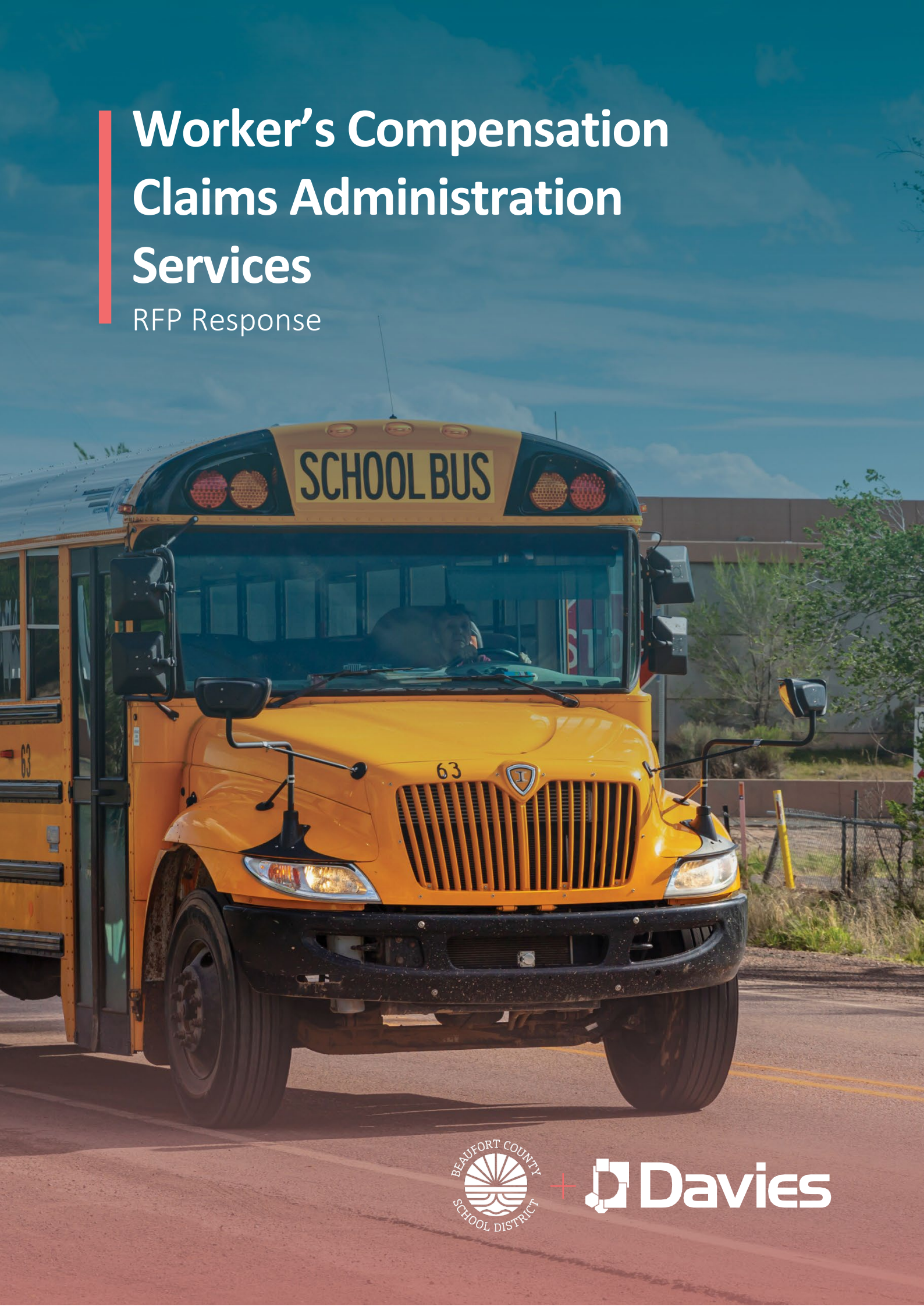
Worker's Compensation Claims Administration Services

RFP Response



BEAUFORT COUNTY SCHOOL DISTRICT + Davies

Beaufort County School District

Solicitation Number:	25-029
Date Printed	April 1, 2025
Date Issued:	April 24, 2025
Procurement Officer:	Kaylee Yinger, NIGP-CPP, CPPB
Phone:	843-322-2349
Email:	Kaylee.Yinger@beaufort.k12.sc.us

Request for Proposal (RFP)

DESCRIPTION:	**Workers' Compensation Claims Administration Services**
SUBMIT OFFER BY (Opening Date & Time):	**May 22, 2025 @ 4:00 PM EST**
QUESTIONS MUST BE RECEIVED BY:	May 10, 2025 @ 4:00 PM EST
NUMBER OF COPIES TO BE SUBMITTED:	**One (1) Original Signed; Six (6) Signed Copies and One (1) Redacted Version on USB**

Offers must be submitted in a sealed package. Solicitation Number & Opening Date must appear on package exterior.

SUBMIT YOUR SEALED OFFER TO EITHER OF THE FOLLOWING ADDRESSES:

PHYSICAL ADDRESS:
Beaufort County School District
Procurement Office
2900 Mink Point Blvd
Beaufort, SC 29902

Electronic Bid Submissions will be accepted through the following web address: Here

AWARDS & AMENDMENTS:
Award will be posted at the Physical Address stated above on or after May 23, 2025. The award, this solicitation, and any amendments will be posted at the following web address:
https://www.beaufortschools.net/community/working-with-the-district/finance.

You must submit a signed copy of this form with Your Offer. By submitting a proposal or bid, you agree to be bound by the terms of the Solicitation. You agree to hold Your Offer open for a minimum of ninety (90) calendar days after the Opening Date.

NAME OF OFFEROR: (Full legal name of business submitting the offer) ENTITY TYPE:

Davies Claims North America, Inc — Corporation

AUTHORIZED SIGNATURE (Person signing must be authorized to submit binding offer to enter contract on behalf of Offeror named above)

Beverly Adkins — President, WC TPA

PRINTED NAME — TITLE

Instructions regarding Offeror's name: Any award issued will be issued to, and the contract will be formed with, the entity identified as the Offeror above. An offer may be submitted by only one legal entity. The entity named as the Offeror must be a single and distinct legal entity. Do not use the name of a branch office or a division of a larger entity if the branch or division is not a separate legal entity, i.e., a separate corporation, partnership, sole proprietorship, etc.

PAGE TWO

(Return Page Two with Your Offer)

HOME OFFICE ADDRESS (Address for Offeror's home office/ Principal place of business):	NOTICE ADDRESS (Address to which all procurement and contract related notices should be sent):
6015 Resource Lane Lakewood Ranch, FL 34211-0004	PO Box 110259 Lakewood Ranch, FL 34211-0004
PHONE NUMBER: [redacted]	
EMAIL ADDRESS: [redacted]	

PAYMENT ADDRESS (Address to which payments will be sent):	ORDER ADDRESS (Address to which all purchase orders will be sent):
☐ Payment Address Same as Home Office Address	☐ Payment Address Same as Home Office Address
☒ Payment Address Same as Home Notice Address	☒ Payment Address Same as Notice Address
(Check one only)	(check one only)

ACKNOWLEDGEMENT OF AMENDMENTS:	Amendment Number	Amendment Issue Date
	1	4/28/25
	2	5/6/25
Offeror acknowledges receipt of amendments by indicating amendment number and its date of issue.	3	5/19/25

MINORITY PARTICIPATION- Are you a Minority Business Enterprise: Yes ☐ No ☒
If yes, please include a copy of your certification.

4.0.1.2. Cover Letter

Kaylee Yinger, NIGP-CPP, CPPB
Procurement Officer
Beaufort County School District
2900 Mink Point Blvd
Beaufort, SC 29902

Dear Ms. Yinger,

Davies is delighted to submit our response for the opportunity to serve as the TPA for Beaufort County School District. With a proven ability to deliver customized solutions for our clients and the scale and depth of resources you need, we are confident in our ability to assist in exceeding your strategic risk management goals.

This confidence originates from the fact that each year Davies successfully handles over 50,000 workers' compensation claims for our clients. Davies represents hundreds of diverse clients, maintaining an average client relationship of 14 years, with some exceeding 30 years. We have provided workers' compensation TPA services to Duval County Public Schools since 1996, Alvin Independent School District (ISD) since 2007, Texas City Independent School District (ISD) since 2005, Port Neches-Groves Independent School District (ISD) since 2003, School District of Lee County since 2004, and Nederland Independent School District (ISD) since 2003.

Davies now employs more than 2,600 desk professionals in the US, over 10,000 field adjusters, and manages over 300,000 claims annually. Our specialized divisions within our claim solutions unit have the expertise to handle diverse claims and deliver the highest level of customer service to meet the individual needs of our clients. Oversight of our TPA operation is provided by Beverly Adkins, President, WC/P&C TPA and Alice Wells, Sr. Vice President, WC TPA.

Davies offers an end-to-end range of comprehensive claims solutions and unmatched flexibility through our customizable service and pricing options, to accomplish your objectives. From process flows and reporting styles, every aspect of our adjusting solution is tailored to each client. This personalized approach coupled with our best practices in claims handling ensures a targeted focus on reducing the overall cost of claims, optimizing customer experience, and eliminating avoidable litigation. Our claims administration services include a truly customer-centric, boutique approach, where you will have direct access to your designated account manager, Nicole Stephens, as well as our executive leadership team.

Our dedicated model allows for exclusive attention by our experienced adjusters who are ready to promptly provide support and become an extensive of your team. Our approach fosters the development of relationships and the provision of knowledgeable claims services, the ability to flexibly attend staff meetings and address all urgent needs, and the level of service across required to proactively focus on continuous improvement. Our highly experienced team is supported by a combination of sophisticated, flexible managed care solutions and a scientific approach to data analytics. These components work together seamlessly to return injured workers back to work in the quickest possible time. Data analytics is critical to achieving optimum claim outcomes in workers' compensation. Davies vast managed care and ancillary service offerings include triage & telephonic case management; field nurse case management; medical bill review; pharmacy benefit management; physical therapy; telemedicine; diagnostics; utilization and peer reviews; network access; Medicare, OSHA & EDI reporting; fraud investigations; subrogation recovery and 24/7 claim intake services. Additionally, our full-service, user-friendly RMIS offers automated workflows, advanced reporting, and analytic capabilities needed to efficiently manage your claims program and provide the District with real-time access to claims data with as many users as they wish to access the system.

Our strategies for cost containment have consistently delivered substantial savings, and our commitment to risk management and legal compliance has reduced legal exposure. Davies staff bring extensive experience in managing the unique challenges associated with school district claims, including those involving faculty, staff, transportation personnel, and custodial teams. We understand the importance of resolving claims efficiently to minimize disruption to school operations and ensure the well-being of employees. Our team is highly responsive and skilled in navigating the complexities of workers' compensation in the public education setting, including

return-to-work coordination, medical case management, and compliance with state-specific regulations. Many of our school board clients operate with significant self-insured retentions (SIRs), and we have well-established processes to monitor SIR erosion, notify excess carriers in a timely manner, and manage reimbursement follow-through. This experience allows us to serve as a trusted partner to school districts, helping them manage claims effectively while supporting their mission to provide safe and uninterrupted educational services.

By selecting our services, the District will realize significant savings in the following areas:

- We audit medical and expense bills to contracted rates.
- We build long-term relationships with our carefully vetted strategic business partners to yield the best results for our clients and their injured employees.
- Our firm does not self-refer for ancillary services with the goal of gaining additional revenue. Referrals will only take place if they bring value to the claim, and only with the District's approval.
- To help detect and deter fraud, we report all lost time claims and questionable medical only claims to the Index Bureau.
- We will handle all reporting, documentation, and recovery requirements on behalf of the District at no extra charge. Each claim which has subrogation potential is investigated and appropriate documentation submitted for collection. We pursue subrogation recoveries at no additional cost and have recovered more than $45 million over the past five years for our clients.
- We minimize the number of claims going into litigation.
- We contract with a legal bill review vendor, if desired, to examine defense counsel invoices for any unreasonable fees and/or inappropriate or questionable expenses.
- We offer non-traditional sources of prescriptions at the lowest cost through re-directed billing.
- To prevent overbilling, our QA Bill Reviewer reviews re-considerations and conducts interdepartmental audits of processed bills.
- Our nurse case managers pursue and track medical cost savings (MCS), which is input directly into the claims system.
- Hospital admissions, surgeries, and invasive procedures are pre-certified and reviewed for appropriate length of stay and services.
- This allows possible savings on claim expenses and ensures appropriate medical treatment.
- We will provide mandatory Medicare reporting.
- We maximize efficiency through advanced analytics and technology, including ODG by MCG in setting accurate reserves early in the claims process, predictive analytics that identifies claims that will respond favorably to medical case management treatment pattern alerts from care providers, analysis of costs and field case management usage along with live network performance monitoring to continuously evaluate, identify and direct care to the most effective providers on behalf of our customers.

Davies fully complies with the terms and conditions set forth by the District and is enthusiastic about the opportunity to demonstrate our capabilities. We are hopeful you find our RFP response of interest and we welcome the opportunity to discuss our proposal in further detail.

Best Regards,



Beverly Adkins, AIC, AIM
President, WC TPA
T: (877) 326 - 5326 x1373
E: beverly.adkins@us.davies-group.com

Table of Contents

4.0.1.1. Cover Page and Page 2 2

4.0.1.2. Cover Letter 4

4.0.1.3. Table of Contents 6

4.0.1.4. Narrative on Scope of Work 7

Attachment A 7

Attachment B 12

Attachment C 20

Attachment D 22

Scope of Work 42

4.0.1.5. Firm Information 85

4.0.1.6. Financial Strength 86

4.0.1.7. Account Servicing 87

4.0.1.8. Section 9.0 – Attachments to this Proposal 94

Business Utilization Form. 95

Statement of Intent. 96

4.0.1.9. Objections, Exceptions, Observations 97

Appendices 98

4.0.1.4. Narrative on Scope of Work

Attachment A

1)Servicing Office and Personnel

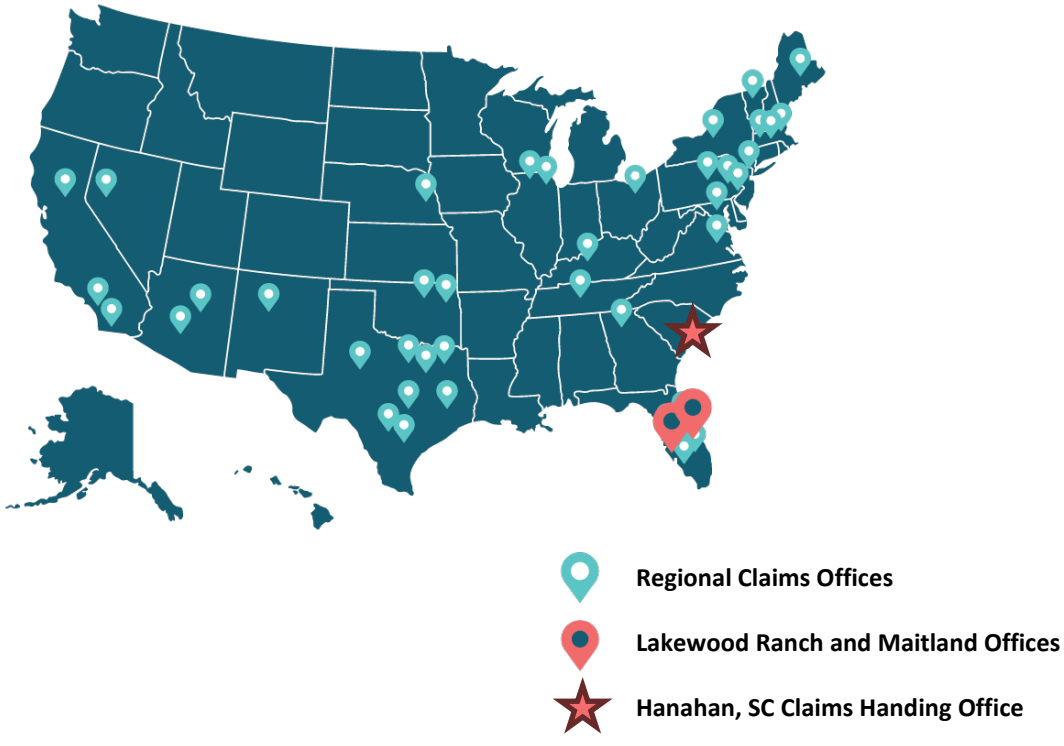
A. Office Locations - Please indicate your proposed handling location(s). Provide a list and description (number of personnel, experience levels, etc.) of your servicing office or offices.

Davies leverages its extensive network of regional offices nationwide, including our headquarters in Lakewood Ranch, Florida.

PO Box 110259
Lakewood Ranch, FL 34211-0004
Tel: 941-907-3100 | **Toll Free:** 1-877-326-5326

Additionally, many of our adjusters work throughout the country from their home offices and are flexibly able to handle claims and be deployed as needed.

Davies will be handling the claims for Beaufort County School District out of our Hanahan, SC regional claims office.



There are 515 claims personnel based out of our Lakewood Ranch office, including executives, managers, supervisors, claims adjusters, assistants and support staff.

There are 64 claims personnel based out of our Maitland office, including managers, supervisors, claims adjusters, assistants and support staff.

B. Caseloads of Adjusting Personnel Identify the maximum caseload assignment for adjusters handling the following types of claims: Workers' compensation medical only claims Workers' compensation indemnity claims

Caseloads

Davies maintains caseloads that are aligned with industry best practices to ensure quality, responsiveness, and compliance in claims handling.

These caseload thresholds are carefully managed to ensure that each adjuster has the capacity to:

- Conduct timely investigations and communications
- Monitor medical treatment and return-to-work progress
- Accurately set and adjust reserves
- Maintain compliance with South Carolina Workers' Compensation statutes and reporting requirements

We adhere to the following average case load policy:

Medical Only - 225 claims

Lost time/Indemnity - 140 Claims

This volume is easily monitored by management using internal reports. This volume will vary slightly depending upon the severity of the claims and the complexity of the account. This philosophy reduces adjuster turnover and allows the adjuster to devote the proper amount of time to each claim. By devoting the proper amounts of time on a regular basis, the need for crisis claims handling is eliminated.

C. Account Management TPA will assign an account coordinator/account manager to the program who will serve as the single point of contact for all communication, including, but not limited to, the following: Overall development, implementation and monitoring of the service delivery. Monitoring the claim service and quality assurance compliance. Addressing questions, issues, concerns and requests relating to the program. Communicating special account instructions to the claim service offices. Working with the carrier(s), as required. Coordination of periodic meetings, claim file reviews/audits and renewal activities. Information System issues. Resumes of proposed account coordinators/account managers, including length of service with TPA, shall be included in your response.

Davies confirms that the account manager, Nicole Stephens, will serve as the single point of contact for all communication, including but not limited to, overall development, implementation and monitoring of the service delivery, monitoring the claim service and quality assurance compliance, addressing questions, issues, concerns and requests relating to the program, communicating special account instructions to the claim service offices, working with the carrier(s), as required, coordination of periodic meetings, claim file reviews/audits and renewal activities, and information System issues.

Nicole Stephens

AVP WC TPA/ Account Manager

Ms. Stephens joined Johns Eastern, now Davies, in early 2016, handling claims for self-insured public and private entities. In 2019, she was promoted to Claims Supervisor, followed by a promotion to Claims Manager in 2022. Most recently, she was promoted to Assistant Vice President of Workers' Compensation TPA Services, where she now provides strategic and operational leadership across the TPA division.

In her current role, Ms. Stephens oversees multiple teams of supervisors and adjusters, ensuring quality, compliance, and consistency across all aspects of claims handling. She is responsible for developing and implementing best practices, driving standards, and aligning operational workflows with client-specific service expectations. Ms. Stephens collaborates closely with client leadership and internal stakeholders to evaluate outcomes, provide stewardship reporting, and support ongoing program enhancements.

Her responsibilities also include high-level oversight of complex claims, litigation strategy coordination, reserving accuracy, and execution of training initiatives to support adjuster development. She plays a key role in client retention and new business onboarding, acting as a senior liaison for issue resolution and service delivery.

Ms. Stephens is a Board-Certified All-Lines Adjuster and has earned the Certification of Workers' Compensation Litigation Management (CWCL) and the Associate in Claims (AIC) designation. She is currently pursuing the Associate in Risk Management (ARM) designation through The Institutes.

D. File Retention Provide your standard procedures for claim file destruction.

Davies works in a paperless system where all claims-related documents coming into the office are scanned. The document images are maintained in a computer-based image retrieval system, organized by each document's category (medical bills, legal, claimant, etc.) and the claim with which it is associated. Email and e-fax documents received are uploaded individually to the corresponding claim file. All claims-related documents are available for the client to view online 24/7 in real time. These documents are stored in our claim system indefinitely, unless otherwise specified by the client.

To accommodate the District's program, Davies will evaluate the volume of physical files that remain in paper form from the current TPA. Depending on the amount, we will either store these files securely or convert them into electronic files for integration into our system. This ensures seamless accessibility and consistent organization of all claims-related documentation.

2) Communication and Coordination

A. Claim Reporting Please discuss internet, e-mail and telephone claim reporting options.

Reporting Claims

The preferred method of reporting workers' compensation losses to Davies will be to complete the First Notice of Loss on our website, which will enable our clients to quickly report claims electronically 24 hours a day, 7 days a week, 365 days a year. The computer-controlled edits and validations will help ensure proper responses and fully completed forms are submitted directly to our database. Once the form is completed, a visual confirmation will be displayed, assuring the client that the information was successfully transmitted to Davies. This allows for rapid setup and assignment of the claim, so immediate contacts can be made and investigations started. We also offer telephone, email, and fax reporting options.

The computer-controlled edits and validations help ensure that proper responses and fully completed notices are submitted directly to our database. This allows for rapid setup of the claim, immediate contacts can be made, and investigations started. Upon submission, a control number is generated by the database confirming acceptance of the FROI record and it is your assurance that the information was

successfully transmitted to us. You will have the option of printing a FROI recap of submitted information which the injured employee can sign for your files. As an option to this program, you may choose to periodically provide Davies with information about your employees to be used to pre-fill the iFROI with their demographics. With this option, when an employee is injured, you need only enter their Social Security number or Employee ID — the system will then pre-fill their name, address, work location, and other information. This not only saves you time, but it also improves accuracy and leaves you to only be concerned with entering the details of the loss. You can also provide us with the names and addresses of your most utilized first aid providers and we will make them available as pre-filled choices on the form, as well.

We can also offer Beaufort County School District the option of having a designated toll-free, after-hours reporting line to assist in reporting claims quickly. The advantage of this is that the after-hours nurse case manager will be available to complete an immediate triage upon request if it is deemed urgent. The after-hours staff also has access to the online reporting system, which allows them to complete the intake process at the time of injury reporting, in accordance with any special instructions developed by Beaufort County School District. The after-hours nurse case manager can provide recommendations and will refer the injured employee to Beaufort County School District's preferred initial treatment facility, if deemed appropriate, or the ER if the injury warrants emergency treatment. In either case, the injured employee will be contacted by our designated nurse case manager (if one has been assigned) or adjuster after the claim has been formally assigned and authorization for follow-up treatment can be provided at that time.

B. Settlement Authority The selected TPA will have workers' compensation lump sum settlement authority to $10,000. BEAUFORT COUNTY SCHOOL DISTRICT authorization is required for proposed settlements of more than $10,000 (TPA will have authority to pay statutory workers' compensation benefits). When TPA feels that a settlement is warranted, TPA will provide BEAUFORT COUNTY SCHOOL DISTRICT with a written (e-mail is acceptable) evaluation and recommendations for settlement. TPA's settlement evaluation and recommendations will be provided at least 10 days prior to any critical dates that may impact the settlement, such as trials, hearings, mediation conferences, statutory time periods, time limit demands, etc.

Davies agrees to the above-mentioned responsibilities.

C. Claim Review Meetings TPA agrees to provide for, and participate in a minimum of two formal claim review meetings for each year that its service contract is in place. Please plan on reviewing indemnity claims each review. The threshold may vary. Claims currently subject to review are open claims with an incurred value of $10,000 or greater, plus any additional claims that BEAUFORT COUNTY SCHOOL DISTRICT may elect to add to the review process, at its discretion. Meetings will be held at either Beaufort County School District, at a TPA servicing office, or other location selected by BEAUFORT COUNTY SCHOOL DISTRICT. Protocol surrounding the claim review meetings will be as follows: BEAUFORT COUNTY SCHOOL DISTRICT, or its designated representative, will provide 30 days advance notice to TPA requesting scheduling of a claim review meeting. TPA will coordinate meeting date(s) with planned attendees, and confirm meeting date(s) and location. TPA will prepare written summary/status reports on each claim that will be subject to review, and will provide copies of such reports to BEAUFORT COUNTY SCHOOL DISTRICT, and broker, a minimum of five (5)

business days prior to the review meeting. TPA attendees at the meeting will include all handling adjusters, with local adjusters attending in person and others attending via telephone. Each claim will be presented by the handling adjuster, or supervisor, for discussion surrounding status, reserve accuracy and disposition strategy. Attach a specimen copy of your proposed status/summary report to be used for claim review meetings, and indicate willingness to allow a customized report format.

Davies agrees to the above-mentioned responsibilities.

Please see Appendix A for our Status/Summary Report.

D. Claim File Audits BEAUFORT COUNTY SCHOOL DISTRICT retains the right to conduct a physical audit of any BEAUFORT COUNTY SCHOOL DISTRICT claim files being handled by the TPA in order to determine compliance with minimum performance standards and practices. Audits will be conducted on an "as needed" basis. BEAUFORT COUNTY SCHOOL DISTRICT will provide the TPA with 30 days advance notice of intent to exercise its right to conduct a physical audit.

Davies agrees to the above-mentioned responsibilities.

Attachment B

1) Worker's Compensation Medical Management and Cost Containment

A. Medical Bill Review/Audit TPA will be responsible for review and audit of all medical bills for causal relationship, necessity of treatment, reasonableness of charge, and compliance with any applicable statutory and/or regulatory requirements. To the extent that TPA will perform any of such services through the use of a vendor or outside contractor(s), identify such vendor(s) and/or outside contractor(s), to include any affiliation with your company. Any vendor(s) or independent contractor(s) utilized for these services must be approved by BEAUFORT COUNTY SCHOOL DISTRICT. Describe your process for medical bill review, including hospital bill review. Quoted service fees for medical bill review services will apply for the life of the claims under contract. TPA agrees there will be no charge for duplicate, send backs, re-submissions of medical bills.

Bill Review

Our medical bill review process is a cornerstone of our claims management strategy, designed to ensure compliance with state fee schedules, network agreements, and industry best practices, while maximizing savings for our clients. This process is carried out with precision and consistency, ensuring every medical bill receives a thorough review for accuracy, appropriateness, and cost containment opportunities. Key aspects of our procedure include:

Comprehensive Bill Review Process

- **Automated and Manual Review:** All medical bills undergo a two-tiered process involving automated review to apply fee schedules, coding validation, and initial edits, followed by a manual review for additional accuracy and oversight.
- **Code Validation and Unbundling:** Each bill is meticulously reviewed to identify incorrect coding, unbundled services, or duplicate charges. Adjustments are applied to align charges with industry standards and guidelines.
- **Fee Schedule and Reasonable Pricing Analysis:** Bills are analyzed using the applicable state fee schedules or usual, customary, and reasonable (UCR) rates for out-of-network providers, ensuring adherence to regulatory requirements and minimizing overpayment.

Negotiation and Network Optimization

- **PPO Network Access:** We leverage an extensive network of preferred provider organizations (PPOs) to secure the best possible discounts, ensuring access to quality care at the most competitive rates.
- **Bill Negotiations:** For out-of-network providers or complex charges, we initiate direct negotiations to achieve additional savings, utilizing experienced negotiators to secure agreements that benefit all parties.

Utilization Review and Audit Process

- **Medical Necessity Verification:** All bills are cross-referenced with utilization review outcomes to confirm that services align with approved treatment plans and are medically necessary.
- **Auditing for Compliance:** High-value and complex bills are subject to an additional layer of auditing to ensure compliance with treatment guidelines, identify potential fraud or abuse, and further reduce costs.

Turnaround Times and Communication

- **Efficient Processing:** Routine bills are processed within 7-10 business days, while more complex bills requiring additional handling or negotiations are completed within 15-20 business days. Bills involving PPO transmissions typically add one additional business day.
- **Real-Time Data Integration:** Payment details, including Explanation of Benefits (EOB) and Explanation of Review (EOR), are integrated into the claims system daily, ensuring that adjusters, nurse care managers, and clients have immediate access to payment status and supporting documentation.

Proven Results and Ongoing Optimization

- **Savings Impact:** Through a combination of fee schedule compliance, network discounts, and negotiation strategies, our bill review process achieves average savings exceeding 70% on billed charges.
- **Provider Communication:** By delivering detailed EOBs/EORs with every payment, we minimize provider inquiries and disputes, maintaining strong relationships with medical providers while ensuring transparency.
- **Continuous Improvement:** We consistently analyze billing trends, regulatory changes, and client-specific needs to refine our process and optimize outcomes.

Our approach to medical bill review not only ensures adherence to cost containment protocols but also delivers meaningful savings while maintaining the quality of care and compliance with regulatory standards. Through this robust and detailed process, we provide an integrated solution tailored to meet the unique needs of each client.

2. MEDICAL CASE MANAGEMENT Describe your company's philosophy, approach and process with respect to early intervention ("EIP"), telephonic case management ("TCM") and field case management ("FCM"), along with any other activities utilized to manage the medical component of workers' compensation claims. This should include, but is not limited to, triage procedures, methodologies and selection criteria used to identify the need for TCM and FCM, as well as the adjuster's role in the medical case management process.

Medical management is a significant component of work-related injury and illness management. Our organization has a dedicated team with extensive experience and systems to effectively handle and manage medical issues often seen in the workers' compensation environment today, from traditional Musculo-skeletal injuries to complex disease exposure and disease processes. Led by experienced nurses and other health care professionals since 1985, we provide medical management services for numerous public and private entities through AmeriSys, now a Davies Company.

We offer an extensive selection of medical management and managed care programs, ensuring that every aspect of your program is thoughtfully addressed. Our services include:

- Medical Provider Network (MPN)
- Rapid Response (Nurse Triage)
- Telephonic Case Management
- 4C Catastrophic Care
- Rebound (Return-to-Work Program)
- Utilization Review
- Whole Person Assessment (Disability Tool)



Our Telephonic Case Manager (TCM) play a pivotal role as the central point of contact, ensuring seamless delivery and communication with all approved medical providers, including the Pharmacy Benefit Manager, while reporting outcomes to relevant parties, including the our Quality Assurance Committee.

The TCM's primary responsibility is to coordinate the delivery of high-quality, timely, and cost-effective medical treatment and other necessary health services for injured employees, both within and outside the client's primary service area. This coordination aims to facilitate a timely return to work when medically indicated.

Key responsibilities and principles guiding the TCM's work include:

Adherence to Treatment Guidelines: The TCM manages the claim file while strictly adhering to treatment guidelines and utilization criteria established by client-mandated guidelines, proprietary protocols, nationally published standards, and any specific requirements. This includes staying informed about relevant case laws in accordance with state statutes and rules and modifying the plan of care as needed to ensure compliance.

Utilization Management: Once the plan of care is received from the treating physician, the TCM initiates utilization of management tools to verify that care aligns with evidence-based medical practices. The TCM collects information on clinical conditions and recommended procedures from providers and consults established guidelines and accepted practice parameters. If the data meets the criteria, the request for service is deemed medically necessary. If it does not meet the criteria, the request is referred to Utilization Review or the medical director for a determination.

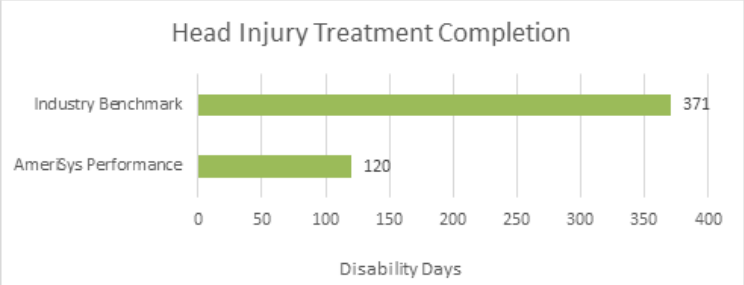
Patient-Centric Approach: The primary goal is to provide excellent service and have a positive impact on the patient's recovery process. The TCM serves as a liaison to all stakeholders involved in the patient's recovery and well-being. This is achieved through clinical expertise, communication, and strategic actions that prioritize the patient's health and recovery as well as return to work outcome.

The TCM's involvement is triggered by specific criteria and reasons, including but not limited to:

- Inpatient Hospitalization or Discharge Planning
- Head Injuries
- Catastrophic Case
- Medical or Surgical Care Coordination
- Task Assignments
- Anticipation of Medical Treatment and Medical Cost Projection

Additionally, we take pride in consistently surpassing industry benchmarks, and a prime example of this is our Head Injury TCM Initiative. In 2022, our performance in this initiative demonstrated remarkable results. On

average, our time to treatment completion for head injuries was just 120 disability days, a significant achievement compared to the industry benchmark, which stood at a staggering 371 disability days.



4C CATASTROPHIC

The AmeriSys 4C program prioritizes the needs of the catastrophically injured employee utilizing best practices, pharmacy management and care modalities, including the purchase of any necessary equipment. These services are coordinated from a central point using industry leaders inside one network providing all levels of care to meet the needs of severely injured employees. By proactively facilitating the injured worker to the most appropriate and cost-efficient care of services claims costs are reduced.

A few benefits of this program include:

- Early intervention reduces unnecessary and costly treatments while quickly identifying co-morbidities, preexisting and other red flags that impact recovery.
- Promotes a faster return to work for the injured employees.
- Reduces the likelihood of claimants hiring legal representation.
- Maximize the injured employee's comfort level.
- Reduce overall claim cost both medically and indemnity.

Referral criteria for this program are as follows:

- Designated "Catastrophic"
- Spinal Cord Injury
- Traumatic Brain Injury
- Amputations
- Facial Burns
- Third Degree Burns covering 10% of the body, or Second-Degree Burns covering 30% of the body.
- Electrocution
- Any Claim with high severity rating

WHOLE PERSON DISABILITY ASSESSMENT (DISABILITY TOOL)

A disability assessment tool that can be used for funding a claim where there is anticipated permanent impairment.

Key Features

Narrative of Medical Treatment

Industrial and Non-Industrial Review

Disability Opinion

Medical Cost Projection

Analysis of future medical needs and expenses associated with catastrophic claims or long-term disability. This report can serve as a valuable tool for claims and legal professionals for settlement or reserves setting. Typically completed near the end of a claim.

We are committed to leveraging clinical expertise, communication skills, and effective actions to drive appropriate and effective treatment plans that result in a strong recovery and a successful return to work outcome.

TCM and FCM assignment protocols

TCM is most often utilized immediately following injury to:

• assess severity of injury,

• establish appropriate providers,

• coordinate initial treatment,

• identify opportunities for early return to work, and

• determine need for task or field-based case management

The TCM ideally initiates services within 48 hours of notice of injury. The injured worker may remain in TCM until one or more of the criteria is met for Task or Field case management or at the point of return-to-work full duty.

Referrals for case management services will be assigned to a field case manager within two hours of receipt. Contacts are made to the claimant, employer, and provider within 24 hours. Email updates are provided on the same day or within 24 hours of each provider's appointment or significant change in status. Treatment plans are monitored to ensure they fall within the parameters of evidenced based guidelines (ODG), including decision points for intervention and telephonic case management (TCM) Criteria.

Referrals for case management services will be assigned to a field case manager within two hours of receipt. Contacts are made to the employee, employer and provider within 24 hours. Email updates are provided on the same day or within 24 hours of each provider's appointment or significant change in status. Treatment plans are monitored to ensure they fall within the parameters of evidenced based guidelines (ODG), including decision points for intervention and telephonic case management (TCM) Criteria.

Telephonic Case Management (TCM) Criteria

- Lack of established treatment plan with specific goals
- Compromised patient safety
- Over-utilization of services or use of multiple providers

- Under-utilization of services
- Premature or delayed discharge from appropriate level of care
- Use of inappropriate services
- Ineffective treatment plan
- Permanent or temporary alterations in functioning

Task Assignment Criteria

Task based case management referrals are generated at the discretion of the adjuster and/or based on the recommendation of the TCM. Task assignments are specific activities performed by the case manager based on claim status. This includes medical and vocational rehabilitation tasks within the parameters of the IOD program. Task assignment may include up to three client contacts, after which time approval must be obtained from the adjuster to convert to field-based case management. Recommendations of task-based case management activities include but are not limited to:

• Lost time more than 4 weeks with no projected return to work date

• Disability durations exceeding expected disability duration per ODG

• Return to work coordination

• Vocational ergonomic evaluation

• Job site analysis

• Medical clarification for complicated medical issues

• Assist client in understanding and compliance with treatment plan

• Miscellaneous situation as identified by adjuster and/or TCM

Field Case Management Criteria

The adjuster and/or TCM should consider the assignment of a field case manager for the following situations or diagnosis:

Medical Factors

• Inpatient hospitalization

• Medicals over $10,000

• Lost time over 60 days

• Medical stability without return-to-work release

• Length of disability exceeds evidence-based criteria such as ODG

• Back pain over 30-45 days without documented treatment plan

• Aggravation of a pre-existing condition

• Failed and / or repeated surgeries

• Non-compliance with treatment plan

• Opioid use greater than 45 days

• Multiple ER visits/repeat hospitalizations

- Co-morbid complications (diabetes, heart disease, hypertension)
- Home Health/IV meds
- Continued complaints without objective findings
- Experimental Treatments

Diagnoses

- Herniated disc
- Low back pain without a specific diagnosis
- Rotator cuff tears
- Brachial plexus injuries
- Thoracic outlet injuries
- Fractures of the pelvis / hip
- Complex fractures
- Compression fractures
- Ligamentous knee injury (ACL, MCL)
- Stress disorders
- Complex Regional Pain Syndrome
- Fibromyalgia

Catastrophic Case Management Criteria

Upon notice and confirmation of the following injuries, the claim should be immediately assigned to a field case manager trained in catastrophic injuries.

- Multiple trauma / complex fractures (e.g., (amputations, brain injury, multiple dislocations, multiple severe lacerations, ruptured spleen/internal organs, internal hemorrhage)
- Burns ((3rd degree burn, chemical burn, skin graft required)
- Spinal cord injuries
- Head injuries (excluding superficial)
- Amputations
- Paralysis or partial loss
- Puncture wounds involving the chest/lung, abdomen, or face
- Myocardial infarction
- Chemical inhalation
- Septicemia
- Stroke with paralysis or significant impairment
- Miscellaneous as determined by adjuster

Frequency and duration of case manager intervention

In general, case management continues until return to work or MMI is reached, and duration is dependent on diagnosis, treatment plan and the type of case management referral (TASK, FCM, CATA). The average duration

for field case management services is 3-6 months. Our turnaround time for utilization review is excellent for the industry, including 24 hours for nurse review and 48 for MD review, with the network of physician reviewers encompassing all specialties.

All telephonic, task-based and field case management cases will be reviewed at 30,60 and 90 days by the adjuster for appropriate further action or case closure.

Please refer to Section 3.3, Subsection a, on page XX for our Medical Case Management personnel qualifications.

3. PREFERRED PROVIDER ORGANIZATION (PPO) Describe the PPO networks available to BEAUFORT COUNTY SCHOOL DISTRICT through your company TPA must be able to provide a match for each BEAUFORT COUNTY SCHOOL DISTRICT location with an adequate PPO medical provider within a 15 mile radius, along with an exception report for each location where no such match is found. Please also describe the following:

Preferred Provider Network Access

The recommendation of PPO networks for each account is based on a careful analysis of claims history to ensure the greatest PPO penetration possible. In addition to contracting with a high percentage of regional facilities and providers at competitive rates, best-in-class PPOs contract with the best providers, retain those providers, and provide mechanisms for steering patients to their network providers. This contributes to the best medical outcomes at the lowest cost.

The primary PPO Networks for Davies clients are PRIME Healthcare Network, Coventry and Three Rivers Provider Network.

Davies will also work with the District to develop a carve-out network of medical providers which includes specialties such as orthopedics, cardiology, pulmonology, neurosurgery, psychiatry, infectious diseases, occupational medicine, and physical therapy Our Quality Assurance Supervisor remains at your service to add to your carve-out network of practitioners that provide criteria-based medical care.

Attachment C

1) Data Reporting and Risk Management Information Systems

A. LOSS RUN FORMAT/CODING FLEXIBILITY TPA agrees to accurately capture and report detailed claim information to BEAUFORT COUNTY SCHOOL DISTRICT on a monthly basis for all open and closed claims. Claim information will be provided to BEAUFORT COUNTY SCHOOL DISTRICT via hard copy loss runs, and will be accessible through electronic download in .pdf or Excel format. The loss runs should break out losses by line of coverage according to the location structure provided by BEAUFORT COUNTY SCHOOL DISTRICT. Describe your ability to accommodate BEAUFORT COUNTY SCHOOL DISTRICT location coding (up to 5 or more levels), and your ability to capture additional data elements through optional/miscellaneous data fields. Indicate ability to allow customized injury codes for cause, result or body part.

Davies agrees to the above-mentioned responsibilities.

2. Risk Management Information System (RMIS)

Describe all related services including installation, training, support/help desk, hours of operation (accessibility), different levels of access, etc. Describe RMIS platform/accessibility and BEAUFORT COUNTY SCHOOL DISTRICT system requirements. Describe capabilities of your RMIS product, to include: Frequency of financial data updates ("real time"?)Ad hoc/custom report writing, including "point in time" analysis Access to adjuster notes ("real time")?Ability of user to perform edits of non-financial information Lost workday reports OSHA reporting E-mail alerts Ability to create loss triangles Ability to upload/consolidate historical data from other sources

Our claims system, ClaimsVision by PCIS, is a robust claims, risk, and policy management platform driven by user configurability, intelligent business rules, and automated compliance. Built upon 40 years of insurance application knowledge, ClaimsVision utilizes the latest Microsoft .NET technology, reporting services, and Business-to-Business (B2B) infrastructure. ClaimsVision enables paperless processing, efficient claims management, and actionable analytics. ClaimsVision boasts industry-leading compliance automation for federal and state reporting.

Its many user-friendly features include:

- Claims information organized into tables and stored in an encrypted SQL database
- "Alerts" that can be set on a claim to help the adjuster remain aware of certain situations
- "Warnings" which display if a claim reaches certain conditions
- "Reminders" that can be set to trigger on a particular date
- Advanced diary system to ensure each claim is examined periodically at a customizable interval
- Tool to assist in properly setting the reserves on a claim, including integration with ODG
- Tools for calculating any potential recoveries

- Litigation module which tracks legal expenses and all upcoming depositions, mediations, and hearings in the litigation calendar
- Imaged documents in paperless environment sorted by category
- Medicare Screens to document the status of the Query and identify Medicare recipients
- Limits which can be set to allow supervisors to monitor the progression of each claim's resolution
- Email capabilities within the claim file
- Client-customizable dashboards to view pertinent program metrics
- Instant messaging

Our claims system also includes:

Built-in Dashboard

Davies utilizes an analytics tool powered by Microsoft Power BI that is available to our clients. This tool allows clients to visualize data using a unified, scalable platform for business intelligence (BI) that is easy to use and helps you gain deeper insight into your data. It also allows for fast, AI-powered answers to your business questions — even when asking with conversational language. We have a team of programmers ready to assist with the creation of your custom BI environment.

Enhanced Business Rules

Attach business rules to virtually any button in the system and automatically generate emails, letters, reports, diaries, or notes on the completion of a task.

Seamless Third-Party Integrations

Our software integrates effortlessly with third parties. For example: EDI, ISO, Medicare, Medical Bill Review, Pharmacy Bill Review, OFAC, ODG and more.

Browser Independent

Our system is HTML 5 and CSS3 compliant, which also provides more freedom to use your favorite web browser, while also eliminating the need for Active X controls. This ensures a more personalized user experience as well as the ability to utilize mobile devices.

3. Data Transfers

TPA agrees to provide a monthly data feed to Beaufort County School District's excess insurer(s). The tape must contain both the current claim activity and historical information with respect to Beaufort County School District's claims.

Davies agrees to the above-mentioned responsibilities.

Attachment D

Please answer the following to the best of your ability.

What differentiates your firm from industry competitors? Identify your differentiated services?

Davies stands apart from other TPAs through our fully integrated, in-house service model, our flexible and proactive claims philosophy, and our unmatched investment in innovation and technology. Unlike many competitors who outsource key functions, Davies delivers all core services—including Nurse Case Management, Medical Bill Review, Subrogation, and Litigation Management—through highly qualified, licensed in-house professionals, ensuring consistency, accountability, and superior outcomes.

We bring extensive experience working with school boards and public sector clients, including long-standing partnerships with multiple school districts across the Southeast. We understand the unique challenges educational institutions face—such as managing claims involving school staff, navigating seasonal employment, and maintaining continuity of care—and we tailor our programs to meet those specific needs. Our team is well-versed in the regulatory and operational nuances of school systems, ensuring a smooth and compliant claims process.

Our designated adjuster model fosters deep program knowledge and accountability, while our customizable claims strategies are tailored to mirror each client's unique goals and risk tolerance. We don't believe in one-size-fits-all solutions—our programs evolve with your needs.

Davies also leads the industry in technology-driven claims administration, with a dedicated global team of over 700 consulting and technology experts, including 200+ developers. Our proprietary tools, AI-enhanced workflows, and real-time Power BI dashboards empower clients with actionable insights, faster decisions, and measurable cost savings.

With a 96% client retention rate, Davies is not just a service provider—we are a strategic partner committed to delivering results, reducing costs, and enhancing the experience for both clients and claimants.

Quality Assurance

Davies upholds stringent performance criteria to ensure the efficient handling of workers' compensation claims by our staff. Our evaluation and supervision processes are meticulously designed to maintain high standards of quality, accuracy, and professionalism in every aspect of claim management.

Performance Criteria

- **Quality of Claim Handling:** Our staff is evaluated based on their ability to effectively investigate, assess, and manage liability and workers' compensation claims, ensuring accuracy, thoroughness, and adherence to industry best practices and regulatory requirements.
- **Timeliness and Efficiency:** We emphasize prompt and efficient claim resolution, evaluating staff performance based on their ability to manage claims within established timelines while minimizing delays and maximizing productivity.
- **Customer Service Excellence:** Staff members are assessed on their communication skills, responsiveness, and ability to provide exceptional customer service throughout the claims process, prioritizing client satisfaction and retention.
- **Legal Compliance:** Compliance with legal and regulatory guidelines is paramount in claims handling. Our evaluation criteria include adherence to legal protocols, ethical standards, and compliance requirements to mitigate risks and ensure legal soundness in claim management.

- **Problem-Solving and Decision-Making:** We value staff members' ability to analyze complex situations, exercise sound judgment, and implement effective problem-solving strategies to resolve workers' compensation claims efficiently and satisfactorily.

Performance measures are a key metric used to evaluate timely claims handling. Adjusters and supervisors should maintain a 90% compliance ratio in categories such as initial contacts, diary review, subrogation potential, medical plan of action, average weekly wage determination and excess reporting. These metrics provide feedback on how well Davies is performing and exceeding best practice claim-handling guidelines. Monthly supervisory reports are monitored to ensure timely claims handling and that appropriate investigations for compensability are conducted. Davies utilizes benchmark goals for our claims staff, such as maintaining a high closure ratio; reserving accuracy; timeliness of appointment scheduling; accuracy and timeliness of indemnity payments; timeliness of excess reporting and reimbursement follow-up; adherence to and quality of diary; timely filing of forms, and more. Each adjuster is expected to maintain a 97% closure ratio. Closure ratio reports are reviewed monthly. Each time claims are reviewed on diary, the adjuster and supervisor will review to assess for the appropriateness and timeliness of closures. A monthly supervisory report is monitored for any open claims with no activity in the last 60 days to review for possible claim closures. Salary incentives are tied to performance measures which include closure ratios.

Supervision and Evaluation

- Ongoing Training and Development: Our supervisory team provides continuous support, guidance, and training to enhance staff knowledge, skills, and performance in liability and workers' compensation claim. Regular training sessions, workshops, and mentoring opportunities are provided to ensure ongoing professional development.
- Regular Performance Reviews: Staff performance is regularly reviewed through formal performance appraisal processes, where supervisors assess individual performance against predefined performance criteria and provide constructive feedback for improvement.
- Quality Assurance Audits: We conduct consistent quality assurance audits to evaluate the quality and accuracy of claim handling processes, identify areas for improvement, and ensure compliance with performance standards and regulatory requirements.
- Supervisor Accessibility: Supervisors remain accessible to staff for guidance, clarification, and support, fostering an environment of open communication, collaboration, and accountability

Claims professionals are evaluated through various means, including: claim audits, performance metrics, claims outcomes, customer service, client recognition, continuing education and supervisory observations. Quarterly evaluations are used to measure each employee's performance development and goals. Workflow reports and management reports are used to review individual work processes such as reserving accuracy, diary, case closure ratios, timeliness of contacts, bill payments, etc. We meet with our staff quarterly to discuss strengths and area for improvement. We also have management reports to monitor performance on a monthly or quarterly basis. Outcome-based evaluations are also involved in evaluating our adjusters and case managers. Average lost time days, percentage of successful return to work and "below the split" assessments of PPD are some of the outcome-based criteria we review. By implementing rigorous performance criteria and providing effective supervision and evaluation mechanisms, we strive to maintain excellence in claim handling, ensuring optimal outcomes for our clients.

Fraud Prevention Policy

At Davies, we proactively and aggressively deter, detect, and investigate both internal and external fraud. Our adjusters and supervisors are well-trained in fraud detection and are vigilant in identifying "red flags" that may indicate questionable, suspicious, or fraudulent activities. Recognizing the significant impact of insurance fraud on business costs, our internal anti-fraud systems, controls, and processes are applied across all areas of our

business, including claims handling, bill review, and surveillance. Each claim handler is expected to take a leading role in identifying and combating insurance fraud.

Effective fraud management is fundamental to good claim handling. Specifically, each claim handler is responsible for:

- Identifying and recording all cases of suspected fraud using standard profiling techniques as part of the ongoing claim investigation. This is a critical first and final step in the fraud-management process. Accurate records must be maintained on how potential fraud is managed within their assigned caseload.
- Developing and documenting in file notes a plan of action for further investigation to determine the facts of the incident and either prove or disprove fraudulent intent.
- Working equally hard to prove that no fraud exists as they do to prove that fraud exists.
- Partnering with the SIU, when appropriate, to investigate potentially fraudulent claims. While not all potentially fraudulent claims will be investigated by our SIU, the claim handler will investigate most claims. In all cases, the claim handler retains control of the investigations and utilizes the SIU as an effective investigative tool.
- Resisting claims with reasonable, conclusive evidence of fraud, consistent with state laws and sound claim-handling practices. If a complete denial is not possible, effective negotiation of key points of suspicion or proof should lead to compromised settlements that account for the possibility of fraud.
- Paying legitimate claims promptly and fairly.
- Documenting the results of each investigation in the file notes, whether the investigation is inconclusive or demonstrates that fraud was not committed.
- Notifying appropriate state agencies of suspected or proven fraud, as required by state laws.
- Attending internal and external continuing anti-fraud education courses to hone skills in identifying and investigating insurance fraud.

Special Investigations Unit (SIU)

Davies' Special Investigations Unit (SIU) supports our anti-fraud efforts by implementing and managing all national regulatory compliance requirements, including State Anti-Fraud plans, mandated training, public awareness programs, and all fraud bureau reporting. Services also include background checks, investigative canvasses, and oversight of surveillance and field investigations.

To ensure the effectiveness of our fraud-prevention program, Davies has implemented procedures for the expeditious review and referral of potentially fraudulent matters to our internal SIU personnel. When a claim is identified as suspicious, the adjuster consults with Davies SIU to determine if further investigation is required. If an injured worker is suspected of malingering or it is expected that continued disability is not warranted, surveillance will be considered. Approval will be obtained from the City before making any referrals for surveillance.

We will provide the investigator with a description and digital photo of the injured employee, information related to the employee, the reason for the request, the number of hours to work on the case, and any other pertinent information to increase the potential for significant findings. All surveillance assignments and social media checks will be clearly documented in the claim file. We will track and notify the City of the results of all surveillance/social media checks.

Davies SIU will review the claim file and issue an assessment report. The investigator will then file any necessary forms for the suspected fraud, pursuant to state laws in the applicable jurisdiction. Davies SIU evaluation report will address red flags, evidence supporting reasonable suspicion of fraudulent activity, potential exculpatory evidence, and make recommendations for further investigation.

Once a suspicion of insurance fraud has been substantiated, Davies SIU will package and refer the case to the appropriate law enforcement agency and/or prosecuting authority for review. The investigator will maintain

contact with the investigative and prosecutorial agencies and update the adjuster on the status of ongoing investigations and pending prosecutions.

DaviesConnect

Davies has partnered with Gain Life to offer DaviesConnect — an easy-to-use engagement platform to help improve communication between injured workers and claim professionals and reduce negative outcomes. Built by behavioral scientists, technologists and claim experts, DaviesConnect offers specialized features to mitigate issues that drive up claim costs and recovery time. It empowers injured workers to understand and easily navigate the insurance claims process by increasing transparency and streamlining access to resources.

Injured employees can access the portal via their phone, tablet or computer to securely view details of their claim any time, including the claim number, adjuster's name, current claim status and any outstanding tasks they need to complete. With 24/7 access to a library of helpful resources and frequently asked questions, your injured employees can get immediate answers about incident reporting, the claims process, what to do with their medical bills, and more. Users also can easily upload documents and images directly to their claim file, such as detailed injury information; copies of medical records; or any photos, videos or other evidence related to the incident.

In addition to providing faster turnaround of completed paperwork with an automated document delivery and e-signature platform, DaviesConnect allows injured employees to securely communicate with the claims team via text, email or in-app messaging, with auto-translation built in so they can have a real-time discussion with the adjuster even if their native language isn't English. The portal also helps users track and manage medical appointments and guides them through the claim process so they can focus on their recovery and returning to work as soon as possible.

Loss Control

We offer safety and loss control/prevention services in-house across all 50 states delivered by engineers, specialists, risk control and other safety professionals. This is delivered by in-house provider, Davies Risk Services. These consultants are well versed in OSHA regulations and can provide workplace-specific guidance to meet compliance standard needs.

In partnership with Davies Risk Services, we can offer the City the highest-quality premium audits in the industry. Each audit is tailored to meet the specific needs of your organization, all while exceeding industry standards of quality, reporting and time service. Davies Risk Services has the most advanced loss control reports in the business, including customized reports with automation options found nowhere else. They also conduct on-site surveys that provide specific underwriting information, hazard identification, and hazard control measure recommendations. Reports can be tailored to the unique needs of the City, which can also access a robust library of online tools, presentations and technical bulletins geared toward loss control and Services include:

- Online resources and branded safety materials
- Development of written safety programs
- Targeted training, including workplace safety, fire prevention and vehicle operation
- Construction and general industry certified training
- State-specific Workplace Safety Committee Certification
- Accident analysis to create focused action plans
- Risk assessment
- Surveys that measure progress of health and safety programs
- OSHA compliance assistance
- Ergonomic workstation evaluation and adjustment

- Industrial hygiene services and evaluations
- Requested and specific consultative services

*Services can be delivered every 12 months or upon client request. Safety and Loss Control services can be tailored to individual client needs

How many clients do you have?

We currently provide services to approximately **540 clients**, encompassing a diverse range of industries and needs. These clients rely on our expertise to support their operations, optimize efficiency, and achieve their goals.

Describe your firm's Business Continuity Plans?

Business Continuity Plan (BCP)

We have a documented Business Continuity Plan (BCP) and processes in place. As such, we are able to ensure that in the event of a disaster that affects our primary claims offices, we will resume services to Subaru. Our BCP includes provisions for protection against natural disasters, malicious attacks, accidents, and malware (e.g., ransomware).

The Business Continuity Plan outlines procedures that will be enacted if a catastrophic event or major failure affecting the premises and/or essential infrastructure services occurs. The goal is to ensure that an adequate level of business performance is maintained while we work to fully restore the business area affected. There are plans and protocols in place for conducting business at a temporary location in the event of a disaster. Each local office has access to the RMIS, allowing staff at any office to temporarily assume management of claims from another location. Additionally, our claims team can work from anywhere using Lenovo Thinkpad laptops and integrated softphones, which also allow for secure remote access to systems necessary to perform claims services.

Please see Appendix B for our Business Continuity Policy.

Please describe your firm's Disaster Recovery Plans?

Disaster Recovery Plan (DR)

We have a documented Disaster Recovery (DR) plan and processes in place. As such, we are able to ensure that in the event of a disaster that affects our primary claims offices, we will resume services to Subaru. Our DR includes provisions for protection against natural disasters, malicious attacks, accidents, and malware (e.g., ransomware).

Per our Disaster Recovery Plans, our claims system maintains an audit trail of all financial transactions and key non-financial transactions. All data is backed up during the day and verified nightly. Because data is backed up periodically during the day to storage sites in multiple locations, if a catastrophe occurs at one of those locations, duplicate data can be retrieved from the other. The system administrator uses a two-week rotation, saves the monthly tapes for six months, and creates a permanent save annually. Our backup tapes are safely stored off-site. We have tech support in place that is available to provide replacement hardware for servers, computers, and phone systems. Temporary servers can also be provided if existing ones are inoperable.

Attempted intrusions, including denial of service attacks, would be escalated, investigated, and resolved according to the company's Security Incident Management procedures as well as local and global incident management and escalation procedures. In the event of a security incident, the Information Security Officer would be notified. Depending on the severity of the event and if client data has been affected, the IT Security Committee and head of affected business areas would be informed. The information security team would work

to contain the incident to prevent further damage and begin necessary investigative steps to perform root cause analysis. Corrective actions would be conveyed to the necessary team members to perform mitigation steps to eliminate the cause of the incident. All incidents are recorded and reviewed on a quarterly basis by the information security team to learn from past incidents and create effective countermeasures to better protect company information and assets.

Please see Appendix C for our Disaster Recovery Plans.

Please describe your TPA firm's Cyber Security Program?

Davies has a dedicated Cyber Security team who are responsible for deploying and managing our security tooling and responding to and reporting on incidents. Processes in place protect the privacy of claimant health information store in our systems.

The tools in use include but are not limited to the following:

- Firewalls at all internet borders
- IPS (intrusion prevention system) at all internet borders
- WAF (web application firewall) protecting all web applications
- Identity and access management platform which provides identity verification and MFA (multi-factor authentication)
- Anti-virus protection with both signature based and behavioral based detection
  SIEM (security information and event management) which collects logs from all of the above systems
- Alerts based on predefined data such as IOCs (indicators of compromise) from our threat intelligence feed and suspicious activity.

Passwords control the security clearance to access certain functions within our RMIS. Username and password are required by both the claim adjuster, nurse case manager and authorized client user.

Practices enforced include but are not limited to the following:

- Civil, and criminal background checks on all new employees.
- VP-level and HR coordination to RMIS access/revoking (an SSAE16 measurement.)
- Strong password requirements.
- Limits to the number of attempts (5) to enter a password before enforcing a lockout of a user.
- Masked passwords on the screen during entry.
- Automatic password expiration.
- Recent password prevention.
- Passwords encrypted in resting state and during transmission.
- Secure wireless VPN security access for remote users.
- Malicious code anti-virus security software
- Logged security events (i.e., system logon/logoff, password failures, password resets, and administrator and operator activity) through our IT vendor.
- Encrypted laptops.
- Remote wipe cell phones upon termination/leave .
- Uninterruptible power supplies which are constantly monitored by our IT vendor.
- Server room generator.
- Server room limited access.
- Server room with a special server room fire monitoring system.

We maintain documented Back Up and Privacy Policies, etc., which are available upon request.

Explain your internal audit procedures to eliminate fraudulent activities that could be committed by your TPA firm's own staff?

Davies takes the integrity of our operations and the trust of our clients extremely seriously. To safeguard against fraudulent activities—including those that could potentially be committed by internal staff—we have implemented a robust internal audit and compliance framework, supported by independent third-party audits and industry best practices.

Annual SSAE 18 / SOC Audits

Davies undergoes an annual SSAE 18 audit conducted by an independent third-party auditing firm. These audits evaluate the design and operational effectiveness of our internal controls related to:

- Financial reporting
- Data security
- Confidentiality
- Processing integrity
- Access controls and change management

The results of these audits are shared with clients upon request and demonstrate our ongoing commitment to transparency, accountability, and risk mitigation.

Segregation of Duties

We maintain strict segregation of duties across all financial and claims-handling functions. No single employee has end-to-end control over claim payments, approvals, and system access. This layered approach reduces the risk of unauthorized activity and ensures multiple levels of oversight.

Internal Audit and Compliance Monitoring

Our internal audit team conducts regular audits and random file reviews to detect anomalies, ensure adherence to client protocols, and verify compliance with regulatory and contractual requirements. Any irregularities are escalated immediately for investigation and resolution.

System Controls and Access Management

Access to our claims system is role-based and tightly controlled. All user activity is logged and monitored, and sensitive data is masked or restricted based on user permissions. We utilize multi-factor authentication (MFA) and intrusion detection systems (IDS) to protect against unauthorized access.

Fraud Detection Tools

We employ automated fraud detection tools that flag suspicious activity, such as duplicate payments, unusual billing patterns, or inconsistent claim data. These tools are integrated into our claims platform and reviewed by both adjusters and supervisors.

Through this multi-tiered approach—combining technology, oversight, and independent validation, Davies ensures that all client programs are managed with the highest standards of integrity and security.

Implementation is key to the start of a new TPA program. Explain your implementation process.

Implementation/Transition

Davies' experienced team of Information Systems professionals is extremely adept at navigating the nuances of file transitions and will ensure a smooth transition of Beaufort County School District's claims. To ensure a seamless transition of services, members of Davies Information Services Department and representatives from our administrative and adjusting teams will meet with the district prior to the July 1, 2025 start date to discuss program implementation.

In our initial meetings, Davies will review our best practices with the district and determine a list of client-specific instructions to be incorporated into the management plan for your account. The agreed-upon client instructions will be saved on a shared server so that all adjusters, regardless of which office they work, can access and review them. Your account manager and account supervisor will ensure that your preferred claims-handling practices are followed.

Included below is a sample of our transition plan to ensure that all aspects of your account are addressed and properly migrated to our system. Members of Davies' management team will be involved in all aspects of the transition. This plan can be tailored and revised as needed based on future conversations with the district. We expect that it will take about 45 days (although it can be completed in less time) to coordinate the transfer of the district's program and complete the takeover of claims by July 1, 2025. This sample project timeline outlines the proposed transition beginning June 2, 2025. If the open claims are to be transferred and the current TPA provides preliminary data, the conversion would be completed as early as the third week of July. New claims can be set up on day one.

Responsible Parties:

Beaufort County School District	Davies Account Manager
Davies President – WC TPA	Davies Dir. of Operations - TPA WC Services
Davies Sr. Vice President – WC TPA	Davies Claims Teams
Davies Head of IT Claims Solutions	Davies QA Supervisor
Davies Conversion Programmer	Davies Supervisor, Pay Dept.

Responsible	Target Date	Action
Head of IT Claims Sol. Davies Conversion Programmer	6/2/25	Obtain Information from Current TPA to begin Conversion • Data by email • File Layout • Sample Data • Alpha Listing of all open and closed claims • Most recent loss runs Dedicated conversion programmer will be assigned
Davies Conversion Programmer Beaufort County School District	6/4/25	District to review with Davies Information Services changes in codes on prior claims to correct in conversion.
Dir. of Ops Account Manager Beaufort County School District	6/4/25	Obtain the following information from the District: • List of department and location codes, with descriptions • Email instructions for reports • Federal Tax ID Number • Medicare RRE ID • Obtain current excess insurer info from the District

		Notify CMS that Davies is the new servicing agent
President Sr. VP Dir. of Ops Beaufort County School District	6/9/25	Prepare contract for execution.
President Sr. VP Dir. of Ops Account Manager Beaufort County School District	6/16/25	Meet with District's team to develop detailed claims-handling instructions: • Determine type, frequency and delivery method of reports. • Develop approved vendor network. Obtain department contacts, including address and telephone numbers.
Supervisor, Pay Dept. Beaufort County School District	6/9/25	Establish checking account(s), including: • Finance contact name and number • Bank to be utilized • Account name desired for check stock • Beginning check number Funding amount for bank reconciliation and reimbursements • Check writing restrictions and instructions • Prepare direct deposit arrangements Positive pay setup (if selected)
Account Manager Beaufort County School District	6/23/25	Set up online access for the District including any necessary training for claim system and iFROI.
Dir. of Ops	6/23/25	Contact carriers
Current TPA	6/3/25	For all open tail claims current TPA will: • Provide litigation calendar • Provide alpha list of all open claims • Provide alpha list of claims open for recovery purposes • Ship any physical files to Davies for receipt on 2/28/25
Dir. of Ops Account Manager	7/1-7/31/25	• Review open files. Send informational letter to claimants and attorneys.
Head of IT Claims Sol.	7/7/25	Obtain final loss runs valued as of 6/30/25.
Account Manager	7/1/25	Conference with defense counsel regarding any outstanding legal issues.
Head of IT Claims Sol.	7/7/25	Complete data conversion. Convert all document images into Davies' imaging system.

Davies Conversion Programmer		
Head of IT Claims Sol.	8/2/25	Run first set of client loss runs as of 7/1/25 and deliver to District via email.
Account Manager Claims Teams Beaufort County School District	9/30/25	Initial file review with adjusting team and the District.

Do you have predictive modeling capabilities? If yes, what do you predict?

Yes, we offer predictive modeling capabilities through our integration with ODG analytics by MCG. Our system uses predictive analytics to:

- Forecast time away from work for claims benchmarking.
- Assess claim risk using the ODG Risk Assessment Score (RAS).
- Predict disability duration and total medical/indemnity costs.
- Identify high-risk claims early for targeted intervention.

The predictive model leverages a wide range of inputs, including:

- ICD diagnosis codes
- National Drug Codes (NDC)
- CPT procedure codes
- Durable Medical Equipment (DME) codes
- HCPCS codes
- First Notice of Loss (FNOL) nature and body part codes
- Claim demographics

If yes, provide the results your predictive modeling is generating. Demonstrate that your use of predictive analytics is attributing to better outcomes.

Key Results from Our Predictive Modeling:

- Early Identification of High-Risk Claims: Our models flag claims likely to become complex or costly within the first 7–14 days of reporting. This allows for early intervention, such as Nurse Case Management, vocational rehab, or legal review.
- Improved Reserve Accuracy: Claims flagged by our models have shown a 25% improvement in reserve accuracy within the first 30 days, reducing the risk of under- or over-reserving and improving financial forecasting.
- Reduced Claim Duration: Claims identified early and managed proactively show an average 15–20% reduction in claim duration, particularly for lost-time cases.

- Lower Litigation Rates: By identifying psychosocial risk factors and communication gaps early, we've seen a 12% reduction in litigation rates among flagged claims.
- Enhanced Return-to-Work Outcomes: Predictive insights help us tailor return-to-work strategies, resulting in a 10% increase in successful modified duty placements.

Explain your ability to benchmark clients against their peers by state and by industry?

As part of our commitment to providing comprehensive services, we can utilize industry-standard data and tools such as NCCI to assess your workers' compensation program's performance. We are also able to run benchmark reports for clients like in our system, while maintaining the integrity of the data.

We can provide comprehensive benchmarking services for pharmacy benefit management, PPO network utilization, and our bill review processes. Our approach involves regular comparisons of bill review performance among clients, enabling us to identify variances promptly. Depending on the significance of the variance, concerns are addressed with the client immediately or discussed during quarterly performance reviews. Additionally, we can conduct in-depth analyses of both network and PBM performance, comparing offerings "apples to apples" to ensure optimal savings tailored to each client's needs. Our network solutions are customizable, allowing us to address the specific challenges and opportunities unique to each client.

Accidents don't always happen from 9 a.m. to 5 p.m. Monday through Friday. How does your firm prepare for 24-hour intake of claims and serious catastrophic claims?

Our internal Call Center is operational 24/7, 365 days a year. The call center is equipped to quickly escalate catastrophic claims to an on-call nurse and the assigned account manager. In partnership with the District, we will develop a procedure for escalating after-hours calls. Additionally, our web-based portal complements our telephone reporting system; it's accessible 24/7 and is specifically designed for the efficient submission of an Employer's Initial Report of Injury or Illness.

Describe your process and/or ability to customize intake scripts for clients to collect data?

Davies offers a fully customizable intake process designed to align with the specific needs and preferences of each client. For Beaufort County School District, we will work closely with your HR and risk management teams to develop a tailored intake script that captures all necessary data points at the time of claim reporting. This includes understanding your internal workflows, terminology, and any regulatory or reporting requirements unique to your operations. We also regularly review and update the script based on feedback or changes in requirements, ensuring it remains accurate and effective. This approach ensures that the School District receives complete, consistent, and actionable information from the very first report of injury, supporting efficient claims handling and compliance from day one.

Turnover is always a major concern for clients. What is your annual retention rate for claim representatives NOT INCLUDING internal movement: promotions or reassignments?

Davies feels that our employees are extremely important in the running of our business; without them we would not be successful. To minimize turnover, we provide a stimulating workplace environment that fosters personal and professional growth and encouragement on all levels, which produces happy, motivated and empowered individuals. We also offer competitive salaries, advancement opportunities and a comprehensive employee benefits package that is among the best in the industry. These factors are among the many reasons that our annual turnover rate for workers' compensation adjusters is only 8%.

How do you ensure timely return of phone calls as well as meaningful claim representative discussions?

Davies is committed to delivering responsive, high-quality communication as a cornerstone of our claims management philosophy. We ensure the timely return of phone calls and meaningful discussions with claim representatives through a combination of structured protocols, technology, and accountability. All adjusters are required to return phone calls within one business day, and this expectation is reinforced through internal performance metrics and supervisor oversight. Our claims system includes task tracking and diary features that prompt follow-up actions and ensure no communication is overlooked. Additionally, we prioritize meaningful engagement by training our adjusters to provide clear, empathetic, and informative updates during every interaction—whether with injured workers, school district staff, or medical providers. Supervisors regularly review client feedback to ensure communication standards are being met and to identify opportunities for improvement. This proactive approach helps build trust, reduce misunderstandings, and support better outcomes throughout the life of each claim.

How often are training sessions provided to your claim representatives?

Upon hire, each adjuster will receive our Claims Procedure Manual for review and training. Each new employee completes formal and thorough orientation training on our procedures and expectations, including our culture, policies, utilization of the computer system and various software programs. All adjusters are also given account-specific training before working with a new client, which includes special account handling instructions, state-specific policies and procedures as well as our quality assurance program and auditing requirements. The adjusters will be trained in the return-to-work policies and procedures, emphasizing communication with the City and with the medical providers to assist the injured employees in returning to work as quickly as possible. The adjusters will demonstrate proficiency in such areas as the management of a lost time claim, medical only claim, large/ catastrophic claim and litigated claim.

Our senior leadership team provides ongoing training to continually broaden the technical skills of our adjusting staff. This includes many classes targeted to specific responsibilities, including fraud and red flag indicators, statement taking, reserving, investigations, subrogation, claim resolution strategies, settlements, reporting, return to work strategies, occupational disease, presumption claims, calculation of benefits, EDI, excess reporting, litigation, state/federal regulatory updates. customer service and ethics. Training can also be customized based on client needs (e.g., disaster response, stress claims administration, catastrophic injuries). RMIS training is ongoing for staff and clients. We can also provide training sessions for our clients upon request, which can be tailored with your needs and interests in mind.

We also sponsor monthly continuing education classes and have our business partners, including medical SMEs and defense attorneys, present specific target topics to our staff. Training bulletins are sent to adjusters via e-mail on subjects pertinent to current events, changes, and/or updates in the industry. A monthly roundtable is held to discuss claims that present unique challenges and strategies to implement if similar situations occur. Additionally, we provide our employees with 24/7 access to our online web portal, Thrive at Davies, where they can learn new skills in a variety of industry-related subjects, from leadership, to handling customer concerns, how to build a professional network, setting and achieving goals, data management training, information security, and how to use the Microsoft Office suite of software.

Davies assumes the cost of professional designations, attendance of seminars, and work-related courses for our adjusters to obtain necessary CEUs to maintain their state license requirements annually. Davies senior management also encourages membership in local professional associations and claims groups to remain abreast of industry updates and changes, such as legislation and litigation trends. Local offices subscribe to industry newsletters, including the AIA Claims Administration Digest and the ALFA State by State Workers' Compensation Analysis. Each claim manager is responsible for disseminating information concerning changes in the jurisdiction covered by their office.

How often are your supervisors engaged in reviewing claim representative's files?

At Davies, supervisors play an active and ongoing role in ensuring the quality and consistency of claims handling. Our supervisors do not carry individual caseloads, which allows them to focus entirely on oversight, coaching, and quality assurance. They regularly review claim files through both formal and informal processes. This includes monthly audits of a representative sample of each adjuster's files to ensure compliance with best practices, client-specific protocols, and regulatory requirements. In addition, supervisors conduct weekly check-ins to monitor complex or high-exposure claims and provide real-time guidance as needed. Our claims system enables supervisors to view adjuster activity and documentation in real time, allowing for immediate intervention when necessary. Supervisors also participate in quarterly performance reviews that include assessments of file quality, communication effectiveness, and overall claim outcomes. This structured and hands-on approach ensures that all claims are managed with diligence and accountability, while also supporting the professional development of our claims staff and delivering consistent, high-quality service to our clients.

Does your TPA firm offer any rewards to your staff for exceptional service or outcomes that are generated for your clients?

Davies offers competitive salaries and benefits. We reassess salary during formal annual reviews and provide opportunities to receive bonuses during regular merit-based assessments. Additionally, the unique DIP program offers a unique opportunity for employees to earn shares of the business which can be turned into cash, further allowing employees to grow with the business. We acknowledge achievements and successes publicly so that all employees feel appreciated and provide coaching opportunities so that all adjusters can feel confident and equipped in all facets of their job. Davies offers low caseloads and low supervisor to adjuster ratios, which promotes high staff morale and limits turnover. Flexible scheduling, work from work and telecommuting options also help to improve employee satisfaction. We also provide opportunities for in-person engagement whenever possible. Employees can participate in opportunities such as the Davies innovation lab, Diversity and Inclusion Action Groups, and The Davies Foundation.

How is compliance handled to ensure claim representatives adhere to Special Claim Handling Instructions?

Davies will ensure strict adherence to Beaufort County School District's Special Claim Handling Instructions through a combination of structured training, system automation, and supervisory oversight. Upon implementation, the account manager will collaborate with the District to establish and document all special handling protocols. These instructions are distributed to all assigned claims staff and reinforced through initial and ongoing training.

Our claims system includes automated workflows and diary triggers that guide adjusters through client-specific procedures and flag any deviations. Supervisors regularly review claim files, monitor adjuster performance, and ensure compliance through supervisory diaries and performance metrics. Compliance reports—such as diary audits and EDI tracking—can be generated on a regular basis to provide transparency and accountability. This multi-layered approach ensures consistent, timely, and accurate service aligned with the District's expectations.

Has your TPA firm been fined by any regulatory body in the last 3 years? Explain. Please provide a number and amount of fines.

Davies Claims North America, Inc. has had one administrative matter within the past three years. In February 2024, a regulatory agency issued a $3,000 administrative fine, which was promptly resolved. We remain in good standing with all regulatory bodies and are committed to full compliance with all applicable licensing and operational requirements.

Has your TPA firm been a part of any bad faith actions over the last 5 years? Explain.

Davies has not been a part of any bad faith actions over the last 5 years.

Provide your TPA firm's process for reviewing the accuracy and timeliness of financial reserves.

Our reserving philosophy is to set realistic reserves, based on the current information available, and to reserve at ultimate probable exposure. Initial reserves are established within 10 business days of receipt of the claim, and in accordance with the anticipated value of the claim based on the investigation to date. Claims are reviewed upon receipt by the supervisor, conducting additional reviews within the first 30 days of the claim being received. These initial reviews include reviewing the reserves. Claim supervisors review reserves at each diary to ensure adequacy. In addition, the claim supervisor will review and approve reserve adjustments that exceed the adjuster's authority level. Our claim system contains pre-set reserve authority levels and triggers to ensure reserve approvals follow the proper hierarchy.

The claim adjuster addresses reserve adequacy at each diary or whenever significant changes occur. Davies reserve review process takes place when events such as the following occur:

- Litigation is instituted
- Return to work
- Medical information warrants a change
- MMI is attained
- Settlement is contemplated
- File remains open beyond a designated time period
- Perfection of a recovery

All reserve evaluations are then documented in the electronic claim file. Reserve adjustments will be based on information known and/or available and will be adjusted promptly or at a minimum within 30 days of the date the claim handler knew of a change in the realistic, probable exposure of the claim. With each increase or decrease in reserves, claim adjusters document a detailed reserve rationale in the electronic file notes. This documentation must also include the various aspects of exposure such as liability, injury/damages, permanency, legal/other expenses, etc., as appropriate based on lines of coverage. Reserves are continuously monitored as the claim develops.

We leverage the robust predictive analytics capabilities of ODG by MCG to support accurate reserve setting early in the claims process. This tool utilizes evidence-based guidelines, benchmarking data, and industry best practices to assess potential claim outcomes. By analyzing factors such as injury type, severity, and expected recovery timelines, ODG provides data-driven insights that enable us to establish reserves reflective of the claim's likely trajectory.

This process enhances reserve accuracy, reduces the risk of over- or under-reserving, and supports financial forecasting for our clients. By integrating these analytics into our workflows, we ensure a proactive approach to reserve management, fostering greater transparency and alignment with the anticipated costs of a claim.

A reserve evaluation worksheet is completed whenever the reserve is changed. The reserve worksheet is available for review 24/7 through the claims system. A complete reserve history is maintained and available for review by:

- Beaufort County School District
- Outside auditors or actuaries

- Claims manager/supervisor
- Excess carrier

What differentiates your TPA firm from industry competitors and what services do you provide which are unique with regards to Managed Care Services?

Davies is a leading cost containment organization that offers knowledge of the managed care industry and a sincere dedication to improving outcomes for all involved. Not only do we provide early intervention, medical treatment plans and return-to-work programs, but we also offer complete bill review and PPO network savings. These strategies all work together for the good of injured employees, while also having a positive effect on your risk management program.

Our medical Cost Containment is based on a simple formula. We combine state-of-the-art software, professional expertise and a national PPO network built for the casualty market. Each cost containment innovation offers employers improved return-to-work outcomes and industry leading savings that are unsurpassed in the marketplace.

Cost Containment

- National & Regional PPO
- Negotiation Unit
- Compounded/Narcotics
- Med Review/Management Utilization Review/Peer Review
- Clinical Prescription

Davies flexible Technology plays a critical role in minimizing costs, ensuring patient' access to the information they need. Our technology team works with a variety of vendors who assist our effort in providing clients with the most seamless work experience possible.

Technology

- Claims Software Integration
- Paperless Case Management System
- Sophisticated Business Rules Engine
- Duplicate Bill Checks and State Reporting

We assist our clients in helping to resolve issues sooner in order to help increase cost savings.

What recourse would our client have if the services provided by your TPA firm were not satisfactory in relation to your billing regarding any of the following charges: field based case management, telephonic case management, prescription services and benefit manager, medical bill re-pricing, network access fees, medical bill savings charges, and durable medical equipment?

At Davies, we are committed to delivering transparent, high-quality services and maintaining full accountabilities for all charges related to workers' compensation claims, including field-based and telephonic case management, prescription benefit management, medical bill re-pricing, network access fees, medical bill savings charges, and durable medical equipment (DME). If the Beaufort County School District finds any aspect of our services or associated charges to be unsatisfactory, we offer a clear and responsive recourse process. Clients may raise concerns at any time by contacting their designated account manager, who will initiate a

thorough internal review of the charges in question. This includes examining service documentation, billing records, and vendor data where applicable.

If any service is found to have been provided without justification, the associated charges will be waived or credited. We do not bill for services that are not medically necessary or appropriately managed by our claims team. The School District will have access to detailed billing reports and supporting documentation for all services rendered, and we fully support periodic audits of our billing practices. Our systems provide real-time visibility into service utilization and associated costs, ensuring full transparency.

All medical bill review and repricing is performed in-house by Davies. Our team is trained in South Carolina-specific workers' compensation billing rules and fee schedules, ensuring accuracy and compliance. Should any discrepancies arise, we will promptly investigate and correct them. We maintain close oversight of our pharmacy benefit manager (PBM), their performance and billing practices. If issues occur, Davies will work directly with the PBM to resolve them on the client's behalf, ensuring that services and charges remain appropriate and aligned with expectations.

Davies takes billing integrity seriously and is committed to working closely with the School District to ensure that all charges are fair, accurate, and reflective of the value delivered.

What managed services do you allow clients to unbundle?

We allow most ancillary services to be unbundled and are fully committed to working with Beaufort County Schools' preferred vendors. This includes services such as diagnostics, durable medical equipment (DME), transportation, translation, and home health care. We are flexible and collaborative in integrating these services to align with the District's needs and vendor relationships.

However, there are three core components of our program that are essential to achieving optimal outcomes: bill review, pharmacy benefit management (PBM), and physical therapy management. These services are deeply integrated into our claims handling model and data analytics processes. Unbundling these components could compromise the efficiency, cost-effectiveness, and clinical oversight that are central to our program's success. Therefore, we strongly recommend retaining these services within our program to preserve the integrity and performance of the overall claims management strategy.

Who is your Pharmacy Benefit Manager (PBM)?

Pharmacy Benefit Management (PBM)

Davies, in partnership with Mitchell ScriptAdvisor, an Enlyte company provides a full-service, fully integrated Pharmacy Benefit Management (PBM) program. Upon receipt of the claim, injured employees are provided with a first-fill card that they take to their local drug store, allowing them to obtain medications with zero out of pocket cost. Script Advisor has a large network of more than 71,000 pharmacies nationwide, including an in-house mail order pharmacy. The program reduces drug unit costs through contracted rates with pharmacies and ensures that the drugs prescribed are accurately and effectively managed for each claimant. Our unique approach generates significant savings, including an additional savings of 30%-50% through the mandatory generic substitution program. Our PBM services also include early intervention monitoring of opioids; first-fill processes and prescription cards; formulary management; bill monitoring/ audits; and pharmacy, utilization, and peer review services.

We also understand the complexities involved when an injured individual has multiple claims. ScriptAdvisor can track crossclaim prescription activity for the same injured employee who is treating for multiple claims. This is a configurable option to define unique claim criteria designed for identifying and flagging crossclaim prescription activity across injured employees with multiple claims and dates of injury (DOIs). This enables ScriptAdvisor to ensure injury relatedness on each individual claim.

Quality Patient Experience

ScriptAdvisor is dedicated to ensuring injured employees have a quality experience with Enlyte. From ease of access via online and text availability of first fill and pharmacy cards, to real-time authorization at point of sale, our program is designed to maximize ease of access for your injured employees. In addition, we measure patient satisfaction with our Call Center through post-call surveys, which have resulted in an average score of 4.8-5.0 out of 5.

Drug Utilization Review Program (DUR)

Comprised of safety, appropriateness, and utilization alerts, our program offers the best-in-class WC DUR management with a multitiered approach. Our real-time electronic connectivity with the retail pharmacy network ensures that all prescriptions are adjudicated at the point of sale against eligibility, formulary(s), DUR, and additional prior authorization rules for each injured employee. All DUR edits in ScriptAdvisor function across the network, even if an injured employee fills prescriptions in multiple pharmacies. Some edits can be overridden by the pharmacist, such as drug-drug interaction and drug-allergy interaction. These decision/soft edits are determined by the pharmacist based on the severity or potential threat to the injured employee versus the benefit of the medication.

Our peer-to-peer reviews give physician peer reviewers the opportunity to educate prescribing physicians on medical necessity criteria, prescribing habits, and other clinical issues. Pain management physicians discuss the functional benefit, efficacy, appropriateness of medication continuance per guidelines, and agree on the treatment plan with the treating physician. There is an incremental fee for peer-to-peer review.

Five-Step Risk Scoring

This clinical pharmacy review program evaluates an injured employee's entire drug therapy to ensure the regimen produces the best outcomes for the claim. ScriptAdvisor bases scores on ODC, ACOEM, CDC and various other guidelines and industry best practices. Our proprietary Risk Scoring tool gives clients early insight into therapeutic concerns by identifying at-risk claims and recommending the appropriate intervention.

Strategy for Maximizing In-Network Utilization and Minimizing Prescription Costs

The Enlyte ScriptAdvisor program maximizes network penetration utilizing proven strategies throughout the prescription fulfilment process. The strategies employed are focused on increasing the numerator in the above calculation (in-network spend) and decreasing the denominator (reducing out-of-network spend) based on clinically appropriate and effective protocols. Success in these strategies is measured by comparing the total improvement of network penetration following implementation of the ScriptAdvisor solution as compared to the initial baseline established during the prior 12 months before implementation. Enlyte continuously monitors overall network penetration each month, as well as within each of the following:

- **Robust, actively managed network:** ScriptAdvisor has an extensive retail pharmacy network. Enlyte leverages out-of-network pharmacy transaction data to identify any newly dispensing pharmacies as candidates for recruitment and monitors the success of its network recruitment conversion rates. In addition, Enlyte's network administrator, Script Care, has an extensive network provider management function that actively recruits new retail pharmacies to its network to maximize network penetration.
- **First Fill:** Our first fill program was designed to reduce and manage the use of out-of-network, third party and physician-dispensed transactions. This increases network penetration, integrates easily with existing first report of injury reporting processes. Any first fill prescriptions from a network pharmacy that are not processed through ScriptAdvisor and are submitted by a third-party biller will also be retrospectively reviewed by ScriptAdvisor and in-network retail discounts applied to approved medications. As a result, these are considered in-network transactions and ensures 100% coverage on all first fill and third-party biller submitted charges from network pharmacies are processed through the ScriptAdvisor solution.

- **Extended Pharmacy Network Partnerships:** A major component to improving network penetration is to extend the network to encompass occupational medicine centers. As a result, we have developed a contractual relationship with the nation's largest and leading occupational health provider, Concentra® (including US Healthworks and other acquisitions). When one of our clients' injured employees are treated at the clinics, they use our rules for processing and filling medication out of their facilities, including cost discount, formulary management, dispense generics medications, enforce opioid controls, dispense limited fills, and then convert the claim to ScriptAdvisor. Through these strategic relationships, we have maximized network penetration and delivered market-leading pricing levels for our customers. This relationship provides us the ability to monitor the injured employee's use of prescription medication.
- **Ensuring Appropriateness of Out-of-Network Spend:** Paying fee schedule for inappropriate out-of-network prescriptions is more detrimental to network penetration than any other component of pharmacy spend. ScriptAdvisor's proprietary integration with the SmartAdvisor bill review system, enables a comprehensive approach to all pharmacy transactions, regardless of origin, ensures that out-of-network transactions related to the injury, are appropriate, and cost-effective pharmaceutical therapy. ScriptAdvisor clients average a 23% reduction in out-of-network spend from the denial of unrelated or inappropriate pharmaceutical therapy, and up to 29% reductions on Physician dispensed medications, including prescription-only or comingled invoices. The elimination of non-compensable out-of-network pharmacy spend provides ScriptAdvisor customers with a substantial increase in over network penetration and savings.
- **Pharmacy Paper Bill to Point-of-Sale Conversion:** Enlyte implements aggressive out-of-network re-indexing efforts. Any paper pharmacy bill originating from an in-network pharmacy (third-party biller, retail pharmacy bill via paper, etc.) is billed to the District at your ScriptAdvisor retail contracted rate. Enlyte proactively contacts providers upon receipt of OON Rx transactions to provide our necessary BIN and group number to the pharmacy technician to update their billing system. This ensures subsequent fills are captured in-network on subsequent refills of a prescription. Enlyte measures success of its reindexing program by analyzing all subsequent prescriptions dispensed by a network pharmacy on each claim following a reindex effort and measuring the incremental impact to savings to the overall program.
- **Patient and Provider Letter Campaigns:** As an optional component of the ScriptAdvisor program, clients may choose to send notification letters to the injured employee and/or the treating physician upon receipt of an out-of-network transaction. These letters are customizable by client and employer. In non-pharmacy direction of care states, these letters generally remind patients to fill their prescriptions at a network pharmacy and bill through their card. Provider letters range in message from a reminder to the provider requesting cooperation in complying with the PBM dispensing protocols to a direct reminder that they are a contracted network provider.
- **Generic Dispensing to Help Control Costs:** In addition, in order to reduce the high cost of brand drugs, ScriptAdvisor takes a mandatory approach to generic dispensing when available and allowed. All network pharmacies are required to comply with these mandatory generic regulations, and fill prescriptions with suitable, medically appropriate generic equivalent drugs. Our claims-processing system prompts pharmacists to dispense generic drugs when available. In most jurisdictions, if a physician writes "Dispense as Written" or "Medically Necessary" on the prescription, brand drugs cannot be automatically substituted and dispensed as generics. In these cases, the physician typically indicates a mandatory brand prescription, not for clinical reasons, rather, at the request of the injured employee. In these instances, when we cannot automatically convert the prescription, ScriptAdvisor employs both Dispense as Written (DAW) and Letters of Medical Necessity (LMN) correspondence processes to help ensure treating physicians convert brand medication to a generic when a generic equivalent is available. DAW and LMN letters can be automatically submitted to the physician via the ScriptAdvisor web portal or by contacting our Customer Assistance Center. The ScriptAdvisor DAW letter addresses the specific dispense as written medication and offers therapeutic equivalent generic alternatives. Once the DAW has been received, the letter is emailed to the adjuster for review and uploaded to the claim within the web portal for future reference. Please note, Mitchell does not simply send one DAW letter and hope the physician complies; we continuously fax and/or contact the physician daily until a response is received. With the ScriptAdvisor automated Letter of Medical Necessity (LMN)

tool, an adjuster can easily request a letter be e-faxed to a prescriber to address occupational injury relatedness, as well as the length of time the prescriber anticipates the therapy to continue. When the signed LMN is received back from the prescriber, the adjuster is alerted that the LMN is available via the ScriptAdvisor Web Portal. In fact, all correspondence with providers are logged into the notes section in the web portal and are available to the adjuster or nurse case manager. In addition, when a new generic is released into the market, it is automatically loaded into our system and immediately available – these rules force the use of that generic versus the brand.

Prior Authorization

Prescriptions not meeting clinical plan design, formulary or eligibility requirements generate a prior authorization (PA) request. The workflow is highly configurable and includes an intuitive, easy to use email notification with the ability to take action directly from within the email. We also provide the same PA notification directly within the ScriptAdvisor portal for determination. Finally, Enlyte also supports customized messaging and task notifications directly into the District's claim system and medical management system to alert District adjusters or nurse professionals with Single Sign On (SSO) to ScriptAdvisor.

- Prior Authorization – Email: Emails are sent to the assigned adjusters, nurses or other approvers if the medication does not pass formulary edits. Emails include all critical claim, patient, drug, and pharmacy information for the recipient to make an informed decision and provide the user the ability to approve or deny medications directly in the email (i.e., no need to log into the ScriptAdvisor portal) using FDA-approved indications and drug description information.
- Prior Authorization – Portal: The ScriptAdvisor portal dashboard displays real-time prior authorization notifications to quickly deny or approve the medication, view the current and future MED (if approved), reassign the PA to a new owner/group and/or configure additional dispense information. The dashboard includes Enlyte's advanced Claim Risk Score indicator, providing visibility of the current clinical risk level, and the projected risk level if the drug is authorized as well as clinically appropriate recommendations on intervention strategies.
- Intelligent Smart Routing Automation: Enlyte ScriptAdvisor Smart Routing technology provides the ability to customize and configure the approval process by a broad range of criteria (e.g., medication, user role, dollar threshold, drug type/ therapeutic class, etc.). The system can be set up to auto-approve or auto-deny targeted medications, and the adjuster will be automatically notified of the adjudication of the prior authorization.
- Customized Communication Workflows: The District can easily customize its individual communication and escalation preferences within the ScriptAdvisor portal. Clients can set time frames when they would like users to take action on a PA to limit patients waiting at the pharmacy. The system can be configured to allow pharmacies to dispense a formulary-based "short fill" (typically a 3-day supply) of medications. Specific procedures for managing prescription needs during the weekends or after hours can also be customized to address the District's requirements. ScriptAdvisor's flexibility drastically reduces patient wait time and allows customers time to thoughtfully review prior authorization requests before making a final determination of medical necessity. As soon as a prior authorization request is generated from the pharmacy a real-time notification is pushed out the adjuster to take action on. We have the capability of set adjusted internal turnaround requirements (4 hours, 8 hours or 24 hours) based on the District's need to ensure injured employees are not waiting a long to pick up their prescriptions.

Do you have a complex Rx review to address opioids and other narcotic usage? Explain the process.

Monitoring Narcotics Use

Davies has a robust and multi-layered approach to managing complex prescription drug use, particularly opioids and other narcotics, to ensure safe, appropriate, and cost-effective care for injured workers.

Our pharmacy management program includes advanced utilization controls and predictive modeling to identify potential misuse, overuse, or dependency risks. All claims are regularly analyzed for activity that exceeds

established utilization thresholds. Red flags include early refills, chronic or high-dose opioid use, multiple prescribers or pharmacies, and elevated morphine equivalent dosages (MED). Our system includes an integrated MED calculator and NDC crosswalk to convert opioid dosages into total MED and compare them against ODG guidelines. When thresholds are met or exceeded, automated alerts are generated and sent to the assigned adjuster, prompting timely clinical intervention.

Through our partnership with ScriptAdvisor and the RightRx program, we offer targeted interventions on high-risk claims. RightRx combines clinical expertise and integrated technology to assess prescriptions at the point of entry. Interventions may include assignment to a utilization review nurse, peer-to-peer physician consultations, and prescriber education to ensure medical necessity and promote safer prescribing practices.

In addition, Davies partners with Fourstone Partners to support the coordination of medication monitoring for injured employees on chronic opioid therapy. Fourstone provides specialized oversight and clinical support to ensure that long-term opioid use is medically appropriate, closely monitored, and aligned with evidence-based guidelines. This partnership enhances our ability to manage complex pharmacy cases and reduce the risk of opioid dependency, diversion, or adverse outcomes.

Together, these tools and partnerships allow Davies to deliver a comprehensive, proactive pharmacy management strategy that improves clinical outcomes, reduces prescription costs, and supports the safe recovery of injured workers.

Scope of Work

3.1 Scope of Work / Specifications – Detailed:

a) Complete a prompt and thorough investigation of all incidents, accidents, work-related illnesses (including infectious disease exposures) and/or claims assigned, including but not limited to:

Our approach to claim investigations is thorough, systematic, and client-focused, ensuring that each claim is handled with the utmost diligence and integrity. Upon receiving a claim, our experienced adjusters conduct an initial assessment to gather all pertinent information, including reviewing the claim report, medical records, and any other relevant documentation. We establish contact with the injured worker, employer, medical provider and any witnesses to obtain preliminary statements and clarify details. Based on this initial assessment, we develop a tailored investigation plan outlining the specific steps and resources required, including field investigations, surveillance, and expert consultations if necessary. We prioritize timely and efficient investigations to minimize claim duration and associated costs.

Our adjusters conduct comprehensive interviews with the injured employee, employer, and witnesses to gather detailed accounts of the incident, verifying the accuracy of the information provided through cross-reference with medical records, employment history, and other relevant data sources. When necessary, we deploy field investigators to conduct on-site inspections, gather photographic evidence, and perform surveillance to verify the legitimacy of the claim, adhering to legal and ethical standards to ensure all evidence collected is admissible and reliable. We collaborate with medical professionals and industry experts to obtain independent evaluations and opinions on the injured employee's condition and the circumstances of the incident, helping us determine the extent of the injury, appropriate treatment plans, and potential for recovery.

Upon implementation, the designated account manager will work with you to establish special handling guidelines and implement initial and ongoing training to ensure all assigned claims staff fully understand your specific service instructions. The Special Account Handling guidelines are given to all assigned adjusting staff as a resource, and include key contacts, authority levels, reporting procedures, workflows, etc. The account manager and claims supervisor will collaborate closely to ensure that your claims service aligns with your requirements and that any special handling instructions are consistently followed.

Our claims handling best practices dictate that adjusters work in a proactive manner to bring the claim to a positive conclusion for all parties involved. Adjusters adhere to our documented best practices and client special handling instructions. The below details our typical practices, however, we are flexible in developing customized solutions and practices to meet your specific needs. In situations where the client's practices differ from those listed below, we will alter our practices to match those of the client.

Reporting Claims

The preferred method of reporting workers' compensation losses to Davies through our claims system will be to complete the First Notice of Loss on our website, which will enable our clients to quickly report claims electronically 24 hours a day, 7 days a week, 365 days a year. The computer-controlled edits and validations will help ensure proper responses and fully completed forms are submitted directly to our database. Once the form is completed, a visual confirmation will be displayed, assuring the client that the information was successfully transmitted to Davies. This allows for rapid setup and assignment of the claim, so immediate contacts can be made and investigations started. We also offer telephone, email, and fax reporting options.

The computer-controlled edits and validations help ensure that proper responses and fully completed notices are submitted directly to our database. This allows for rapid setting up of the claim, immediate contacts can be made, and investigations started. Upon submission, a control number is generated by the database confirming acceptance of the FROI record and it is your assurance that the information was successfully transmitted to us. You will have the option of printing a FROI recap of submitted information which the injured employee can sign for your files. As an option to this program, you may choose to periodically

provide Davies with information about your employees to be used to pre-fill the iFROI with their demographics. With this option, when an employee is injured, you need only enter their Social Security number or Employee ID — the system will then pre-fill their name, address, work location, and other information. This not only saves you time, but it also improves accuracy and leaves you to only be concerned with entering the details of the loss. You can also provide us with the names and addresses of your most commonly utilized first aid providers and we will make them available as pre-filled choices on the form, as well.

We can also offer Beaufort County School District the option of having a designated toll-free, after-hours reporting line to assist in reporting claims quickly. The advantage of this is that the after-hours nurse case manager will be available to complete an immediate triage upon request if it is deemed urgent. The after-hours staff also has access to the online reporting system, which allows them to complete the intake process at the time of injury reporting, in accordance with any special instructions developed by Beaufort County School District. The after-hours nurse case manager can provide recommendations and will refer the injured employee to Beaufort County School District's preferred initial treatment facility, if deemed appropriate, or the ER if the injury warrants emergency treatment. In either case, the injured employee will be contacted by our designated nurse case manager (if one has been assigned) or adjuster after the claim has been formally assigned and authorization for follow-up treatment can be provided at that time.

Claim Intake and Timely Assignment

When an injury occurs, the supervisor completes the necessary report and submits it to Davies through one of several available reporting options, including our 24/7/365 online claims intake process. To support workers' compensation claims, we offer a nurse triage program that connects injured employees with a registered nurse, providing immediate recommendations for care.

Early intervention is critical to successful outcomes. All claims are processed upon receipt, with files established and assigned the same day. A claims supervisor reviews injury reports and assigns them to the appropriate adjuster and nurse case manager (if applicable) via electronic workflow within hours. The assigned claim number and adjuster's name are promptly communicated to the client, along with initial supervisory notes available for review online.

Upon claim setup, the client receives an email acknowledgment containing a copy of the WC1 and adjuster name.

Initial Contact

The assigned adjuster initiates contact with all parties involved within 24 hours for all lost time claims. This includes three-point contact:

- **Employee**: To address compensability, medical treatment, and any emergency issues.
- **Employer**: To clarify information and confirm employee details.
- **Medical Provider**: To understand treatment plans, identify potential delays, and mitigate prolonged recovery times.

In addition, the adjuster will promptly reach out to any witnesses or coworkers identified as having relevant information about the accident or injury. This ensures a thorough understanding of the incident and supports a well-documented investigation.

All lost-time and questionable medical-only claims are reported to the Index Bureau to identify any prior claims history and support accurate compensability decisions.

Case File Analysis

Davies case file analysis procedures introduce a management plan in each file that analyzes all issues and allows the formulation of a thorough action plan with the intention of bringing the claim to conclusion. This analysis includes issues such as, but not limited to:

- Medical questions
- Compensation questions
- Subrogation questions
- Field investigation questions
- Medicare issues
- Any other questions dictated by the facts of the case
- Possible defenses

This process occurs immediately upon receipt of the First Report of Injury or Illness, and involves simultaneously the medical case manager, claims supervisor and the adjuster. This analysis is then reviewed through our diary system on a regular basis to ensure both the proper completion of tasks, and the updating of the Action Plan as more facts become known.

Investigations/Statements

A detailed initial investigation is completed for all claims. All lost time or questionable medical only claims are reported to the Index Bureau. Our procedure is to file additional indexes every six months until the claim is closed. If claim compensability is in question, the claim is monitored by the Claims Manager until a decision is made to pay or deny the file.

In some cases, it is necessary to question witnesses and request the injured employee's prior medical records to determine compensability. We recommend taking recorded statements on all questionable claims. Some cases with subrogation or indication of potential fraud also may require a recorded statement.

Our investigation of liability or compensability of injury may require recorded statements of:

- Injured employees
- Injured employees
- Witnesses
- Employer

The statements may be taken in person or telephonically. Recorded statements should always be taken in any claim involving serious bodily injury, death, or as needed in the opinion of the handling adjuster or supervisor. Statements will also be taken at your request. The entire statement is stored as a .wav file and can be accessed through the claims system at any time. Where appropriate, we will analyze statements taken from witnesses as part of the investigation.

The investigating adjuster will document key points of the interview in the file by entering them into the claims system, allowing access to the results by Beaufort County School District.

Our assigned telephonic adjusters have received specialized instruction and training in recorded statement techniques.

Davies uses investigative profile forms for all lines of business. These investigative profiles are used to isolate claims which merit scrutiny and further investigations. No single indicator is necessarily conclusive. The investigative profiles list indicators of possible fraud, not evidence that a fraud has occurred. Training on the proper use of these profiles is provided to all claim's personnel throughout the year.

When a claim is identified as suspicious, the adjuster will consult with our Special Investigative Unit (SIU) to determine if further investigation by one of our approved surveillance business partners is required. If an injured worker is malingering or it is expected that continued disability is not warranted, surveillance will be considered. Approval would be obtained from [Client Name: Beaufort County School District] before making any referrals for investigation or surveillance.

We will provide the investigator with a description and digital photo of the injured employee, information related to the employee, the reason for the request, the number of hours to work on the case and any other pertinent information to increase the potential for significant findings. All surveillance assignments and social

media checks will be clearly documented in the claim file. We will track and notify [Client Name: Beaufort County School District]of the results of all surveillance/social media checks.

If supporting evidence is identified to clearly articulate and support the suspicions of fraud, the adjuster will forward the claim to SIU. On claims identified as potentially fraudulent, no settlement negotiations or claim payments will be made prior to an investigation into the potentially fraudulent aspects of the case.

The SIU will review the claim file and issue an assessment report. The SIU will then file any necessary forms for the suspected fraud, pursuant to state laws in the applicable jurisdiction. The SIU evaluation report will address red flags, what evidence is present that supports reasonable suspicion of fraudulent activity, potential exculpatory evidence, and make recommendations for further investigation.

Once a suspicion of insurance fraud has been substantiated, the SIU will package and refer the case to the appropriate law enforcement agency and/or prosecuting authority for review and then keep the adjuster updated on the status of those ongoing investigations and pending prosecutions.

Davies' adjusters and supervisors are well-trained in fraud detection and are always watching for "red flags" that may indicate questionable, suspicious or fraudulent activities. We expect each claim handler to take the lead role in our effort to identify and defeat insurance fraud. Effective fraud management is part of the well-handled claim. It is not a special duty — it is one of the fundamentals of good claim handling.

Diary

Our diary reviews are used to update the case file analysis and action plan. Claim files are reviewed by the adjuster and supervisor throughout the life of the file. Initial diary will take place within seven days of claim assignment. For lost time and litigated cases, adjuster diaries are set at 14-day intervals to ensure the timeliness of payment of indemnity and responses to petitions or other legal pleadings. Adjuster diaries for medical only cases are set at 30-day intervals to coincide with reserve reviews.

The supervisor has the ability to do a complete file review through the claims system. The adjuster's file notes contain specific medical excerpts from treating providers. The Nurse Case Manager Supervisor also reviews the file for medical management through the claims system.

- Items of special interest that are reviewed are:
- Appropriate and timely contacts
- Adherence to the Action Plan and modification where necessary
- Reserves
- Proper calculation and payment of benefits
- Excess reporting, recoveries, and application of special deductibles
- Issues of compensability
- State Form filing
- Medical management and over utilization
- File documentation
- Medical Management Services
    - Approved providers
    - Securing initial treatment plan
    - Checking accuracy of impairment ratings
    - MMI obtained in accordance with treatment parameters
    - Overutilization review

b) Provide a medical cost containment program, to include:

Davies is committed to delivering a robust and proactive Medical Cost Containment Program designed to reduce unnecessary medical expenditures while ensuring high-quality care for patients. Our program includes the following core components:

Fee Schedule Management

We implement and maintain a comprehensive, evidence-based fee schedule aligned with industry standards and payer requirements. This ensures consistent, fair, and transparent reimbursement practices across all provider types.

Hospital Utilization Review

Our utilization review process includes:

- Pre-admission certification
- Concurrent review during hospitalization
- Post-discharge planning These reviews are conducted by licensed clinical professionals to ensure medical necessity, appropriate length of stay, and optimal resource use.

Hospital and Physician Bill Audit

We perform detailed audits of hospital and physician bills to identify and correct:

- Duplicate charges
- Upcoding or unbundling
- Non-covered services
- Charges inconsistent with clinical documentation Our audit team uses advanced analytics and clinical expertise to ensure billing accuracy and recover overpayments.

Negotiated Discounts

Davies leverages its extensive network and negotiation expertise to secure:

- Hospital discounts through direct contracts and third-party agreements
- Physician discounts via preferred provider arrangements and bundled payment models

Continuous Improvement

Our program is continuously refined based on outcome data, regulatory changes, and client feedback. We conduct regular performance reviews and adjust strategies to maximize savings and care quality.

c) Provide a quarterly medical cost containment report to the HR designee.

We will provide the medical cost containment report at any frequency requested by the HR designee, whether quarterly, monthly, or as needed.

d) Compile and file, on behalf of the School District, all notices, reports and admissions required by state statues relating to workers' compensation claims.

Davies agrees with the above responsibilities.

e) The selected Workers' Compensation Claims Administrator will have specific personnel assigned to handle all School District claims. The expectation is the assigned personnel will have offices and will be equipped with access available by telephone, fax and email and on-site meetings with designated School District staff, as required. This claims team will handle claims with the HR designee on the day- to-day basis. The

lead adjuster, which will be assigned to the School District account, should be part of any presentation team.

Davies fully understands and agrees with the requirement to assign specific personnel to handle all workers' compensation claims for Beaufort County School District. We will designate a claims team who will be solely responsible for managing the District's claims.

We believe that continuity, communication, and accountability are key to successful claims outcomes. That's why we ensure our clients work with a consistent, experienced team who understands the unique needs of the public sector and educational institutions. Our team will work in close partnership with the District to deliver responsive, transparent, and proactive claims administration.

f) With the approval of the HR designee, arrange for independent medical examinations, rehabilitation services and other medical care, when such procedures may constructive.

Davies agrees to coordinate and arrange for Independent Medical Examinations (IMEs), rehabilitation services, and other medical care as needed, with the prior approval of the School District's designated HR representative.

Our experienced claims professionals and Nurse Case Managers will evaluate each case to determine when such services may be constructive to the resolution of a claim, such as:

- Clarifying medical diagnoses or treatment plans
- Assessing return-to-work readiness
- Evaluating permanent impairment
- Resolving conflicting medical opinions

Independent Medical Exams

All recommendations for IMEs or additional medical services will be discussed with and approved by the HR designee before scheduling. We will handle all logistics, including provider selection, appointment coordination, and documentation of findings. Our team ensures that all services are performed by credentialed, impartial providers and that results are promptly shared with the School District.

This collaborative approach ensures transparency, supports informed decision-making, and helps drive timely, cost-effective claim resolutions.

Physical and Occupational Therapy Program

Davies has partnered with SPNet Clinical Solutions to manage the physical and occupational therapy needs of our clients' injured workers. This partnership has delivered significant savings to our clients as we work with SPNet to prospectively manage the needs of all stakeholders throughout the episode of care, resulting in an industry-leading 97% network penetration rate.

We utilize cost containment strategies at three distinct junctions (or "gates") during the claim:

- Placement into the network (Prospective or Front Gate)
- Clinical oversight during the injured worker's care (Concurrent or Middle Gate)
- Discharge and discounting (Retrospective or Back Gate)

By placing the City's injured workers into a network facility, we can capture the benefits of SPNet's clinically focused model, which utilizes evidence-based solutions to provide predictable clinical outcomes and reduce

your physical/occupational therapy costs. Using SPNet's peer-to-peer oversight (physical therapist talking to physical therapists), we can drive velocity, resulting in a shorter duration of care. While industry averages for quarterly closure rates range from 45-60%, through our program, we are hitting rates of 85-90% closure with our clients. Operating and managing these "gates" allows us to deliver the right services at the right time, translating into a reduction in lost workdays and a decrease in your overall claim costs.

According to current NCCI data, medical expenses in the workers' compensation arena make up approximately 58% of total claim costs. Physical and occupational therapy are generally associated with 25-35% of all work-related injuries, according to Workers' Compensation Research Institute (WCRI) data, and as a result, represent 18-22% of the medical costs related to the claim. Davies has partnered with SPNet to create a managed care program that encompasses strategies insulating the payor around multiple touch points or "gates" that medical providers have access to claims. Our "gate system" provides a check and balance on how many claims access medical services, combined with our utilization management system on appropriate level of medical services and finalized through our gate with market-leading discounting. The combined approach of clinical utilization management and competitive discounting with the oversight of our claims team allows us to offer a program that consistently delivers a 15-20% reduction in physical therapy/occupational therapy exposure.

Vocational Rehabilitation:

Inability to Return to Work: If an injured worker is unable to return to their pre-injury job due to physical limitations or changes in job requirements, Davies conducts a thorough assessment to determine the need for vocational rehabilitation services. This includes evaluating transferable skills, educational background, and labor market conditions to identify suitable alternative employment opportunities.

Long-Term Disability: For cases involving significant injuries that may lead to long-term or permanent disability, we explore rehabilitation options that support the worker in gaining new skills or transitioning to a more appropriate role. This may include retraining, job placement assistance, or educational programs.

Proactive and Collaborative Approach: Our vocational rehabilitation process is collaborative and includes input from the injured worker, treating physician, employer, and the School District's HR designee. We aim to develop a realistic and supportive return-to-work plan that aligns with the worker's capabilities and the employer's operational needs.

Services Offered:

- Functional capacity evaluations (FCEs)
- Transferable skills analysis
- Labor market surveys
- Job coaching and placement assistance
- Resume development and interview preparation
- Educational or vocational training referrals

Our goal is to help injured employees regain independence and return to meaningful employment whenever possible, while also reducing claim duration and associated costs for the School District.

g) Report claims to the School District's excess insurer in accordance with policy requirements, and monitor all recoveries due. This shall include providing notice to excess insurers of all claims or potential losses which may exceed the School District's per occurrence retention and, if requested, provide such insurers with necessary information on the current status of those claims, including total aggregate loss information for the policy year.

Davies is fully committed to ensuring that all injuries and illnesses are reported within the required timeframes as outlined in the agreement and applicable regulations. This is achieved through clear communication protocols, effective staff training, and streamlined internal reporting processes designed to ensure compliance and minimize delays.

We will timely report all losses that meet the criteria outlined by the School District's excess insurance carrier. This includes:

- Providing initial notice of any claim or potential loss that may exceed the District's per-occurrence retention
- Submitting regular status updates to the excess carrier, including total incurred values and reserve changes
- Preparing and submitting quarterly reimbursement requests, unless otherwise directed by the District or carrier
- Recording all reimbursements directly into the claim file and tracking them against the total incurred for the policy period

To support this process, our claims system is equipped with automated alert functionality that monitors claim activity and financial thresholds. When a claim approaches or exceeds the District's self-insured retention (SIR), the system generates a real-time alert to the assigned adjuster and supervisor. This ensures that potential excess claims are identified early and reported promptly, reducing the risk of missed reporting deadlines or delayed recoveries.

We also rely on customizable reporting tools to track and manage excess reporting obligations across all open claims, ensuring full visibility and accountability.

It is the responsibility of the District to provide accurate and complete coverage information for all applicable insurance policies. This includes:

- Carrier contact details
- Policy numbers
- Effective dates
- Limits of liability
- Deductibles and retentions
- Copies of actual policies

This information must be provided for each claim year Davies is administering within 90 days of contract inception, and for renewal years within 90 days of the renewal date. If this information is not made available as outlined, Davies cannot be held responsible for any penalties, interest, or reductions in excess recoveries due to late reporting.

h) The selected Workers' Compensation Claim Administrator will need to have electronic capability for communication with School District staff, designated medical providers and attorneys. This may include claims data available through secure website access and encrypted email.

Davies is fully equipped to meet and exceed the Beaufort County School District's requirements for secure and efficient electronic communication among all stakeholders involved in the Workers' Compensation claims process. Our system is designed to ensure seamless, real-time collaboration with School District staff, designated medical providers, and legal representatives. Authorized users are provided with role-based access to our secure claims management system, which allows School District personnel to view real-time claim status and documentation, access payment history and reserve data, and submit notes, documents, and requests directly to the claims team. All email correspondence with medical providers and attorneys containing sensitive

information is transmitted using end-to-end encryption protocols, ensuring compliance with data privacy regulations, and protecting all parties from unauthorized access.

i) The selected Workers' Compensation Claims Administrator is expected to return phone calls and/or respond to emails from designed School District staff and calls from injured School District employees within 24 hours.

Davies prides ourselves in providing the best customer service in the industry, and we demonstrate our service orientation to our clients and their employees through timely, responsive communications. Prompt contact with the injured employee is made within 24 hours of receipt of a new claim. All other contacts with department representatives, witnesses, and medical providers are made within 24-48 hours. Incoming mail must be handled on the same day of receipt. Incoming faxes must be forwarded to the adjuster within two hours of receipt. In addition, our adjusters and supervisors will recognize and follow any client-specific guidelines that the District may wish us to implement in the handling of your claims.

To ensure compliance regarding our communication policy, the claims supervisor will monitor new claims on a tight diary until compensability is determined. Pertinent incoming mail including legal, client and excess is not only routed to the adjuster, but also the supervisor for review. Emails are generated out of the claims system and are monitored by management. These customer service best practices are monitored and evaluated through various means, including performance metrics, claims audits, client recognition, claims outcomes, customer satisfaction surveys, continuing education, and supervisory observations. It is our expectation that claims professionals meet or exceed client expectations.

We also utilize a claimant portal to enhance our initial contacts with injured workers. This user-friendly tool empowers claimants to easily navigate the insurance claims process by increasing transparency and improving communication. Claimants can securely access their claim details 24/7 through their devices, including the claim number, adjuster's name, and status. They also benefit from a library of resources and FAQs to get quick answers about their claims. With features for document uploads and secure messaging, DaviesConnect facilitates efficient communication between claimants and our claims team, helping them focus on their recovery and return to work.

The District will have 24/7 access to the system and employees will have 24/7 access to Davies connect. Claims can also be reported electronically 24/7. Your designated account manager and/or claims supervisor will ensure responsive support during business hours. For after-hours needs, Davies provides a dedicated call center to handle urgent matters, with an escalation plan tailored specifically for the District to address emergencies.

j) The selected Workers' Compensation Claim Administrator is expected to set an ultimate claim reserve for all lost time cases within 30 days of the receipt of the claim. This reserve would be adjusted as needed to always reflect the ultimate claim reserve.

Our reserving philosophy is to set realistic reserves, based on the current information available, and to reserve at ultimate probable exposure. Initial reserves are established within 10 business days of receipt of the claim, and in accordance with the anticipated value of the claim based on the investigation to date. Claims are reviewed upon receipt by the supervisor, conducting additional reviews within the first 30 days of the claim being received. These initial reviews include reviewing the reserves. Claim supervisors review reserves at each diary to ensure adequacy. In addition, the claim supervisor will review and approve reserve adjustments that exceed the adjuster's authority level. Our claim system contains pre-set reserve authority levels and triggers to ensure reserve approvals follow the proper hierarchy.

The claim adjuster addresses reserve adequacy at each diary or whenever significant changes occur. Davies reserve review process takes place when events such as the following occur:

- Litigation is instituted
- Return to work

- Medical information warrants a change
- MMI is attained
- Settlement is contemplated
- File remains open beyond a designated time period
- Perfection of a recovery

All reserve evaluations are then documented in the electronic claim file. Reserve adjustments will be based on information known and/or available and will be adjusted promptly or at a minimum within 30 days of the date the claim handler knew of a change in the realistic, probable exposure of the claim. With each increase or decrease in reserves, claim adjusters document a detailed reserve rationale in the electronic file notes. This documentation must also include the various aspects of exposure such as liability, injury and damages, permanency, legal/other expenses, etc., as appropriate based on lines of coverage. Reserves are continuously monitored as the claim develops.

We leverage the robust predictive analytics capabilities of ODG by MCG to support accurate reserve setting early in the claims process. This tool utilizes evidence-based guidelines, benchmarking data, and industry best practices to assess potential claim outcomes. By analyzing factors such as injury type, severity, and expected recovery timelines, ODG provides data-driven insights that enable us to establish reserves reflective of the claim's likely trajectory.

This process enhances reserve accuracy, reduces the risk of over- or under-reserving, and supports financial forecasting for our clients. By integrating these analytics into our workflows, we ensure a proactive approach to reserve management, fostering greater transparency and alignment with the anticipated costs of a claim.

A reserve evaluation worksheet is completed whenever the reserve is changed. The reserve worksheet is available for review 24/7 through the claims system. A complete reserve history is maintained and available for review by:

- Beaufort County School District
- Outside auditors or actuaries
- Claims manager/supervisor
- Excess carrier

3.2 Organization and Background:

a) Briefly describe your organization, the year it was founded, location of its headquarters and other offices, its ownership structure (e.g., publicly held, employee-owned), and any affiliations with other companies, including any parent corporation(s).

Davies Group Limited, established in 1968, is the parent company of Davies US, LLC. Davies US, LLC Principals are Dan Saulter (Group Chief Executive Officer), Matt Button (CEO, Davies US) and Paula Kenneson (CFO, Davies US).

Davies Claims North America, Inc., is a wholly owned subsidiary of Davies US LLC. In the US, Davies has over 2,600 desk employees in the US, which includes over 1,600 teammates across the Davies Claims North America division.

Davies' ownership structure is described below:

In August 2021, BC Partners, a leading international investment firm, acquired a majority stake in Davies. This new partnership has diversified and strengthened Davies' shareholder base, as we seek to drive further global expansion, increase investment in technology and digital transformation and continue to partner with complementary businesses via M&A. Existing investors HGGC and AIMCO continue to hold minority ownership

stakes in the business, alongside the Davies leadership team and employees. Davies expansion drive will see us continue to acquire like-minded tech enabled insurance focused businesses to support truly strategic partnerships with our clients, across the full spectrum of their supply needs.

Davies leverages its extensive network of regional offices nationwide, including our headquarters in Lakewood Ranch, Florida.

6015 Resource Lane
Lakewood Ranch, FL 34211-0004
Tel: 941-907-3100 | **Toll Free:** 1-877-326-5326

Additionally, many of our adjusters work throughout the country from their home offices and are flexibly able to handle claims and be deployed as needed.

b) Describe your company's customer service philosophy and management style.

Customer Service

Customer service is Davies' number one priority. We pride ourselves in providing the best customer service in the industry. We require our claims teams to remain in close communication with our self-insured clients via telephone and email. Supervisors make monthly contact with each client to ensure that they receive the best service possible. This also gives the supervisor an opportunity to discuss and resolve any concerns that may have developed. Adjusters are expected to maintain daily communication to confirm work status, reserve requests and conferences to provide a plan of action on difficult claims.

Injured workers also have the option to contact their assigned adjuster through our user-friendly engagement platform, DaviesConnect. This empowers them to understand and easily navigate the insurance claims process by increasing transparency, improving communication, and streamlining access to resources, including allowing them to securely communicate with the claims team via text, email or in-app messaging. The portal can be accessed via their phone, tablet or computer to securely view details of their claim at any time.

Clients are kept informed about the status of claims through frequent communication with their assigned claims team by telephone and email as well as through monthly reports and regular claim review meetings. The County will also have 24/7 access to all your claims information through the Davies website, enabling you to access up-to-date information on the status of any claim at any time.

We prioritize transparent and consistent communication with our clients to ensure the highest level of service delivery and seamless sharing of claims information. Our communication strategy encompasses both formal and informal channels, tailored to accommodate the preferences and requirements of our clients.

Formal Communication

We recognize the importance of structured communication methods to facilitate comprehensive updates and discussions. Therefore, we propose the following formal communication practices:

- Scheduled Meetings: Regular phone or in-person meetings will be arranged as per mutually agreed upon schedules to discuss pertinent concerns, review progress, and align strategies.
- Routine Reports: Our team will generate and share routine reports at agreed intervals, providing insights into claim status, performance metrics, and any relevant updates.

Informal Communication

Informal communication channels are equally crucial for fostering a collaborative and responsive partnership. Our approach to informal communication includes:

- Real-time Access: The County will have real-time access to claims information stored in our system, enabling quick and seamless updates and inquiries.

- Proactive Updates: We are committed to providing proactive and informative updates to our clients, ensuring they are kept informed about significant developments and changes in their claims.

Accessibility and Responsiveness

Our claims team remains easily accessible to address any queries or concerns that may arise. As part of our standard practices, we guarantee prompt responses to all phone calls and emails, with a commitment to returning communications within one business day.

Adapting to Client Preferences

We understand that each client may have unique preferences regarding communication methods and frequency. Therefore, we are flexible and adaptable, willing to collaborate with clients to establish communication protocols that best suit their needs and preferences.

c) Describe your company's expertise in each area as it relates to Workers' Compensation administration including but not limited to the following:

1. Designated customer service and account management staff including email addresses.

2. Secure, web-based application.

3. Monthly/quarterly reporting and payment options.

4. Problem resolution methodology.

5. New coverage process.

6. Claims process.

7. Termination of coverage process.

Davies brings deep and proven expertise in all facets of Workers' Compensation administration, supported by a highly experienced and responsive service team. Each client is assigned a designated account manager, claims supervisor, and designated adjuster(s), all of whom specialize in public sector claims. This team structure ensures continuity, accountability, and a high level of personalized service. Direct contact information, including email addresses, is provided for all key personnel to facilitate efficient communication and issue resolution.

Our secure, web-based claims management platform, ClaimsVision by PCIS, offers 24/7 access to real-time claim data, including adjuster notes, payment history, reserves, and supporting documentation. The system features customizable dashboards, automated alerts, and a robust diary system to ensure timely and compliant claim handling. It supports paperless processing, integrates seamlessly with third-party services such as Medicare reporting and litigation tracking, and allows clients to generate both reports and dashboards on demand.

Davies provides flexible reporting and payment options tailored to client needs. Clients receive monthly, quarterly, and annual loss runs, along with customized reports that include financial summaries, reserve changes, and medical cost savings. Medical bills are processed in-house with an average turnaround time of 15 days, well within statutory limits. Our system monitors payment timeliness daily, and CMS Section 111 reporting is available for a nominal fee per claim.

Our problem resolution methodology is proactive and structured. All inquiries, whether by phone or email—are responded to within 24 hours. Supervisors closely monitor new claims to ensure timely communication and action. Performance is evaluated monthly and quarterly, with adjusters held to high standards in areas such as contact timeliness, reserve accuracy, and claim closure ratios. Any issues are escalated promptly to supervisors or the account manager to ensure swift resolution and continuous improvement.

The new coverage process is streamlined through our online First Report of Injury (iFROI) system, which allows for 24/7 claim reporting. In urgent situations, our escalation protocol enables immediate medical treatment

authorization even before a formal claim is filed. Injured workers benefit from our "First Fill" pharmacy program, which ensures immediate access to necessary medications without delay.

Our claims process is comprehensive and proactive. Adjusters initiate three-point contact within 24 hours of claim receipt, engaging the injured worker, employer, and medical provider to assess compensability and treatment needs. Caseloads are carefully managed, with averages of 140 indemnity and 225 medical-only claims per adjuster. Diaries are maintained rigorously, with 14-day intervals for lost time claims and 30-day intervals for medical-only cases. Subrogation is pursued in-house at no additional cost, with client approval. Fraud detection is supported by a partnership with specialized investigation firms, and all suspicious claims are referred to our in-house Special Investigations Unit (SIU).

In the event of contract termination, Davies works collaboratively with the outgoing third-party administrator to facilitate a seamless and accurate transfer of all claim data and documentation. This process is carefully managed to minimize any disruption and ensure uninterrupted service. Additionally, we offer the option to continue administering tail claims at mutually agreed-upon rates, providing flexibility and continuity for ongoing claim management needs.

d) Within the last 5 years, has your company in any capacity been a party to any litigation, including any administration or self-regulatory proceeding, directly or indirectly related to the conduct of your business.

N/A - Davies has no pending litigation held against us, nor have we been involved in any litigation with clients in the past five (5) years.

e) Describe any merger/acquisition plans or other major organizational changes under consideration by your company.

Davies is committed to sustainable, profitable growth and continue our program of activities to meet our strategic business plan. We do not foresee any immediate takeovers or acquisitions of our business, however the strategic acquisition of businesses operating in our core markets remains one of our key strategic business objectives as we continue to broaden our geographical reach and capabilities for the benefit of our clients. Our investors and Group Executive Board are fully supportive and eager to back acquisitions to enable us to take advantage of consolidation opportunities in the insurance and regulated markets.

f) Please submit in verification that your firm is a State-approved third-party administrator for self-insured workers' compensation programs.

We are fully licensed and approved to operate as a TPA for self-insured workers' compensation programs in all states where we conduct business and where such licensing is required.

g) What is the total number of clients using your services? How many independent self-funded government employers do you have as customers?

We currently provide services to approximately **540 clients**, encompassing a diverse range of industries and needs. These clients rely on our expertise to support their operations, optimize efficiency, and achieve their goals.

Additionally, we collaborate with around **340 independent self-funded government employees,** providing them with tailored solutions to meet their needs.

3.3 Service Team and Services Provided:

a) List the personnel you would propose to assign to this relationship and their responsibilities. Provide brief biographical information on each individual, including their positions in the company, education, licenses held (noting if they are licensed SC adjusters), training, years and type of experience and major clients served by the individual (including the period of service for each client). Please elaborate on how many mediations and hearings the adjusters to our account have attended within the past twelve months.

Executive Leadership

Beverly Adkins
President – WC TPA
Ms. Adkins joined Johns Eastern, now part of Davies, in 1986 after graduating from the University of South Florida with a Bachelor of Arts degree in Finance. She has served in various branch offices, including Tampa, Clearwater, and Jacksonville, Florida. Ms. Adkins was promoted to Claims Manager of the Orlando Branch in 1990 and Executive Director of Centralized Claims in Sarasota, Florida in 2001. She was promoted to Vice President of Special Account Services in 2004 and then to Executive Vice President in 2008.
Ms. Adkins is licensed as an all-lines adjuster in Florida. She earned her Associate in Claims designation in 1989 and her Associate in Management in 1993. She is presently working on her CPCU designation. Ms. Adkins has experience handling all-lines, including Workers' Compensation, General Liability, Automobile Liability, Professional Liability, Homeowners, and Commercial Property claims. Ms. Adkins serves on the board of the Florida Association of Self-Insurers (FASI). She is a member of the Bradenton/Sarasota Claims Association, the Association of Workers' Compensation Claims Professionals, the Risk and Insurance Management Society (RIMS), and the Public Risk and Insurance Management Association (PRIMA). She is also an associate member of the Georgia Workers' Compensation Association (GWCA), Florida Educational Risk Management Association (FERMA), Virginia Self-Insurers Association (VSIA), and Pennsylvania Self-Insurers' Association (PSIA), as well as an affiliate member of North Carolina PRIMA, South Carolina PRIMA and the University Risk Management & Insurance Association (URMIA).

Alice Wells,
Senior Vice President – WC TPA
Ms. Wells joined Davies, previously Johns Eastern, in 2006 and has over 30 years of experience in the industry. Throughout her career, she has held various leadership roles including Claims Supervisor in 2007, Claims Manager in 2009, Director of TPA Operations in 2014, and Executive Director of TPA Operations in 2020. In 2024, she was promoted to Senior Vice President of WC/P&C TPA for Davies

As Senior Vice President, Ms. Wells is responsible for the overall operational production and strategic direction of the workers' compensation unit for self-insured clients. She oversees key functions such as budgeting, business development, bill review, nurse case management, and client relationship management. Her role involves driving operational excellence, ensuring compliance with industry standards, and fostering innovation to enhance service delivery and client satisfaction. Ms. Wells has extensive experience working with a diverse range of clients, enabling her to effectively address their unique needs and challenges.

She holds the designation of Board-Certified All-Lines Adjuster and is a member of the Association of Workers' Compensation Claims Professionals. Additionally, Ms. Wells has obtained her Certification of Workers' Compensation Litigation Management (CWCL) and her Associate in Claims (AIC) designations. She is currently pursuing her Associate in Management (AIM) designation through The Institutes, further demonstrating her commitment to professional development and excellence in the field.

Kristin Brown,
AVP Account Management - WC TPA

Ms. Brown, currently the AVP of Account Management, joined Davies/Johns Eastern in 2012 as a workers' compensation adjuster, managing lost time claims for self-insured public and private entities. In 2015, she was promoted to Account Manager, where she served as the primary contact for clients' administrative and regulatory needs, ensuring seamless communication and efficient resolution of issues. By 2018, she advanced to Special Accounts Supervisor, overseeing both the Account Management and Marketing Departments. In this role, she was responsible for developing and implementing strategies to enhance client satisfaction and retention.

In 2020, she was promoted to Manager of Special Account Services, where she managed a team dedicated to providing tailored services for high-profile clients. She also took on the role of primary contact for new client implementation, guiding clients through the onboarding process and ensuring a smooth transition. Ms. Brown's comprehensive understanding of client needs and her ability to foster strong relationships have been instrumental in her success.

Ms. Brown holds a General Lines (Property & Casualty) Agent License, obtained in 2017. She earned a Bachelor's degree in Public Health from the University of South Florida. Additionally, she achieved her Associate in Risk Management (ARM) designation in 2019 and her Associate in Management (AIM) designation in 2020. She is currently pursuing her Associate in Claims (AIC) designation.

Amanda Radcliffe,
AVP – Compliance

Ms. Radcliffe joined Davies/Johns Eastern in 2003. Throughout her adjusting career, she specialized in managing litigated claims for self-insured clients across public and private sectors. Her expertise encompasses thorough investigation, adept negotiation skills, and effective management of presumption claims.

Throughout her tenure, Ms. Radcliffe has held pivotal roles, including Claims Supervisor in 2008, Claims Manager in 2014, and Quality Assurance Manager in 2016. As of 2024, Ms. Radcliffe serves as AVP of Compliance, providing strategic oversight across several critical areas. This includes ensuring compliance with regulatory requirements and EDI (Electronic Data Interchange). She also oversees the Pay Department, which involves managing and maintaining oversight of client bank accounts to ensure accuracy, timeliness, and compliance with financial regulations. Additionally, Ms. Radcliffe monitors and addresses findings from compliance and performance evaluations through CPS findings, aiming to enhance operational efficiency and ensure adherence to regulatory standards. She further conducts comprehensive branch audits to assess compliance with internal policies, regulatory standards, and best practices, driving continuous improvement initiatives within the organization.

Ms. Radcliffe holds an Associate of Arts degree in Accounting and a Bachelor of Science degree in Finance from the University of South Florida. She attained her Associate in Claims (AIC) designation from The Institutes in 2021 and her Certification of Workers' Compensation Litigation Management (CWCL) designation from the Association of Workers' Compensation Claims Professionals in 2023. Ms. Radcliffe is licensed as an Accredited Claims Adjuster (all lines) in Florida and holds adjuster licenses in Florida, Georgia, North Carolina, and South Carolina.

Workers' Compensation Claims Team

Nicole Stephens
AVP WC TPA/ Account Manager

Ms. Stephens joined Johns Eastern, now Davies, in early 2016, handling claims for self-insured public and private entities. In 2019, she was promoted to Claims Supervisor, followed by a promotion to Claims Manager in 2022. Most recently, she was promoted to Assistant Vice President of Workers' Compensation TPA Services, where she now provides strategic and operational leadership across the TPA division.

In her current role, Ms. Stephens oversees multiple teams of supervisors and adjusters, ensuring quality, compliance, and consistency across all aspects of claims handling. She is responsible for developing and implementing best practices, driving performance standards, and aligning operational workflows with client-specific service expectations. Ms. Stephens collaborates closely with client leadership and internal stakeholders to evaluate outcomes, provide stewardship reporting, and support ongoing program enhancements.

Her responsibilities also include high-level oversight of complex claims, litigation strategy coordination, reserving accuracy, and execution of training initiatives to support adjuster development. She plays a key role in client retention and new business onboarding, acting as a senior liaison for issue resolution and service delivery.

Ms. Stephens is a Board-Certified All-Lines Adjuster and has earned the Certification of Workers' Compensation Litigation Management (CWCL) and the Associate in Claims (AIC) designation. She is currently pursuing the Associate in Risk Management (ARM) designation through The Institutes.

Alanna Ryder

WC Claims Supervisor

Ms. Ryder joined Johns Eastern, now a Davies Company, in 2022 and currently serves as a Claims Supervisor within our Workers' Compensation TPA division. She brings valuable experience in managing claims for self-insured public entities, having previously handled legal, lost time, and medical-only claims for several municipalities.

Throughout her career, Ms. Ryder has demonstrated expertise in all phases of workers' compensation claims, including determining compensability, establishing and maintaining appropriate reserves, conducting thorough investigations, developing action plans, and ensuring timely resolution of claims. Her strong communication skills and commitment to responsive service make her a trusted point of contact for both clients and injured workers.

Ms. Ryder holds a Florida All-Lines Adjuster License and earned her Bachelor of Arts degree from Meredith College.

Peyton Decker

Lost Time/Legal Adjuster

Peyton joined Johns Eastern Company, now a Davies company, in 2021. She began her career as a receptionist and quickly advanced through roles as an adjuster trainee, medical-only adjuster, and currently serves as a Lost Time Claims Adjuster in South Carolina. Her progression reflects a strong commitment to professional development and a deep understanding of workers' compensation claims.

Ms. Decker holds a Bachelor's degree in Health, Wellness, and Nutrition from the University of Arizona Global Campus. She is certified in First Aid, CPR, AED, and Lifeguard Training, and maintains an active Insurance License. Her strengths include time management, administrative support, and a proactive, team-oriented approach to problem-solving.

Angela Morgan

Medical Only Adjuster

Ms. Morgan brings over two decades of comprehensive insurance industry experience and currently holds an All-Lines Adjuster License in the State of Florida. Throughout her career, she has handled a wide variety of claims, including workers' compensation, general liability, commercial motor vehicle, premises liability, products liability, subrogation, and homeowners/property claims.

Previously, Ms. Morgan served as a Government Analyst II and Training Coordinator for the Florida Department of Financial Services, where she developed training programs, monitored policy compliance, and supported risk

management initiatives for state employee workers' compensation claims. Earlier in her career, she held adjuster roles with Florida School Boards Insurance Trust, North American Risk Services, and Integrated Healthcare Delivery Services, where she was responsible for claim investigations, reserve management, negotiations, and customer service excellence.

Ms. Morgan earned her High School Diploma from Wakulla High School and holds multiple industry accreditations, including Accredited Claims Adjuster and Certified Workers' Compensation Adjuster certifications.

Medical Management

Robin Martin

Ancillary Services Manager

Ms . Martin joined Davies/Johns Eastern in 2017 as a nurse case manager with more than 30 years of nursing and management experience . Prior to coming on board with Johns Eastern, she worked as a Health Services Coordinator, Medical Operations Manager and Medical Director for a large, self-insured employer . In those positions, Ms . Martin was responsible for developing and implementing medical policies and procedures to ensure the health and safety of employees . She had oversight of four medical clinics and negotiated cost-effective medical contracts .

Ms . Martin was promoted to Ancillary Services Manager at Johns Eastern in 2020 and is currently in charge of overseeing our Medical Management services, Cost Containment services, Medical Networks and Medicare reporting .

Ms . Martin has a Bachelor of Science degree from Georgetown University and is licensed as a registered nurse by the states of Florida and New York. She is committed to continuing education through industry workshops and seminars.

Dorothy Lenz

Nurse Case Manager Supervisor

Ms . Lenz joined Davies, previously Johns Eastern, in 2006 and was promoted to Nurse Case Manager Supervisor in 2015. She obtained her degree in nursing from Helene Fuld School of Nursing in Trenton, New Jersey and her BSN from the Southern College of Seventh Day Adventists in Collegedale, TN.

Ms. Lenz has over 30 years of experience in the field of nursing. She began her career in medical surgery and was previously employed as the Occupational Health Nurse and Case Manager at Blake Medical Center for 10 years, where she was responsible for 1,500 employees and volunteers. She participated in the success of Blake Medical Center becoming a merit site in OSHA's Voluntary Protection Program.

Ms. Lenz also completed a case management course at the Florida Risk Management Institute in 1997. Her extensive case management experience benefits her work as a supervisor of medical management services. Ms. Lenz is licensed as a registered nurse by the State of Florida. She received her Certified Occupational Health Nurse - Specialist (COHN-S) certification in 2000 from the American Board for Occupational Health Nurses, Inc., and in 2012 she received a Certified Case Manager (CCM) certification from the Commission for Case Manager Certification.

Jessica Brown

Nurse Case Manager

Ms. Brown currently serves as a Nurse Case Manager with Davies, supporting public entity clients by providing clinical expertise and care coordination for injured workers throughout the claims process. She brings a strong background in critical care nursing, with experience in high-acuity settings including surgical, medical, and neurological intensive care units.

Prior to joining Davies, Ms. Brown provided bedside care across a range of specialties, including oncology, emergency medicine, orthopedic, telemetry, and medical-surgical units. Her clinical insight and ability to navigate complex medical conditions allow her to effectively collaborate with physicians, adjusters, and injured employees to promote recovery and facilitate timely return-to-work outcomes.

Ms. Brown holds a Bachelor of Science in Nursing from Palm Beach Atlantic University and an Associate of Arts in Pre-Nursing from Palm Beach State College. She is licensed as a Multi-State Registered Nurse and maintains multiple advanced certifications, including ACLS, Stroke Certification, and CRRT.

IT Personnel

Jason Ricci

Head of IT Claims Solutions

Mr. Ricci came to Johns Eastern, now Davies, in 2009 as Information Services Manager. Before joining Johns Eastern, he was Director of I.S. Support for the Golf Channel in Orlando, FL. During his time at the Golf Channel, Mr. Ricci worked for two years as a Systems Support Analyst, two years as a Project Manager and three years as Director of I.S. Support. As Director he planned, budgeted, and developed staff and customer relations.

Mr. Ricci earned his undergraduate degree from the University of Florida in Management Information Systems. He graduated with Honors, obtaining a master's degree in business administration from the University of Central Florida.

b) What is the caseload of open files that would be managed by the adjuster(s) assigned to the School District? Break down into incoming claims, outstanding claims, medical-only and lost-time cases. What is the annual turnover of your adjusters? What is your typical process on assigning claims?

Caseloads

Davies maintains caseloads that are aligned with industry best practices to ensure quality, responsiveness, and compliance in claims handling.

These caseload thresholds are carefully managed to ensure that each adjuster has the capacity to:

- Conduct timely investigations and communications
- Monitor medical treatment and return-to-work progress
- Accurately set and adjust reserves
- Maintain compliance with South Carolina Workers' Compensation statutes and reporting requirements

We adhere to the following average case load policy:

Medical Only - 225 claims

Lost time/Indemnity - 140 Claims

This volume is easily monitored by management through the use of internal reports. This volume will vary slightly depending upon the severity of the claims and the complexity of the account. This philosophy reduces adjuster turnover and allows the adjuster to devote the proper amount of time to each claim. By devoting the proper amounts of time on a regular basis, the need for crisis claims handling is eliminated.

Turnover

Davies feels that our employees are extremely important in the running of our business; without them we would not be successful. To minimize turnover, we provide a stimulating workplace environment that fosters personal

and professional growth and encouragement on all levels, which produces happy, motivated and empowered individuals. We also offer competitive salaries, advancement opportunities and a comprehensive employee benefits package that is among the best in the industry. These factors are among the many reasons that our annual turnover rate for workers' compensation adjusters is only 8%.

Claims Assignment

Claims are assigned manually. When a claim is received, management reviews the details of the claim and considers the following:

- the complexity of the claim
- capacity of the individual handlers - we look at how many claims they have and how many were recently assigned
- multiples of the insured - we try to keep the same handlers with the same insureds or divisions of insureds
- jurisdiction
- likely or potential exposure and any other factors that appear relevant.

c) Do you have legal counsel, worker's compensation specializing attorneys on staff? Other specialty personnel? Indicate any additional fees that may be associated with the use of this staff.

Davies does not employ in-house attorneys to defend workers' compensation claims on behalf of our clients. However, we do maintain a nationwide panel of highly qualified law firms, including those with deep expertise in South Carolina workers' compensation law. These firms are carefully selected based on their legal expertise, responsiveness, and cost-effectiveness. We have negotiated rates in place and require all panel firms to carry appropriate Errors & Omissions (E&O) insurance.

We are also fully supportive of working with legal counsel with whom the District already has an established relationship, and will coordinate closely to ensure alignment with your litigation philosophy and expectations.

All legal expenses incurred in the defense of a claim are treated as Allocated Loss Adjustment Expenses (ALAE) and are charged directly to the claim file, ensuring accurate financial tracking and transparency.

Litigation Management Philosophy

Our approach to litigation is proactive and adjuster-driven. While legal counsel provides formal representation, our adjusters remain actively involved in all litigated claims to control costs and drive resolution. This includes:

- Developing and managing litigation plans in collaboration with defense counsel and the District
- Participating in depositions, mediations, and hearings as needed
- Conducting additional investigations, witness interviews, and medical record reviews
- Negotiating settlements directly with claimants or their attorneys when appropriate

We believe that litigation should be a last resort, and our adjusters are trained to resolve claims early through thorough investigation, timely communication, and strategic intervention. When litigation is necessary, our team ensures that files are litigation-ready, and that defense counsel is fully supported throughout the process.

Our supervisors maintain oversight of all litigated files through diary reviews and regular case conferences, ensuring that legal strategies remain aligned with the District's goals and that costs are managed effectively. On average, our legal expenses represent just 7% of the total costs incurred on workers' compensation claims—well below industry norms.

d) Describe your process for understanding the plan's business, culture and participants needs.

At Davies, we believe that a successful partnership begins with a deep understanding of our client's organizational goals, operational environment, and the unique needs of their workforce. Our approach to understanding the plan's business, culture, and participant needs is both structured and collaborative, ensuring that our services are aligned with your values and objectives from day one.

Our process begins with a comprehensive onboarding and discovery phase. This allows us to gain insight into the School District's mission, operational priorities, communication preferences, and historical claims experience. We also review existing policies, procedures, and reporting structures to identify opportunities for alignment and improvement.

Understanding the organizational culture is a critical component of our approach. We take the time to learn how decisions are made, how communication flows between departments, and how employees interact with the workers' compensation program. This cultural insight enables us to tailor our communication style, training materials, and service delivery to fit seamlessly within your environment.

Throughout the engagement, we maintain an open line of communication with designated contacts and provide regular updates, performance reviews, and opportunities for feedback. This ongoing dialogue allows us to continuously refine our approach and ensure that we are meeting the evolving needs of your organization and its employees.

Ultimately, our goal is to become an extension of your team—one that understands your business, respects your culture, and is fully invested in the well-being of your workforce.

e) How often do you typically meet with the client to discuss plan utilization/compliance, services, etc.?

At Davies, we believe that ongoing communication and collaboration are essential to the success of any workers' compensation program. To ensure transparency, alignment, and continuous improvement, we maintain a structured schedule of client engagement at multiple levels:

Annual Stewardship Meeting

Once per year, we will conduct a comprehensive stewardship meeting with Beaufort County School District. During this session, we will:

- Review overall program performance
- Analyze key metrics such as claim frequency, severity, closure rates, and cost drivers
- Evaluate return-to-work outcomes and medical management effectiveness
- Identify trends, opportunities for improvement, and strategic recommendations
- Present a detailed stewardship report with year-over-year comparisons and benchmarking

This meeting provides a high-level view of the program's effectiveness and helps guide future planning and goal setting.

Quarterly Program Reviews

Your assigned Assistant Vice President (AVP) of WC will reach out on a quarterly basis to:

- Discuss program activity and performance updates
- Address any emerging issues or concerns
- Share updates on regulatory changes, technology enhancements, or service innovations
- Collaborate on any adjustments to workflows, reporting, or service delivery

These quarterly touchpoints ensure that the program remains aligned with the District's evolving needs and priorities.

Monthly Operational Check-Ins

The claims supervisor assigned to your account will maintain monthly contact with the District's HR designee or other designated staff. These check-ins are designed to:

- Review open claims and discuss specific case strategies
- Address any urgent matters or escalations
- Ensure smooth day-to-day operations and communication

This layered approach to client engagement ensures that Beaufort County School District receives strategic oversight, operational support, and responsive service throughout the life of the partnership.

f) Describe your procedures for making initial and follow-up contact with injured employees, supervisors and HR designated representatives. Will you be able to perform this within 24 hours of receiving the claim? What criteria will be used to determine style of investigations?

Initial Contact

The assigned adjuster initiates contact with all involved parties within 24 hours for all lost time claims. This includes three-point contact:

- **Employee**: To address compensability, medical treatment, and any emergency issues.
- **Employer**: To clarify information and confirm employee details.
- **Medical Provider**: To understand treatment plans, identify potential delays, and mitigate prolonged recovery times.

In addition, the adjuster will promptly reach out to any witnesses or coworkers identified as having relevant information about the accident or injury. This ensures a thorough understanding of the incident and supports a well-documented investigation.

All lost-time and questionable medical-only claims are reported to the Index Bureau to identify any prior claims history and support accurate compensability decisions.

g) Describe your investigative and reporting procedures. What criteria will be used to determine the extend of an investigation?

Investigations/Statements

A detailed initial investigation is completed for all claims. All lost time or questionable medical only claims are reported to the Index Bureau. Our procedure is to file additional indexes every six months until the claim is closed. If claim compensability is in question, the claim is monitored by the Claims Manager until a decision is made to pay or deny the file.

In some cases, it is necessary to question witnesses and request the injured employee's prior medical records to determine compensability. We recommend taking recorded statements on all questionable claims. Some cases with subrogation or indication of potential fraud also may require a recorded statement.

Our investigation of liability or compensability of injury may require recorded statements of:

- Injured employees
- Injured employees
- Witnesses
- Employer

The statements may be taken in person or telephonically. Recorded statements should always be taken in any claim involving serious bodily injury, death, or as needed in the opinion of the handling adjuster or supervisor. Statements will also be taken at your request. The entire statement is stored as a .wav file and can be accessed through the claims system at any time. Where appropriate, we will analyze statements taken from witnesses as part of the investigation.

The investigating adjuster will document key points of the interview in the file by entering them into the claims system, allowing access to the results by Beaufort County School District

Our assigned telephonic adjusters have received specialized instruction and training in recorded statement techniques.

Davies uses investigative profile forms for all lines of business. These investigative profiles are used to isolate claims which merit scrutiny and further investigations. No single indicator is necessarily conclusive. The investigative profiles list indicators of possible fraud, not evidence that a fraud has occurred. Training on the proper use of these profiles is provided to all claim personnel throughout the year.

When a claim is identified as suspicious, the adjuster will consult with our Special Investigative Unit (SIU) to determine if further investigation by one of our approved surveillance business partners is required. If an injured worker is malingering or it is expected that continued disability is not warranted, surveillance will be considered. Approval would be obtained from Beaufort County School District before making any referrals for investigation or surveillance.

We will provide the investigator with a description and digital photo of the injured employee, information related to the employee, the reason for the request, the number of hours to work on the case and any other pertinent information to increase the potential for significant findings. All surveillance assignments and social media checks will be clearly documented in the claim file. We will track and notify Beaufort County School District of the results of all surveillance/social media checks.

If supporting evidence is identified to clearly articulate and support the suspicions of fraud, the adjuster will forward the claim to SIU. On claims identified as potentially fraudulent, no settlement negotiations or claim payments will be made prior to an investigation into the potentially fraudulent aspects of the case.

The SIU will review the claim file and issue an assessment report. The SIU will then file any necessary forms for the suspected fraud, pursuant to state laws in the applicable jurisdiction. The SIU evaluation report will address red flags, what evidence is present that supports reasonable suspicion of fraudulent activity, potential exculpatory evidence, and make recommendations for further investigation.

Once a suspicion of insurance fraud has been substantiated, the SIU will package and refer the case to the appropriate law enforcement agency and/or prosecuting authority for review and then keep the adjuster updated on the status of those ongoing investigations and pending prosecutions.

Davies' adjusters and supervisors are well-trained in fraud detection and are always watching for "red flags" that may indicate questionable, suspicious or fraudulent activities. We expect each claimer to take the lead role in our effort to identify and defeat insurance fraud. Effective fraud management is part of the well-handled claim. It is not a special duty — it is one of the fundamentals of good claim handling.

h) What will be the frequency of status reports on any claim involving temporary total disability and/or permanent total disability?

Davies is committed to providing timely, transparent, and client-driven communication on all claims involving Temporary Total Disability (TTD) and Permanent Total Disability (PTD). We understand that these claims often involve complex medical treatment, extended recovery timelines, and significant financial exposure—making regular updates essential.

We will provide status reports at a frequency determined by the School District, whether that be bi-weekly, monthly, or another preferred cadence. Our team will work closely with the District's HR designee to establish a customized reporting schedule that aligns with your operational needs and internal review processes.

In addition to scheduled reports, Davies will provide real-time updates on any significant developments, such as:

- Major changes in medical condition
- Return-to-work clearance
- Settlement discussions
- Excess reporting thresholds being met

Our claims system also allows for on-demand reporting and dashboard access, giving the District the ability to view claim status and trends at any time.

This proactive and flexible approach ensures that the School District remains fully informed and empowered to make timely decisions throughout the life of each claim.

i) Where will medical bills be processed? Where will lost wage checks be processed? What is the average length of time that it takes from receiving a provider bill to the mailing of the payment to the provider?

All medical bills are processed through Davies' Florida-based operations, ensuring compliance with state-specific regulations and providing exceptional expertise. Our bill reviewers are highly experienced and fully trained in South Carolina's workers' compensation billing regulations, including the South Carolina Medical Services Provider Manual, applicable fee schedules, and state-specific compliance requirements. This ensures that all medical bills are reviewed and processed in strict accordance with South Carolina law, with a focus on accuracy, timeliness, and provider transparency.

Routine medical bills are typically processed within 7 to 10 business days from the date of receipt. More complex bills—such as those requiring additional documentation, provider negotiations, or PPO repricing—are completed within 15 to 20 business days. If a bill involves PPO transmission, an additional business day may be required. All payment details, including Explanation of Benefits (EOB) and Explanation of Review (EOR), are integrated into our claims system in real time, providing immediate visibility to adjusters, nurse case managers, and School District staff.

Lost wage checks are processed at our Lakewood Ranch, Florida headquarters. Centralizing this function ensures consistency, accuracy, and timely disbursement of indemnity payments. Our secure financial systems and experienced personnel are dedicated to managing wage-related payments in full compliance with South Carolina's workers' compensation regulations and statutory timelines.

By maintaining centralized processing while applying state-specific expertise, Davies ensures that both medical and indemnity payments are handled efficiently, compliantly, and with a strong understanding of South Carolina's regulatory environment.

j) Describe criteria used for providing systematic medical/hospital bill audits?

Davies performs core cost containment services in-house. All medical and hospital bills are reviewed for accuracy and reasonableness per client guidelines and approved by the adjuster for authorization. They are sent to our cost containment/bill review department via paperless workflow and are paid in order of the latest date to ensure timely payment. A unique combination of software and nurse review controls medical provider billings and allows us to identify maximum reductions for the District's benefit. The uniqueness is embodied in our program's ability to reduce bills according to State fee schedule, PPO discounts, usual & customary billing, utilization review, and specially negotiated rates. Our review for accuracy includes the following components:

- Duplicate Billings
- Unbundling of Charges
- Upcoding of Charges

- Approval and Appropriate Pre-Certification

Our Lead Bill Reviewers in conjunction with specialized software will review all medical bills that:

- Are not subject to fee schedule coding
- Are for services not specifically addressed in the fee schedule
- Need an in-depth medical interpretation of the rules and regulations
- In the exercise of professional judgement, specifically warrant review

Our QA bill reviewer reviews re-considerations and conducts interdepartmental audits of processed bills. Bills received and reviewed under provider disputes/ AHCA are handled by our Bill Review Supervisor.

k) Please describe procedures for reviewing the adequacy of claim reserves.

Our reserving philosophy is to set realistic reserves, based on the current information available, and to reserve at ultimate probable exposure. Initial reserves are established within 10 business days of receipt of the claim, and in accordance with the anticipated value of the claim based on the investigation to date. Claims are reviewed upon receipt by the supervisor, conducting additional reviews within the first 30 days of the claim being received. These initial reviews include reviewing the reserves. Claim supervisors review reserves at each diary to ensure adequacy. In addition, the claim supervisor will review and approve reserve adjustments that exceed the adjuster's authority level. Our claim system contains pre-set reserve authority levels and triggers to ensure reserve approvals follow the proper hierarchy.

The claim adjuster addresses reserve adequacy at each diary or whenever significant changes occur. Davies reserve review process takes place when events such as the following occur:

- Litigation is instituted
- Return to work
- Medical information warrants a change
- MMI is attained
- Settlement is contemplated
- File remains open beyond a designated time period
- Perfection of a recovery

All reserve evaluations are then documented in the electronic claim file. Reserve adjustments will be based on information known and/or available and will be adjusted promptly or at a minimum within 30 days of the date the claim handler knew of a change in the realistic, probable exposure of the claim. With each increase or decrease in reserves, claim adjusters document a detailed reserve rationale in the electronic file notes. This documentation must also include the various aspects of exposure such as liability, injury/damages, permanency, legal/other expenses, etc., as appropriate based on lines of coverage. Reserves are continuously monitored as the claim develops.

We leverage the robust predictive analytics capabilities of ODG by MCG to support accurate reserve setting early in the claims process. This tool utilizes evidence-based guidelines, benchmarking data, and industry best practices to assess potential claim outcomes. By analyzing factors such as injury type, severity, and expected recovery timelines, ODG provides data-driven insights that enable us to establish reserves reflective of the claim's likely trajectory.

This process enhances reserve accuracy, reduces the risk of over- or under-reserving, and supports financial forecasting for our clients. By integrating these analytics into our workflows, we ensure a proactive approach to reserve management, fostering greater transparency and alignment with the anticipated costs of a claim.

A reserve evaluation worksheet is completed whenever the reserve will be changed. The reserve worksheet is available for review 24/7 through the claims system. A complete reserve history is maintained and available for review by:

- Beaufort County School District
- Outside auditors or actuaries
- Claims manager/superviso
- Excess carrier

l) Describe your approach to claims adjusting and management, including but not limited to: scheduling independent medical evaluations, arranging rehabilitation services, securing medically approved employment; activity checks and legal assistance.

Davies takes a proactive, collaborative, and outcomes-driven approach to claims adjusting and management, with a strong emphasis on early intervention, medical oversight, and return-to-work strategies. Our experienced claims professionals and Nurse Case Managers evaluate each case individually to determine the most appropriate course of action, ensuring that all services are medically necessary, cost-effective, and aligned with the School District's goals.

Davies agrees to coordinate and arrange for Independent Medical Examinations (IMEs), rehabilitation services, and other medical care as needed, with the prior approval of the School District's designated HR representative.

Our experienced claims professionals and Nurse Case Managers will evaluate each case to determine when such services may be constructive to the resolution of a claim, such as:

- Clarifying medical diagnoses or treatment plans
- Assessing return-to-work readiness
- Evaluating permanent impairment
- Resolving conflicting medical opinions

Independent Medical Exams

All recommendations for IMEs or additional medical services will be discussed with and approved by the HR designee before scheduling. We will handle all logistics, including provider selection, appointment coordination, and documentation of findings. Our team ensures that all services are performed by credentialed, impartial providers and that results are promptly shared with the School District.

This collaborative approach ensures transparency, supports informed decision-making, and helps drive timely, cost-effective claim resolutions.

Physical and Occupational Therapy Program

Davies has partnered with SPNet Clinical Solutions to manage the physical and occupational therapy needs of our clients' injured workers. This partnership has delivered significant savings to our clients as we work with SPNet to prospectively manage the needs of all stakeholders throughout the episode of care, resulting in an industry-leading 97% network penetration rate.

We utilize cost containment strategies at three distinct junctions (or "gates") during the claim:

- Placement into the network (Prospective or Front Gate)
- Clinical oversight during the injured worker's care (Concurrent or Middle Gate)
- Discharge and discounting (Retrospective or Back Gate)

By placing the City's injured workers into a network facility, we are able to capture the benefits of SPNet's clinically focused model, which utilizes evidence-based solutions to provide predictable clinical outcomes and reduce your physical/occupational therapy costs. Using SPNet's peer-to-peer oversight (physical therapist talking to physical therapist), we can drive velocity, resulting in a shorter duration of care. While industry averages for quarterly closure rates range from 45-60%, through our program, we are hitting rates of 85-90% closure with our clients. Operating and managing these "gates" allows us to deliver the right services at the right time, translating into a reduction in lost workdays and a decrease in your overall claim costs.

According to current NCCI data, medical expenses in the workers' compensation arena make up approximately 58% of total claim costs. Physical and occupational therapy are generally associated with 25-35% of all work-related injuries, according to Workers' Compensation Research Institute (WCRI) data, and as a result, represent 18-22% of the medical costs related to the claim. Davies has partnered with SPNet to create a managed care program that encompasses strategies insulating the payor around multiple touch points or "gates" that medical providers have access to claims. Our "gate system" provides a check and balance on how many claims access medical services, combined with our utilization management system on appropriate level of medical services and finalized through our gate with market-leading discounting. The combined approach of clinical utilization management and competitive discounting with the oversight of our claims team allows us to offer a program that consistently delivers a 15-20% reduction in physical therapy/occupational therapy exposure.

Vocational Rehabilitation:

Inability to Return to Work: If an injured worker is unable to return to their pre-injury job due to physical limitations or changes in job requirements, Davies conducts a thorough assessment to determine the need for vocational rehabilitation services. This includes evaluating transferable skills, educational background, and labor market conditions to identify suitable alternative employment opportunities.

Long-Term Disability: For cases involving significant injuries that may lead to long-term or permanent disability, we explore rehabilitation options that support the worker in gaining new skills or transitioning to a more appropriate role. This may include retraining, job placement assistance, or educational programs.

Proactive and Collaborative Approach: Our vocational rehabilitation process is collaborative and includes input from the injured worker, treating physician, employer, and the School District's HR designee. We aim to develop a realistic and supportive return-to-work plan that aligns with the worker's capabilities and the employer's operational needs.

Services Offered:

- Functional capacity evaluations (FCEs)
- Transferable skills analysis
- Labor market surveys
- Job coaching and placement assistance
- Resume development and interview preparation
- Educational or vocational training referrals

Our goal is to help injured employees regain independence and return to meaningful employment whenever possible, while also reducing claim duration and associated costs for the School District.

Work Task Analysis

A Work Task Analysis (WTA) is a physical demands assessment that objectively measures the frequency, force, height, distance and duration of the material handling (lift, carry, push or pull) and positional tolerance functions of a job. It provides a useful framework for improved communication among all team members for maximum

effectiveness and timely case resolution. The WTA determines the essential functions, physical demands, environmental conditions and other factors necessary for the safe and productive performance of a particular job and securing medically approved employment. The assessment is performed by professionals trained in on-site job analysis, EEOC compliance, ADA guidelines and OSHA regulations.

The WTA can be utilized effectively in:

- Modified/Light Duty Return to Work: Assists in the objective determination of defining modified and/or light duty essential job functions and physical demands (lifting, carrying, pushing and pulling). An employee's ability to return to work in a modified or light duty capacity can be matched to the appropriate essential job functions and physical demands for a safe return-to-work.
- Return-to-Work: The physical demand requirements of the full-time/full-duty job position must be clearly identified for the physician and medical team to determine if the employee can safely return to work. A well-defined WTA can help the physician and medical team determine return-to-work capability or the need to establish medical restriction(s) or job modification(s) for a reasonable accommodation. The physician, therapist and case manager have the advantage of a clear and objective understanding of the job position to which the employee is returning. There is a delineation of the physical capacities necessary to complete the job safely and effectively, which helps guide return-to-work goals.
- Work Conditioning: Used when returning an employee to work after meeting the defined essential job functions, physical demands and rehabilitation goals. The WTA can assist in case closure when a plateau in rehabilitation occurs by documenting essential job functions and comparing the ability level of the employee to the job.
- Post-Offer Employment Testing (POET): Serves as the foundation and baseline for an employment test to ensure the new hire applicant is safe and capable of meeting or not meeting the essential job functions. The employee understands the essential job functions and the expectations of the employer when they are hired.
- Fitness-For-Duty Testing: Assists with ADA-compliant annual testing procedures that determine if employees can meet the essential compliance with The Americans with Disabilities Act (ADA), improve ergonomic awareness, compliance with OSHA standards, litigation substantiation and used as a tool for the workers' compensation administrator in monitoring injury management.

Litigation Management Philosophy

Our approach to litigation is proactive and adjuster driven. While legal counsel provides formal representation, our adjusters remain actively involved in all litigated claims to control costs and drive resolution. This includes:

- Developing and managing litigation plans in collaboration with defense counsel and the District
- Participating in depositions, mediations, and hearings as needed
- Conducting additional investigations, witness interviews, and medical record reviews
- Negotiating settlements directly with claimants or their attorneys when appropriate

We believe that litigation should be a last resort, and our adjusters are trained to resolve claims early through thorough investigation, timely communication, and strategic intervention. When litigation is necessary, our team ensures that files are litigation-ready, and that the defense counsel is fully supported throughout the process.

Our supervisors maintain oversight of all litigated files through diary reviews and regular case conferences, ensuring that legal strategies remain aligned with the District's goals and that costs are managed effectively. On average, our legal expenses represent just 7% of total costs incurred on workers' compensation claims—well below industry norms.

Davies does not employ in-house attorneys to defend workers' compensation claims on behalf of our clients. However, we do maintain a nationwide panel of highly qualified law firms, including those with deep expertise in South Carolina workers' compensation law. These firms are carefully selected based on their legal expertise,

responsiveness, and cost-effectiveness. We have negotiated rates in place and require all panel firms to carry appropriate Errors & Omissions (E&O) insurance.

We are also fully supportive of working with any legal counsel. The Beaufort County School District already has established relationships with and will coordinate seamlessly to ensure alignment with your litigation philosophy and expectations.

All legal expenses incurred in the defense of a claim are treated as Allocated Loss Adjustment Expenses (ALAE) and are charged directly to the claim file, ensuring accurate financial tracking and transparency.

Davies' claims management model is built on responsiveness, accountability, and a deep understanding of public sector needs. By combining clinical oversight, strategic partnerships, and experienced adjusters, we deliver a comprehensive program that supports injured workers, controls costs, and ensures compliance with South Carolina Workers' Compensation Commission (SCWCC) regulations.

m) Detail your ability to monitor regulatory and legislative developments at both the state and federal level and how this will be communicated to Beaufort School District School District.

Our claims personnel are required to remain abreast of market changes and issues related to the maintenance of a risk management program. Davies' monthly and quarterly training sessions address these topics, and Davies encourages membership in local professional associations.

Davies is highly involved with the Risk Management Society (RIMS) and the Public Risk Management Association (PRIMA), both regionally and on a national scale. Our involvement in both organizations allows us to remain informed of current legislative changes. These organizations are constantly lobbying Congress to improve laws as they relate to workers' compensation. Our national membership in and regional support of these organizations allows Davies to remain involved with legislative initiatives and changes. It is our desire to always obtain the most updated knowledge and insight into current legislative changes and those on the horizon.

In addition to being aware of legislative changes, Davies recognizes the importance of alerting and educating our clients about those changes. We accomplish this through the following proactive methods:

- Quarterly meetings with our clients and round table discussion of complex claims
- Use of social media: LinkedIn, Facebook and Twitter
- E-blasts summarizing case law, legislative changes and more
- Quarterly "Digital Dialogue" webinars, including insights on a range of claims-related subjects
- Davies blogs

Davies maintains a global suite of compliance policies covering Financial Crime, Conduct Risk, and Responsible Business, regularly reviewed, and updated for regulatory changes. Risk is managed both globally and, in the US, with monitoring through outside counsel, subject matter experts, regulatory groups, and alerts from Departments of Insurance. Davies employs trained professionals in Privacy, Information Security, Data Governance, Cyber Security, and Regulatory Compliance at both US and global levels. The goal is to ensure compliance with all applicable laws in all the jurisdictions we operate. Davies is Sarbanes-Oxley compliant and has received a clean opinion on recent audits. Documentation is available on request.

n) Talk to us about your firm's steps that have been taken to ensure dedication to compliance with the statues and rules of SC Worker's Compensation Act.

Davies has been providing workers' compensation claims administration services in South Carolina for over 34 years and is deeply familiar with the South Carolina Workers' Compensation Act (Title 42 of the South Carolina Code of Laws) and the regulations set forth by the South Carolina Workers' Compensation Commission (SCWCC).

To ensure full compliance with all applicable statutes and rules, Davies has implemented a multi-layered compliance framework that includes:

Licensed and Knowledgeable Staff

All adjusters assigned to Beaufort County School District will:

- Be licensed in South Carolina as required by law
- Receive ongoing training on SC-specific statutes, case law updates, and SCWCC procedural changes
- Be supervised by experienced claims managers who ensure adherence to jurisdictional requirements

Automated Compliance Monitoring

Our claims management system is configured with jurisdiction-specific rules and alerts to ensure:

- Timely filing of all required forms (e.g., Form 12A – First Report of Injury, Form 18, Form 15, etc.)
- Monitoring of statutory deadlines for compensability decisions, benefit payments, and medical authorizations
- Automated alerts to notify adjusters of upcoming or overdue compliance tasks, including excess reporting thresholds and filing deadlines

Structured Claims Handling Protocols

We follow a structured adjudication process that aligns with SCWCC regulations, including:

- Prompt investigation and compensability determination
- Accurate calculation and timely payment of benefits
- Coordination of medical care and vocational rehabilitation
- Proper documentation and recordkeeping for audits and legal review

Regulatory Reporting and Filing

Davies ensures the timely compilation and submission of all required notices, reports, and forms to the SCWCC and other relevant entities. This includes:

- Filing of all mandated forms within statutory timeframes
- Reporting of all lost-time and questionable medical-only claims to the Index Bureau
- Coordination with the District's excess insurer for claims that may exceed the self-insured retention

Internal Audits and Quality Assurance

We conduct regular internal audits to verify compliance with SCWCC rules and client-specific protocols. Any discrepancies are addressed immediately through corrective action and retraining.

Client Collaboration and Transparency

We work closely with the District's HR designee to ensure:

- Full transparency in claims handling
- Real-time updates on regulatory filings
- Access to compliance reports and audit results upon request

Davies is committed to upholding the highest standards of regulatory compliance, protecting the District from penalties, and ensuring injured employees receive timely and appropriate benefits in accordance with South Carolina law.

3.4 Loss Control and Claims Reporting/RMIS Requirements:

The selected Workers' Compensation Claim Administrator shall provide a fully integrated risk management system. In the areas of claim information, loss control information and general financial information, the firm shall have the capability to provide the following:

Our claims system, ClaimsVision by PCIS, is a robust claims, risk, and policy management platform driven by user configurability, intelligent business rules, and automated compliance. Built upon 40 years of insurance application knowledge, ClaimsVision utilizes the latest Microsoft .NET technology, reporting services, and Business-to-Business (B2B) infrastructure. ClaimsVision enables paperless processing, efficient claims management, and actionable analytics. ClaimsVision boasts industry-leading compliance automation for federal and state reporting.

Its many user-friendly features include:

- Claims information organized into tables and stored in an encrypted SQL database
- "Alerts" that can be set on a claim to help the adjuster remain aware of certain situations
- "Warnings" which display if a claim reaches certain conditions
- "Reminders" that can be set to trigger on a particular date
- Advanced diary system to ensure each claim is examined periodically at a customizable interval
- Tool to assist in properly setting the reserves on a claim, including integration with ODG
- Tools for calculating any potential recoveries
- Litigation module which tracks legal expenses and all upcoming depositions, mediations, and hearings in the litigation calendar
- Imaged documents in paperless environment sorted by category
- Medicare Screens to document the status of the Query and identify Medicare recipients
- Limits which can be set to allow supervisors to monitor the progression of each claim's resolution
- Email capabilities within the claim file
- Client-customizable dashboards to view pertinent program metrics
- Instant messaging

Our claims system also includes:

Built-in Dashboard

Davies utilizes an analytics tool powered by Microsoft Power BI that is available to our clients. This tool allows clients to visualize data using a unified, scalable platform for business intelligence (BI) that is easy to use and helps you gain deeper insight into your data. It also allows for fast, AI-powered answers to your business questions — even when asking with conversational language. We have a team of programmers ready to assist with the creation of your custom BI environment.

Enhanced Business Rules

Attach business rules to virtually any button in the system and automatically generate emails, letters, reports, diaries, or notes on the completion of a task.

Seamless Third-Party Integrations

Our software integrates effortlessly with third parties. For example: EDI, ISO, Medicare, Medical Bill Review, Pharmacy Bill Review, OFAC, ODG and more.

Browser Independent

Our system is HTML 5 and CSS3 compliant, which also provides more freedom to use your favorite web browser, while also eliminating the need for Active X controls. This ensures a more personalized user experience as well as the ability to utilize mobile devices.

Customized loss reports are preferred. Please comment on your firm's ability to provide reports to a variety of formats.

Reporting Criteria and Schedule

Davies recognizes client reporting criteria and ensures reporting is timely. Authorized client personnel can remain current on claim status through review of loss reports and closing notices, as well as online access to adjuster notes through the claims system. Davies complies with reporting thresholds established by the client. The Account Manager maintains a diary to furnish claim reporting to the states, as required. Claim data reports to the regulatory agency on self-insured clients are furnished directly to the state.

Reports

Davies maintains an extensive library of reports through our Microsoft Power BI reporting platform. With its user-friendly interface and robust capabilities, Power BI enables users to generate interactive and visually appealing dashboards and reports. These reports are available in real-time and can be accessed at any time.

Microsoft Power BI provides a powerful tool for analytics, benchmarking, and KPI tracking, enabling our clients to harness their data for insightful decision-making. Power BI ensures that key performance indicators are monitored in real-time, allowing our clients to measure progress toward their goals and make data-driven adjustments. The interactive and user-friendly dashboards in Power BI make it simple to visualize complex data, empowering our clients to gain a comprehensive understanding of their business performance and drive impactful outcomes.

Our reports are developed to best illustrate claims-handling progress, and program trends for our clients. Typical standard reports include loss runs, check registers, and status reports, which can be provided upon request or accessed through our reporting platform. These reports may include a listing and summary of claims, along with information such as amounts reserved and paid, and any other details requested by the client.

Our list standard reports provided within the service fee include but are not limited to the following:

- Alpha Claims List: Alphabetical Claims Listing Report
- Loss Report
- Detailed Loss Report
- Detail Loss Run - Total Only
- Summary Report by Policy
- Full SIR Specific Excess Received or Anticipated
- Half SIR Specific Excess Received or Anticipated
- Payment Check Register: Check Register
- Location Register: Check Register by Location
- Claim Year Register: Check Register by Claim Year
- Potential Recoveries Report

- Actual Recovery Report: Detailed Listing by Claim Year, all recoveries received

In the event there is a termination of any service agreement, will the School District continue to receive periodic loss reports on open and closed claims? If so, what will be the costs for such reports? Will access to claim information via online be available after agreement termination? If so, what will be the charge and availability time?

If the service agreement is terminated and Davies continues handling the School District's existing open tail files, a new contract will be required. The terms of this agreement will be negotiated and will include access to claims information as well as standard reports via the online claims system.

Should the service agreement be terminated and all open existing claims be transferred to a new TPA for handling, the School District will retain access to our claims system and standard reports for 30 days at no additional cost. If extended access is required beyond this period, associated fees will be negotiated at that time.

Submitted proposals should address ownership of data/loss files. Please comment on special ownership of claim file media.

Davies acknowledges that all claim files, documentation, and data related to the district's program are the sole property of the district. These materials will be delivered to the district upon request or upon contract termination. Furthermore, it is understood that the district retains full and unlimited rights to these documents.

3.5 Financial and Accounting Services:

Please submit an explanation of the establishment of any fund which may be required for payment of claim. Details should include, but not be limited to:

a) Any monthly requirements after initial establishment of the fund

b) Procedures under which funds are to be transferred

c) Frequently of adjustment to determine accuracy of funding level

d) Reconciliation of check issuance

e) Maintain accurate and current claim payment records to prevent the issuance of duplicated payments

Davies offers flexible options for the establishment and management of claim payment funds, depending on the client's preference. Clients may choose to manage their own bank account or authorize Davies to manage the account on their behalf. If the client manages the account, Davies will request basic banking information, including ABA number, account number, and check layout specifications. Claim payments can be issued from a zero-balance account, a separate escrow account, or the client's main checking account, depending on internal preferences. Clients are responsible for ensuring sufficient funds are available to cover issued checks, and Davies will provide monthly check registers to support account reconciliation.

For clients who prefer Davies to manage the account, we will establish a dedicated escrow account with JP Morgan Chase under our name and FEIN. Davies monitors the account daily, manages all disbursements, and requires positive pay services to prevent fraud. Clients receive a monthly funding request based on actual disbursements, and replenishment is expected within one week. If the account is underfunded, Davies will notify the client and may suspend payments until adequate funds are restored. Regardless of the account setup, special funding requests can be accommodated as needed, and the specifications for handling such requests will be determined during the initial account setup process. All accounts managed by Davies are subject to strict internal controls and banking security protocols to ensure accuracy, compliance, and transparency.

3.6 Medical Case Management:

a) Please describe your medical case management program with details on who you typically work with and the criteria that is used in selecting cases. Please provide description of the professional experience/qualifications on medical case management personnel who you would recommend to be assigned to work with

TCM and FCM assignment protocols

TCM is most often utilized immediately following injury to:

• assess severity of injury,

• establish appropriate providers,

• coordinate initial treatment,

• identify opportunities for early return to work, and

• determine need for task or field-based case management

The TCM ideally initiates services within 48 hours of notice of injury. The injured worker may remain in TCM until one or more of the criteria is met for Task or Field case management or at the point of return-to-work full duty.

Referrals for case management services will be assigned to a field case manager within two hours of receipt. Contacts are made to the claimant, employer, and provider within 24 hours. Email updates are provided on the same day or within 24 hours of each provider appointment or significant change in status. Treatment plans are monitored to ensure they fall within the parameters of evidenced based guidelines (ODG), including decision points for intervention and telephonic case management (TCM) Criteria.

Referrals for case management services will be assigned to a field case manager within two hours of receipt. Contacts are made to the employee, employer and provider within 24 hours. Email updates are provided on the same day or within 24 hours of each provider's appointment or significant change in status. Treatment plans are monitored to ensure they fall within the parameters of evidenced based guidelines (ODG), including decision points for intervention and telephonic case management (TCM) Criteria.

Telephonic Case Management (TCM) Criteria

- Lack of established treatment plan with specific goals
- Compromised patient safety
- Over-utilization of services or use of multiple providers
- Under-utilization of services
- Premature or delayed discharge from appropriate level of care
- Use of inappropriate services
- Ineffective treatment plan
- Permanent or temporary alterations in functioning

Task Assignment Criteria

Task based case management referrals are generated at the discretion of the adjuster and/or based on the recommendation of the TCM. Task assignments are specific activities performed by the case manager based on claim status. This includes medical and vocational rehabilitation tasks within the parameters of the IOD program.

Task assignment may include up to three client contacts, after which time approval must be obtained from the adjuster to convert to field based case management. Recommendations of task-based case management activities include but are not limited to:

- Lost time more than 4 weeks with no projected return to work date
- Disability durations exceeding expected disability duration per ODG
- Return to work coordination
- Vocational ergonomic evaluation
- Job site analysis
- Medical clarification for complicated medical issues
- Assist client in understanding and compliance with treatment plan
- Miscellaneous situation as identified by adjuster and/or TCM

Field Case Management Criteria

The adjuster and/or TCM should consider assignment of a field case manager for the following situations or diagnosis:

Medical Factors

- Inpatient hospitalization
- Medicals over $10,000
- Lost time over 60 days
- Medical stability without return-to-work release
- Length of disability exceeds evidence based criteria such as ODG
- Back pain over 30-45 days without documented treatment plan
- Aggravation of a pre-existing condition
- Failed and / or repeated surgeries
- Non-compliance with treatment plan
- Opioid use greater than 45 days
- Multiple ER visits/repeat hospitalizations
- Co-morbid complications (diabetes, heart disease, hypertension)
- Home Health/IV meds
- Continued complaints without objective findings
- Experimental Treatments

Diagnoses

- Herniated disc
- Low back pain without a specific diagnosis
- Rotator cuff tears
- Brachial plexus injuries
- Thoracic outlet injuries
- Fractures of the pelvis / hip
- Complex fractures
- Compression fractures

- Ligamentous knee injury (ACL, MCL)
- Stress disorders
- Complex Regional Pain Syndrome
- Fibromyalgia

Catastrophic Case Management Criteria

Upon notice and confirmation of the following injuries, the claim should be immediately assigned to a field case manager trained in catastrophic injuries.

- Multiple trauma / complex fractures (e.g., (amputations, brain injury, multiple dislocations, multiple severe lacerations, ruptured spleen/internal organs, internal hemorrhage)
- Burns ((3rd degree burn, chemical burn, skin graft required)
- Spinal cord injuries
- Head injuries (excluding superficial)
- Amputations
- Paralysis or partial loss
- Puncture wounds involving the chest/lung, abdomen, or face
- Myocardial infarction
- Chemical inhalation
- Septicemia
- Stroke with paralysis or significant impairment
- Miscellaneous as determined by adjuster

Frequency and duration of case manager intervention

In general, case management continues until return to work or MMI is reached, and duration is dependent on diagnosis, treatment plan and the type of case management referral (TASK, FCM, CATA). The average duration for field case management services is 3-6 months. Our turnaround time for utilization review is excellent for the industry, including 24 hours for nurse reviews and 48 for MD review, with the network of physician reviewers encompassing all specialties.

All telephonic, task-based and field case management cases will be reviewed at 30,60 and 90 days by the adjuster for appropriate further action or case closure.

Early intervention is critical to successful outcomes. All claims are processed upon receipt, with files established and assigned the same day. A claims supervisor reviews injury reports and assigns them to the appropriate adjuster and nurse case manager (if applicable) via electronic workflow within hours. The assigned claim number and adjuster's name are promptly communicated to the client, along with initial supervisory notes available for review online.

b) How often are reports on managed care cases submitted? Please provide a copy of typical medical case management report. Will the managed care personnel be willing to play an active role in our critical claims' management process? If so, in what capacity would they see their role in this process?

Please see Appendix D for a copy of our typical medical case management report.

Our managed care personnel—including Nurse Case Managers—play an active and collaborative role in critical claims management. They work closely with the assigned claims adjuster and the School District's HR or risk management team to coordinate care, monitor treatment effectiveness, and ensure timely medical interventions. Their role includes scheduling independent medical evaluations (IMEs), facilitating return-to-work plans, identifying modified duty opportunities, and providing clinical insight during claim reviews and strategy meetings. This integrated approach ensures that medical management is aligned with the overall claim resolution strategy, helping to reduce claim duration and improve outcomes for injured employees.

c) Please describe the fees associated with your case management.

The fees associated with case management services can vary depending on several factors, including the type of case management and the complexity of the case. Assignments can be made for a task to be accomplished, full telephonic case management or field case management for the most severe claims.

Please see the pricing schedule for medical management services in the pricing proposal.

3.7 PERFORMANCE MEASUREMENT AND EVALUATION:

a) Provide a sample of the reporting utilized. Can the reports be customized?

Reporting Criteria and Schedule

Davies recognizes client reporting criteria and ensures reporting is timely and adheres to proper formatting requirements and schedules. Authorized client personnel can remain current on claim status through review of monthly loss reports and closing notices, as well as online access to adjuster notes through the claims system. Special captioned reports will be provided on a regularly scheduled interval or by special request from the client. Davies complies with reporting thresholds established by the client. The Account Manager maintains a diary to furnish claim reporting to the states, as required. Claim data reports to the regulatory agency on self-insured clients are furnished directly to the state.

Reports

Davies maintains a large library of reports which can be run and delivered on a periodic basis. These reports have been developed to best illustrate claims-handling progress, program trends and performance for our clients. Most commonly, our reports are run and delivered monthly. However, different reports can be run upon request and/or at the frequency you choose — daily, weekly, monthly, quarterly, or annually. We have several different methods of delivery depending on the restrictions of your IT systems.

If we do not have the desired report in our library, we can build a custom report to suit your requirements. We have an Information Services department to support the needs of our staff and our clients. This team not only provides the ability to run standard reports, but to also design your own custom reports to generate the desired data. Once a report is run, it can be output to many formats, including Excel and PDF.

Typical standard reports include loss runs, check registers, and status reports that can be provided upon request or according to an agreed upon schedule. This can include a monthly listing and summary of claims, and information including amounts reserved and paid, and all other information requested by the City.

Our list standard reports provided within the service fee include but are not limited to the following:

- Alpha Claims List: Alphabetical Claims Listing Report
- Loss Report
- Detailed Loss Report
- Detail Loss Run - Total Pages Only
- Detailed Loss Report (Total Pages Only)
- Unit Statistical Report (BSI-17) (for state filing)
- Summary Report by Policy
- Full SIR Specific Excess Received or Anticipated
- Half SIR Specific Excess Received or Anticipated
- Payment Check Register: Check Register
- Location Register: Check Register by Location
- Claim Year Register: Check Register by Claim Year
- Disbursement Report
- Potential Recoveries Report
- Actual Recovery Report: Detailed Listing by Claim Year, all recoveries received

Please see Appendix E for our sample reports and dashboards.

b) Provide a sample of the benchmarking reports with respect to the plan's incurred utilization. Include any additional fees for this service.

Please see Appendix G for a sample of our Stewardship Report.

What are your proposed fees on a full-service basis (e.g., commission, annual consulting fee), including all out of pocket expenses (e.g., benchmarking reports, communication materials, etc.)? Describe how all fees are proposed to be billed, paid and or received.

Please see the pricing envelope for details regarding our fees.

If you have unbundled services, describe the service and the fee or fee basis for each service.

Please see the pricing envelope for details regarding our fees.

Describe all fees/commissions that may be received by your firm with respect to the program's other than those paid directly by Beaufort County School District.

Davies maintains full transparency with our strategic partners and receives no commissions, service fees or other forms of remuneration. We will ensure complete transparency of fees related to our cost containment efforts by providing the District with a Reductions and Services Fees report every month showing the original amounts billed, the schedule amount applied to each billing, the total amounts paid after discounting, network

penetrations, total savings, and the total service fee due to Davies for the bill review service. The report will offer the District a snapshot of monthly savings that resulted from our cost containment services.

Strategy: Describe issues and challenges as you view them, facing Beaufort County School District in the upcoming year and describe how your organization can assist.

Beaufort County School District, like many educational institutions, faces a unique set of challenges in the coming years related to workforce management, budget constraints, and evolving regulatory expectations. Based on our extensive experience working with school boards and public sector clients, Davies has identified several key issues and developed strategies to support the District in navigating them effectively:

Rising Medical and Indemnity Costs

Challenge: Inflation in medical costs and increasing wage rates are driving up the cost of both treatment and indemnity benefits, placing pressure on school district budgets.

How Davies Can Help:

- Leverage our in-house Nurse Case Management (NCM) program to ensure appropriate, cost-effective care and reduce unnecessary treatment.
- Use predictive analytics to identify high-risk claims early and implement proactive interventions.
- Apply aggressive medical bill review and cost containment strategies to control expenses without compromising care quality.

Timely Return-to-Work and Modified Duty Programs

Challenge: Limited availability of modified duty roles in school settings can delay return-to-work timelines, increasing claim duration and costs.

How Davies Can Help:

- Collaborate with HR and school administrators to develop customized return-to-work strategies that align with school operations.
- Utilize vocational rehabilitation and functional capacity evaluations to support safe and timely reintegration into the workforce.

Compliance with South Carolina Workers' Compensation Regulations

Challenge: Ensuring timely and accurate reporting, benefit payments, and documentation in accordance with SCWCC rules is critical to avoid penalties and maintain compliance.

How Davies Can Help:

- Assign licensed adjusters with deep knowledge of South Carolina law and configure our claims system with jurisdiction-specific compliance alerts.
- Provide real-time reporting and audit support to ensure transparency and accountability.

Communication and Engagement with Injured Workers

Challenge: Injured employees may feel disconnected or confused about the claims process, which can lead to dissatisfaction and litigation.

How Davies Can Help:

- Offer access to DaviesConnect, our secure claimant portal, which allows injured workers to view claim updates, communicate with their adjuster or nurse case manager, and upload documents.
- Maintain consistent, empathetic communication to build trust and improve outcomes.

Data-Driven Decision Making

Challenge: School districts need actionable insights to manage risk, allocate resources, and demonstrate program performance.

How Davies Can Help:

- Provide customized Power BI dashboards and analytics tools to track trends, benchmark performance, and support strategic planning.
- Deliver quarterly stewardship reports and participate in regular review meetings to align on goals and outcomes.

Davies is committed to being a strategic partner to Beaufort County School District—not just a claims administrator. Our proactive, flexible, and data-driven approach is designed to help the District reduce costs, improve outcomes, and support the well-being of its employees.

Describe your vision of the transition from the current TPA program to your program. Provide a timeline of transition steps.

Implementation/Transition

Davies' experienced team of Information Systems professionals is extremely adept at navigating the nuances of file transitions and will ensure a smooth transition of Beaufort County School District's claims. To ensure a seamless transition of services, members of Davies Information Services Department and representatives from our administrative and adjusting teams will meet with the district prior to the July 1, 2025 start date to discuss program implementation.

In our initial meetings, Davies will review our best practices with the district and determine a list of client-specific instructions to be incorporated into the management plan for your account. The agreed-upon client instructions will be saved on a shared server so that all adjusters, regardless of which office they work, can access and review them. Your account manager and account supervisor will ensure that your preferred claims-handling practices are followed.

Included below is a sample of our transition plan to ensure that all aspects of your account are addressed and properly migrated to our system. Members of Davies' management team will be involved in all aspects of the transition. This plan can be tailored and revised as needed based on future conversations with the district. We expect that it will take about 45 days (although it can be completed in less time) to coordinate the transfer of the district's program and complete the takeover of claims by July 1, 2025. This sample project timeline outlines the proposed transition beginning June 2, 2025. If the open claims are to be transferred and the current TPA provides preliminary data, the conversion would be completed as early as the third week of July. If they do not, it could take until mid-July to complete. New claims can be set up on day one.

Responsible Parties:

Beaufort County School District	Davies Account Manager
Davies President – WC TPA	Davies Dir. of Operations - TPA WC Services
Davies Sr. Vice President – WC TPA	Davies Claims Teams
Davies Head of IT Claims Solutions	Davies QA Supervisor
Davies Conversion Programmer	Davies Supervisor, Pay Dept.

Responsible	Target Date	Action
Head of IT Claims Sol. Davies Conversion Programmer	6/2/25	Obtain Information from Current TPA to begin Conversion • Data by email • File Layout • Sample Data • Alpha Listing of all open and closed claims • Most recent loss runs Dedicated conversion programmer will be assigned
Davies Conversion Programmer Beaufort County School District	6/4/25	District to review with Davies Information Services changes in codes on prior claims to correct in conversion.
Dir. of Ops Account Manager Beaufort County School District	6/4/25	Obtain the following information from the District: • List of department and location codes, with descriptions • Email instructions for reports • Federal Tax ID Number • Medicare RRE ID • Obtain current excess insurer info from the District Notify CMS that Davies is the new servicing agent
President Sr. VP Dir. of Ops Beaufort County School District	6/9/25	Prepare contract for execution.
President Sr. VP Dir. of Ops Account Manager Beaufort County School District	6/16/25	Meet with District's team to develop detailed claims-handling instructions: • Determine type, frequency and delivery method of reports. • Develop approved vendor network. Obtain department contacts, including address and telephone numbers.
Supervisor, Pay Dept. Beaufort County School District	6/9/25	Establish checking account(s), including: • Finance contact name and number • Bank to be utilized • Account name desired for check stock • Beginning check number Funding amount for bank reconciliation and reimbursements • Check writing restrictions and instructions • Prepare direct deposit arrangements Positive pay setup (if selected)

Account Manager Beaufort County School District	6/23/25	Set up online access for the District including any necessary training for claim system and iFROI.
Dir. of Ops	6/23/25	Contact carriers
Current TPA	6/3/25	For all open tail claims current TPA will: • Provide litigation calendar • Provide alpha list of all open claims • Provide alpha list of claims open for recovery purposes • Ship any physical files to Davies for receipt on 2/28/25
Dir. of Ops Account Manager	7/1-7/31/25	• Review open files. Send informational letter to claimants and attorneys.
Head of IT Claims Sol.	7/7/25	Obtain final loss runs valued as of 6/30/25.
Account Manager	7/1/25	Conference with defense counsel regarding any outstanding legal issues.
Head of IT Claims Sol. Davies Conversion Programmer	7/7/25	Complete data conversion. Convert all document images into Davies' imaging system.
Head of IT Claims Sol.	8/2/25	Run first set of client loss runs as of 7/1/25 and deliver to District via email.
Account Manager Claims Teams Beaufort County School District	9/30/25	Initial file review with adjusting team and the District.

Describe any additional services not outlined under your response to the scope of services that your firm would offer and how these would accomplished.

Actuarial Solutions: Property, casualty, life, and health pricing and product development, reserves analyses, modeling, profitability analyses, rates changes, transaction advisory, and more.

Audit Solutions: Expert and customized Property & Casualty and Accident & Health auditing and TPA services to meet the client's goals.

Underwriting audits: We review of the technical handling of premium, claims and underwriting as well as a comprehensive review of systems and operations. We measure processes against industry trends and standard practice.

Premium Audits: Through each of our service offerings, including traditional (on-site) audits, virtual audits, mail audits, traditional (remote) audits, or verified phone audits, clients receive an easy to navigate audit with robust resources that allow them to quickly mine each audit for detailed data.

Pre-risk inspections: With resources spread across the county, our inspectors are the eyes of the underwriter in the field, delivering imagery, assessments and data of property and liability exposures to help determine the risks worth taking.

Field inspections/Investigations Davies provides a broad range of residential and commercial solutions that allow clients to make accurate and informed underwriting and pricing decisions. We specialize in residential and commercial on-site, self, and drone property inspections. Through a nationwide network of more than 1,000 field representatives, we deliver fast, high-quality reports tailored to your needs by our highly trained customer support team.

Liability Claims Handling

With over >75 years of experience, Davies provides a comprehensive offering for liability management. Our specialized team of adjusters, averages >15 years of experience and handles all liability lines, including General Liability, Product Liability, Professional Liability, Auto/Transportation Liability and Property Liability. We have a proven ability to save customers time and money claims through immediate investigations, enhanced fraud detection systems and virtual claims handling technology. We couple this approach with insightful claims data analysis to provide insurers with sector by sector claims trends and your insured customers with proactive casualty defensibility strategies. Please see below for some quick stats regarding our abilities.

>75 years

of experience

> 13,000

General Liability claims handled each year

> 47,000

Auto Liability claims handled each year

>15 years
average adjuster experience

$28M
claims costs saved

50
states covered

Property Claims Handling

Handling >100,000 claims each year across all 50 states, our dedicated property division contains the range and depth of expertise required to support both daily claims and the most complex property losses. We have a clear understanding of the needs of insurers and the property interests of your insurers, and our experience in all elements from commercial property to cargo ensures we speak the same language.

Our extensive national network is strategically located to focus resource availability in catastrophe prone locations, making us a reliable partner in the face of major events. From desk and field adjusting to fraud detection, our people and systems are geared to support the full range of property claims. Please see below for some quick stats regarding our abilities.

>70
years of property experience

>100k
claims handled each year

>6,000
property field adjusters

>500
desk and TPA adjusters

50
states covered

Auto/Transportation Claims Handling

Davies has over 75 years' experience in all lines of transportation and heavy equipment adjusting and claims solutions, with expertise including auto liability, personal and commercial auto TPA services and auto and heavy equipment appraisals. Davies has more than 500 adjusting staff with extensive experience in transportation and auto claims. Our proficiency in developing and creating TPA programs to the specific needs of our clients, as well as our ability to leverage technological products (both proprietary and non-proprietary), has allowed us to provide an efficient claims process to our client customer base while actively controlling indemnity spend and allocated loss adjustment expenses. We specialize in building fully tailored TPA programs and have standalone divisions that focus on claims solutions for both the Insurtech and Lloyd's markets. Please see below for some quick stats regarding our abilities.

>75
years of experience

>50k
claims handled each year

>500
transportation adjusters (staff)

50
states covered

24/7/365

FNOL

3.8 Performance Location:

After award, all services shall be provided to the location specified by this Solicitation.

We are fully prepared to deliver all required services in accordance with the terms outlined by Beaufort County School District, including any designated physical or virtual locations.

Our designated claims team will be equipped to:

- Communicate and coordinate with District staff through on-site visits, virtual meetings, and secure digital platforms
- Ensure timely delivery of all services, documentation, and reporting to the specified location(s)
- Maintain flexibility to adapt to any location-specific requirements or changes as directed by the District

Davies is committed to seamless implementation and service delivery, ensuring that all expectations related to location, access, and responsiveness are fully met.

4.0.1.5. Firm Information

Firm Information

Firm Name: Davies Claims North America, Inc

Firm Address: 6015 Resource Lane, Lakewood Ranch, FL 34211-0004

Contact information for the Officer of the Firm in charge of this Proposal: Beverly Adkins, President, WC TPA

Contact information for proposed account manager: T: (877) 326 - 5326 x1373 E: beverly.adkins@us.davies-group.com

4.0.1.6. Financial Strength

Safety and Soundness

In August 2021, BC Partners, a leading international investment firm acquired a majority stake in Davies. This new partnership has diversified and strengthened Davies shareholder base, as we seek to drive further global expansion, increase investment in technology and digital transformation and continue to partner with complementary businesses via M&A. Existing investors HGGC and AIMCO continue to hold minority ownership stakes in the business, alongside the Davies leadership team and employees.

Through a combination of organic growth and strategic acquisitions, the firm has increased its annual proforma revenues ten-fold over the last 6-years, to more than $1 billion across the group enterprise (as per our last financial year-end of Jun24). Our financial statements can be found in Appendix XX.

Financial Statements

Please see Appendix F for a copy of our most recent annual financial report.

4.0.1.7. Account Servicing

References

[redacted]

Competitive Position and Future Commitment

Flexible and Proactive Approach

Our designated approach, with adjusters exclusively assigned to the account, handling claims from initial notice through resolution, results in our adjusters being fully invested in the success of your program. Adjusters are trained in and measured against best practice benchmarks to quickly address any areas of improvement for immediate resolution and coaching. All best practice processes dictate proactive return-to-work strategies,

including prompt initial and ongoing communication, assuring appropriate medical care is received, frequent follow up, thorough investigations, maintaining detailed diaries and assertive action plans, and ensuring high employee satisfaction. Reports that show current outcomes and trends over time can be readily run for data tracked in the system, including closing ratios, lag time, claim duration, as well as costs and savings.

Our claims-handling philosophy is one of close supervision and attention to detail. Customer satisfaction is key to our success and supports our 96% retention of self-insured clients in the last five years. We believe our industry success is due to our flexibility in structuring each program to mirror our clients' claims-handling philosophies and financial objectives. We continually tailor our services as our clients' needs evolve. Davies management team also maintains close involvement with every client, ensuring the quality and responsiveness of our customer service.

The considerable industry expertise that our staff has accumulated over the years gives Davies a key advantage in influencing claim outcomes. We are exceedingly thorough in our investigative efforts and reviews of injuries. We aggressively pursue subrogation recoveries that will help bring money back to your program. We are proven negotiators and dedicated litigation managers who are devoted to saving our clients' money. We believe that attention to even the smallest of claim details can lead to major overall improvements in claim outcomes.

In-House Resources

As our proposal illustrates, Davies expertise administering workers' compensation TPA programs is unparalleled — but unlike some TPAs, all key services are provided in-house by highly qualified and duly licensed Davies employees. The considerable industry expertise that our staff has accumulated gives us a major advantage in influencing claim outcomes. We are exceedingly thorough in our investigative efforts and reviews of losses, we aggressively pursue subrogation recoveries that will help bring money back to your program, and we are proven negotiators and litigation managers who are devoted to saving you money. We believe that attention to even the smallest claim details can lead to major overall improvements in claims outcomes.

- All key components of the program are offered in-house by Davies employees.
- Our state-of-the-art electronic claims system provides all the tools, accessibility, flexibility and ease of use needed to successfully manage claims for the County. Document images are available for your review 24/7. Client note input allows for documentation and communication. Power BI reporting capabilities provide both standard reports and our query tool allows for report customization.
- Our Information Services department and Help Desk are available to answer questions and assist the County with any IT needs at no extra charge.
- Our in-house cost containment/bill review department enables us to offer our clients state-of-the-art cost containment programs at competitive rates.
- Medical management program is staffed by experienced registered nurses who provide clinically informed oversight, ensuring optimal care coordination, early intervention, and improved outcomes for injured workers.

Innovation

Davies pursues innovation that reduces costs through both process efficiency and smarter claims management. Our investment in cutting-edge technology is unrivaled in today's global claims market. With a dedicated technology division, in-house software developers, and data scientists, we are pioneers in leveraging automation, analytics, and AI to enhance every stage of the claims lifecycle.

A key differentiator is our use of predictive analytics to identify potentially complex or high-cost claims early in the process. These insights empower our adjusters to take proactive, rather than reactive, steps—such as initiating early intervention strategies, engaging Nurse Case Management, or escalating investigations—before issues escalate. This approach not only improves outcomes but also supports the accurate setting of reserves earlier in the claim, which is critical for financial planning and transparency.

Our full technology stack, developed in partnership with Davies' global team of over 700 consulting and technology professionals (including 200+ developers), includes automation of routine tasks so our adjusters can focus on high-value activities. We continually assess and refine our use of AI and automation to support—not to replace the human expertise, empathy, and judgment that are essential to successful claims resolution.

To enhance the experience of injured workers, we offer **DaviesConnect**, a secure, user-friendly portal that allows claimants to:

- Access key claim information
- Communicate directly with their assigned adjuster or nurse case manager
- Receive updates and upload documentation
- Ask questions and get timely responses

This transparency and accessibility help build trust, reduce confusion, and improve satisfaction throughout the recovery process.

Innovative Priorities

Davies continue to expand our capabilities. Key developmental priorities in progress include:

- We will continue to expand our Power BI dashboards to present greater benchmarking between our programs and industry standards.
- AI and machine learning will continue to play a significant role in claims processing, fraud detection, risk assessment, and automation of various tasks for the next decade. Davies will rely on these technologies to analyze data, improve decision-making, and enhance operational efficiency. Davies is already embracing AI and machine learning tools to automate routine tasks, such as claims triage and low value tasks while investing in training staff to work alongside AI systems effectively. We will also more broadly use machine learning in our back-end systems to accelerate processing, reduce fraud and improve experience.
- Davies will continue to partner with data analytics SMEs to leverage predictive modeling techniques effectively, further integrating analytics tools into claims management systems to enhance decision-making, identify fraud patterns, and allocate resources more efficiently while establishing feedback loops to validate model accuracy and refine predictive algorithms based on real-world claims data.
- Further expanding our API data feeds for items such as indemnity payments, return to work and impairment ratings to our PBM and PT network will continue to be implemented to offer even better treatment plans and claim outcomes.
- Expanded process automation will be used to improve employee engagement and top talent retention through proactive skill development, removal of administrative tasks and creating a culture of progress for both our employees and clients. We are further refining our straight-through processing procedures and automation of more routine claims to increase productivity and better identify which claims would benefit from a nurse case manager, cost containment reviews, and subrogation opportunities.
- Davies Global Solutions has a large team focused on designing intuitive self-service portals and mobile apps that simplify claims reporting, tracking, and communication with customers. They are implementing chatbots and virtual assistants to provide instant support and personalize interactions with policyholders throughout the claims process while gathering feedback from customers to identify pain points and areas for improvement in the digital claims experience and iterate based on user input.
- Davies continues to stay abreast of evolving data privacy regulations and compliance requirements to ensure adherence to industry standards. We have invested material resources into creating robust cybersecurity measures, including encryption, intrusion detection systems, and regular security audits while also educating employees about the importance of data security and implementing protocols for handling sensitive customer information securely.

What sets Davies apart:

As outlined above, Davies stands apart from other TPAs through our fully integrated, in-house service model, our flexible and proactive claims philosophy, and our unmatched investment in innovation and technology. Unlike many competitors who outsource key functions, Davies delivers all core services—including Nurse Case Management, Medical Bill Review, Subrogation, and Litigation Management—through highly qualified, licensed in-house professionals, ensuring consistency, accountability, and superior outcomes.

We bring extensive experience working with school boards and public sector clients, including long-standing partnerships with multiple school districts across the Southeast. We understand the unique challenges educational institutions face—such as managing claims involving school staff, navigating seasonal employment, and maintaining continuity of care—and we tailor our programs to meet those specific needs. Our team is well-versed in the regulatory and operational nuances of school systems, ensuring a smooth and compliant claims process.

Security and Disaster Recovery

Disaster Recovery Plan (DR)

We have a documentation Disaster Recovery (DR) plan and processes in place. As such, we can ensure that in the event of a disaster that affects our primary claims offices, we will resume services to Subaru. Our DR includes provisions for protection against natural disasters, malicious attacks, accidents, and malware (e.g., ransomware).

Per our Disaster Recovery Plans, our claims system maintains an audit trail of all financial transactions and key non-financial transactions. All data is backed up during the day and verified nightly. Because data is backed up periodically during the day to storage sites in multiple locations, if a catastrophe occurs at one of those locations, duplicate data can be retrieved from the other. The system administrator uses a two-week rotation, saves the monthly tapes for six months, and creates a permanent saving annually. Our backup tapes are safely stored off-site. We have tech support in a place that is available to provide replacement hardware for servers, computers, and phone systems. Temporary servers can also be provided if existing ones are inoperable.

Attempted intrusions, including denial of service attacks, would be escalated, investigated, and resolved according to the company's Security Incident Management procedures as well as local and global incident management and escalation procedures. In the event of a security incident, the Information Security Officer would be notified. Depending on the severity of the event and if client data has been affected, the IT Security Committee and head of affected business areas would be informed. The information security team would work to contain the incident to prevent further damage and begin necessary investigative steps to perform root cause analysis. Corrective actions would be conveyed to the necessary team members to perform mitigation steps to eliminate the cause of the incident. All incidents are recorded and reviewed on a quarterly basis by the information security team to learn from past incidents and create effective countermeasures to better protect company information and assets.

Please see Appendix C for our Disaster Recovery Plans.

Implementation

Implementation/Transition

Davies' experienced team of Information Systems professionals is extremely adept at navigating the nuances of file transitions and will ensure a smooth transition of Beaufort County School District's claims. To ensure a seamless transition of services, members of Davies Information Services Department and representatives from our administrative and adjusting teams will meet with the district prior to the July 1, 2025 start date to discuss program implementation.

In our initial meetings, Davies will review our best practices with the district and determine a list of client-specific instructions to be incorporated into the management plan for your account. The agreed-upon client instructions will be saved on a shared server so that all adjusters, regardless of which office they work, can access and review them. Your account manager and account supervisor will ensure that your preferred claims-handling practices are followed.

Included below is a sample of our transition plan to ensure that all aspects of your account are addressed and properly migrated to our system. Members of Davies' management team will be involved in all aspects of the transition. This plan can be tailored and revised as needed based on future conversations with the district. We expect that it will take about 45 days (although it can be completed in less time) to coordinate the transfer of the district's program and complete the takeover of claims by July 1, 2025. This sample project timeline outlines the proposed transition beginning June 2, 2025. If the open claims are to be transferred and the current TPA provides preliminary data, the conversion would be completed as early as the third week of July. If they do not, it could take until mid-July to complete. New claims can be set up on day one.

Responsible Parties:

Beaufort County School District	Davies Account Manager
Davies President – WC TPA	Davies Dir. of Operations - TPA WC Services
Davies Sr. Vice President – WC TPA	Davies Claims Teams
Davies Head of IT Claims Solutions	Davies QA Supervisor
Davies Conversion Programmer	Davies Supervisor, Pay Dept.

Responsible	Target Date	Action
Head of IT Claims Sol. Davies Conversion Programmer	6/2/25	Obtain Information from Current TPA to begin Conversion • Data by email • File Layout • Sample Data • Alpha Listing of all open and closed claims • Most recent loss runs Dedicated conversion programmer will be assigned
Davies Conversion Programmer Beaufort County School District	6/4/25	District to review with Davies Information Services changes in codes on prior claims to correct in conversion.
Dir. of Ops Account Manager Beaufort County School District	6/4/25	Obtain the following information from the District: • List of department and location codes, with descriptions • Email instructions for reports • Federal Tax ID Number • Medicare RRE ID • Obtain current excess insurer info from the District

		Notify CMS that Davies is the new servicing agent
President Sr. VP Dir. of Ops Beaufort County School District	6/9/25	Prepare contract for execution.
President Sr. VP Dir. of Ops Account Manager Beaufort County School District	6/16/25	Meet with District's team to develop detailed claims-handling instructions: • Determine type, frequency and delivery method of reports. • Develop approved vendor network. Obtain department contacts, including address and telephone numbers.
Supervisor, Pay Dept. Beaufort County School District	6/9/25	Establish checking account(s), including: • Finance contact name and number • Bank to be utilized • Account name desired for check stock • Beginning check number Funding amount for bank reconciliation and reimbursements • Check writing restrictions and instructions • Prepare direct deposit arrangements Positive pay setup (if selected)
Account Manager Beaufort County School District	6/23/25	Set up online access for the District including any necessary training for claim system and iFROI.
Dir. of Ops	6/23/25	Contact carriers
Current TPA	6/3/25	For all open tail claims current TPA will: • Provide litigation calendar • Provide alpha list of all open claims • Provide alpha list of claims open for recovery purposes • Ship any physical files to Davies for receipt on 2/28/25
Dir. of Ops Account Manager	7/1-7/31/25	• Review open files. Send informational letter to claimants and attorneys.
Head of IT Claims Sol.	7/7/25	Obtain final loss runs valued as of 6/30/25.
Account Manager	7/1/25	Conference with defense counsel regarding any outstanding legal issues.
Head of IT Claims Sol.	7/7/25	Complete data conversion. Convert all document images into Davies' imaging system.

Davies Conversion Programmer		
Head of IT Claims Sol.	8/2/25	Run first set of client loss runs as of 7/1/25 and deliver to District via email.
Account Manager Claims Teams Beaufort County School District	9/30/25	Initial file review with adjusting team and the District.

4.0.1.8. Section 9.0 - Attachments to this Solicitation

Section 9.0 - Attachments to this Solicitation

M/WBE Compliance

Davies recognizes the importance of utilizing Diverse Businesses, including MBE/WBE/DSBE vendors. Although Davies is not registered as a minority-, woman-, or disabled-owned business or as a disadvantaged business, we firmly believe that maximum utilization of MBEs/WBEs/DSBEs is an essential goal in our program. Our Company recognizes that tremendous efforts must be made by everyone to overcome the long-standing pattern of discrimination in the marketplace and in employment.

We are building our files from all known sources, as well as through informal personal referrals, and will continue to actively seek out new sources. We have and will continue to use qualified MBE/WBE/DSBE sub-consultants and vendors whenever feasible, including EZ Comp Care, Inc. (dental) and TransComm Solutions (transportation/translation) for the Beaufort County School District's program.

Davies will continue to pursue, identify and utilize certified MBE/WBE/DSBE vendors whenever feasible.

Business Utilization Report

In order to facilitate an effective monitoring system, each contractor, bidder or offeror must submit a completed and signed Utilization Report with the bid submission which lists the names, addresses and contact persons of the M/WBE and majority owned businesses, if any, to be used in the contract, the type of work each business will perform, the dollar value of the work and the scope of work. The Utilization Report submitted by the contractor shall be submitted as a part of the contract with BCSD. If the information contained in the Contractor's Utilization Report changes by the time the contract is executed, the Contractor shall amend the Utilization Report and such amended Utilization Report shall be incorporated into the contract.

Business Enterprise Utilization Report

List all vendors/subcontractors to be used on this project. All MBEs or WBEs proposed for utilization on this project must be certified by the Small and Minority Business Assistance Office through the State of South Carolina according to the criteria of the Beaufort County School District's Minority Business Enterprise Plan prior to utilization on this project.

In column 2 below, please specify ethnic/racial/gender group as follows:

- AABE – African American Business Enterprise
- HBE – Hispanic Business Enterprise
- ABE – Asian-American Business Enterprise
- WBE – Woman Business Enterprise

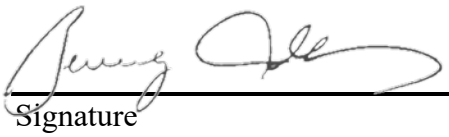
Sub-Contractor Name	Gender Group	Address	Phone #	Other	E-Mail
EZ Comp Care, Inc	WBE	PO Box 6787, Brandon, FL 33508	[redacted]	See below	[redacted]
TransCom Solutions	WBE	PO Box 2998, Riverview, FL 33568	[redacted]	See below	[redacted]

EZ Comp Care, Inc provides management and oversight of simple to complex worker's compensation dental claims

TransCom Solutions provides nationwide transportation, language, and concierge services for injured workers

Statement of Intent

We, the undersigned, have prepared and submitted all the documents required for this project. We have prepared these documents with a full understanding of the Beaufort County School District's goal to ensure equal opportunities in the proposed work to be undertaken in performance of this project. Specifically, the BCSD seeks to encourage and promote on an inclusionary basis contracting opportunities without regard to the race, gender, national origin or ethnicity of the ownership or management of any business and that it is an equal opportunity employer and contracting entity. We certify that the representations contained in the Minority/Woman Business Enterprise (M/WBE) Utilization Report, which we have submitted with this solicitation, are true and correct as of this date. We commit to undertake this contract with the Minority/Woman Business Utilization Report we have submitted, and to comply with all non-discrimination provisions of the Minority/Woman Business Enterprise Program in the performance of this contract.



Signature

5/22/25

Date

Name: Beverly Adkins

Title: President, WC TPA

Project: Worker's Compensation Claims Administration Services

4.0.1.9. All objections, exceptions and observations regarding the specified Services and requirements collated in a separate document with regards to specific Section to which the offeror objects, takes exception(s), or provide(s) observation

4.0.1.9. All objections, exceptions and observations regarding the specified Services and requirements collated in a separate document with regards to specific Section to which the offeror objects, takes exception(s), or provide(s) observation

We respectfully request consideration of a minor revision to Section 7.1.5, specifically item (i), for clarity and alignment with industry practices. The current language reads:

> *'The District reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insure, coverage, or other special circumstances.'*

We propose the following revision:

> *'The District reserves the right to modify these requirements, including limits* ***to the extent commercially possible****, based on the nature of the risk, prior experience, insure, coverage, or other special circumstances.'*

Appendix A – WC Claim Summary Report

Davies

Appendix C – Disaster Recovery

Davies

Appendix D – Sample Medical Case Management Report

Davies

SAMPLE REPORT

Medical Management

Outcomes Report

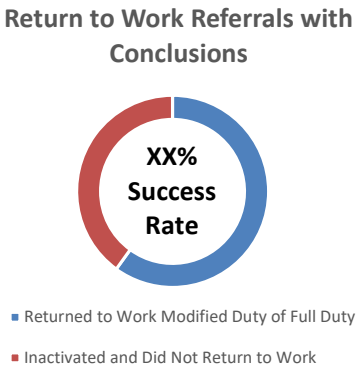
Reporting Period

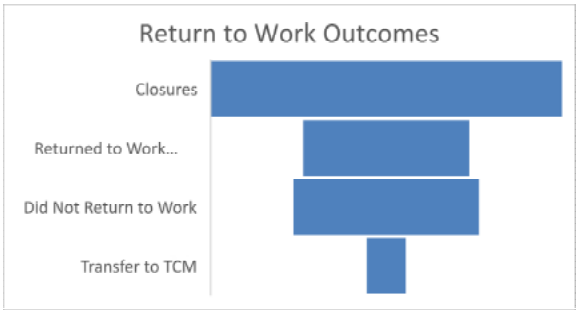
Claims Count

There was a total of **(XXX)** new telephonic case management (TCM) referrals. There was a total of **(XXX)** claims closed during the same time period. Your total number of open claims currently under TCM management is **(XXX)**. There are **(XXX)** RX transactions during the period and a total of **(60)** Rapid Response referrals that were transferred to a TCM.

Return to Work

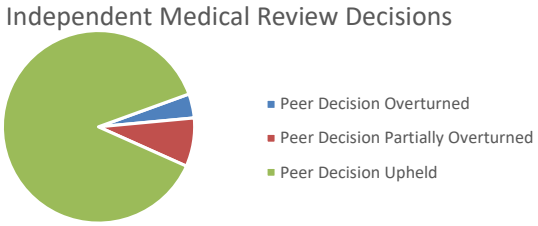
There were **(XXX)** new early return to work referrals and **(XXX)** closed during this period. The current caseload is **(XXX).** There was a total cost savings of **$XXX**.





Utilization Review

There was a total of **(XXX)** medical procedures that were reviewed. Of those **(XXX)** procedures reviewed, **(XXX)** were pre-certified, and **(XXX)** surgical pre-certification procedures were reviewed and were escalated to 2nd level review. This level of review includes a peer physician opinion. Of the **(XXX)** that were escalated to 2nd level, **(XXX)** procedures were certified, **(XXX)** were modified, and **(XXX)** were non-certified. There were **(XXX)** appeal filed related to Utilization Review activity; **(XXX)** were upheld and **(XXX)** were overturned. There was a total of **(XXX)** IMR reviews completed with **(XXX)** of those being upheld, **(XXX)** were partially overturned and **(XXX)** were overturned.



There was a total cost savings offered from the Utilization Review Department of **$XXX,XXX**.

The average turnaround time from date received is **XX** days.

There were **(XXX)** files reviewed with an average compliance of **XXX%**

These audits were composed of 4 different criteria related to the medical management of the file. The criteria included:

- ◊ California DWC (state) requirements
- ◊ Timeframes for all reviews
- ◊ URAC compliance
- ◊ Dispute resolution process; internal appeal and telephone conference

Case Management Quality Assurance

Thirty (30) day QA audits results were as follows:

XX files completed with an average compliance of **XXX%**

These audits were composed of 14 different criteria related to the medical management of the file. The criteria included:

- ◊ PTP is Network Physician
- ◊ LOV Identified
- ◊ Current W/S Documented
- ◊ Projected MMI documented
- ◊ Guidelines/Red Flags
- ◊ Current Medications
- ◊ Practice Parameters
- ◊ NOV Identified
- ◊ RTW Addressed
- ◊ TCM Plan for next 30 days
- ◊ Notification to Adjuster
- ◊ Concern Regarding Medication Regimen
- ◊ Case Notes addressing and relevant to stated injury
- ◊ Diaries are timely and pertinent

These consistent results represent the continued attention to detail and dedication we have for the employees and business.

Head Injury Initiative

There was a total of **(XX)** head injuries where a telephonic case manager will be instrumentally involved.

Return on Investment

Submitted Medical Charges: **$XXXXXXXXXX**

Fee Schedule Reduction	
PPO Savings	
Professional Savings	
Utilization Review	
Return to Work	
Total Savings:	
Total Fees:	
ROI:	

Without Fee Schedule

PPO Savings	
Professional Savings	
Utilization Review	
Return to Work	
Total Savings:	
Total Fees:	
ROI:	

As you can see, we are providing an excellent Return on Investment. You can see during this period that our savings provide **no less than XXXX** times in savings.

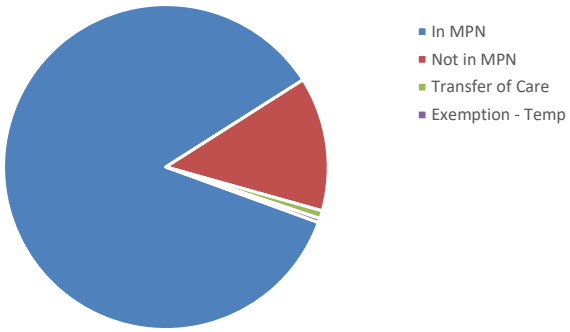
We are pleased to be able to report these extraordinary savings to you this quarter.

Bill Review and Savings

There was a total of **XXXX** bills processed. The review activity of those bills produced savings and they are as follows:

Fee Schedule Reduction	$
PPO Savings	$
Professional Savings	$

MPN Penetration

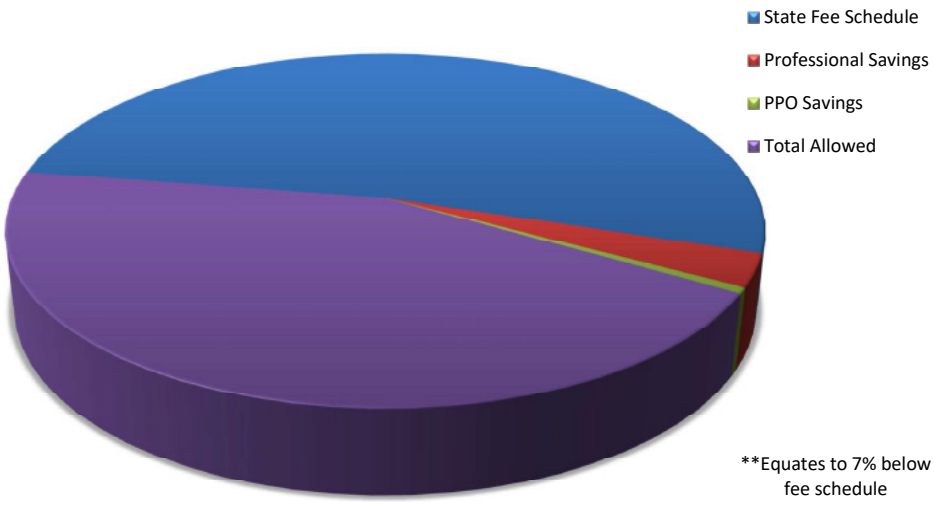


Savings Report

DESCRIPTION		
	PROVIDER BILLS	%
Total Charges Submitted		
Savings:		
State Fee Schedule		
Professional Savings		
PPO Savings		
Total Savings		
Total Allowed		

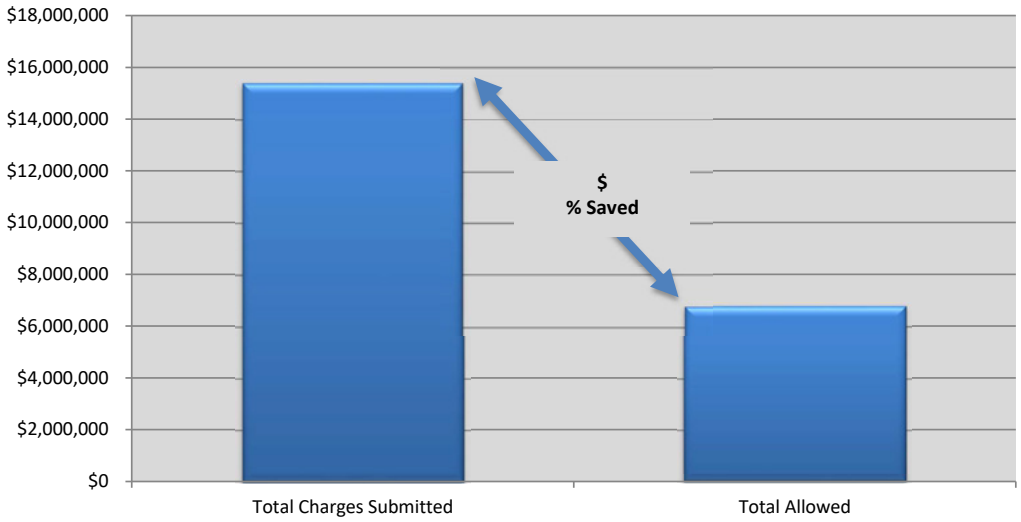
% Below Fee Schedule

TOTAL SAVINGS BREAKDOWN



**Equates to 7% below fee schedule

SAVINGS


$18,000,000
$16,000,000
$14,000,000
$12,000,000
$10,000,000
$8,000,000
$6,000,000
$4,000,000
$2,000,000
$0
$
% Saved
Total Charges Submitted
Total Allowed

Appendix E – Sample Reports and Dashboards

Davies

Appendix F – Financial Statements

Davies