment records

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- Obtain all prior medical records after securing a signed medical authorization from the spouse or designated representative.
- Statement from claimant's spouse concerning events preceding the death, information concerning status of dependents and prior marriages.
- Obtain copies of marriage license and dependents' birth certificates.
- Recorded statements from co-worker(s), supervisor(s), and all known witnesses.
- Secure a copy of autopsy report, if autopsy was performed.
- IME and/or expert review of medical records for opinion on causal relationship of work to illness.
- Activity check of spouse on yearly basis to confirm marital status.
- Work with the employer to ensure that OSHA reporting is done in an appropriate and timely manner.

* Recorded statements are preferred

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PROTOCOL FOR QUESTIONABLE COMPENSABILITY

WORKERS' COMPENSATION CLAIMS

When a new workers' compensation loss is reported, the workers' compensation supervisor or his/her designee will review it. On any claim that involves questionable compensability, i.e., heart attack, stress claims, occupational disease, chemical exposure, etc., a detailed claims investigation must be completed before a decision is made. This investigation must be comprehensive and done in a timely fashion.

- **Investigation:** See Section IV, "Investigation Standards — Serious Claims (Workers' Compensation)" in the Claim Manual.

- **Required Communication:**

  - Contact letter to the Claimant requesting a signed Medical Authorization

  - Contact Letter to the Member

- **Compensability Decision:**

a) If case is compensable:
1. Review the file and determine the need for possible vocational or medical rehabilitation. If medical management is assigned, the representative will notify the member. The medical case manager will send e-mail status update reports to the Claims Representative and e-mail a copy to the Claims Coordinator at the member.

2. Schedule meetings with the member, defense counsel (if assigned), and the rehab specialist to discuss the case, when appropriate or if specially requested by the Member.

b) If case is denied:
1. Send denial letter to injured employee fully explaining reasons for denial.
2. Send a copy of the denial letter to the Member.

DISABILITY MANAGEMENT

- **Claimant/Physician Contact:** If the claimant is off on temporary total disability (TTD), the Claims Representative will contact the claimant, member, or treating physician on an ongoing basis as indicated by medical reports. Reports will be requested as needed.

- **Activity Checks:** Activity checks will be conducted only as needed, after discussion between the Claims Representative and the Director of Claims Administration or his/her designee. The member shall also be included in the discussion if warranted.

- **IME:** An IME will be utilized on an as needed basis to assess appropriateness of treatment, to address causal relationship, to confirm disability, or to determine the extent of permanency.

- **Nurse Case Management:** Cases will be assigned on all lost time claims and all claims involving injured workers on modified duty for more than 45 days. The assignment will be made by telephone, email or fax. Necessary file contents are provided via e-mail or fax.

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~~• **Return-To-Work Program:** Work closely with the members to bring the claimant back to work within the parameters of the return-to-work program.~~

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DOCUMENTATION

- **Documentation Standards:** The claim file (hard-copy file and computer system notes) must be an accurate reflection of the work performed. File contents in the hard-copy file are to be placed in chronological order (most recent on top). ~~For workers' compensation claims, medical bills will be kept on the left side of the hard-copy file.~~ Recorded statements should be attached to the electronic file and there should be a summary in the text. A copy of any letter or form sent out on any file should be placed in the specific claim file or attached to the electronic file. Letters that are created but not sent should be deleted from the system and discarded.

- **System Diary Notes:** All file activity must be documented in the diary notes. Independent thought process must be documented, but personal, subjective comments should be avoided. Diary notes must reflect the method and date of contact (and attempted contact) with members, claimants and witnesses, etc. If a statement is not taken from a claimant, witness, etc., (where one would be normally required), the reasons must be documented. The liability, damages and rationale of every settlement, regardless of amount, must be explained and supported in the diary notes.

    - Liability: Every fee shifting case must have an offer of judgment analysis entered in the notes no more than 90 days after receipt of the file. This analysis should be added under the "Offer of Judgment" caption. Each case update that pertains to the offer of judgment should be documented under this case caption as well.

- **Correspondence:** All mailed correspondence must be typed onto IRMA letterhead and must be of professional quality. All correspondence and electronic messages must be proofread.

- **Reserve/Settlement Authority:** All requests for authority above the Claim Representative's level must be approved by the person with the appropriate authority level. This should be reflected in the file notes. File notes must reflect the thought process used in arriving at the reserve/settlement figures.

CLAIM RESERVING

- **Philosophy:** IRMA's goal is to establish each case reserve to the most likely ultimate outcome as early as possible in accordance with the IRMA Claims Policy. Stair stepping (incremental increases to cover short-term expenses) must be avoided. The Member will receive written notice (Reserve Notice) of any settlement reserve set over $10,000, except that a Reserve Notice shall not be required for the first party property or auto physical damage claims when the Member has provided the estimates or invoices for payment of the claim to IRMA.

The setting of these reserves, and their written notice, shall also be considered advance notice of settlement, in accordance with the IRMA Bylaws ~~Laws,~~ Section 4.02(A).

The Board of Directors has granted to the Executive Director full authority to establish reserves and associated procedures, consistent with well-recognized claims standards and practices, in accordance with the provisions of the IRMA Claims Policy. Independent Claims Auditors will perform claims Audits every 2-3 years.

QUALITY CONTROL

- **Authority Levels:**

  - Executive Board

    Liability Indemnity over $ $750,000

    ~~Workers' Compensation over~~

    ~~$750,000~~

  - Coverage Claims and Litigation Committee

    Liability Indemnity over $500,000 to

    $750,000

    ~~Workers' Compensation over $500,000 to $750,000~~

- Executive Director

  Liability Indemnity up to $500,000

  ~~Workers' Compensation Indemnity up to $500,000~~

  Unlimited Reserving

- Director of Legal Services

  Liability Indemnity up to $300,000

  ~~Workers' Compensation Indemnity up to $300,000~~

- Supervisor of Liability Claims Operations up to $100,000

- ~~Supervisor of Workers' Compensation Claims Operations up to $100,000~~

Claims Staff	Reserving authority levels to be determined at the discretion of the Executive Director

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Claims Staff Member	Reserve	Expense	Settlement
Claims Supervisor	$150,000	$30,000	$100,000
Senior Claim Representative	$100,000	$15,000	$ 60,000
Claims Representative III	$ 80,000	$10,000	$ 50,000
Claims Representative II	$ 60,000	$10,000	$ 40,000
Claims Representative I	$ 30,000	$ 5,000	$ 20,000
Claims Representative	$ 10,000	$ 5,000	$ 7,500

- **Standard Timelines for Claims Processing:** The IRMA claims staff desires to provide prompt, efficient and professional claims service to each of the Members. Our main contact with the Member is through the designated Claims Coordinator. Below is a list of the primary timeliness the Claims Representative is required to meet when processing the Member's claims:

  1. Set up all new claims within one business day of receipt.

  2. Send claim acknowledgment letter within one business day (by email or fax) to the Claim Coordinator, from date new claim received.

  ~~3. Contact the injured employee (WC lost time cases) or injured third party claimants within one work day from date claim was set up.~~

  ~~4.~~3. Follow up with the claims coordinator in all cases where accident report information is needed.

  ~~5.~~4. Within one business day from claim representative's receipt of claim, coordinate through the Claims Coordinator when automobile/property appraisals are needed.

  ~~6.~~5. Return all phone calls as soon as possible or no later than one work day.

  ~~7.~~6. Acknowledge lawsuits~~/workers' compensation applications~~ within three (3) business days of receipt and assign legal counsel when appropriate.

  ~~8.~~7. All claims involving coverage issues should be given to the Director of Legal Services within two (2) business days. The reservation of rights or coverage denial should be completed and sent to the member within a reasonable time frame.~~within three (3) business days thereafter.~~

  ~~9.~~8. Third-party claimants should be advised of denials promptly whenever possible.

  ~~10.~~9. Notify the Claims Coordinator of settlements and denials.

~~11.~~10. Assigned defense counsel keeps the Claims Coordinator and Claims Representative advised on the status of all assigned lawsuits, and provides copies of 60-day litigation reports with defense budget estimates and subsequent 60-day reports.

The goal of this process is to keep the Claims Coordinator fully informed each step of the way from inception to disposition of the claim/lawsuit. The Claims Representative has the ultimate responsibility of keeping the Claims Coordinator advised of all significant activity.

In addition, reserves must be established within fourteen (14) calendar days after creation of a claim file. The Claims Representative, upon all file reviews, must evaluate reserve levels. If warranted, the reserves should be either increased or decreased to reflect the most likely outcome of the case in accordance with the Claims Policy Statement. ~~In workers' compensation cases, the PPD reserve will be established when the Claims Representative has received sufficient file documentation to reflect the permanency exposure.~~

- **Periodic Audit:** Regular claim audits will be performed by independent auditors pursuant to By-Laws, Section 3.09(E).

- **Diary System:** The Claims Representative must establish a formal diary system. Files should be reviewed on a thirty (30) to sixty (60) day basis. Longer or shorter diaries can be established on certain files, and the reason for longer diaries should be clearly documented. The Claims Supervisor will maintain a formal diary for all files requiring reporting to the excess/reinsurance carrier. All claim files must have a diary.

- **Accuracy of Information:** The file handler is ultimately responsible for all information on the computer or in the hard-copy file, including, coding accident description, names, etc.

- **Open and Closed File Review**; See Section XII.

SETTLEMENT

IRMA's settlement philosophy is described in the Claims Policy Statement adopted by the IRMA Board of Directors.

- **Member Service Payments:** If a member opts pay a claim when there is no legal obligation to pay damages, we should change the coverage code to MSP. In this case, the member must send a letter to the Claims Representative acknowledging that there is no liability and no legal obligation to pay damages. The letter must also state that the member agrees to reimburse IRMA for the entire amount of the settlement. The IRMA Claims Representative will evaluate the damages and discuss the proposed claim settlement with the member before settlement occurs and the claim will be handled in accordance with the normal claims handling procedures.

    - Supervisor approval is required for MSPs over $2,500 and approval from the Executive Director is required for MSPs over $10,000
    - Once the settlement draft is issued, the Claims Representative must notify the Principal Accounting Assistant and t~~for invoicing purposes.~~he Claims Representative must send the invoice to the member. The claim will remain open until the member sends the reimbursement to IRMA.

- **Timeliness Standards:** Settlement checks will be processed as soon as proper documentation is received, or has been verified by the Claims Representative. A check will be released by the Claims Representative upon receipt of a signed release.

RELEASES

A signed release is required for all BI and 3rd party PD claim settlements.

~~Settlement contracts are required on all workers' compensation cases settled in which an application has been filed or Pro Se.~~

- **Standard wording:** Claims Representatives and Defense Counsel will utilize IRMA's standard release form (or wording). Defense Counsel may modify the standard language if necessary.

EXPENSE PAYMENTS

- **Bill Review:** The Claims Representative assigned to the file will review all bills for appropriateness and reasonableness. For bills in excess of a Claims Representative's authority, the bill should be submitted to the next level of authority. ~~An authorization sheet is not necessary. The bill should also be signed or initialed by the Claims Representative, indicating that they agree with payment of the bill.~~

PAYMENT PROCEDURES

~~**CALCULATING TTD & PPD BENEFITS**~~

~~**Pursuant to the provisions of Section 138.10 of the Illinois Workers' Compensation Act, the TTD rate will be determined as follows:**~~

~~When handling "Lost Time" cases involving three (3) missed work shifts, we will obtain a wage statement from the Member outlining the wages for the injured employee for fifty-two (52) weeks prior to the date of injury.~~

~~Temporary Total Disability (TTD) Benefits will be calculated based on 66 2/3% of the employee's average weekly wage, not to exceed the maximum TTD rate for that time period. The calculation tape (done by Claims Representative) should be attached to the wage statement form.~~

~~All TTD checks will be made payable to the injured worker. All payments will be made in accordance with the Illinois Workers' Compensation Act. Payment of TTD benefits is not taxable under Federal or State law.~~

~~Permanent Partial Disability (PPD) will be calculated based on 60% of the employee's average weekly wage, not to exceed the maximum PPD rate for that time period.~~

~~All PPD payments will be made in accordance with the Illinois Workers' Compensation Act.~~

Employees Returning Part-Time (TPD)

If an employee returns to work on a part-time basis, pursuant to the treating doctor's orders, IRMA will continue to pay a proportionate share of TTD for the time the injured worker misses from work, when the Member continues the full salary of the injured worker. The TTD check needs to be signed over by the claimant to the member so that the member receives TTD reimbursement for the portion of salary they paid the employee for the time the employee missed from work while on light duty.

When an injured employee is working light duty on a part-time or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job, the employee shall be entitled to Temporary Partial Disability (TPD) Benefits. TPD benefits are equal to two-thirds of the difference between the employee's average weekly wage at the time of the injury and the amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working.

Workers' Compensation Medical Bill Review Procedure: Medical bills received by IRMA will be forwarded to the approved medical bill review firm (Corvel) for auditing and applicable PPO discount.

When a medical bill is received at IRMA, the Claims Processor will date stamp the bill and put the bill in Corvel's mail bin. The medical bills can also be sent directly to Corvel by the Member. The medical bills are reviewed by Corvel and charges are reduced when appropriate. The recommended payments are entered into Corvel's CareMC system, where the Claims Representative reviews the recommended payment and releases or denies the payment as appropriate.

The Claims Processor prints payable sheets on Tuesday and Thursday and gives them to the Claims Representatives to review and approve. The payable sheets will include any medical bills that are not reviewed by Corvel.

TIMELINESS STANDARDS – MEDICAL BILLS

Bills will be reviewed and approved if compensable within five (5) business days after receipt by the Claims Representative.

TELEPHONIC CASE MANAGEMENT REFERRAL GUIDELINES

1. All new lost time claims with an uncertain return to work date.

2. All modified duty claims with 45 days or more of modified duty with an uncertain date of release to full duty.

3. All claims where surgical intervention is recommended.

4. Percutaneous disc decompression (lumbar)

5. IDET procedures (radiofrequency, radioablation)

6. Extra Corporeal shock wave therapy treatments (for epicondylitis)

7. Claims with ongoing pain management treatment.

8. Claims with ongoing psychiatric or psychological treatment.

9. Injuries involving lacerations of muscles or tendons.

UTILIZATION REVIEW CRITERIA GUIDELINES

1. All Inpatient Hospitalization

2. Cartisel Transplants (meniscus tears)
3. Artificial lumbar disc replacements

4. Percutaneous disc decompression (lumbar)

5. Repeat surgeries (2nd surgery same diagnosis/body part) (inpatient/outpatient)

6. Outpatient surgeries with questionable diagnostic evidence/clinical findings. An example would be when a claimant has a negative MRI and doctor is still recommending surgery.

7. IDET procedures (radiofrequency, radioablation)

8. Extra Corporeal shock wave therapy treatments (for epicondylitis)

9. PT/OT treatment meeting the following criteria:
   a. Treatment exceeding 12 visits &/or 6 weeks of treatment, unless post operative therapy.
   b. No documented improvement.
   c. Any physical therapy in doctor owned facility.

10. Chiropractic treatment meting the following criteria:
   a. Chiropractor has determined patient to be temporary totally disabled.
   b. Treatment exceeding 12 chiropractic adjustments &/or 4 weeks of treatment.
   c. No documented improvement.

11. Work Hardening meeting the following criteria:
   a. Treatment exceeds 4 weeks
   b. Program is not directed towards a specific type of employment/simulation of work activities absent.

12. Pain Management meeting the following criteria:
   a. Injections requested within first 6 weeks of treatment.
   b. Request for third injection without any documented relief from prior injections.
   c. More than 3 injections
   d. Treatment exceeding 12 weeks.
   e. Cervical injections without use of imaging to guide needle localization.
   f. Experimental treatment.

13. All unnecessary high cost diagnostic test to include:
   MRI, CT Scan, Bone Scan, Myelogram, Arthrogram, Discogram, EEG, Video Fluoroscopy

~~14. Other treatment that may need to be referred to Utilization Review:~~

~~a. Psychiatric treatment~~
~~b. Ongoing psychological testing &/or services.~~
~~c. All weight loss programs~~
~~d. Gym programs vs. physical therapy~~
~~e. All bone growth stimulators~~
~~f. All cognitive therapy~~
~~g. Biofeedback exceeding 6 visits.~~
~~h. All acupuncture.~~

SUBROGATION

Subrogation is an essential activity for the IRMA claims program. All claims personnel are required to make a special effort to identify subrogation potential, to thoroughly investigate the possibility of recovery, and to pursue recovery aggressively.

- **Investigation:** All claims will be evaluated for subrogation potential. If potential exists, investigation of the third party (or product) will be completed in conjunction with the standard accident investigation.

- **Notice:** If the investigation suggests any potential for liability of a third party, that party and/or their insurance carrier will be placed on notice of a possible claim.

- **Subrogation Settlement Authority:** Same as settlement (if no reduction is taken).

- **Follow-Up:** All subrogation files should be updated as needed.~~at least every ninety (90) days. Exceptions must be clearly documented in the diary notes.~~

- **Use of Counsel and/or Collection Agency:** Counsel and/or a collection agency will be utilized only when necessary. IRMA claims personnel are to exhaust all means available to them before turning over a subrogation file to an outside source. Counsel and/or a collection agency's fees for subrogation should be in accordance with litigation and billing guidelines. The Claims Supervisor must be consulted before a file is sent to an attorney for collections~~.~~

- **Write-off:** Any write-off can be done only when all efforts to recover have been exhausted without results. Management must approve any write-off over the Claims Representative's settlement authority. The reason for any write-off should be documented in the diary notes.

NOTE: **See "Subrogation File Handling Procedures" (Section XVI) for in-depth details on IRMA's handling of subrogation matters.**

EXCESS NOTIFICATION (See Section XI)

FILE CLOSURE

- **Timeliness Standards:** All payments (including expense bills) must be made prior to closing. Bills received after the file is closed will require documentation in the claim notes, review, and payment by the ~~the file to be reopened by the~~ Claims Representative.

- **Notification of Rights (to Claimant):** Denial letters must be sent directly to the claimant and carbon copied to the member. ~~For claims denied, a written denial letter must be sent.~~ For unrepresented claimants, the statute-of-limitations should be defined, and the date clearly noted on those files in which the denial letter is being sent within sixty (60) days of expiration.

- **Closed File Checklist:** A closed file checklist must be completed when a file closes. The checklist is in Section XII.

- **Closed File Review Procedures:** See Section XII.

- **Destruction Date:** All closed files will be assigned a destruction date of seven (7) years from date of loss, or two (2) years from date-of-closing (whichever is greater). Cases involving minors will be retained until the person reaches twenty-one (21) years of age. Destruction dates will be entered into the computer as well as on the file jacket.

- **Claim File Storage and Purging Procedure:** Closed files will be purged based upon the above destruction date criteria. A computer run will be generated to identify those files to be purged and destroyed. One report will be run for the closed files IRMA inherited from Gallagher Basset. Another report will be run for the open files that IRMA has created.

- **Purging Procedure for Closed Claim Files:** See Section XIV.

  The Claims Department will purge closed files on a quarterly basis.

SECTION XI

WORKERS' COMPENSATION

EXCESS NOTIFICATION

The following criteria should be used for reporting claims to our excess/reinsurance carriers. The initial report should include preliminary claim information. A detailed captioned report should be submitted to the carrier as an update once the case develops. The captioned report should outline the facts of the loss, injury/damages, liability, case value, status of litigation, current reserves, etc. A copy of defense counsel's evaluation can also be attached.

Safety National Casualty Corporation
1832 Schuetz Road
St.Louis, MO 63146
(314)995-5300
first.report@safetynational.com

Criteria

Report all claims where the gross incurred exceeds 50% of the SIR.

Additionally, report all claims involving the following criteria regardless of liability:

1. Fatalities
2. Quadriplegia, paraplegia
3. Third degree burns exceeding 25% of skin area
4. Amputation and/or permanent loss of use or sensation of a major extremity
5. Head/brain injuries (resulting in permanent disorientation, behavior disorders, personality changes, seizures, aphasia or coma)
6. Loss of sight and/or hearing
7. Spine/back injury resulting in incontinence of bowel/bladder
8. Claims involving: rape, molestation, AIDS, class actions, environmental exposure
9. Claims where the trial is likely to occur within six months and the demand is greater than the retention (consider reporting)

WORKERS' COMPENSATION SUBSEQUENT REPORTING

Subsequent reporting is required after the initial report per the excess carrier guidelines, but no less than on a quarterly basis even if the excess carrier has closed their claim and has different reporting requirements. If we need to make a significant reserve change or there is a significant change in the status of the claim, an update should be sent to the excess carrier at that time. The current reserve amount should be provided with each subsequent report. A copy of the update should be attached to the electronic file.

REIMBURSEMENT REQUESTS

Claims on which our payments exceed the SIR will have a claim status of ER Excess Open Recovery. Reimbursement will be sought from the excess carrier on a quarterly basis.

SECTION XI

GENERAL LIABILITY

EXCESS/REINSURANCE NOTIFICATION

The following criteria should be used for reporting claims to our excess/reinsurance carriers. The initial report should outline the facts of the loss, injury/damages, liability, case evaluation, status of litigation, current reserves, etc. A copy of defense counsel's evaluation should also be attached if the matter is in litigation. At a minimum, unless otherwise indicated in the excess or reinsurance agreement, the claim representative should send an updated captioned report on a quarterly basis. The captioned report as well as the email should be attached to the claims system and labeled accordingly for retrieval purposes.

All reinsurance agreements are located at:

G:\IRMA Organization\CoverageDocuments.Reinsurance Agreements by Year

Once the SIR has been pierced, the claim representative must change the claim status to E.R. (Excess Recovery) and set a diary for follow-up. When the reinsurance agreement does not specify billing protocols, the claim representative must bill the carrier quarterly.

TO REPORT A PROPERTY CLAIM

The Hartford
Susan Daigle
(860) 547-4701
susan.daigle@thehartford.com

Please have the pertinent information available, including the following: Insured Name, Member information, Certificate Number, Specific Location of Loss, and the Person's Name and Telephone Number that the Hartford adjuster can contact for additional information.

TO REPORT A CLAIM TO GREAT AMERICAN INSURANCE GROUP

Great American Insurance Group
Andrew A. Kay
4510 Cox Road, Suite 301
Glen Allen, VA 23060
(804) 396-6012
akay@gaic.com

TO REPORT A GENERAL LIABILITY CLAIM TO MUNICH RE

Munich Re America
Beth Capek
30 S. Wacker Drive-38th Floor
Chicago, IL 60606
(312) 993-3623
ecapek@munichreamerica.com
clmschi@munichreamerica.com

Criteria

The claim representative must review the applicable excess or reinsurance agreement and follow reporting guidelines as required by the particular carrier.

Report all claims where the gross incurred exceeds 50% of the SIR. Additionally, report all claims involving the following criteria regardless of liability:

1. Fatalities
2. Quadriplegia, paraplegia
3. Third degree burns exceeding 25% of skin area
4. Amputation and/or permanent loss of use or sensation of a major extremity
5. Head/brain injuries (resulting in permanent disorientation, behavior disorders, personality changes, seizures, aphasia or coma)
6. Loss of sight and/or hearing
7. Spine/back injury resulting in incontinence of bowel/bladder
8. Claims involving: rape, molestation, AIDS, class actions, environmental exposure, exoneration
9. Claims where the trial is likely to occur within six months and the demand is greater than the retention (consider reporting)

Revised 6/18

M E M O R A N D U M

TO: Coverage, Claims & Litigation Committee

FROM: Margo Ely, Executive Director

DATE: September 12, 2018

RE: Litigation Successes

Purpose: The purpose of this memorandum is to highlight recent litigation successes.

The Mandatory Retirement age of 65: what does it really mean?

Section 17 of the Board of Fire and Police Commissioners Act states, in relevant part:

> The age for retirement of policemen or firemen in the service of any municipality which adopts this Division 2.1 is 65 years, unless the Council or Board of Trustees shall by ordinance provide for an earlier retirement age of not less than 60 years.

Recently, a certain public safety employee's 65th birthday was approaching, and he received a letter telling him that his birthday would also be his retirement date, relying on the language above. He disagreed and argued that he would be 65 for the entire year following his 65th birthday, so he could retire any time during that year. The employee had a right to a hearing before the Board of Fire and Police Commission to present his argument, so he did. The Board denied his claim and found that retirement at 65 means you retire on the day you turn 65, stating the language was simple and there was no ambiguity. The employee disagreed and appealed the Board's decision to the Circuit Court of Cook County, which considered the arguments and recently rendered an opinion affirming the Board's decision.

"The Court finds that the Act is not ambiguous as its meaning can be interpreted from its plain language. The plain language of the Act requires mandatory retirement upon reaching age 65, in other words, on a public safety officer's sixty-fifth birthday." In further support for its decision, the court stated, "Plaintiff's argument that the mandatory retirement age is essentially a year-long window would lead to impractical and absurd results."

Big Win in Gun Club Zoning Case

Land use decisions are frequently very controversial issues, compelling residents to organize opposition to proposed uses, pack the board room and speak at public meetings for hours. These situations implicate legal issues ranging from procedural due process rights of residents to cross examine developers to constitutional rights to free speech. Recently, the Village of Willowbrook had such an experience.

The developer wanted to build a Gun Club; a 31,000 square foot indoor shooting facility with shooting lanes, classrooms, lounges, retail and offices. The proposal required not only a special use permit, but a rezone. After two nights of public outcry from residents opposing the use, the Village Board denied the request. And the developer sued.

In recent years, caselaw has evolved in the Second Amendment context, leading to a higher level of scrutiny for zoning decisions involving gun uses. Similar to the law related to adult uses, there have been 2 recent 7th Circuit opinions leading land use cases involving guns in the direction of heightened scrutiny under the Second Amendment. However, Judge Kocoras recently granted Willowbrook's motion to dismiss the lawsuit in an opinion that puts a stop to the Second Amendment momentum in the zoning context.

The developer argued that the Village's denial of their development deprived them of the highest and best use of their property, destroyed the value of their property and effectively imposed an outright ban on gun ranges and gun sales in Willowbrook, in violation of the Second Amendment. The judge disagreed, noting that there were several other properties available for this type of development and that there are 2 gun ranges within just a few miles of the Village.

The conclusion really hit the point home: "The Second Amendment was never intended to be a battering ram, used to push aside the beliefs and concerns of American citizens. The idea that a gun range and gun store located in the middle of a small village is incompatible with concepts of a more perfect Union or the enjoyment of domestic Tranquility – an idea espoused in a public forum by its residents – is entitled to credence." Attorney John Murphey won the case for us.

Budgets Matter: 2 Legal Victories for Municipalities

Municipalities face significant budgetary constraints, especially in Illinois where the threat that the state will further reduce municipal revenues is real. Similarly, the change in market conditions due to increasing on line sales, directs municipalities to recruit future revenues from the 5 F's (furniture, fitness, fashion, fun and food). With declining revenues, maintaining infrastructure is often a challenge. When municipal property isn't maintained, claims are more likely. We frequently see claims related to trips and falls on sidewalks and drainage/flooding issues. It is common that these exposures are attributable to a lack of funding. In 2 recent cases, the budgetary argument won the day. According to the Illinois Appellate Court, "It is well established that deciding how best to spend limited resources is a policy determination."

In one case, the Village of Tinley Park was sued by a resident/homeowner because their house was damaged by a storm pipe that needed to be replaced. It ultimately took the Village 16 months to complete the necessary repair to the pipe. After the trial court granted judgment for the Village, the plaintiff appealed. In affirming the judgment in favor of the Village, the Appellate Court relied on the discretionary immunity provided in the Tort Immunity Act, stating, "policy determinations are decisions that require a governmental employee to balance competing interests and to make a judgment call as to what solution will best serve each of those interests." As such, the Village's decisions during that 16 months, when it tried various remedial measures to fix the problem, were discretionary acts and were therefore immune.

Similarly, in another recent case, the plaintiff sued the Village of East Hazel Crest after she tripped and fell on a deviation in the asphalt near a manhole cover in a commuter parking lot. Cook County Circuit Court Judge Kathy Flanagan stated, "A public entity exercises discretion when it selects and adopts a plan in the making of public improvements, however, once the public entity is carrying out the plan, it acts ministerially and is bound to see that the work is done in a reasonably safe and skillful manner." In the case at hand, the judge granted discretionary immunity to the Village, "the decision to not repair the parking lot due to budgetary

constraints required the balancing [of] competing interests of the safety of the users of the lot with the available resources of the Village." Both of these cases were won by IRMA attorneys Hartigan & O'Connor.

The recent Illinois Supreme Court opinion in Monson v. Danville did not change the law with regard to the availability of discretionary immunity to municipalities. Rather, based on the facts of the case, the court found that Danville did not present sufficient evidence to support the defense. We encourage all IRMA members to have a written sidewalk inspection and repair policy in place and to document the basis for decisions being made – especially when the decision is to forego a repair. We also remind our members that we have an early intervention program and if they have questions, we can assist. Call us with questions.

No Good Deed Goes Unpunished: But, Sometimes Good Deeds Win the Case

Police officers encounter difficult domestic situations on many of their calls. Domestics tend to be more volatile, with high levels of emotion, animosity and history. Sometimes these types of calls are really more "civil" in nature with parents fighting over visitation, custody, child support or other related issues. Police Officers have no duty to assist in these civil situations, but it's no uncommon for them to help out. In a recent case, the officers helped out. And in return, they were sued. But, in the end, the judge ruled in favor of the officers.

The Plaintiff had lived with a woman as friends for a few years when the woman decided she wanted to sell the house. Her real estate agent told her that she needed to "evict" the plaintiff in order to have the house staged to sell. The Plaintiff returned from work and his personal property was packed in boxes, so he started to unpack his property since he did not want to move out. At some point in the chaos, the police were called and responded. There are disputed facts about what went on at the scene and thereafter, but ultimately, the police made no arrests and the Plaintiff moved out of the house. But, he filed a lawsuit. As is always the case with these scenarios, the plaintiff claimed an unlawful eviction, theft of his property, failure to protect him and conspiracy theories.

The lawsuit was filed in federal court and included several constitutional theories. Despite potential factual issues, we filed a motion to dismiss and the judge granted it with prejudice, so the plaintiff has no opportunity to amend the complaint. The judge stated, "In considering the totality of the circumstances as alleged, [the officers] actually helped Plaintiff retrieve his personal property." This particular plaintiff admitted in his pleadings that he routinely engaged in the unauthorized practice of law. And he may have misjudged his legal skills. The judge found that he actually pled himself out of court. "Plaintiff's allegations show that his constitutional rights were not violated by the actions of the police officers." A nice victory for the good guy. IRMA attorney Allie Burnet at Best, Vanderlaan & Harrington won this case for us.

ME/ds

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